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Verbeek, Linda (2016) Therapists who self-identify as being 'recovered': experiences working with body image disturbance and eating disorders. DProf thesis, Middlesex University / Metanoia Institute.

Final accepted version (with author's formatting)

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Therapists Who Self-Identify as Being 'Recovered': Experiences Working with Body Image Disturbance and Eating Disorders

Linda Verbeek

A joint programme of Middlesex University and Metanoia Institute.

Submitted in partial fulfilment of the requirements for the degree of Doctorate in Counselling Psychology and Psychotherapy by Professional Studies (DCPsych).

2016

DEDICATION

I dedicate this to my husband Dean. Thank you for being my rock and for filling my life with meaning. Your unwavering patience, love and encouragement throughout this entire doctoral process has enabled its fulfilment to be possible.

ACKNOWLEDGEMENTS

I am grateful to my loving parents and siblings for believing in me, encouraging me to pursue my goals and for supporting me with this very lengthy project.

Many thanks also go to my dearest friends, old and new, for providing me with balance, joy and humour along the way which I've needed to keep going with this pursuit.

I extend my deepest appreciation to my research supervisor, Dr. Patricia Moran whom I am grateful to for your investment in my work through your knowledge, advice, revisions and constructive feedback which have helped in shaping my research project.

I would also like to acknowledge the support of Dr. Janet Dutton for your knowledge, kindness and helpful consultation in guiding me with the initial creation, proposal and ethics approval of this project. Furthermore, my tutors, clinical supervisor and fellow trainees who have travelled this doctoral journey with me, I thank you for continuing to inspire, mentor and encourage me.

Lastly, my sincere gratitude goes to the participants who made this project possible by generously sharing their stories and experiences with me.

ABSTRACT

Female therapists who have recovered from past body image disturbance or an eating disorder are often drawn to working with others suffering with these problems. They may have a lot to offer in their work by having important insight into the healing process; however this client group may evoke various emotional and embodied feelings in the therapist, particularly in relation to body image, food and weight. By using an Interpretative Phenomenological Analysis method of qualitative enquiry, a sample of nine recovered female therapists was interviewed to explore the subjective experience and management of feelings and countertransference reactions that emerged with clients struggling with eating disorders and/or body image disturbance; as well as the self-support strategies they use alongside their work.

Through an analysis and interpretation of the data, three master themes emerged: firstly, 'Understanding the Struggle: A Shared Experience' capturing the therapist's personal understanding of the struggle; secondly, 'Becoming Entangled: Old Feelings Resurfacing' conveying the negative consequences for the recovered therapist when their own wounds became entangled with those of the client; and thirdly, 'Self-Support Strategies: A Life-Long Healing Process' which includes effective methods used by participants.

The implications for practice include: the importance of recovered professionals nurturing their reflexive capacity to continually process and manage their subjective experiences and countertransference responses which are evoked in their work; the need for training courses to place greater emphasis on personal therapy as a course requirement, and the educating of trainees on the management of embodied experience in the therapy room, particularly when working with body issues; the importance of therapists having explored their issues in personal therapy, and being 'recovered enough' before working with an eating disorder or body image disturbance client group; the importance of regular supervision for support and reflection; and lastly the maintaining of recovery and wellbeing through 'bio-psycho-social' self-support strategies.

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1. INTRODUCTION

Body image is viewed as a multidimensional concept which includes perceptual, attitudinal and affective components; therefore a disturbance in an individual's body image may have an adverse impact on their quality of life and psychological wellbeing (Striegel-Moore & Franko, 2004). According to psychodynamic theories, for both men and women, a person's earliest experience of the self, and the relation of self to others, is rooted in one's physical body through preverbal experiences of loss and trauma, love, attachment, abandonment, and betrayal. Thus, one's sense of self appears to be inextricably intertwined with the body in both intrapsychic and interpersonal arenas.

The body image literature also indicates that body image concerns occur more often in females than males, regardless of age (Murnen, 2012). A socio-cultural explanation of this gender difference in Western society (particularly in relation to weight concern) suggests three causal factors: stigma related to obesity; idealisation of thinness in females; and the core role that physical attractiveness plays in ideas of femininity (Striegel-Moore & Franko, 2004). Thus many women may feel dissatisfied with their bodies, particularly body size, weight and a desire to be thinner, to the extent that "*weight has been aptly described as a 'normative discontent' for women"* (Tiggemann, 2012, p.12)*.

Current feminist theory stresses that this normative body dissatisfaction seen in many women is a systemic social phenomenon rather than a function of individual pathology (McKinley, 2012). Therefore, the current cultural view in Western society, of the woman's body as an object to be watched and evaluated, and the exploitation of the female form to sell and seduce, may also exacerbate the internalised self-critical views that women have of themselves, complicating efforts to improve negative body image (Bordo, 1993; McKinley, 2012). Women (both therapists and clients) have a shared culture as they are exposed to socially-constructed notions about female attractiveness and goodness (Burka,

1996) and unachievable standards of perfection and slimness (Ruskay-Rabinor, 1995). Furthermore, women are often judged more critically when they show signs of aging, and they many feel a social pressure to maintain a youthful appearance as they age, thus sometimes resorting to plastic surgery to try achieve this (Grogan, 2012). The acceptance and internalisation of this complex cultural schema, that beauty, appearance and the slender ideal are vital to happiness, success and desirability, may create a core basis of self-evaluation, with the individual's self-worth being equated with their self-perceived attractiveness (Tiggemann, 2004). This often leads to dieting and other unhealthy attempts to pursue the slender, youthful ideal, ultimately resulting in the development of body image problems and disordered eating symptoms (Tiggemann, 2012).

A woman's body image may also be impacted during the reproductive phase of pregnancy and early postpartum which comprises rapid physical, psychological and hormonal changes for women over a relatively short (40-week) period. Thus the changes to a woman's body from pregnancy-related physical symptoms (e.g. nausea, backache, weight gain, stretch marks, varicose veins, acne, swollen ankles and feet) may result in the individual re-evaluating their body image as their size and body shape changes, resulting in a greater vulnerability for body image dissatisfaction. This may often be associated with negative psychological functioning such as depression, and maladaptive behaviours such as disordered eating and attempts at extreme, rapid weight loss (Skouteris, 2012).

Body image difficulties may manifest in different ways for individuals as a result of both the internalisation of these slender beauty ideals and the perceived pressures to be thin (Levine & Smolak, 2004). Some examples include body dissatisfaction and shame; body comparisons; self-monitoring; affective distress about appearance; difficult relationships with food and eating; and negative perceptual distortions of body size and shape. If these go unchecked, they may

potentially lead to the development of more serious eating disorders or body dysmorphic disorder (Cash & Pruzinsky, 2004).

1.1 Working with Body Image Issues

Contemporary psychoanalytic theory recognises that the therapist is not a 'blank screen' and that particular aspects of the therapist's unique personality, theoretical stance, and style of intervention, can influence, limit or facilitate the client's development. Therefore the therapist's body will also play a significant role in their unique contribution to the process of therapy (Burka, 1996), as the way in which the therapist experiences their body and is able to express this experience, has been thought to significantly impact the treatment process (Ruskay-Rabinor, 1995).

Female therapists who have a past history of body image disturbance or an eating disorder may often be drawn to working in the mental health field in the hope of supporting others in overcoming these often painful and challenging problems. The recovered therapist understands these issues on a personal level, and therefore may have a lot to offer in her work with this client group by having important insight into the healing process (Bowlby, Anderson, Hall & Willingham, 2012; Costin & Johnson, 2002). Therefore the issue is not so much that therapists have struggled at times in their lives, but rather how they have transformed their trauma and distress into something meaningful for themselves through working as therapists (Adams, 2014). In this regard Gerson (1996, p.xv) proposes that:

> *Crises of all kinds -past, present, and ongoing- heighten the often silent background influence of therapists' lives and personalities on interactions with patients and thus can provide a new perspective on how interactions may operate. In addition, crises may deepen one's views and reactions to the central dilemmas of therapy and life, such as freedom, responsibility,*

will, courage, choice, or limitation. As a result, new patterns of feeling and thinking may appear in the intimate work with patients, providing new leverage for movement for both patient and therapist.

Research has shown that approximately 30% of professionals working in the eating disorder field have recovered from an eating disorder (Barbarich, 2002; Bloomgarden, Gerstein & Moss, 2003; Johnston, Smethurst & Gowers, 2005), however upon a review of the current literature there is very little research available on the experiences of these professionals working in this field.

This challenging client group may evoke various emotional and embodied feelings or countertransference reactions in the therapist, particularly in relation to body image, food and weight (Delucia-Waack, 1999; Costin, 2009); and therapists may hold a silent fear that to be effective in their client work, a resolution of their body image issues must occur, otherwise the role of them as healer feels fraudulent (Ruskay-Rabinor, 1995). Furthermore, therapists may feel personal shame about revealing their vulnerabilities after qualifying, particularly if life becomes challenging or past traumas are evoked in the therapy room with clients. To illustrate this conflict, Adams (2014, p.140) states facetiously:

If we cannot keep ourselves psychologically healthy, how can we promote the psychological health of others? The best means of dealing with this may be to simply deny that we need help, cling to our narcissistic raft and hope that we can endure until the storm passes.

This denial of 'needing help' and retreating behind a professional mask is perhaps underpinned by a deep fear for some therapists that if they are not 'above' their clients, they are not worthy of working with them. This may potentially risk further harm for the therapist and their client, and perpetuates the 'myth' of the untroubled therapist (Adams, 2014). Thus it is essential that as 'wounded healers' (Larisey, 2012) looking after the psychological wellbeing of

others, that therapists should engage in their own process of self-reflection; and the literature emphasises the importance of supervision for therapists working in the body image and eating disorder field amongst other support strategies (Delucia-Waack, 1999; Schwimmer, 2010; Warren, Crowley, Olivardia & Schoen, 2009, 2013; Warren, Schafer, Crowley & Olivardia, 2012).

My rationale for conducting this research is to investigate how the recovered female therapist is impacted professionally and personally when working with body image issues and eating disorders. Furthermore, this study explores the implicit embodied relational exchange between female therapist and female client who both have a heightened awareness of their own body image issues. Initially in this study, I set out to explore the phenomenon of body image in the context of the therapeutic encounter, but as I immersed myself deeper into the project I realised that for the female therapists I interviewed, this was so highly connected to weight dissatisfaction, relationships with food, and eating disorders; and this became a significant part of the work. The wider implication is that for so many women, including the participants in this study, body image is so often strongly tied to weight, body shape and eating issues.

1.2 Purpose of the Research

By using an Interpretative Phenomenological Analysis method of qualitative enquiry, this research seeks to explore what happens in the therapeutic process when a female therapist and client have experienced similar body image issues. The study will investigate the therapist's subjective emotional and embodied feelings that are evoked in their work with eating disorders and body image disturbance. Those from a more analytic background may understand this experience in some instances as '*countertransference*'; therefore to be inclusive of all therapeutic modalities in exploring, understanding and discussing this phenomenon, I have used terms throughout the study such as '*emotional and embodied feelings*' or '*subjective feelings and experiences'*, as well as

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'*countertransference*' where appropriate. This study will also explore how these professionals manage the feelings that are evoked for them in the therapy room, as well as the self-support strategies they use alongside their work. For the purpose of this study I have focused on female therapists who identify as being 'recovered' from past body image and eating issues, due to the higher proportion of females that tend to suffer from body image problems and eating disorders in the general population (Barbarich, 2002; McKinley, 2004). Furthermore, female therapists may also identify more with their client's experiences of embodiment, as they grow up with similar socio-cultural messages and pressures about weight and physical appearance (Costin, 2009; Ruskay-Rabinor, 1995).

1.3 Significance of the Issue and Contribution to the field of Counselling Psychology and Psychotherapy

A review of the literature when proposing this study indicated that very little had been written about the experiences of recovered female therapists in their work with clients struggling with body image disturbance and eating disorders. Thus further research in this area is both important and necessary in order to increase the knowledge-base for recovered therapists choosing to work in this field, and to increase the attention given to these issues in training and supervision.

This research topic is therefore relevant to society's apparent obsession with appearance and body image; and more specifically to psychotherapy training and practice, as ongoing self-development and supervision is of great importance so that therapists are aware of their blind-spots and vulnerabilities, and how this may impact their clinical work. The qualitative findings from this study may therefore make a wider contribution to the literature about notions of the therapist's recovery, self awareness and reflexivity; as well as understanding the subjective feelings and countertransference responses that may be evoked when working with body issues. The findings also seek to demonstrate effective ways in which these experiences may be managed in the therapy room, and aim to highlight various self-support mechanisms for therapists to use alongside their

work. Based on the findings, recommendations are made for clinical practice and training as guidelines for recovered therapists working in the eating disorder and body image field.

1.4 Locating Myself in this Topic

This area of enquiry has personal relevance for me from my own past, and has led to my interest in this subject and journey in training to become a psychological therapist. During my studies, one of the challenges I've faced in my client work has been to manage my personal embodied experience when working with body image concerns. This led to my interest in exploring how other female therapists might manage the same issue, both therapeutically with their clients and outside of the therapy room in terms of self-support strategies. As this is a personal issue I was mindful of the potential risks to myself as a researcher (i.e. over-identifying with participants; feelings about my personal history being evoked), thus I have taken care to ensure that I received adequate support in supervision and personal therapy.

I have also taken measures to ensure the trustworthiness of the data collection and analysis as I'm aware of bringing my own subjective stance to this endeavour. For instance I kept a reflexive journal of the developments and inquiry process of the study, and was assisted during the data analysis process by a doctoral peer and my research supervisor in reviewing the stages of my coding against the raw transcribed data. I have included some thoughts from my reflexive journal in the findings and discussion sections to share my critical reflexivity and personal experience of conducting this research process with the reader.

2. LITERATURE REVIEW

In this chapter I will provide a review of the literature related to the topic of recovered professionals working with body image disturbance and eating disorders.

2.1 What is Body Image?

In seeking a broad definition of body image, the Oxford dictionary describes this as: "*the subjective picture or mental image of one's own body*" (Oxford Dictionaries, 2015). However, to expand on the complexity of this construct, an overview of the various conceptualisations in the clinical literature indicates that body image is seen generally as a 'multidimensional' phenomenon. For example, Cash and Smolak (2012) describe body image as a multifaceted psychological experience of embodiment which has a profound influence on the quality of human life: "*More than a mental picture of what you look like, your body image consists of your personal relationship with your body –encompassing your perceptions, beliefs, thoughts, feelings, and actions that pertain to your physical appearance*" (Cash, 2008, p.1). Individual personality attributes may also influence body image attitudes; and poor self-esteem, perfectionism and public self-consciousness, may heighten an individual's body image vulnerability (Cash, 2004).

Body image has also been defined as a "*cumulative set of images, fantasies, and meanings about the body and its parts and functions; it is an integral component of self-image and the basis of self-representation*" (Krueger, 2004a, p.31). Furthermore, it is suggested that individuals are continually incorporating new information into their body image, and that it fluctuates with changes in mood, environment, and physical experience; thus the development of body image appears to be a fluid process throughout the lifespan (Fallon & Ackard, 2004), richly affected by normal psychosocial development, as well as traumatic experiences (Costin, 2009).

Fallon and Ackard (2004) also describe body image as essentially being a multidimensional concept, encompassing a mental representation of the body that includes components such as perceptions of appearance, attitude, affect and physical sensations of how it feels to be in the body, and the body's functions and capabilities. Body image concerns may result from disturbances in these components (e.g. negative distortions of one's appearance, body dissatisfaction, or overemphasis of one's appearance in defining sense of self). Therefore, body image concerns may adversely impact quality of life and psychological wellbeing (Striegel-Moore & Franko, 2004).

Disturbances in body image are generally focused on specific body characteristics, commonly involving body weight and shape, as well as concerns about particular facial characteristics, body hair, skin appearance, height, muscularity, fitness and strength (Wertheim & Paxton, 2012). These disturbances may range in severity from mild to moderate, or to the extreme-end of more severe psychological disorders. These include eating disorders such as anorexia nervosa, bulimia nervosa, and binge-eating disorder as defined in the DSM-5 (APA, 2013); as well as 'body dysmorphic disorder' which is diagnosed in the DSM-5 when an individual demonstrates a markedly excessive preoccupation with non-existent or minimal perceived flaws in appearance, causing them clinically significant distress or impaired functioning; and individuals most often exhibit repetitive, compulsive, time-consuming behaviours with the intent to inspect, camouflage or fix their perceived defects (Phillips, 2004; American Psychiatric Association (APA), 2013).

For the purposes of this study, the focus will however be on investigating the experiences of female therapists in recovery from mild to moderate body image disturbance (demonstrated by body dissatisfaction rather than severe distortion); as well as recovery from eating disorders.

2.2 Body Image and Gender

The body image literature suggests that the nature of body image ideals in Western culture varies for different genders, with female ideals being more focused on 'thinness' and signifiers of 'sexiness' such as large breasts and a slim waist and hips, and male ideals being more associated with leanness and muscularity (Murnen, 2012). This fundamental gender difference in the conceptualisation of the body is described by McKinley (2004; 2012) in her Objectified Body Consciousness Theory to convey how the female body may be more likely than the male body to be regarded in an evaluative, objectifying way; and when the male body is evaluated, it may be more in terms of functionality than aesthetics. Furthermore, from a young age, females are exposed to societal expectations to strive for physical attractiveness, and gradually internalise an objectifying observer's view of their bodies, leading to self-monitoring and self-improvement behaviours in an attempt to meet cultural standards of beauty.

This internalised cultural association for women between appearance and social success in employment and romantic relationships therefore results in body image satisfaction for females being more strongly tied to their psychological wellbeing. As a result, females spend more time, money and effort in an attempt to achieve these appearance ideals; however as these ideals are unrealistic, females are more likely to experience body shame (Murnen, 2012). Ruskay-Rabinor (1995) similarly suggests that males and females experience their bodies differently from birth, as little girls are taught the paradoxical message that their interpersonal worth is measured by how physically attractive they are, but that the female body is inherently shameful.

This gender difference is particularly relevant to female therapist's working with women with eating disorders, as the therapist may inevitable identify to some degree with the client's body dissatisfaction because of their shared culture (Ruskay-Rabinor, 1995). Costin (2009) also suggests that most male therapists will also identify less with their female client's experiences of embodiment, as

they grow up with fewer socio-cultural messages and pressures about weight and physical appearance.

2.3 Body Image and Culture

It is widely acknowledged that body dissatisfaction has become a normative experience for women in Western societies due to the pressure to achieve unrealistic thin ideals and the current cultural perceptions of beauty (McKinley, 2012). In contrast, body image conceptualisations and ideals in non-Western cultures vary enormously. For instance, it is well-documented that relative to other ethnic groups, Black females generally tend to have higher body satisfaction and self esteem, and are more comfortable with their bodies being at a higher weight and bigger size. However, despite these larger body ideals, some Black women and girls do also experience body image dissatisfaction and disordered eating, and this is typically seen with higher rates of obesity, binge-eating disorder, and bulimia nervosa (Franko & Roehrig, 2012).

There appears to be greater awareness in the body image literature of the impact of globalisation and increasing multicultural communities on the exportation of Western body image ideals to other parts of the world. A possible reason for whether these ideals are either accepted or rejected, may be the influence of certain macro-structural factors which play an important role, alongside particular cultural beliefs and practices, in determining ideal body shape and size in certain non-Western cultures (Anderson-Fye, 2012). These factors include the following:

- *Availability of Food:*

In societies where food is a scarcity (i.e. due to poverty and/or political unrest), only individuals of higher social status have the resources to consume enough or excess food, and they also do less physical labour than those of lower social status, so they tend to carry a higher body weight. Therefore it is rare to see distorted body image and disordered eating in communities where the idealised

body shape and size is bigger. This contrasts with wealthier countries where the abundance of food creates an inverse relationship between social status and size, whereby the ideal social body shape and size is slimmer, and food-refusal and more time for physical leisure activities is more common, thereby enabling a slim body is an indicator of success and higher social status.

- *Health Indicators:*

In certain areas where wide-spread health problems and epidemic diseases occur (i.e. HIV/AIDS; malnutrition), this typically causes physical emaciation for the individual sufferers. As a result this has a significant impact on cultural body ideals, where a more robust body size is more desirable as it is seen as an indicator of health and wellbeing.

- *Gender:*

In non-Western cultures, body image ideals tend to vary by gender as well as culture-specific gender roles. For instance, for women from Latin America, the Caribbean, sub-Saharan Africa, and the Pacific Islands, the local ideal body shape tends to embrace a more curvaceous female form, with emphasis on the large hips and an hourglass figure. For men in most non-Western cultures, typically larger body sizes are preferred, with more muscular development.

- *Industrialisation and Development*

In societies where there has been a shift from agriculture to industrialisation and modernisation over the past few decades, there has also been an influence of Western medicine and media. This has meant that social perceptions of body shape and size have gradually become more influenced by slender Western ideals. This intercultural impact appears to occur most often amongst up-and-coming urban individuals.

These factors highlight the importance of mental health professionals being aware of the particular cultural, social and ethnic influences on an individual's

unique experience of body image, which has implications for the development of culturally relevant prevention and treatment programs (Franko & Roehrig, 2012).

2.4 Affective Neuroscience, Psychotherapy and Body Image

The focus of current neuroscience is on the critical role of affective processes that operate below levels of conscious awareness, exchanges of language and explicit cognitions (Schore, 2005). There is extensive evidence which attests to the relevance of affective neuroscience to psychotherapy and the integration of the body and mind. For instance Cozolino (2010) suggests that psychotherapeutic interventions, regardless of specific approach, affect neural network integration and cause behavioural change. This supports psychoanalytic notions that early developmental experiences significantly affect the trajectory of each human being, because social interaction stimulates neurotransmitters, neural growth hormones, and brain plasticity.

In exploring how one's body image impacts development, Kreuger (2004b) states that body image is integral to an individual's sense of self and self-organisation; and the self and its emotional processes are co-created in relationship, evolving continuously in an inherently embodied manner. Before children acquire language, communication is made at a nonverbal, affective level by holding, touching and sensing; and shown facially in their posture, gestures and affective state. Hence, attachment communication between mother and infant is important to the development of the structural right-brain neurobiological systems that process emotion, modulate stress and facilitate self-regulation. These systems hold the functional origins of the bodily-based implicit self (Schore, 1994) which is activated with the unconscious processing and regulation of emotional stimuli (Schore, 2005).

If we consider how this relates to the therapy process, an individual's self-awareness, empathy, identification with others, and intersubjective functioning, appear to depend greatly on their implicit right-brain operations, and these become specifically activated in the therapeutic relationship. Furthermore, from a psychodynamic perspective, the embodiment of preverbal, undifferentiated or unsymbolised developmental experiences may present in the body-based transference and countertransference feelings of both the therapist and client (Kreuger, 2004b). In this regard, Shaw (2004) states that the body is the very basis of human subjectivity, and that psychotherapy is an inherently embodied process; therefore therapists need to stay attuned to the rich bodily countertransference reactions and imagery they have with their clients from moment to moment, as these somatic and sensory experiences link right-brain feeling and left-brain thinking.

To explore this further, we may look to 'Regulation Theory' (Schore & Schore, 2008; 2014) which is a modern update of attachment theory, informed by neuroscience with specific implications for therapeutic work. It looks at the central role of affect regulation in the development of the human unconscious system which remains active throughout an individual's life span; and demonstrates the interpersonal neurobiology of implicit nonverbal communications between therapist and client's right-brain systems in the form of transference-countertransference transactions. At the core of the intersubjective field between two individuals is a co-constructed attachment bond of emotional communication and interactive regulation with two minds as well as two bodies (Schore, 1994).

Thus, the capacity of the empathic therapist to regulate the client's state of arousal within the affectively-charged unconscious transference-countertransference relationship, may significantly impact clinical effectiveness (Schore, 2001). Furthermore, the therapist's empathic immersion, resonance and response in the therapeutic process facilitates the healthy development of one's psychological-self, body-self and a positive body image (Kreuger, 2004b).

2.5 Criteria for Recovery: A Multi-Dimensional View

There is a lack of consensus in the literature on a clear definition and criteria for recovery from body image disturbance and eating disorders, resulting in various definitions and assessment instruments of recovery being operationalised during research. Consequently, rates of recovery seem to vary significantly between different studies, and the absence of consistent guidelines makes the comparisons between outcome studies quite problematic (Herzog, Keller & Lavori, 1988; Jarman & Walsh, 1999). Furthermore, this may also make it difficult for therapists with a personal experience of body image issues or an eating disorder to 'objectively' demonstrate their own recovery before working with this client population.

Exploring the concept of recovery, Noordenbos and Seubring (2006) conducted a quantitative study about the criteria important for recovery from an eating disorder. The participants included 41 'ex-patients' and 57 eating disorder therapists who completed a semi-structured questionnaire of 52 possible criteria for recovery, representing factors such as eating behaviour, body experience, physical and psychological wellbeing, and emotional and social functioning. Results showed that 50% to 79% of the ex-patients identified achieving 44 of the 52 criteria for recovery when their therapy ended; and after an average of two-years since treatment ended, they had improved on 47 criteria. There was also a general agreement in the comparison of answers by ex-patients and therapists on the criteria they considered important for recovery, and further suggestions were made by the participants that the criteria should be more detailed, and include additional factors.

This quantitative study was limited in that the participant group of ex-patients was relatively small, so the results may not necessarily be representative of the target population; furthermore, self-evaluations were made by patients who had to rely on memory to assess their recovery at the final stage of their therapy, which could potentially have produced biased evaluations. This study does however

support the view that in order to reduce the risk of relapse during the recovery process from an eating disorder, this should encompass not only normalising eating behaviour and regaining weight, but also psychological, emotional and social dimensions of change.

A qualitative study by Sovak (2011) similarly demonstrates the multi-dimensional nature of recovery from the perspective of recovered therapists. Sovak interviewed six therapists who described themselves as 'recovered' or 'in recovery', about their personal recovery process and their experiences of working in the eating disorder field. Using a modified grounded theory method of analysis, the findings demonstrated the 'Nature of Recovery', which encompassed *biological factors* (i.e. weight restoration; impact of underweight clinicians); *psychological factors* (i.e. psychological wellbeing; identity development); and *social factors* (i.e. support by family and friends, treatment providers, supervision, collegial support and personal therapy).

These themes were seen as key factors in the recovery process, which extend beyond merely the cessation of eating disorder behaviours and restoration of weight. A second main theme was about the 'Nature of the Work', that it supported and strengthened the therapist's recovery; it was challenging and rewarding; and the recovered therapist's understanding and empathy strengthened the therapeutic relationship and instilled hope. I believe Sovak's study makes a valuable contribution to the literature on the experiences of recovered professionals and emphasises that the debate should be less about whether recovered therapists should be working in the body image and eating disorder field, but rather about finding the best ways to support and nurture these professionals in the valuable contributions they can make to the field, their clients and their colleagues.

These two studies demonstrate the multi-dimensional view of recovery which includes biological, psychological, emotional and social change factors (Bowlby

et al 2012; Noordenbos & Seubring, 2006; Sovak, 2011). In my view this also has implications for recovered therapists who work with body image disturbance and eating disorders, that to reduce the risk of their own relapse, they should ensure that they continue to manage all these aspects of their recovery in an ongoing manner. The concept of recovery is revisited in the discussion section 5 in light of the findings of this research.

2.6 Body Image Disturbance and Eating Disorder Treatment

2.6.1 Overview of Treatment

The most common aspect of body image research has been weight dissatisfaction, and the majority of studies have been conducted on females suffering with eating disorders, as well as the most severe form of body image distortion: body dysmorphic disorder (Striegel-Moore & Franko, 2004). Body image disturbances in women with eating disorders has been attributed to factors such as cultural standards for beauty, family influences, disturbed development of self-identity and effectiveness, disturbed psychosexual development and poor self-esteem (Rosen, 1990).

Kearney-Cooke and Striegel-Moore (1997) have applied the cognitive therapy construct of 'schemas' to their understanding of body image disturbance of clients with eating disorders, and describe schemas as central cognitive structures within the system of the self. A negative body schema therefore may influence feelings, thoughts, behaviours and perceptions about the body, and may be powerful in maintaining body image problems because the individual's negative schema provides a basis for what is noticed, attended to and remembered about experiences (Kearney-Cooke, 2004).

Recovery from an eating disorder with regards to weight restoration and eating pathology does not guarantee improvements in body image, and disturbances in body image may contribute significantly to relapse (Costin, 2009). Hence, it

seems essential that eating disorder treatment includes work on body image as well as eating behaviour; however this seems to be greatly underemphasised in eating disorder treatment programs (Rosen, 1997). We can therefore appreciate that the treatment of body image disturbance and eating disorders should involve both the working through and understanding of historical material regarding body hatred and negative projections onto the body, as well as the development and strengthening of alternative, more adaptive body schemas (Kearney-Cooke & Striegel-Moore, 1997).

2.6.2 Impact of the Therapist's Body

It seems inevitable that a therapist's particular physical stature will impact clients in different ways, and may become an element in the unconscious life of the therapeutic work (Burka, 1996). Upon a sweep of the literature on the impact of the therapist's body shape and size in the work with clients struggling with body image problems and eating disorders, my search indicated that the views on this topic are predominantly from the perspective of feminist writers in the field, most of whom are recovered themselves (Baker-Pitts, 2007; Burka, 1996; Costin, 2009; Lowell & Meader, 2005; Orbach, 2003; Ruskay-Rabinor, 1995).

Aside from these personal accounts, only one research article was found in relation to this issue, by Rance, Clarke and Moller (2014) who sought to investigate eating disorder clients' interpretations of their therapists' bodies. It looked specifically at how clients evaluate therapist body size and speculate on their therapists' relationship with food; with a key focus on determining the potential impact which this had on the therapeutic relationship. Qualitative interviews were conducted on 11 women from the UK (aged between 18 and 50 years) who had all been in therapy with a female therapist at some stage to address their eating disorder. All these participants saw themselves as being 'recovered' or 'on the road to recovery', however the duration of their illnesses had ranged between 2 and 28 years.

In the findings, the participants spoke about feeling 'primed' to notice and compare their body shape and size to others, including their therapist; and were prone to make assumptions about the therapist based on their observations about their appearance, and speculations about the therapist's relationship with food. This appeared to impact their confidence in the therapist's ability to help them, and clients tended to resist therapists they saw as being 'too fat' or 'too thin'. For instance, 'fat therapists' were perceived as having 'lost control' and being untrustworthy as the participants expressed concern that their therapist would let them spiral out of control themselves; and 'thin therapists' were perceived as having a double standard when asking them to gain weight or eat more, as the therapist was 'allowed' to stay thin. 'Healthy-looking therapists' in contrast were perceived as being more helpful and tended to taken more seriously when they gave advice on normal, healthy eating.

I was interested to read that some of the participants had not actually been in therapy with a therapist who would 'objectively' be viewed as being overweight, so for some clients these were assumptions that they *might* feel negatively towards working with a therapist with a larger body. This is acknowledged by the authors as a significant limitation of the study, as it impacts the conclusions we may draw from the results.

Despite the study's limitations, I believe it makes an important contribution as it highlights the view that eating disorder clients often have regarding appearance and perception of 'goodness', and the subsequent impact this may have on their engagement with the therapist and 'the work'. By implication, this does not suggest by any means that therapists should alter their bodies to try improve their therapeutic relationship with a resistant client. Instead, a key point demonstrated from this study is the importance of therapists being aware of the explicit and implicit factors which impact the therapeutic alliance, of which the therapist and clients' bodies play a significant role.

It is similarly suggested by Orbach (2003) that clients already scrutinize the way their therapist's body looks, and also how comfortable and at ease they are in them. This can be deeply uncomfortable for some therapists, especially those in recovery from a body image concerns. Furthermore, individuals with body image disturbances tend to become preoccupied and obsessed with particular body parts, and often want to disown or compartmentalise areas of their bodies because of extreme self-loathing.

It is also common for these individuals to compare their bodies and particular body parts with those of other people. When this other person is their therapist, there is likely to be a pronounced effect on the therapeutic relationship and treatment process, as it is predictable that the client may make powerful assumptions, either in thought, fantasy or words, about the therapist's attitudes, morality, competence, and mental and physical health (Lowell and Meader, 2005). For instance, as demonstrated in the findings by Rance et al (2014), a thin eating disorder client may react to an overweight therapist with feelings of fear that they may end up looking like the therapist unless they continue with their eating habits. In contrast, an overweight client may react with intensified feelings of self-hatred and jealousy if they work with a slim therapist.

Rather than this issue impeding the work, we may consider the impact of including the therapist's body in the therapeutic dialogue with this client group as a means rather than an obstacle to recovery. For instance, Lowell and Meader (2005) describe themselves as 'thin therapists', who have experienced clients using the therapist's thin body as evidence to explain and support their disturbed beliefs and assumptions, as an object for transference projections and fantasies, and as a target of envy. These writers suggest that it is common for a therapist's body image to fluctuate according to the client's body size, and the way that the client affects the therapist. Thus, valuable information may be gained from the therapist's subjective experiences and countertransference reactions with their clients, facilitating a deepening of the therapeutic process.

As the female therapist is bringing her own body image to the therapy room, it is emphasised by Lowell and Meader (2005) that it is important for her to be self-aware both externally and internally. They suggest further that it is the therapist's responsibility to become aware about how she views her body, and that over time, she must work towards inviting her clients to express their feelings and thoughts about their own body and the therapist's body in order to fully explore the emerging themes between them.

In a similar manner, Burka (1996) provides an honest account of her perspective as a 'very overweight therapist', and describes her clients' differing reactions to the reality of her body, and the fantasies that this stirs up in their unconscious minds. She has also experienced her body in varied ways with different clients, and suggests that her 'earth-mother' body fosters positive maternal transferences in some clients; however for others, her rounder, softer body evokes powerful negative reactions. By travelling a difficult, emotionally challenging journey, she has gradually become better equipped to respond comfortably to her clients' comments and reactions to her physical size, and has become more tolerable of having her body as a subject of discourse. She identifies that when feelings are evoked for her which involve her body image and weight (personal areas of importance), she is aware of not putting exclusive emphasis on her own intrapsychic life; and is conscious of not ignoring the intersubjective therapeutic context (Burka, 1996).

While both Burka (1996) and Lowell and Meader (2005) promote an open dialogue in the therapy room about the bodies of the therapist and client, this implies that the therapist is comfortable talking about her body and having her weight and size scrutinised and commented on by clients. In this regard, Ruskay-Rabinor (1995) suggests that for the female therapist in clinical practice with eating disorder clients, both conscious and unconscious feelings of shame may be evoked and reawakened on at least three levels: firstly, from her own body dissatisfaction; secondly, from feeling fraudulent in her role as 'healer'; and

thirdly, from early preverbal experiences where her intrapsychic conflicts were played out in a body devalued because of her gender. The profession of psychotherapy and counselling does not encourage therapists to self-disclose and acknowledge their own shameful feelings to their clients, however, the process of silencing their feelings may inevitably disconnect them from their clients (Ruskay-Rabinor, 1995).

Feminist theory emphasises the importance of the relationship between female therapist and female client, in which the therapist may serve as a role model of a woman struggling to be 'comfortable with her discomfort', and willing to speak the unspeakable even if the truth is imperfect, messy and unfinished (Eichenbaum & Orbach, 1983). Clients may observe their therapists' visual bodies and take note of their movements, appearance, affects and aura to create an awareness of who the therapist is and how they should relate to them (Liebermann, 2000). For instance, eating disorder clients appear to relate to others through comparing and contrasting their body to that of the other, thus the therapist's body, regardless of size, shape and appearance, will evoke transferential feelings in the client (Sheehy, 2009). Therefore the therapist is not merely an object to her client which contains, tolerates and survives in the transference; but equally important for therapeutic change, she is a model of a woman with her own subjectivity (Baker-Pitts, 2007).

Costin (2009) similarly states that ideally, female therapists should aim to be positive, healthy role models who demonstrate self-acceptance, care and love for their own bodies, as it is healing for clients to observe other women who feel comfortable with their bodies and are able to live their lives free from disordered thoughts, behaviours, desires and restrictive eating. Therefore it is not expected that the therapist should never have negative body image concerns, but rather that she knows how to manage her feelings and behaviours without becoming destructive towards herself.

2.6.3 Countertransference and Subjective Experiences of the Therapist

The therapeutic relationship is viewed by contemporary interpersonal therapists as an intersubjective, cultural context where therapist and client are constantly influencing one another in a system of complex parallel body-mind processes (Soth, 2005). According to intersubjectivity theory, 'transference' may be described as the manifestation of an individual's unconscious organising activity which is influenced by archaic perceptions of the self in relation to others, and which impacts their perception of the world at an unconscious level (Stolorow, Atwood & Brandchaft, 1994). Thus in the therapy room, it is thought that the client unconsciously projects onto the therapist, their feelings, fears, desires, emotions and ways of relating to figural people from their past. 'Countertransference' is viewed as the therapist's unconscious reaction to the client's transference together with the therapist's own archaic and emotional issues that are triggered (Costin, 2009); thus Clarkson (2003) suggests that countertransference is an inevitable part of the therapeutic relationship.

When there are two subjectivities and their respective organising principles in operation, this will always create a unique interaction between two individuals (Stolorow et al., 1994) where "*each subjectivity is intimately involved in the shape and feel of the relationship and in how each experiences self and other in it*" (DeYoung, 2003, p.149). Therefore, the transference and countertransference arising in the relationship is jointly created and is an interpersonal rather than an intrapsychic experience (Rothchild, 2006) of two individuals who are both wounded and whole (Soth, 2005).

Some countertransference responses, which therapists may have in their work with eating disorders, may range from feelings of redundancy, guilt, disorganisation and anger; to feeling drained both emotionally and physically, and dreading certain client sessions (Kearns, 2005). Therefore, the countertransference feelings which are evoked, or the embodied and emotional reactions that the therapist experiences with this client group may significantly

impact the work, and if left unattended, may damage the therapeutic relationship and outcome of treatment. Although the clinical literature validates the powerful impact of transference/countertransference issues on the treatment of eating disorders, it generally neglects to explore these issues in relation to body image. Hence, body image countertransference issues may also have a critical effect on the success of therapy, and may cause personal consequences for therapists if sensitive unconscious material is evoked (Costin, 2009).

When a therapist has suffered from similar body image concerns and eating problems as their client, it comes as no surprise that an experience of body shame may be pathologised, denied, distanced, omitted or minimised in the therapy room. Projections that the client and therapist have about one another's bodies may remain hidden, and thus cannot be translated and reassociated. This creates the likelihood of unresolved projective identification, which may be particularly strong in female therapists because of the shared cultural messages about the female body, resulting in the therapist finding it hard to determine whether the projections came from the client, from herself, or from their common culture (Gutwill, 1994).

Therefore in the course of working with body image disturbance and eating disorders, it is common for therapists to experience a heightened awareness of their personal shame triggers if they identify (perhaps to a lesser degree) with their client's body dissatisfaction, are more aware of their body imperfections, dread gaining weight, and are conscious of their own diet and exercise routines. They may fear that to be effective, their body image concerns must be resolved, leaving them to feel fraudulent in their role as 'healer': that to 'heal' one must be 'healed' (Ruskay-Rabinor, 1995).

The therapist might also feel incompetent due to the intensity of the client's eating disorder symptoms, may question whether another therapist would be

able to offer better treatment, or may possibly experience guilt about not suffering as their client does. In this regard, Baker-Pitts (2007, p.127) asks:

> *How does a female analyst provide her patients with a secure body to 'use' as a subject and object in the clinical arena when she shares a culture of idealised images and sexual objectification, and when her own subjectivity is unstable*?

This question highlights the importance of therapists becoming aware of the complex dynamics of their emergent feelings or countertransference responses to avoid inadvertently shaming their clients, or becoming overwhelmed by their own shame (Shure and Weinstock, 2009). Thus "*the extent to which a therapist is informed of her own truths and has understood and integrated her unconscious self, will inform the value of her interventions*" (Hargaden & Sills, 2002, p.116).

In considering the concept of the therapist's embodied feelings, it is suggested by Orbach (2003) that therapists need to be able to bring their bodies to the therapeutic encounter to be used by clients in addition to them using the therapist's psyche: "*If therapy is an intersubjective experience, this must surely include our bodies too*" (p13). Orbach (2004) discusses the function and meaning of bodily feelings evoked in the therapist during a therapy session as important clues into the client's unconscious experience, and the relational conveyance of attachment issues in the body. Thus, by paying careful attention to their embodied experiences, therapists may gain valuable information to support their work with their clients. Viewing the body as an important aspect of attachment, she states that "*bodies are not born but are acquired in relationship with key caregivers*" (Orbach, 2004, p.141).

Rather than merely being destabilised by society's pressures about appearance, the clients' bodies we meet in therapy may lack the development of a secure attachment to the original maternal body, thereby embedding anxiety and

disorganisation into their developmental history. Attachment dynamics play out at a physical level through the development of an individual's sense of their bodily self which may be secure, avoidant, ambivalent or disorganised. Orbach (2004) suggests that aspects of a disorganised body attachment may be signalled through body distress: imagined (i.e. body dysmorphia) or somatic (i.e. eczema; asthma; colitis etc.). Thus, by providing clients with an authentic, safe therapeutic relationship in which therapists make both their bodies and psyches available, and which is capable of receiving their hated, fragmented, voided bodies, this supports clients to address their pain as well as begin to deconstruct their defences (Orbach, 2004).

For therapists working with body issues, the literature emphasises the importance of supervision as a source of support for examining the therapist's subjective feelings and countertransference responses related to body image, food, and weight that often emerge in the work; and that a therapist's success in facilitating change in their clients may be based on how successfully they've examined these issues themselves (Delucia-Waack, 1999). Some of these countertransference issues include over-identification with the client's problems; reactions to issues of control such as taking too much responsibility for the client or engaging in a power struggle; becoming intrusive or avoidant about a client's secrecy issues; feeling a sense of helplessness, ineffectiveness and inadequacy; and avoidance of affect. Delucia-Waack (1999, p.380) states:

> *It seems essential that counsellors who work with eating disorders must be comfortable with their bodies and have realistic perceptions of healthy body weight, eating habits, and relationship with food because of the continual need to serve as a reality check for their clients about these issues. If counsellors are not aware of the impact of culture on their beliefs about self-worth, body image, and attractiveness, they may inadvertently communicate or reinforce such unrealistic beliefs and values to their clients.*

There may be occasions when the female therapist experiences difficulty dealing with crises in their lives, or may have an ongoing personal struggle with particular identity concerns, especially those related to the body-self (e.g. weight gain/loss through illness, pregnancy, stress). Furthermore, like all woman, they may also be affected to some extent by the socio-cultural emphasis on appearance and ideal body shape (Gerson, 1996). In relation to this, Schwimmer (2010) conducted a quantitative study to explore the influence of female therapist body image distortion on the perceived management of countertransference in their work with female eating disorder clients. The author recruited 296 participants from three professional eating disorder associations, and they completed the Countertransference Factor Inventory, the Body Shape Questionnaire, and a demographic questionnaire.

The findings indicate that factors such as years of work experience, postgraduate training, and supervision, were positively associated with countertransference management. There was no association shown between clinical professional practice or the therapist's history of an eating disorder, and their ability to manage countertransference; however the level of a therapist's current body image distortion was inversely associated with their countertransference management. In my view these findings suggest that although a therapist may have recovered from an eating disorder, they may still struggle with body image concerns which at times may stir up difficult feelings or negative countertransference reactions with this client group. Therefore these concerns and countertransference issues should be continually monitored and addressed in supervision and personal therapy to support the therapist in their personal and professional lives

Unfortunately there may be times when the negative personal impact on the therapist of working with body image disturbance and eating disorders becomes severe. Job burnout is a potential occupational hazard of working within mental health care settings, however there is minimal research on this issue within the

eating disorder field. One recent large-scale qualitative analysis of job burnout in eating disorder professionals was conducted by Warren et al. (2012). They recruited 298 eating disorder treatment providers who completed an online open-ended questionnaire examining perceived contributors of burnout, efforts to manage or avoid burnout, and recommendations for early-career eating disorder practitioners to manage burnout. Approximately 93% of participants were worried or fearful about the overall health of their clients, and 25% had experienced the death of a client causing them to feel sadness, grief, self-doubt, guilt and helplessness.

The most frequently reported contributors to burnout were: the challenging characteristics of eating pathology (e.g. chronicity; relapse; symptom severity); client characteristics (e.g. ambivalence to change; co-morbid conditions); work-related factors (e.g. time demands; lack of support/resources); therapist variables (e.g. negative affect; personal problems; countertransference); financial issues (e.g. inadequate compensation). Some of the recommendations made by the participants for early-career therapists to avoid burnout included: using supervision; maintaining a work/life balance; engaging in self care; limiting/varying caseloads; working on personal issues (especially around body image and eating); and not taking too much responsibility for client change (Warren et al. 2012).

This study provides important findings about understanding and managing burnout; however it is limited in that the participants were a self-selected group, thus possibly attracting individuals for whom burnout was a significant issue. Furthermore, the participants in this study had an average of 13 years experience treating eating disorders; working primarily in eating disorder hospital settings; with caseloads of approximately 65% of eating disorder clients. Therefore, these factors perhaps also heighten the potential for severe negative consequences and burnout to occur; hence the findings may not be representative of the experiences of all therapists working with eating disorders.

To my mind it becomes clear how important it is for therapists to stay alert for the possible influence that their personal issues may have, and to seek the necessary support they may need in working with the particular challenges which often present with this client group. I believe this is essential to prevent burnout and excessive or dysfunctional negative countertransference reactions which can be detrimental to job performance, therapist wellbeing, and client care. As stated by Bloomgarden (2009), a therapist who neglects their own self-care needs while trying to promote better client self-care as a treatment goal, will not be a convincing role model.

2.7 The Recovered Therapist

2.7.1 Prevalence of Recovered Professionals

The empirical evidence in the eating disorder literature indicates that there are a relatively high percentage of professionals working in the eating disorder field who have a past history of eating disorders or body image disturbance (Barbarich, 2002; Bloomgarden et al, 2003; Johnston et al, 2005). In this regard, Bloomgarden et al (2003, p.166) states:

> *Many therapists are drawn to their work with a certain subject, consciously or unconsciously for personal reasons. In some ways having a personal interest in an issue can be positive; there may be greater compassion or greater desire to make a difference because of acute awareness of the suffering in that arena.*

The first large-scale quantitative study to determine the lifetime prevalence of eating disorders among professionals was conducted by Barbarich (2002) in which a survey was completed by 399 participants (322 females and 77 males) who were members of the Academy for Eating Disorders (AED), an association for academic and clinical professionals who show interest and expertise in the area of eating disorders. The results showed that 27.3% of clinicians had

previously had an eating disorder, of which 33.2% were female and 2.3% were male. Furthermore, the study looked at relapse rates and relapse risk factors amongst recovered therapists, and it was shown that the longer the duration of the eating disorder, a history of anorexia nervosa (purging type), and a history of having more than one type of eating disorder resulted in a higher rate of relapse. It was proposed that this may be due to the individual demonstrating more severe eating disorder symptomatology through those variables. This study has its limitations in that only 50% of members at the AED responded to the survey, and the study also used a non-validated questionnaire to assess eating disorder diagnosis.

Despite these limitations, I believe this study is significant as it was the first empirical study to provide quantitative data about recovered professionals in the eating disorder field. Similar results were found by Bloomgarden et al (2003) who surveyed the staff at a national eating disorder treatment centre regarding their personal experience with an eating disorder before becoming professionals in the eating disorder field. They found that 24% had experienced an eating disorder themselves, another 7% admitted to having eating problems, and a further 13% had a family member who had suffered from an eating disorder.

The authors suspect that this percentage may be even higher as more therapists came forward afterwards and admitted to having an eating disorder, but they had felt too guarded to share this in the survey with a fear that this may lead to them losing their jobs if they were 'discovered'. In my view this highlights the issue of shame some therapists may feel about disclosing their history to colleagues and other professionals, thus potentially leaving them unsupported in their clinical work with eating disorders and body image disturbance.

2.7.2 Experiences of Recovered Therapists

An overview of the literature indicates that research on the personal experiences of recovered therapists who work within the eating disorder and body image field is fairly limited, however there appears to have been a gradual increase in studies on this topic in recent years.

In a qualitative investigation by Bowlby (2008) the lived experiences of 13 female recovered professionals working in the eating disorder field were explored using semi-structured interviews. The results demonstrate that they viewed their recovery process essentially as a nonlinear process; including internal and external components; involving learning to understand and value the self; recognizing an identity separate from the eating disorder; developing healthy, meaningful relationships with others; and finding meaning and purpose in life. Furthermore, the success of their recovery journey was impacted positively by relational aspects such as validation, encouragement and support; however the challenges they found in their recovery process included self-criticism; unrealistic expectations; de-identifying with the eating disorder; and choosing to close the door on the eating disorder.

The participants also shared the positive and negative influences of their personal histories on their clinical work. For example, the work provided them with a sense of meaning and purpose; creating something positive out of their recovery; and helping others recover as they had been helped. In a professional capacity their experiences enabled them empathy and understanding; grace and patience; hopefulness about recovery; and the ability to gently challenge clients about their behaviour. The countertransference experiences and difficulties they had within therapy included struggling emotionally with clients who were resistant or in denial; issues related to the family of origin and resistant relational patterns; and discomfort with confronting other struggling professionals.

The implications of the findings by Bowlby (2008) demonstrate the valuable insight that recovered professionals may have in their work with eating disorder clients as they hold two intersecting perspectives as both client and therapist. Furthermore, this study adds to the knowledge base on the essential characteristics of the recovery process, indicating that long-term recovery is possible through making more comprehensive changes to one's identity, and finding greater meaning and purpose in life. This broadens the notion of recovery beyond criteria such as weight restoration, cessation of obsessional thinking and behavioural symptomology (Bowlby et al 2012).

Another mixed-methods study by Warren et al (2009) explored the experiences of eating disorder professionals (with and without eating disorder histories), including the frequency and management of commentary by clients regarding the therapist's appearance; and personal changes in the therapist's affect, vigilance about their appearance, and eating behaviours. A questionnaire was completed by 43 eating disorder therapists (4 men and 39 women) who were attending the Multiservice Eating Disorder Association annual conference; and over 30% of the participants reported having an eating disorder in the past which is consistent with the rates found in previous research (Barbarich, 2002; Bloomgarden et al., 2003; Johnston et al, 2005).

The findings indicated that 83% of therapists felt their clients were monitoring, examining, or evaluating their appearance, even when this was not verbalised; and 33% worried about their clients judging or envying them. Fifty percent indicated that their awareness of other's appearances was heightened after working with this client group which felt uncomfortable, intrusive and hypocritical; 72% reported that during their work they had felt self-conscious and hypervigalent about their appearance, and described feeling offended, angry, vulnerable, self-critical and incompetent. When describing the personal impact of their work, 70% of participants indicated that their view of food had changed (i.e. increased awareness of food; seeing food as a source of nutrition; increased

enjoyment and appreciation of food); 54% experienced a change in their eating behaviour (i.e. becoming more healthy, mindful, moderate and deliberate), however a few participants reported engaging in disordered or unhealthy eating after sessions. Some of the hardest aspects of working with eating disorders were seen as including the resistance of severe, chronic symptomatology to change (i.e. severe body image distortion; rigid thinking; lack of readiness to change); the nature of the illness and its prognosis (i.e. high rates of relapse; slow recovery process); negative personal impact on therapist (i.e. worry; fatigue; sadness; frustration); challenging relationship issues (i.e. managing countertransference feelings; maintaining healthy boundaries); and maintaining therapist health (i.e. staying optimistic; working hard regardless of progress; staying confident and healthy).

The findings of this study by Warren et al (2009) highlight the personal changes that many therapists may experience in terms of their affect, cognition, and behaviour when working with this client group, therefore it is essential that that therapists in the body image and eating disorder field are aware of the potential personal and professional challenges they may face. This study was however limited as it used a small sample group of eating disorder therapists, male and female, attending an eating disorder focused conference, so the results may not be representative of all eating disorder professionals. Furthermore, as approximately a third of the participants reported having an eating disorder in the past, it is not clear whether the reported experiences were similar or more heightened in those who were 'recovered' therapists.

A later study by Warren, Schafer, Crowley and Olivardia (2013) attempted to address some of the limitations of the Warren et al (2009) study. They drew a sample of 139 eating disorder treatment providers in the United States from the large body of 298 participants used in their Warren et al (2012) study on burnout in eating disorder professionals (discussed previously under subheading 2.3.3). All of these participants reported having a history of an eating disorder or strong

eating disorder symptoms, and 11 participants were currently struggling with an eating disorder. The study used an open-ended questionnaire to explore the experiences of these recovered therapists and how their eating disorder history impacted their clinical work, as well as the recommendations they would make to new professionals with an eating disorder history.

The results indicate that most participants (89%) viewed their history of eating pathology as having a range of positive influences on their client work. This included the facilitation of a non-judgmental orientation; increased empathy; understanding emotional processes; holding a unique perspective and positive view of the possibility of recovery; passion for helping others; and helping the therapeutic alliance. Some participants (9%) described both positive and negative consequences of their personal history; and only two participants indicated that they saw only the negative impact their client work, such as feeling 'triggered; and over-identifying with their clients. Some of the recommendations made by the participants to newer therapists, included having personal therapy for their eating disorder issues prior to working in the eating disorder field; developing self-awareness; being conscious of personal triggers and staying accountable in their own recovery; awareness of personal limitations; careful use of self-disclosure; attention to self-care; seeking contact with other therapists with shared experiences; regular supervision; maintaining boundaries; and managing their case load.

This study is important as it contributes to the growing empirical literature about the experiences of recovered professionals in the eating disorder field, particularly regarding some of the positive aspects of the therapist having personal insight into eating pathology and recovery. It was interesting to note that very few negative consequences were reported. I wonder whether there was an element of risk and shame for these recovered professionals in drawing attention to some of the more challenging issues which they may face; as it is common for therapists (with or without a history of body image and eating problems) to

experience heightened countertransference reactions with this client population (Costin, 2009; Delucia-Waack, 1999).

Another instance where recovered therapists potentially wanted to be seen to be coping well in their professional lives, was demonstrated in a qualitative study by Rance, Moller and Douglas (2010). The experiences of seven therapists with eating disorder histories were explored regarding their views about how their work impacts on their personal body image, weight and relationship with food. Results showed three main themes: (1) 'double-edged history' (i.e. both beneficial and dangerous); (2) 'emphasis on normality' (i.e. strategy of minimisation and normalisation); and (3) 'selective attention' (cognitive and attentional strategies to support assertions of normality and recovery). Interestingly, the participants made multiple claims and references to being 'normal', the absoluteness of their recovery, and the unlikelihood of any possibility of relapse.

In my opinion this contradicts previous findings in the literature which indicate that it is 'normal' to be affected by working with eating disorders, particularly if the therapist is recovered themselves (Costin, 2009; Ruskay-Rabinor, 1995; Shure & Weinstock, 2009; Warren et al. 2009; Warren et al 2012, 2013). It is questioned whether these positive assertions by the participants about how little impact their work had on their personal body image, weight and relationship with food, involved "*a denial of what may be non-pathological experiencing*" (Rance et al, 2009, p.389), and an avoidance of any question about their capability and fitness to practice as eating disorder therapists. While this study added to the literature on the topic, is was limited in that it did not explore the eating disorder histories of the participants, therefore it was not possible to explore the details of their journey from eating disorder to their current self-presentations of recovery.

Another recent study about the ethics experiences of recovered professionals was conducted by Williams (2011). Two first-person published written accounts

were analysed and 11 recovered eating disorder therapists were interviewed about their professional ethics experiences and perspectives in order to explore the direct implications for providing safe and ethical therapy services to an eating disorder client group. The findings yielded two main descriptive themes: (1) the 'ethics terrain' of ethical issues and concerns identified/experienced (i.e. significance of helping/harming; therapist impairment; dual relationships and professional competence); helpful therapist characteristics/stances (i.e. realness, congruence, integration, self-awareness, integrity and humility); and interpersonal/workplace environments that either foster or inhibit ethical engagement); and (2) the recovered therapists' experience of being interviewed and their subsequent self-reflections and practice changes that occurred over the course of the data collection process.

This study is beneficial in that it looks at the importance of effective training and supervision of recovered eating disorder therapists; and highlights the need for professional environments to foster a safe, 'positive ethics experience' which supports recovered therapists in their self-reflection and engagement with related ethical issues. This ideally facilitates recovered therapists to develop the skill of 'ethical discernment' relating to their personal history in order to practice safely and ethically with their clients

These five research studies have provided important insights on the experiences of recovered therapists in their work with body image issues and eating disorders, thereby providing greater insight into the strengths, challenges and support needs of recovered professionals.

2.7.3 Perceptions about Recovered Therapists

A contentious issue in the literature exists regarding *when* a therapist may be considered 'recovered enough' to work with eating disorders and body image issues in a way that is ethically safe for the therapist and provides good clinical care for the client. Bloomgarden et al (2003, p.137) emphasise the responsibility

of the therapist to look after their own physical and psychological wellbeing so they can truly be role models, and state that as therapists "*we must also accept our foibles, and not expect that we must be perfect before we can help others*". However, if the recovered therapist's capacity to offer a safe therapeutic space becomes impaired, they should not to become defensive if approached by a colleague who is concerned about them (regarding issues of behaviour, low weight, appearance, unusual eating habits). This is in line with the British Psychological Society's (2009) professional ethical guidelines; that if an individual observes an 'impaired professional' they should first address their concerns to the person directly and encourage them to seek professional help, and if they are unable to recognise that a problem exists, the matter should potentially be reported it to the relevant professional board (e.g. Health and Care Professions Council) as another possible source of intervention. The notion of one therapist challenging another's mental health and ability to practice effectively is indeed a sensitive issue, however this emphasises the importance of therapists being able to respectfully address their concerns to one another in a culture where this is the norm (Bloomgarden et al., 2003).

Regarding the perceived advantages and disadvantages of recovered therapists working in the eating disorder field, Costin and Johnson (2002) discuss their professional views influenced by their own work experiences at two different eating disorder centres in the United States: Laureate Psychiatric Clinic and Hospital, and Monte Nido Treatment Centre. An important advantage is their view that recovered staff may offer understanding, hope and motivation to clients that recovery is possible as they have been to that dark place themselves, and their deep empathy about the struggle towards recovery encourages trust in the client who may desperately fear change. As recovered therapists have been through the process of healing themselves, they are also seen by the authors as having greater licence to confront and challenge issues of self-pity, helplessness, self-centeredness and grandiosity. Furthermore, it's suggested that when clients

can see recovered therapists being valued and acknowledged professionally within the eating disorder field, this challenges the notion that having a history of an eating disorder is shameful, as instead the experience can be used "*to consolidate a more authentic self system that can be valued by others*" (Costin & Johnson, 2002, p.297).

The authors describe the disadvantages of recovered therapists working in the field as: the vulnerability to experiencing various countertransference issues; taking greater responsibility for recovery than the client; and the increased risk of relapse. Johnson, the program director at Laureate Psychiatric Clinic and Hospital, speaks about intentionally hiring eleven recovered therapists over a ten-year period, and states that these therapists contributed to the program in unusual and outstanding ways. He did report some relapse problems in five of the therapists: three reported feeling psychologically vulnerable so supervision was increased; a fourth therapist had a moderate behavioural relapse resulting in outpatient therapy and a decrease in work-load; and the fifth therapist had a serious relapse which required residential treatment and a mutual agreement not to return to work at the centre.

Costin, the program director at Monte Nido Treatment Centre, openly refers to herself as being 'recovered' from anorexia nervosa. She reports that approximately 75% of all the staff members at the centre have recovered from an eating disorder, although this figure is approximately 85% if only therapists, dieticians and support-counsellors are considered. She suggests that this high percentage may be due to the therapists feeling more comfortable revealing their eating disorder history to her because of her personal openness about her own recovery, and proposes that other treatment centres may potentially have higher rates of staff in recovery than are reported. She states that no recovered therapists have relapsed at the centre, and only two staff members had left during a period of six-years after they felt 'uncomfortable' or 'triggered' by their client work.

In the above discussion by Costin and Johnson (2002), their shared view seems to be that there are many positive aspects of recovered professionals working with eating disorders and body image problems, however there is the risk of personal issues being 'triggered' which for some may result in a mild to severe relapse which needs to be addressed and supported. When considering hiring recovered therapists, Costin describes being drawn more to individuals who have made peace with their body and food issues, thereby being 'recovered' rather than 'in recovery'. In my opinion this draws attention to the notion of what recovery is like for the individual and whether it really is an end-state to reach. Furthermore, I feel this also highlights the issue of how to adequately assess the recovery of a therapist with a past history of body issues, in determining whether they can work safely and ethically without risking harm to the client or themselves.

In a study conducted by Johnston, Smethurst, and Gowers (2005), the views of 202 patients, carers and professionals were explored about the possible benefits, drawbacks and suitability of employing recovered therapists to work in the eating disorder field. The researchers used a mixed-methods approach using surveys which included categorical, interval and open-ended questions, thereby providing both quantitative and qualitative data. Participants were drawn from the research database of the UK Eating Disorders Association, and of this sample, one-third of the professional participants had a history of an eating disorder, which is consistent with the prevalence rates found by Barbarich (2002) and Bloomgarden et al (2003).

The findings showed that 81.7% of participants thought it was appropriate for a recovered professional to work with eating disorder clients, however 66,8% thought it would be inappropriate for a therapist who was currently struggling with an eating disorder to work in this field. Regarding the issue of self-disclosure, most professionals (45.8%), with or without a previous history of an eating disorder, were against the obligation to self-disclose, whereas the carers and

those struggling with eating disorders were in favour of it (43.4%). On average, all respondents felt that the therapeutic relationship between a recovered therapist and their client would be at least equal to, or possibly stronger than the therapeutic relationship between a therapist without a previous eating disorder history and their client. The advantages of the recovered therapist were seen generally as the therapist being able to offer useful advice; being an encouraging model of successful recovery; and possessing greater empathy and understanding of the treatment aspects. Furthermore, the participants saw the disadvantages of the recovered therapist as over-involvement and enmeshment; therapist vulnerability; and subjectivity.

The studies by Johnston et al (2005), and Costin and Johnson (2002) provide us with various different views on the suitability, advantages and disadvantages of recovered professionals working in the body image and eating disorder field from the perspective of carers, clients, professionals, and employers. These findings support the notion that despite a number of potential challenges, excluding recovered professionals from this work would in fact be discriminatory.

2.8 Summary

Drawing together the picture that emerges from the above review of the literature, it is clear that recovered professionals may have a lot to offer in their work with individuals struggling with body image issues and eating disorders, as they have important insight into the healing process and understand these issues on a personal level (Bowlby et al, 2012; Costin & Johnson, 2002). The concept of 'recovery' has been explored in more depth, highlighting the multi-dimensional nature of the process (Bloomgarden et al, 2003; Bowlby, 2008; Johnston et al, 2005; Noordenbos & Seubring, 2006; Sovak, 2011; Williams, 2011); and the emphasis in the literature has shifted from questioning the suitability of recovered professionals working with eating disorders (Johnston et al, 2005), to looking at the support needs of these therapists, and the professional responsibility of the

therapist to look after their own physical and psychological wellbeing in order to practice safely and ethically with their clients (Sovak, 2011).

Research has consistently shown that approximately 30% of professionals working in the eating disorder field have recovered from an eating disorder (Barbarich, 2002; Bloomgarden et al, 2003; Johnston et al, 2005), and furthermore that this challenging client group may evoke various feelings or countertransference reactions in the therapist, particularly in relation to body image, food and weight (Costin, 2009; Delucia-Waack, 1999). A number of studies have also emphasised the importance of therapists having regular supervision, amongst other support strategies, when working in the eating disorder field (Delucia-Waack, 1999; Schwimmer, 2010; Warren et al., 2009; Warren et al., 2012, 2013).

The literature on the experiences of recovered female therapists (as a sub-group of the population of eating disorder professionals) is still fairly limited, and includes some conceptual articles (Baker-Pitts, 2007; Orbach, 2004; Shure & Weinstock, 2009); several personal accounts by recovered professionals in the field (Bloomgarden et al, 2003; Burka, 1996; Costin, 2009; Lowell & Meader, 2005; Ruskay-Rabinor, 1995); as well as an increasing number of research articles in recent years which have made valuable contributions to the knowledge-base about this subject (Bowlby et al, 2012; Rance et al, 2010; Rance et al 2014; Schwimmer, 2010; Sovak, 2011; Warren et al, 2009; Warren et al, 2012, 2013; Williams, 2011).

The main focus of these articles relates to recovered therapists working particularly with eating disorders; and while body image disturbance is a central feature of an eating disorder diagnosis (Costin, 2009), this concept also includes other types of body concerns aside from weight. There is however limited literature regarding the experiences of recovered professionals working with

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other types of body image issues. Therefore this study is unique as it offers a different perspective by exploring the therapist's personal experiences of working with body image problems related to weight (i.e. eating disorders) as well as mild to moderate body image disturbance. Furthermore, this study also seeks to demonstrate ways for recovered therapists to manage the subjective feelings that are evoked for them; as well as effective self-support strategies.

2.9 Research Questions

Using Interpretative Phenomenological Analysis, the primary research questions of this study are as follows:

1. What are the subjective experiences and countertransference reactions of the recovered female therapist in her work with clients struggling with issues of body image disturbance and eating disorders?

2. How are the therapist's subjective experiences and countertransference responses managed therapeutically?

3. In what ways do therapists support themselves personally and professionally?

3. METHODOLOGY

In this chapter I will describe the methodology used in this study, including the research paradigm and design; participants and sampling; process of data collection; the sequence of data analysis; criteria of trustworthiness/validity; and ethical considerations.

3.1 Research Paradigm and Design

3.1.1 Philosophical Basis of using a Qualitative Approach

Contextual qualitative research is concerned with describing and displaying phenomena as it is subjectively understood and experienced by a particular population (Ritchie, 2003). This study was seeking to gain a deeper understanding of the subjective experiences of each participant in relation to the subject matter, therefore a qualitative research approach was used to capture the richness and complexity of their experiences, rather than attempting to quantify them (Hoepfl, 1997).

The open, generative nature of a qualitative approach enables the exploration of the phenomenon without prescribing its construction and meaning in advance, as a means for further development of theory (Ritchie, 2003). The focus of this study was deeply rooted in the participant's personal knowledge and understanding of their body image issues. Furthermore, the complex, delicate nature of the subject matter of body image and the elusive thoughts and feelings that this may evoke in client work, required that the participants had time to reflect on their own experience of the phenomenon. Therefore a qualitative questioning process, carefully framed and responsive to each participant's individual circumstances, was best suited to this study to sensitively facilitate the uncovering and relaying of their perceptions and responses (Ritchie, 2003).

3.1.2 Interpretative Phenomenological Analysis

The qualitative methodology I used was Interpretative Phenomenological Analysis (IPA). This idiographic approach was consistent with the research aim which sought to explore rich descriptions of the participants' particular lived experiences (Finlay, 2009) to gain a deeper understanding and interpretation of the context and process of the recovered therapists' experiences in a way that captured the subject matter's inherent nature. IPA is concerned with "*examining how a participant makes sense of, or sees meaning in, their experience*" (Smith, Flowers & Larkin, 2009, p.187) and acknowledges the central active role of the researcher in the research process.

An IPA approach is underpinned by a 'critical realist' assumption of knowledge, that there is a real world that exists which has an objectively knowable, mind-independent reality. However, our understanding of this is influenced by perception and cognition (Barker, Pistrang & Elliot, 2002). The epistemological position of my research question was focused on exploring the participants' understandings of their lived experiences. This is consistent with the IPA approach which has an 'interpretivist epistemology' which argues that an individual's perceptions and experiences are produced by social, cultural, historical and linguistic influences. Therefore the research findings were dependent on context, and as an interpretivist researcher I became part of the world being studied and interpreted rather than being external to it (Finlay, 2006).

As an IPA researcher, I engaged in a 'double hermeneutic' by trying to make sense of the participants trying to make sense of their experiences (Smith et al, 2009). It can be argued that it may not be entirely possible, nor desirable, for a researcher to completely 'bracket' or set aside their existing beliefs, understandings and experiences, therefore I needed to engage in reflexivity, bringing a critical self-awareness of my subjectivity, behaviour, biases and assumptions in order to recognise how these variables may influence the research process and findings (Finlay, 2009). By adopting a 'phenomenological

psychological attitude', the researcher engages in a process of continually reflecting upon their interpretations of both their experiences as well as the issue being studied in order to move beyond the partiality of their previous understandings (Finlay, 2008). This process enables the researcher to acknowledge and value their own subjective experience while empathically entering the lived experience of the participant through the co-created intersubjective encounter, allowing for a relational unfolding of meanings to emerge (Finlay, 2009; Wertz, 2005).

3.1.3 Why IPA rather than other Qualitative Methods?

In deciding upon the research methodology appropriate for this study, I took into consideration which type of qualitative method was most in line with my research question in terms of philosophical and theoretical positioning. Here I will discuss why IPA was my preferred choice over the following types of qualitative analysis that I considered: Grounded Theory and Discourse Analysis.

- *Grounded Theory:*

This approach is essentially used in generating a theory, 'grounded' in data. The results from a typically larger sample group may be used to support wider conceptual generalisations (Barker et al, 2002). In contrast, IPA has an idiographic focus on the unique experiences and perspectives of individual participants, and in finding patterns of meaning across the group of participants. The emphasis in IPA is to provide an in-depth account of the experiences of a smaller homogenous sample which may be transferrable to similar contexts (Smith et al, 2009). IPA was thus more suitable to my research question which focused on gaining a rich, in-depth understanding of the experiences of a small sample group.

- *Discourse Analysis:*

This method examines the constructive, functional nature of language in describing an individual's experiences, but is sceptical of mapping verbal accounts onto underlying cognitions. In contrast, IPA is concerned with cognitions and sense-making, seeking to understand what individuals think and believe about their experiences within a particular context (Chapman & Smith, 2002). By using a careful and explicit process of interpretation, IPA hopes to gain access to the person's cognitive inner world (Smith et al, 2009), thus it was well-suited for this study which sought to understand the meaning participants made of their experiences.

3.2 Participants and Sampling

3.2.1 Purposive Sampling

I used a non-probability (non-random), purposive sampling approach to purposefully select participants who fit particular criteria to enable a detailed understanding and exploration of the research questions (Barker et al, 2002); and I aimed to have a group that was sufficiently homogenous to enable common themes to emerge in the analysis (Ritchie, Lewis & Elam, 2003).

3.2.2 Participant Criteria

The participants included nine female psychologists and psychotherapists (aged between 35 and 65 years) who identified having a personal history of body image concerns. This included recovery from an eating disorder as defined in the DSM-5 (APA, 2013), including anorexia nervosa, bulimia nervosa, and binge-eating disorder; and/or mild to moderate body image disturbance (demonstrated by body dissatisfaction rather than severe distortion as seen in Body Dysmorphic Disorder). A further stipulation was that the participants were not currently struggling with an eating disorder.

Due to the small sample size, the study focused primarily on Caucasion female therapists, excluding gender and ethnic differences as variables in the study. Costin (2009) suggests that male therapists who work with female eating disorder clients are generally not challenged in the same way as female therapists, and are not subjected to the same level of scrutiny and competitiveness from female clients in relation to size, weight and shape. Research has also frequently demonstrated that black females generally have a better body image and greater satisfaction with the shape and weight of their bodies than Caucasian females due to differing cultural standards of attractiveness and body ideals (Celio, Zabinski & Wilfley, 2004; Franko & Roehrig, 2012); and other ethnicities and cultures such as Asian and Hispanic groups also demonstrate diverse beauty ideals (Altabe & O'Gara, 2004; Kawamura, 2004, 2012; Schooler & Lowry, 2012). Considering these factors, I chose to focus on Caucasian females, a group in which body image concerns are more prevalent, in order to gain richer data in the study. Further research on recovered male therapists as well as different ethnic/cultural groups is recommended to determine the impact of these factors on this phenomenon.

Participants were required to have experience of working with clients with eating disorders and/or moderate to severe body image disturbance, including body dysmorphic disorder; but it was not essential that the participants work exclusively in this context. Furthermore, the participants needed to be registered with a professional body such as the British Association for Counselling and Psychotherapy (BACP); United Kingdom Council for Psychotherapy (UKCP); the British Psychological Society (BPS); or similar. This was to ensure that the participants abide by the required ethical guidelines in their practice. It was also necessary that participants work from a relational perspective in their client work, as this could facilitate the emergence of richer material in the interview if the therapists were conscious of the relational space and transference dynamics that may emerge in their work. (See Table 1 for an overview of participant characteristics).

Table 1: Participant Characteristics

No. & Alias	Age	Therapeutic Approach	Professional Registration	Work Context	History of Body Image (BI) Issues
(1) Alice	35-40	Integrative/ Relational	UKCP	Private, NHS	BI Dissatisfaction; Restricting Food
(2) Megan	30-35	Integrative	BPS, UKCP, NCFED	Private	Binge Eating; Bulimia; Anorexia
(3) Candice	30-35	Psychodynamic/ Systemic/ Dance-Movement	ADMT UK	NHS	Binge Eating; Bulimia; Anorexia
(4) Nicola	30-35	Integrative	BPS	Private	BI Dissatisfaction; Binge Eating; Restricting Food
(5) Lauren	40-45	Integrative	UKCP, BPS	Private	Binge Eating; Bulimia; Restricting Food
(6) Penny	35-40	Integrative	BACP	Private	Anorexia
(7) Bridget	60-65	Integrative	BACP, BPS	Private	BI Dissatisfaction; Restricting Food
(8) Leigh	50-55	Integrative	MBACP	NHS, Private	Bulimia
(9) Sandra	40-45	Integrative	BACP	Private	BI Dissatisfaction; Restricting Food

3.2.3 Participant Recruitment

Once I was granted ethical approval for my study from the Metanoia Research Ethics Committee (Appendix 1), I contacted a number of eating disorder treatment centres across the UK about my research. Unfortunately they either turned down my request to advertise or did not respond. Similarly, when advertising to a broader audience on the BPS Counselling Psychology division email circular, I was again disappointed not to receive any response. Feeling somewhat disheartened after seven months of advertising for participants without any positive response, I considered whether to abandon the study and start over with a new research topic. I wasn't quite ready yet to admit defeat though and after exploring this obstacle with my doctoral peers and research supervisor, I decided to try a more direct, purposive approach by making personal contact with individual therapists who advertised themselves as working with body image issues and eating disorders.

I managed to find potential participants by searching online (i.e. Counselling Directory as well as other local counselling centre websites) and sent them an Information Sheet about the study (Appendix 2). Through this I achieved greater success and was able to recruit seven suitable participants in this manner. I was also permitted to advertise on the research page of Beat Eating Disorders (BEAT) website, and managed to recruit a further two participants who expressed an interest in my study. Upon reflection of this process it is interesting to note that although I advertised for therapists who identified having a personal history of body image concerns and/or an eating disorder, the participants that came forward *all* presented with body image issues related to weight and eating issues. This highlights that for women in particular, body image is often strongly associated with weight, body shape, and difficult relationships with food and eating.

3.2.4 Screening Questionnaire

Prospective participants who expressed an interest in taking part in the study were sent a Screening Questionnaire (Appendix 3) in order to establish whether they met all the necessary sampling criteria of the study. This screening questionnaire included questions regarding their ethnic origin; therapeutic approach; professional registration; client work context; experience working with eating disorders and body image issues; personal history of an eating disorder or body image issues, and treatment/support received; and review of their current experience of personal body image concerns or an eating disorder. Once the screening questionnaires were examined, the suitable participants were invited to attend individual interviews.

3.3 Data Collection

The method of data collection used was semi-structured individual interviews as this provided the opportunity for me to gain an in-depth, detailed understanding and clarification of each participant's personal perspective on the subject matter (Ritchie, 2003).

3.3.1 Interview Schedule

As a researcher I played an important role in directing the participants through the various stages of the interview process (Legard, Keegan & Ward, 2003). As a guideline I constructed an Interview Schedule (Appendix 4) based on the research questions of the study which was helpful in phrasing complex questions and sensitive subject material, and provided a loose framework for the interviews in order to cover all the necessary topics (Smith et al, 2009). This is also described by Rubin and Rubin (2005) as a 'conversational guide', which provides question checklists or outlines to guide the answering of the main research questions. As the nature of the study was iterative rather than linear, this

interview schedule changed and developed throughout the research (Smith & Osborn, 2008).

3.3.2 Semi-Structured In-depth Individual Interviews

In-depth interviews are described by Kvale (1996) using the 'traveller metaphor', with the interviewer representing a traveller who goes on a journey with the interviewee, developing meanings through interpretations of the interviewee's stories. There is a transformative nature of the journey through conversation, leading the subject to new insights. Therefore the researcher plays an active role in the development of data and meaning, with knowledge being constructed in a collaborative process. The four key features of an in-depth interview are to combine structure with flexibility; to be interactive in nature; to make use a range of questioning techniques to gain depth, exploration and understanding of the participant's feelings, opinions and beliefs; and to be generative by creating new knowledge and thought (Legard et al, 2003).

The participants each signed a consent form (Appendix 5) and then took part in semi-structured individual interviews which lasted approximately an hour in length. This enabled the participants to share rich, in-depth, first-person accounts of their experiences and perspectives on the subject matter (Smith et al, 2009); and allowed for clarification and a detailed understanding to emerge through in-depth personal discussions (Finlay, 2006). The tape-recording of the interviews enabled the interview data to be captured in its natural form, facilitating the understanding of meaning through depth, nuances and the participants' own language (Legard et al, 2003).

I noticed feeling slightly nervous and unsure of myself prior to starting the earlier interviews as I was conscious of being a novice researcher. Thankfully, I felt reasonably confident in my clinical abilities as a psychological therapist and the process of respectfully exploring sensitive issues with clients. This helped in

grounding me, although initially I also had to be mindful to resist making and sharing my interpretations, connections and insights during the interviews. I also paid careful attention to my own embodied experiences and countertransference reactions during the interviews which emerged with the different participants. After each interview I took time to reflect on these feelings which I then captured in my reflexive journal. I will provide a summary of these reflections under sub-heading 5.6 in the discussion section.

3.4 Data Analysis Procedure

As a guideline for the analytic process of this IPA study, I referred to Smith et al's (2009) steps of analysis. The analysis started by examining each participant's case in detail, followed by cautiously identifying the similarities and differences across the sample group, thereby "*producing fine-grained accounts of patterns of meaning for participants reflecting upon a shared experience*" (Smith et al, 2009, p.38).

3.4.1 Transcribing the Recordings

To prepare the qualitative data, the recordings of the interviews were carefully transcribed and checked for accuracy. To ensure the anonymity of the participants, all names and identifying information was removed from the transcripts. By using an IPA method, the meaning of the participant's experience is central, therefore the aim of phenomenological data analysis is to gain an understanding of the content and complexity of those meanings rather than measuring their frequency (Smith & Osborn, 2008). Essentially, the analysis is a product of both the researcher and the participant, with the end-result being the double hermeneutic, with the researcher tentatively and subjectively conveying the sense they've made about the participant trying to make sense of their lived experience (Smith et al, 2009).

3.4.2 Assigning Exploratory Comments

I began this process by listening to each audio-recording while reading the interview transcripts in order to immerse myself in the original data of the participant's world. I then attempted to start coding by using one of the data analysis software packages available; however, being admittedly lacking in technical prowess, I found this process more frustrating than useful, so I chose instead to create my own spreadsheets in Microsoft Excel. By carefully working through and analysing the transcribed data, I divided the text into meaning units. I then assigned an exploratory comment for each unit which included summaries, associations, connections, contradictions or preliminary interpretations (Smith & Osborn, 2008). This served to highlight the building of trust and rapport across the interview, and the general flow from broad to the richer, detailed sections (Smith et al, 2009).

3.4.3 Capturing Emergent Themes

The focus of the analysis then shifted from the original transcript to the exploratory comments made about particular meaning units of the transcribed data. Using a phenomenological focus to examine the descriptive core of the exploratory comments, emergent themes were identified and documented (Appendix 6), capturing an understanding and interpretation of the essential quality of the original text (Smith et al, 2009). This process is known broadly as 'coding' in qualitative studies which involves assigning a word or short phrase to a portion of language-based data, which symbolically summarises or condenses the data rather than simply reducing it (Saldana, 2009). Although this process breaks up the narrative flow of the interview, it is representative of the hermeneutic circle whereby the original whole interview is divided into a set of parts through the analysis, which then develops into a new 'whole' through the write up of the analysis, "*where the part is interpreted in relation to the whole; the whole is interpreted in relation to the part*" (Smith et al, 2009, p.92).

3.4.4 Developing Super-Ordinate Themes

At this point I ordered the emergent themes chronologically as they appeared in the transcripts (Appendix 7), however I identified feeling quite overwhelmed and lost in all the data and the long list of themes. In order to reduce the data further, the emergent themes and the relevant transcript extracts were listed in a spreadsheet for each participant. This next step enabled me to have more clarity, as these lists were then carefully examined to form clusters of related emergent themes, and I constantly checked them against the original words of the participant in the text in order to accurately capture the individual's concerns on the subject matter (Smith & Osborn, 2008). Super-ordinate themes were then developed for each cluster (Appendix 8) to capture and reflect an understanding of the phenomenological essence of the participant's spoken words as well as my interpretation of them, in a "*synergistic process of description and interpretation*" (Smith et al, 2009, p.92).

3.4.5 Searching for Connections across Cases

The next step involved a cross-analysis of the nine cases to identify patterns and interconnections between them. The common recurring super-ordinate themes were listed in a table format, and shown whether it was present for each participant (Appendix 9). The drawing together of themes provided a structure which highlighted the most interesting and important attributes of the participant's experiences; and some were clustered together according to similarity and regularity, whereas others were discarded. To create the final master themes, the analytic process of 'abstraction' was used in places to assign a new name to a cluster of super-ordinate themes. The process of 'subsumption' was also applied where some super-ordinate themes showed a higher-order position under which a series of related themes could be grouped together (Smith et al, 2009).

Finally a table of master themes and their related sub-ordinate themes for the group was created (Table 2 in Findings section); and a spreadsheet compiled of

the relevant transcript extracts for each participant which best captured their thoughts and feelings about their experiences (Appendix 10). In the findings section to follow, these themes will be translated into a narrative account in order for the findings to be discussed and presented in a coherent and consistent manner (Smith & Osborn, 2008).

3.5 Ethical Considerations

Due to the personal and sensitive nature of the subject matter, it was essential to consider the ethical implications of my research in line with the BPS Code of Human Research Ethics (BPS, 2014). Ethical principles focused on protecting the research participants' rights, dignity and welfare (Barker et al, 2002), as well as ensuring the scientific integrity of the research process. The research was also granted ethical approval by the Metanoia Research Ethics Committee (Appendix 1).

3.5.1 Informed Consent

Before the interview took place, prospective participants were sent an Information Sheet (Appendix 2) to read before agreeing to take part. This explained the purpose of the study, what was involved in taking part, possible risks and benefits, how the data would be stored and who would have access to it. Interested participants were then sent the Screening Questionnaire (Appendix 3) and if suitable, they were invited for an interview. Before commencing the interviews, I made sure that the participants had read and understood the Information Sheet and they were then given a Consent Form (Appendix 5). Freedom of choice was an important factor so the participants' consent to participate was voluntary, and free from direct or indirect coercion; thus the participants were informed verbally and in writing that they could freely withdraw their consent from the study at any time without adverse consequences.

3.5.2 Avoidance of Harm

Due to the nature of the subject matter, I was sensitive to the possibility that participants may experience distress by taking part and I also acknowledged their right to withhold certain information from me in the study. I took care in providing them with detailed information about the study beforehand about what to expect and the areas of discussion to be addressed, so that participants could make an informed decision about whether they wished to participate or not. I was also mindful to conduct the interviews in a sensitive and respectful manner, proceeding at their pace whilst being aware of the time boundaries in order to allow time for debriefing. Once the interviews had ended I thanked the participants for their time and contribution to the study, and checked how they felt after sharing their thoughts about such private, emotionally-charged issues. This debriefing process was important to ensure no harm came to participants through the research process, and to provide referral information about support available.

3.5.3 Privacy and Confidentiality

I was committed to respecting the autonomy, privacy and dignity of the participants and explained to them that although some direct quotes may be used in the final write-up of the study, anonymity would be ensured by removing any identifying personal identification from the transcripts or final document (BPS, 2014). The screening questionnaires did not include the participants' names, but were allocated a participant number for identification purposes which was linked to the recordings, transcripts, and analysis tables. The voice recordings and personal information of the participants were also stored in a safe confidential place.

3.5.4 Scientific Integrity

Throughout the process of designing, conducting, analysing and writing up this study, I took measures to ensure its "*quality, integrity and contribution to the*

development of knowledge and understanding" (BPS, 2014, p.9). These considerations are discussed in the following section (3.6) on assessing the trustworthiness of the study.

3.6 Assessing Trustworthiness

To address the trustworthiness of this IPA study, I will refer to Yardley's (2000, 2008) four broad principles for assessing the quality and validity of qualitative psychological research and describe how I have adhered to these guidelines:

3.6.1 Sensitivity to Context

I endeavoured to demonstrate sensitivity to context throughout the various stages of the research process. For example, I conducted a thorough review of the existing literature which helped to orient this study and demonstrate its rationale. I also gave careful consideration to the literature on qualitative methodology and deemed that IPA was best suited to this study in terms of its philosophical underpinnings and focus on the idiographic and particular lived experiences of the participants.

Furthermore, during the process of data collection, I was sensitive and empathic towards the participants who were sharing very personal experiences. I was also mindful of managing the intricate power dynamics in my position as perceived 'research expert' and the participant as 'experiential expert' by bracketing my assumptions and interpretations, and by using the interview schedule flexibly to engage the participants in order to elicit rich, full answers. As the findings in IPA studies are inherently interpretative, I have included a number of verbatim extracts from the transcribed interviews to support the interpretations I have made through the analysis process (Smith et al, 2009).

3.6.2 Commitment and Rigour

I have aimed to show my personal commitment and investment in this study by demonstrating a high level of care and attention to each participant during the stages of data collection and analysis to ensure they were comfortable, and by listening carefully to each participant's unique narrative. 'Rigour' demonstrates how thorough a study is, and I have aimed to achieve this by carefully and purposefully selecting participants appropriate to the study criteria, and have provided a detailed description of participant characteristics (Table 1); I conducted the in-depth interviews in an attentive, sensitive manner to obtain rich data; and thoroughly and systematically analysed and interpreted the data in order to convey to the reader my understanding of each participant's story, as well as my interpretation of the shared themes across the sample group (Smith et al, 2009).

3.6.3 Transparency and Coherence

To demonstrate transparency I have provided a clear description of each stage of the research process. This enables a clear and transparent audit trail in the appendices which confirms that the research findings emerged directly from the raw data, thereby grounding them in evidence (Schwandt & Halpen, 1988). This includes elements such as: the raw data of the transcribed interviews showing initial coding; data reduction tables and lists created through each stage of the data analysis process such as descriptive and emergent themes and how they are grouped together under higher order super-ordinate themes; as well as illustrative quotes for these from each participant (Campbell, 1996). I have also kept a reflexive research journal of the developments and inquiry process of my research (under subheading 5.6 in the discussion section), from which I have provided a summary of my personal critical reflexivity. The coherence of the study may be demonstrated by my aim of adhering closely to the principles of IPA, with the write-up conveying a phenomenological and hermeneutic sensibility (Smith et al, 2009).

- *Triangulation:*

As IPA is fundamentally an interpretative process, it is suggested by Larkin and Thompson (2012) that certain validation methods such as 'member-checking', whereby the participants review and verify the analytic process, may be less suitable than others. In some instances this may even be counterproductive, particularly in studies with multiple participants, possibly due to the combined effect of the amalgamation of cases, researcher interpretation, and the passage of time. Therefore, in order to establish trustworthiness in this study, triangulation was achieved by using validation strategies such as auditing and peer review. This process involved a suitably experienced doctoral research peer independently reviewing and exploring my stages of coding and the emerging themes against the raw transcribed data for each participant. Furthermore, at each stage of the analytic process I had regular discussions with my research supervisor who conducted mini-audits of my work. By triangulating the data analysis in this manner, the participant's accounts were subjected to a broader perspective, thereby facilitating credibility checking across the themes. This also helped in testing the coherence and plausibility of the analysis, and the checking of inconsistencies and ambiguities.

3.6.4 Impact and Importance

Yardley (2008) argues that the real test of validity for a study, however well it is conducted, depends on whether it provides something of interest, importance or usefulness to the reader, or makes an impact to theory and social change or practice. The impact and importance of the findings from this study is reflected upon in the discussion section and may be best judged by the reader.

4. FINDINGS

The analysis of the nine participant interviews resulted in the emergence of three master themes and their constituent super-ordinate themes shown in Table 2. The focus of this chapter will be to explore these themes, illustrating them with verbatim quotes from the interviews. To improve readability I have removed utterances, word repetitions and hesitations; this is indicated by dotted lines in brackets [...]. Where a person was talking before or after a quotation, I have indicated this with dotted lines. The alias names were maintained throughout to protect the anonymity of the participants.

Table 2: Master Themes and Super-Ordinate Themes for the Group

MASTER THEMES	SUPER-ORDINATE THEMES
1. Understanding the Struggle: A Shared Experience	1.1 Empathic Resonance 1.2 Conveying Empathy 1.3 Exploring Embodied Experiences 1.4 Authenticity and Self-Disclosure 1.5 Assumption about Therapist being 'the Sorted One'
2. Becoming Entangled: Old Feelings Resurfacing	2.1 Over-identifying with the Struggle 2.2 Worry about Judgement and Exposure 2.3 Heightened Body Awareness 2.4 Feeling Ineffective
3. Self-Support Strategies: A Life-Long Healing Process	3.1 Self-Acceptance and Respect 3.2 Healthy Attitude to Eating and Exercise 3.3 Relaxation and Reflection- Sitting with Honesty 3.4 Recognising and Bracketing Own Issues 3.5 Support in Supervision and Personal Therapy

4.1 Master Theme 1: 'Understanding the Struggle: A Shared Experience'

The first master theme reflects the shared experience of body image problems between therapist and client, and the therapist's personal understanding of what this struggle may be like for the client. This theme encompasses five super-ordinate themes: Empathic Resonance; Conveying Empathy; Assumption about Therapist Being 'The Sorted One'; Authenticity and Self-Disclosure; and Exploring Embodied Experiences.

4.1.1 Empathic Resonance

This theme captures the experience of all the participants who spoke of feeling enormous empathy for their clients presenting with an eating disorder or body image disturbance. This was described by Sandra who stated, *"I do feel I have a lot of empathy for it and I do feel it's painful".*

As a young girl Sandra was subjected to a lot of teasing from her family about her weight and appearance which led to her restricting her eating to lose weight in an attempt to stop the constant criticism. Over the years she was able to find healing through a process of self-exploration and now felt good about herself and her body. She could identify with some of her clients' body image issues and here she expresses the empathy she feels for them:

> *Sandra: If clients have said things about maybe a part of their body they wished was different, or feeling that when they look in the mirror they just see something horrible looking back at them, I know what that feels like.*

In my view, having this high degree of empathy had various consequences for participants, some positive and some negative. For example, one of the negative consequences of this deep empathic resonance was therapists over-identifying with their clients' stories, while one positive consequence was the level of hope that the therapists held about their clients' recovery, as expressed by Sandra:

> *Sandra: I guess one of the reasons I chose to work with these issues is because I want to really try and understand, because I have hope that you can overcome this, and I really do believe that. And I guess because it's a personal thing I'm drawn to it.*

Fuelled by a great emphasis placed on appearance and 'looking good' in her family, Bridget had felt self-conscious about her body since childhood. Her body image and weight had fluctuated throughout her life, as she went through phases of feeling in-and-out of control with her eating and level of physical activity. She spoke about relating in some ways to her clients' body image and eating problems:

> *Bridget: ...the feelings and emotions that are attached to how you feel, your body, what you eat, what's perceived by other people. I feel I can relate. Obviously not one hundred percent, because you never know how individuals experience it.*

I notice in Bridget's quote above, she feels that her own experience gives her empathy with her client, but she also seems to say that she is careful not to let this empathy lead her to make assumptions about the client. I believe however that when assumptions are made by the therapist, this may lead to an 'over-identification' with a client's material which I view as one of the 'negative' consequences of empathy. (This sub-theme is discussed more extensively in section 4.2.1).

Leigh had struggled with an eating disorder in her teens and early twenties after being criticised about her appearance, as well as saying it was "*fashionable to be thin*" at the time*.* With the help of a friend who was going through a similar struggle, they supported one another to gain control of their eating. She spoke about her empathic resonance with some of her clients' eating disorder and body image struggles:

Leigh: *It's a big relief to be able to say I feel okay, but I do know what it was like not to, and I remember the struggle to get back to [...] the sense of authenticity about who I am, rather than it being about...am I attractive, whose opinion matters to me, what I wear.*

From Leigh's quote, my sense is that this more authentic internalised experience of herself has been a significant part of her recovery process which enables her to recognise her own worth as no longer being dependant on her appearance. Her own experiences therefore seem to enable a deep empathy about this struggle which puts her in touch with the self-doubt and low self-worth of her clients, as well as the challenges they face.

Echoing Leigh and Bridget's experiences, Megan's empathy also enabled her to really understand what the struggle was like for some clients because of their shared experiences. As a young girl, Megan had battled with a poor body image while training to be a dancer. Feeling great pressure within the 'performance world' to be slim, this resulted in her developing an eating disorder which continued into young adulthood. She had since recovered from her disordered eating behaviours through personal therapy during her therapist training, and had maintained a healthy weight for a number of years. She reflected on the insight this gave her with her clients and stated: "...*sometimes it would be nice because I would feel a sense of understanding the client, you know, because of having some of the experiences that might be similar, although not exactly the same*", but that she also noticed feeling "...*relief that I wasn't in that place anymore*". Megan's quote conveys her awareness of the differences between her past and her client's story, and like Leigh, she expresses her relief about having recovered from her suffering. In my opinion this highlights how a therapist's empathic understanding of what it's like to have body issues, along with the recognition of their own healing, is an important part of the work as it instils hope in the therapist about the possibility of change and recovery in their clients.

There were times when some therapists were more vulnerable to over-identifying with their clients, particularly if their body image issues were a current problem in their own lives. This appeared to be the case for Nicola, who had battled with body image concerns since she was a young girl with a lot of emphasis being placed on being 'slim and beautiful' in order to be acceptable to significant family members. From childhood into adulthood her weight had fluctuated significantly after periods of 'out of control' binge-eating, followed by more disciplined periods of dieting. As a result, I believe that her self-worth was firmly linked to her appearance and the particular size she was at the time.

Although Nicola had been working on these issues in personal therapy, she felt they were not completely resolved, thus in the interview I experienced these feelings as being very present for her in her role as a therapist: *"I saw the dynamic, and thought, well that's like me. When I feel wonderful I lose weight and when I stop feeling wonderful I gain weight. So I can relate to it".* In this quote, I feel it's evident that Nicola's battle with negative body image concerns is still ongoing as she seems to over-identify with her client's story. Therefore I wonder whether she was really as recovered as her or I had initially thought from the outset. In my view this demonstrates the subjective nature of the recovery process which for some may fluctuate and require continual management rather than be an end-state to achieve.

From their own recovery experiences, some therapists also felt a lot of empathy for how challenging and painful it was for clients to start addressing their eating problems and body issues in therapy. For example, Candice stated, *"I can identify with how painful it is sometimes with the clients I'm working with",* and she could empathise with a client who said that, "...*they felt like the biggest in the room, which I know what that feels like".* Candice had been bullied about her appearance at school which led to her developing an eating disorder as a young child, which continued into adulthood. She eventually received support in her

twenties in personal therapy and was able to maintain a healthy weight and body image. Her recovery experience later led to her training to be a therapist, and it appears that her personal history enables her to be empathic and sensitive to the possibility that therapy may be a slow, difficult process for some clients:

> Candice: ...*knowing how much it's helped me to get through some of my difficulties, makes me want to use it with people with similar difficulties, but I have to accept that it's not gonna be for everybody.*

In the above quote, it seems to me that Candice realises that empathy is sometimes not enough and she is aware that her approach to working with eating disorders through psychotherapy, dance and movement may not be effective for everyone. So despite her depth of empathy, I feel she understands that she will not always succeed with such clients. Similarly, Lauren's empathy gave her an understanding about how unique the recovery process was for each individual as she was still working on her own healing and recovery after many years. Lauren had suffered from an eating disorder which first started when she was a young teenager, and continued into her early twenties. Although she no longer had an eating disorder and felt better about herself, she expressed that her recovery was a 'life-long process' which she dealt with day to day, as sometimes she went through phases of overeating or restricting her food intake. Lauren gave an account of experiencing deep attunement with her male client who presented with anxiety about his body:

> *Lauren: Somewhere along the way he's got the message that who he is isn't okay, which is similar to what I was saying to you about myself. So it's hard for him and he's so fearful of rejection if he shows me who he is. So we're struggling with that and acknowledging that something about the work isn't working as he's still not feeling safe enough to completely show me.*

Here I am of the opinion that Lauren's deep empathy and compassion for her client's feelings of low self-worth and fear of rejection seem to guide the therapeutic work. Consequently I feel this enables her to sit with her client's resistance in therapy as she understands some of the feelings he was expressing about his struggle to be present with her. Although she spoke of things being 'stuck' between them, in my view, her empathy about his struggle appears to have opened a dialogue with her client about exploring *why* things are difficult for him.

4.1.2 Conveying Empathy

This theme explores *how* participants convey the deep empathy they experience as part of the therapeutic process, and how this may help in deepening the therapeutic relationship. For instance, Alice was mindful of being present with her clients to convey her empathic attunement: *"I'm there for them and don't talk from my default place. I'm there to really hear them",* and that intersubjectively this could be a *"very powerful, very real relational experience"* in the therapy room.

Alice had a history of body image concerns which started as a young girl and continued into adulthood. Through a period of self-exploration in personal therapy during her training, she had found healing; however, body image issues were still a sensitive area for her, and I feel she was conscious of how this affected her in her role as a therapist:

> *Alice: ...clients might say things that really ring true to me, about their own issues, about dark places where they have been themselves psychically, and [...] I suppose in some ways that helps me to be empathic in a way that is not patronising, and it's more genuine. Genuine, not because I am struggling too, 'cause that's not something that I would share [...] but genuine as in, perhaps an intervention that may really help them to see that I see them, I feel them and I hear what they are saying.*

In the above quote, Alice's understanding of the 'dark places' her clients are in seems to me to enable a 'genuine' and authentic way of being and relating to her

clients. Similarly, in Lauren's work with her male client, conveying empathy meant: "*just trying to be with him, and helping him to understand that I'm open to whoever he is, and at the moment, openly acknowledging that he can't show me who he is'*. From my perspective, Lauren comes across here as having an attitude of 'unconditional positive regard' for her client which I believe allows her to be more present with him in a non-judgemental way, working at the client's pace.

In a similar way, I feel that Sandra's personal experience of recovery enabled her to inhabit a non-judgemental presence in the therapy room. She carried hope and belief from her own experiences that healing was possible if an individual worked on their relationship with themselves to find greater acceptance of their bodies:

> *"I just feel a lot of empathy for them. You know, I'd never laugh at it, or say, oh pull yourself together, you know I feel sad for them. I can really hear what you're saying, and I really do trust that if they can dare to believe, they can form a new relationship with their bodies".*

In the above quote, I experience Sandra as being sensitive and compassionate about her clients' struggles with eating disorders and body image problems. She also shared that part of the work would be to *"encourage them to look at themselves in a different way",* thereby gently challenging them about the way they think and feel about their bodies. Megan also shared the impact of her empathy on her client work:

> *Megan: I've felt a stronger connection with some clients, 'cause I really felt that I knew, at least in part, some of the places within which they struggle. And I think actually in some ways that helped the work, while [...] staying in touch with what's your stuff, and what's their stuff. I think that was helpful and it felt really [...] good to have that connection. And in a way I*

suppose, in clients where it had been successful, it felt very healing, healing for me and healing for them.

To my mind, Megan seems to say here that while empathy facilitates a deeper connection which can aid healing, it is also important not to over-identify. She also acknowledges that this process of being mindful and attending to what is 'her stuff' can also be healing for her as a therapist. I view this as a process of recognising and bracketing one's own issues, and this sub-theme will be explored further in 4.3.4.

For some therapists, it was useful to share their feelings with their clients to convey empathy. For instance, Megan stated: "...*if it's part of the process of the client, then I might find a way of going in and sharing it, share the impact, or share my deepened understanding about [...] where they're at".* Leigh also spoke about using her identification with these issues in her countertransference response to convey her understanding about her client's struggle:

> *Leigh: Countertransferentially, there's a lot of projection coming between us, and also, 'I do know some of what it's like to be in the place you're in', [...] so I found myself saying to her just recently that 'I do understand that it's very difficult having someone challenge you about your eating, and part of you doesn't want to give it up, and another part that realises that it is a problem'.*

From my perspective, Leigh's comments above demonstrate how she acknowledges and understands her client's suffering by making a subtle reference to her own experience, but like Sandra, she speaks of gently challenging the client about her resistance to changing. The notion of challenging clients to think about their behavioural patterns was also expressed by Bridget:

> *Bridget: The emotions that are attached to food, and with clients [...] separating these out from the eating, and then working with the hunger and feeding the body, and finding other ways of feeding the emotions. So*

that's what I find really interesting and how hard that is, even for me, to separate that out. I don't eat emotionally. I stop eating when I'm emotional, whereas my daughter eats when she's emotional. So that's the part that really interests me.

Here Bridget's speaks of gently challenging and supporting her clients to identify when they were eating to feed their emotional hunger rather than their physical hunger. She seems to empathise with this experience from a personal place and in my opinion, Bridget's awareness of how this process differs for her and her daughter seems to enable her to convey empathy and a curiosity about what that unique experience is like for each client rather than making any assumptions.

4.1.3 Exploring Embodied Experiences

This theme is about the participants' exploration of embodied experiences and countertransference reactions with their clients as part of the therapeutic process. This includes talking about the differences or similarities between the therapist's and client's bodies; and noticing body language and physical countertransference reactions.

The subjective experience of how the therapist and client perceive one another's similarities or differences in physical appearance, is an interesting part of the therapeutic work with eating disorders and body image issues. Some participants expressed being mindful of how their clients may feel about their therapist's body. Illustrating this, Bridget stated, "...*clients that really have obesity, I suppose I'm very conscious of not being that size, and bringing it up in the room...how that affects the client, me being that much smaller".* Bridget's quote indicates her awareness that her smaller size and weight may bring about difficult feelings with some of her obese clients. I feel that by Bridget being quite switched on to these issues of body difference with her clients, this enables her to sensitively explore this with them in the therapeutic dialogue, thereby including this as part of the work.

In a similar way, Penny's experience working with anorexic clients made her aware of how her slim body may impact the work. As a teenager and young adult she had trained to be a professional dancer and developed an eating disorder as a result of feeling immense pressure to be slim and 'perfect'. She was later able to find support in personal therapy and maintained a healthy weight for many years until suffering from a long period of ill-health in recent years which resulted in her currently being quite underweight at the time of the interview. Penny was conscious that her thin body may impact her anorexic clients and spoke about how it she addressed this in the therapy room after careful consideration in supervision:

Penny: I can't sit with who I am [...] at a weight that my clients dream of being. [...] When it felt quite figural and I felt comfortable that it was not my stuff, I said, 'I'm aware that I'm a very light weight and I'm wondering what that feels like for you?'

Upon reflection of Penny's quote, my view is that due to her past ill-health which caused her significant weight loss, that professionally there is a part of her which may feel uncomfortable representing an 'idealised' low weight that her anorexic clients wish to be. She thus chooses to bring this into discussion with her clients rather than having them assume she is anorexic herself. At the same time however, I wonder if her personal recovery has been impacted by her weight-loss as I believe there may also be a competitive part of her which has hooked into old disordered ways of thinking about her weight again, and she perhaps feels good about being the smallest, lightest one in the room with clients. This sense of competitiveness was also something I became quite aware of during the interview between myself and Penny, as our size, shape and weight differed significantly and she also spoke about noticing these differences between our bodies and how this felt for her. This is discussed further in my personal reflections in section 5.6.

In some cases it may be the client that brings this subject of difference into the room, by commenting or asking questions about the therapist's body. Alice shared that if a client asked her a direct question about her appearance, she "...*would turn that into an interpretation. Not a punitive interpretation, but just wanting to see what it was about, and why the client would think about asking me that, and what the unconscious had provided".* In my view, Alice's way of managing her client's questions demonstrates a constructive, sensitive approach to exploring the client's feelings about the therapist's embodied presence, rather than answering the client directly or self-disclosing personal information which would draw attention away from the client's process, and potentially risk become more about the therapist.

Alice also shared that when she was gaining weight and changing shape during her recent pregnancy, she had felt comfortable with her clients to explore this and draw attention to her body. She wondered whether this was easier because she felt more permission to be 'bigger' during her pregnancy:

> *Alice: I thought to myself, did you actually intervene like that because you are pregnant and you are allowed to be fat? Would you have done it if you were not pregnant? I want to believe I would've done it regardless of being pregnant or not...but there is still that little voice in my mind that tells me that's why I did that at the time.*

Alice's narrative suggests to me she may feel less comfortable and be less inclined to draw attention to her body as part of the therapeutic work if she *wasn't* pregnant as by implication of her comments, she may feel she's *not* 'allowed to be fat' if *not* pregnant. This experience was echoed by Megan during her pregnancy when she discussed her changing size with some of her eating disorder clients: "*Well obviously I'm pregnant and bigger, how is that for you?*" Like Alice, she admitted that drawing attention to her body and her size with clients may be harder to do if she hadn't been pregnant. Consequently, I consider Megan's comments as suggesting that she also felt permission to be

'bigger' during pregnancy, so discussing her size during that time perhaps felt more acceptable:

> *Megan: I didn't mind [...] during pregnancy, but maybe it was because of the pregnancy rather than having a very frank conversation about sizes. That might be more uncomfortable. It's almost like if it's pregnancy, it's a reasonable or different thing.*

Another way therapists used the body as part of the therapeutic work with their clients was to be mindful of body language and embodied experiences:

> *Sandra: In therapy I use the body quite a lot in that I'm very observant about body language, and I often ask clients what's going on in their bodies. And I do pay attention to what's going on in my body and how I'm sitting.*

In the above quote, my view is that Sandra has an awareness and careful consideration of what may be going on in the unspoken communication between her and the client, and she uses her own body language and embodied reactions with clients to provide her with important information about the therapeutic process. Similarly, Leigh spoke about the value, as well as the challenge, of using her embodied experiences in the moment with clients:

> *Leigh: It can be really helpful at times to be really honest and name it in the room, [...] I do sit back at times and actually acknowledge what I feel like, and it can be helpful to use what is going on in the immediacy. It is challenging.*

She also shared an example of how she used her physical countertransference feelings in the therapy room as important guidelines for exploring how her clients may be feeling:

> Leigh: *...when I work with clients, and a lot in the countertransference, I'll say, 'I notice when you said this that my stomach or my shoulders are killing me, can I just check, are your shoulders bothering you? Or is this*

my response to what you're saying?' And actually, quite often the client will say, 'actually my neck is bothering me, and my shoulders are as tight as anything'. Normally I don't have that feeling, so if parts of me start hurting when I'm with a client, I might think...okay I must check this out. So I use the body a lot.

Here I get a sense that Leigh is well-attuned to her body and mindful of any physical reactions she may have with clients. Her openness and comfort in drawing attention to her body comes across, and by exploring her embodied countertransference responses as part of the therapeutic dialogue, I believe that Leigh appears to model an accepting and healthy attitude about her body to her clients.

4.1.4 Assumption about Therapist Being 'The Sorted One'

This theme captures the experience that some participants had of their clients assuming that they do not, or have never had body image issues or an eating disorder, and therefore wouldn't be able to understand their problems. For example, Leigh talked in transactional analysis terms about the projection from some clients of 'You're Okay, I'm not Okay':

Leigh: In the room, the dynamic between us transferentially, I felt very much that I was on the receiving end of a lot of projection... 'you're okay, I'm not okay, you can't possibly understand'. And I remember her saying to me, and she sounded quite angry, 'You've managed to break down every other part of me and helped me to change, but this'...and she was talking about body image... 'This you will not change'.

In the narrative above, Leigh shares her experience of her client's resistance and assumption that her therapist couldn't possibly understand her struggles. I feel that this projection seems to fuel an angry determination in the client not to change, thereby reinforcing her belief that she is 'not okay'.

Some participants had experienced similar projections from their overweight or obese clients, who assumed that because their therapist had a slim or average sized body, they couldn't understand what their struggle was like. For example, Penny was aware of how her slim body may impact her eating disorder clients and imagined some may think, "*Oh it's alright for you. You've been born tiny, you're tiny so you probably don't have an eating disorder otherwise you wouldn't be doing this job*".

Megan similarly shared that she was conscious of her slim body in the room with overweight clients and wondered if they thought: "*how can you relate to my problem? You know, you're clearly not obese*". She expressed that as a *"general position [...], especially in the therapy room, I'd put on a good face",* and felt that "*as a therapist maybe the pressure is greater to look and feel like you're doing okay".* For both Megan and Penny, I feel their narratives demonstrate the conflict which a therapist with past body issues may feel when working in this field and these assumptions are made about them by clients. They understand first-hand what it is like to struggle with these problems, however because some clients may assume that their therapist would be without problems, there may at times be pressure on the therapist to convey this in their role as 'healer':

> *Megan: ...the notion of the therapist as the person who knows and can cope with and is dealing with, and the healer, when in reality of course, we know that it's much more complicated than that. But I think it's easy to sit in that role, especially if it's being possibly projected by the client...the sorted one.*

Bridget and Sandra had similar experiences with clients. For example, Bridget's obese client stated: *"How do you think I feel sitting here and you don't seem to put on any weight at all".* In my view, it seems that this client based her assumption about Bridget on her observation that her weight did not appear to fluctuate and therefore believed she couldn't personally understand what it was like to struggle with eating problems and body image issues. Similarly, Sandra

shared that some of her female clients made assumptions about her slim body: "*Oh, 'it's alright for you', 'cause I know I'm slim, so they maybe assume that I'm completely at ease, no issues, I don't struggle".* She spoke about her experience with an anorexic client who would often compare herself to Sandra: *"She used to look at me and saw me as being thinner than her, and used to say, 'How many hours do you spend down at the gym', and again make the same assumptions."*

In the next quote by Sandra, she shared how she had challenged this assumption sensitively in the therapy room without self-disclosing:

> *Sandra: ...one day she got very angry with me and said, 'What would you know...you've never had any problems'. Knowing her she probably called me skinny, but she got annoyed with me. And I looked at that with her and said, 'You know, I think we really need to talk about how you see me and if you feel that's getting in the way of the therapy. You know, you have a fantasy that I've never struggled'. So we spoke about that and that's probably the closest I've ever got, and that was good, it helped us.*

In these narratives by Sandra, I feel she conveys the powerful transference projections and woundedness of her client who perhaps felt alone in her struggle and believed that nobody could understand her, including her therapist. In my view, this 'therapeutic impasse' appeared to be impeding the work, however it seems that as Sandra was empathic towards her client's struggle, they were able to positively process this impasse which deepened the therapeutic alliance and opened up the possibility for therapeutic progress.

A contrasting experience was shared by Alice about her work with a client who struggled with her body image and the pressure to be thin to feel attractive. Although the client was a lower weight and smaller size than her, Alice shared that, *"when she looked at me she thought that I was healthy because I had allowed myself to carry extra weight. But in her mind it was something she would never do herself".* During the course of therapy, Alice's client began to slowly

change her way of eating and her exercise routine became less stringent. Alice also *"started to get lot of narratives from her about going to the gym and seeing curvy women doing gym and being very confident. And they were beautiful and that sort of thing"*. Therefore, I view the client's perception that Alice was content with her body and carrying extra weight as a positive experience for the client as I feel it slowly challenged her rigid views of beauty and what she saw as acceptable, enabling her to be kinder and more accepting of her own body.

4.1.5 Authenticity and Self-Disclosure

This theme captures the reflections and experiences of the participants regarding self-disclosure and authenticity in their clinical work with body image and eating problems. For example, Alice stated that "*you can be authentic without self-disclosing*", and Sandra felt that "*knowing that change is possible is what I can somehow bring without self-disclosing"*. These views were shared by most of the participants to varying degrees, as some chose not to disclose anything about their history, whereas others shared things with clients without being specific to convey understanding.

Although some participants expressed strongly that they preferred not to self-disclose details about their history to clients, they did not discount the possible value of self-disclosure as an intervention. For instance, Sandra acknowledged that in general, "*there's always room for self-disclosure",* but felt that, "*on the surface what's similar could be very different"*. Considering Sandra's comment, I believe this highlights the possibility for therapists to over-identify with their client's material, thus self-disclosure in this case may result in the therapist losing focus of the client's unique and subjective experience. In light of her work with eating disorders and body image disturbance, Sandra chose not to self-disclose:

> *Sandra: On the whole, I don't really self-disclose, and haven't really said anything about how I feel about myself in the here and now. But I imagine*

that perhaps because I'm talking about it in a hopeful way that maybe they'll see that somehow. I don't have any desire to self-disclose. I wouldn't say it's wrong, but it does make me feel uncomfortable so I don't want to do it.

In this narrative, I feel that Sandra's discomfort with sharing her history with clients is clear, but to my mind she also conveys a sense that her hopefulness about the recovery process from her own experience may be communicated to her clients nonverbally.

The notion that self-disclosure may be valuable as a therapeutic intervention was also shared by Candice who felt that in some instances, with certain types of client groups, self-disclosure may be helpful: "*very often a lot of people I worked with in the homelessness jobs, had been through the experience themselves, or through drug addictions, and they disclosed that to clients in their relationship, and that was helpful*". Here it seems to me that for Candice, these other contexts appear safe to disclose personal information, but like Sandra, she was also against revealing her own history with eating disorder and body image disturbance clients:

> *Candice: ...personally I've just always felt that as a therapist I can always keep that back, and if I told them it would become about me and them, and both of our body image struggles, rather than the focus being on theirs.*

In the narrative above, I view this as indicative of the potential negative consequence of self-disclosure as suggested by Candice, where she is concerned about the emphasis of the therapeutic work shifting into a shared struggle rather than what the client is going through.

In contrast to Sandra and Candice's views, some participants felt more comfortable with sharing personal information with clients if it felt appropriate. For

instance, Lauren was open to the possibility of self-disclosure, but like Candice, was aware of how this may affect the therapeutic relationship. She emphasised the importance of reflecting on whether this would help or impede the work:

> *Lauren: I don't think you need to disclose a specific experience to be able to work with somebody. On the other hand I think it's entirely dependent on the person and your relationship. [...] Some person perhaps down the road might benefit from hearing that I've had an experience that was a little bit similar, so yes I do have some sense of what they're going through. So I'd never say never, but I think I'd need to weigh it up super carefully because I feel very strongly about putting my fragility on somebody else. It could be very damaging to the relationship.*

Megan was more open to using self-disclosure if appropriate, but like Lauren, she stated that she would "*always use caution about when to actually say something".* Echoing Sandra's views mentioned earlier about the value of nonverbal communication, Megan felt that there was "*something about the unspoken communication as well, almost...conveying without saying...that can be helpful".* She also was mindful that self-disclosure may negatively impact the work:

> *Megan: It's just working out when is the right time, not to make it about you, but also [...] whether the client's going to be able to receive it, and whether it's gonna be helpful. [...] it may destroy how they see you at that time.*

In the above quote I feel that Megan conveys how self-disclosure needs to be carefully considered, as there is the possibility of this damaging the therapeutic relationship and the focus shifting to the therapist rather than the client as suggested by Candice and Lauren. An example of this negative consequence of self–disclosure was experienced by Nicola who shared a time when she felt she had shared too much with a client, which afterwards had "*felt a bit risky"* and she wondered how this had impacted her client's perception of her*:*

> *Nicola: ...in giving a lot of information about myself and my personal struggles, [...] in a therapeutic environment you wonder how is this being perceived, how is she making sense of what I'm saying? You know, is she just finding reasons why I'm not a good therapist, 'cause I was where she was coming from.*

In Nicola's narrative, it appears to me that her disclosure left her feeling vulnerable, exposed and uncertain about how her client was now viewing her capability as a therapist.

When used carefully in a considered way, some participants felt that self-disclosure could be an effective tool in therapy. For example, Leigh reflected on her choice of disclosing some details of her history to her client as an intervention or rather sitting in the negative transference as part of the therapeutic work:

> Leigh: *I find myself contemplating whether it's wise or not wise to disclose that you've had an issue with eating, so you do know exactly what it's like, or whether to hold that projection in the transference that's coming your way*".

In Leigh's narrative above, I feel that although she was discussing whether it's suitable or not to self-disclose one's past eating issues to a client, her words also highlight the risk of recovered therapists assuming that because of the shared experience, that one can actually know 'exactly what it's like' for another. To my mind, one can only ever really empathise with what it's like, as each person's subjective experience and relationship with their body and food is always unique. Leigh also gave an account about an experience with a client whom she had been seeing for two years who struggled with body image disturbance. The client often expressed that she believed Leigh couldn't understand her struggle because she was slim and appeared confident with her body. After careful consideration, Leigh chose to briefly disclose her past to her client, saying to her, "*I have had periods in my life where I've had a struggle with my weight, so I do have some understanding what it is like to struggle with your body*". This seemed

to have impacted the client in a positive way, enabling a deeper, more authentic relational exchange:

> *Leigh: She was relieved, she said, 'really? I can't imagine that, I mean look at you'. And I said to her, 'I understand that because you're seeing me now, but if you had met me twenty-five, thirty years ago, I was struggling, and I guess there's something there about us all being able to change, and your body won't always be like this, things will change through the aging process', so she felt relieved and it dissolved the transference, all the fantasy and projection, and it actually opened the door for a more authentic dialogue, which was much more [...] adult to adult, and she stopped feeling quite like such a awkward child to my adult, and stopped being in such a critical place.*

Here I believe that Leigh's narrative demonstrates the potential benefits of self-disclosure if used carefully and purposefully. Thus, in her client example above, the sharing of her past seems to have enabled the therapy to progress in a deeper, more trusting and authentic way. However, my opinion is that self-disclosure should always be used with caution, as shown with Nicola's experience where her self-disclosure possibly created mistrust in the client, and left Nicola feeling exposed.

4.2 Master Theme 2: 'Becoming Entangled: Old Feelings Resurfacing'

The second master theme reflects the negative personal impact on the therapist of working with eating disorders and body image disturbance, when elements of their personal struggle are evoked in the therapy room, and their own wounds became entangled with those of the client's. This master theme encompasses four super-ordinate themes: Over-Identifying with the Struggle; Worry about Judgement and Exposure; Heightened Body Awareness; and Feeling Ineffective.

4.2.1 Over-Identifying with the Struggle

This theme captures the feelings evoked in many participants when over-identifying with the struggle presented by their clients with body image and eating problems. This was conveyed by Alice who stated, *"there was stuff in their transference [...] about being fat and how horrible that is [...] but that was quite difficult for me to hear having my own issues around eating".*

Some therapists found that when their own material (past or present) was tapped into, they had to be aware not to let their own issues adversely affect the therapeutic process. For instance Alice shared that *"it can be so powerful"* and that there had been *"times that I think I have almost surrendered myself to becoming too entangled with it"*. She also spoke about the impact of this 'entanglement', saying, *"it's almost the same thing, you know, you over-identify with a client's issues. And when you do that, your issues take over".*

Megan similarly spoke about the personal impact of working with this client population, saying that *"it would link me back into my own stuff",* and that *"sometimes clients describing eating issues and image issues [...] would turn the focus back on to my weaknesses".* She shared the feelings that came up with her eating disorder client:

> *Megan: I had one client who's [...] inclined to bulimia and really struggled with her body and was always going to the gym [...]. It would set off that bit in me that would say, you need to do some exercise, you need to do some running, you need to watch your weight, [...] it would set off that critical part in me. I'd notice in sessions with clients, or afterwards I would be more aware. I think that's what it does, it turns the awareness on...it turns the focus back on to your own body.*

In the quotes above, my view is that Megan's over-identification with her client's struggle seems to have stirred up highly critical and punitive feelings towards herself and her own body. She expresses an awareness of her focus shifting

towards herself, thereby possibly losing focus of her client. The notion of 'losing focus' of the client's struggle was emphasised by Nicola who stated, "*it's like a blind spot*" that's hard to see past. With one of her eating disorder clients she had noticed herself "*really relating to the urge of eating and relating to what she was telling me. She'd say, 'I'd planned it', and all I could think of was planning it*". She also shared some of the countertransference responses she had experienced while still a new therapist:

> *Nicola: I felt really stuck. [...] Some of her behaviour was just like my behaviour, you know like thinking I need to eat something and going to get it and stuffing your face. Well I still have that, but I think I'm more in control, whereas this person was not in control, and I just couldn't see myself helping her because I don't even know why I'm doing it, and don't even know how to control it myself, so how can I help this person to do that?[...] I was a very new therapist and I couldn't see past the issue.*

To my mind, these narratives by Nicola demonstrate the deep personal impact of working with client issues that were so similar to her own. I feel that she conveys a sense of hopelessness about how to support her client with problems that she too feels so powerless to tackle in her own life, thereby potentially leaving herself and the client lost in overwhelming feelings.

Some participants had also experienced negative feelings of insecurity and inadequacy about themselves with clients. For instance, Penny had felt more self-conscious about her body: *"I admit it does trigger me. I wonder what she thinks of me",* and Candice also described "*feeling kinda tangled up, worthless and a bit inadequate, and anxious. I think that's quite a strong, powerful countertransference for me".* In Leigh's case, she had been 'recovered' from her battle with bulimia for many years and felt good about herself and her body, however she shared that at times she experienced a sense of 'regression' to an insecure place after feeling judged by her client:

Leigh: ...it takes me back in a form of regression, for a moment I feel like I'm back there, fourteen or fifteen, when people were making comments. [...] It can take me back to the moment, and in that moment it feels hostile to me. [...] I'm aware that that's my own stuff, I know that's my own countertransference.

In my opinion, these quotes by Penny, Candice and Leigh convey that for recovered therapists working with these very painful feelings about the body with their clients, it is inevitable that they may connect to some degree with the client's feelings which at one time were also quite present for themselves. In some instances this had a negative impact on the therapeutic process. For example, Lauren shared that with one client she'd felt inadequate and helpless: "*it zoomed me back to that child-like place, [...] not just inadequacy but feeling that I can't do anything",* and had stirred a desire to escape: *"I felt like running away, and not wanting to be there anymore, not wanting to be the focus of attention, wanting to be invisible".* Here I believe that Lauren's narratives paint a picture for us of how disempowered she may have felt at the time in her role as therapist, as her own feelings had become so overwhelming that she wanted to be invisible.

To a lesser extent than Lauren, Sandra also spoke of not wanting to be seen. Although she held a healthier view of herself now and felt quite comfortable in her body, she shared that there were also times with clients that her old feelings could resurface: *"I've had days where I have not wanted people to look at me, so although a lot of it has been dispersed, I know there's something there that can still touch me".*

4.2.2 Worry about Judgement and Exposure

This theme demonstrates the worry expressed by some participants of being judged by clients about their appearance, and the concern that their body image issues, whether past or present, may be exposed or 'obvious' to others. This was

expressed by Nicola who questioned: *"do they realise that this is my struggle, losing and gaining weight?"*

For some therapists who had recovered from eating disorders and body image problems, there was a sense of shame and a desire to hide this painful part of their history from others. For instance, Candice had managed to maintain a healthy weight since her recovery from an eating disorder, and in the following narrative I feel she conveys a level of self-acceptance. However, in my view she also appears to feel a lot of shame about her past and the worry about what others (both clients and colleagues) would think about her if they knew:

> *Candice: The last year or so I've been working in eating disorder settings. I think sometimes it's perhaps quite difficult, so I think even though I feel okay about myself now, I [...] wonder if clients or staff will pick something up about me or how I used to feel.*

Differing from Candice, some participants shared that they *still* battled with their weight, eating habits and body image at different times in their lives, although not to the extreme of an eating disorder or body dysmorphia. I believe this highlights the fluctuating nature of recovery from these problems, as it appears that at times in one's life, body image problems may re-emerge. For instance, Nicola shared that her weight fluctuations and body image concerns were still a problem for her despite working on these issues for a number of years in personal therapy: *"I don't think I've ever quite dealt with it...I still have issues with it".* Although she had not chosen to work specifically in the field of eating disorders and body image, these issues would sometimes present themselves indirectly with some of her clients. She was conscious of how her own issues may be affecting her professionally and felt that *"nonverbally it's in the room that you have an issue".* She shared her concerns about whether clients were aware of her problems and wondered how they viewed her:

Nicola: I'm wondering how do they perceive me [...] you know, you want your therapist to be stable, you want to trust your therapist, and I wonder what is their association by me doing these large jumps in weight.

In my opinion, Nicola's lack of confidence in herself and her abilities is focal in the quote above. I get a sense that she feels that her credibility as a therapist is undermined by her weight fluctuations and a fear that her clients will interpret this as her being untrustworthy and unstable.

A number of the participants had recently had weight fluctuations due to their pregnancies, and this brought up varied feelings for them in their client work. For instance, Megan had been dieting to get down to her pre-pregnancy weight so she noticed feeling more sensitive about her appearance with her eating disorder clients. She expressed her concern that this may be communicated nonverbally to clients who may be hypersensitive to these feelings themselves:

Megan: If you've got issues and come into a room and worrying about what you look like with clients, feeling a bit sensitive or attentive to that, of course I think clients pick up on that.

Alice also felt she was carrying some extra weight after her recent pregnancy, and although she now had a healthier view of herself, at times her old insecurities and shame about her body would creep back:

Alice: ...when my weight is more than usual, then I get quite down about the fact that I'm overweight and fat, and what do people think about that. How do I fit in? What does that say about me? How do they interpret it?

In the narrative above, I believe that Alice's weight-gain may have triggered a critical view of herself and she begins questioning how others may judge her worth, based on her appearance. She expressed her worry and shame that clients may make assumptions about her:

Alice: I think overall there is the issue of being of a certain shape. We all make assumptions about each other, but I think body shape and body size [...] allows people to draw lots of conclusions about others, so that's where the shame I think for me comes from. The shame of knowing that someone might, and not all the time and in all situations, but the shame from knowing that someone just by looking at me is judging me.

Alice's core wounds become apparent to me here, and I feel it's evident how overwhelming her shame is about her appearance, and her concerns that others may be thinking negatively about her. In her work with clients with body issues, Alice also felt that because of her past she had a default position "*to think that the female client opposite me is going to criticise me in her mind about the way I look. And I have to be very, very careful about that*". I see this quote as indicative of Alice's awareness about her tendency to assume others are judging her, and shows that she is mindful of monitoring this to support herself. Like Megan and Alice, Lauren was also trying to lose excess weight gained in pregnancy and this had similarly resurfaced some of her past negative feelings about her body and a fear of how she may be perceived by clients:

Lauren: I'm still carrying extra weight and don't feel completely comfortable. [...] unfortunately I have to accept that I still haven't got rid of this, and it's still affecting me and how I feel about myself. And I think, what does it say about me that I'm carrying around extra weight? At one level I think, it doesn't say anything about me, it's just a symbol of one of my problems, and we all have problems and mine is manifesting in this way, the way I eat, my particular relationship with food, but in another way then, you know, I see it as I imagine other people see me, as slightly inadequate for being a few pounds overweight.

Although Lauren's old feelings of inadequacy are evident in the quote above, I feel she is also able to consider alternative ways of viewing herself and her weight-gain, which I believe indicates her reflexive capacity and healthier sense-of-self.

4.2.3 Heightened Body Awareness

This theme reflects the feelings of heightened body awareness experienced by participants in their work with eating disorders and body image disturbance. This could occur when confronted with issues of difference, such as being at a higher or lower weight than their clients; having different body shapes, sizes or physical capabilities; as well as when they saw themselves as being less attractive than their clients.

For instance, Candice was conscious that her slim body was being scrutinised in the anorexia group which she facilitated. She noticed "*a lot of comparing*" and shared that *"even though they're painfully thin, they still saw themselves as the largest body in the room".* She had a sense of her body being scrutinised, and with one client felt *"invaded upon with her gaze. My body was being watched and judged".* Candice's narrative conveys to me how mutual body awareness may be heightened for both therapist and client in the room when working with body issues. This experience was also shared by Megan:

> *Megan: ...bearing my body image history in mind, it's always something I've been aware of with clients, so my size, my shape, what I wear, makeup, and how that impacts in terms of the client. So particularly when working with clients who have eating disorders or body image issues, [...] that'll come up for me a bit more, and I'll be a lot more aware of how I look because I know they're tuned into that.*

Some participants also reported feelings of discomfort when it was obvious that they were at a *lower* weight than their clients. For example, Megan described *"not wanting to stand out for being more attractive than or thinner than others"* and shared some of the feelings she experienced with her obese clients:

> *Megan: ...it makes me feel embarrassed about the way I look [...] if I recognise that I'm a lot slimmer than they are, and that's what they desire. I also get very uncomfortable about that [...] I think because I have to work hard to sit in the potential negative transference.*

In these instances Megan said she noticed wanting to "*dull myself down in a way... to avoid sort-of potential jealousies*". In these quotes, I get a sense that her discomfort in these situations and consequent desire to become less noticeable seems to conflict with her need to always look her best. She later describes this conflict as "*wanting to be seen as attractive, maybe even by your clients, but at the same time [...] not necessarily wanting to be visible, and not wanting to be seen*".

For some participants, they noticed feeling more self-conscious about their appearance and their bodies when they saw a client as being *more attractive* than them, and this could bring competitive feelings into the room. For example, in Penny's experience working with anorexic clients, she gave an honest account of the competitive feelings that came up for her:

> *Penny: It's always an issue for me with some of my anorexic clients. I know I'm lighter than them so that's going to be in the field, but sometimes I look at them and think, you're gorgeous, everything is in the right place. I become aware of my pushing-forty body, whereas perhaps before that I wouldn't.*

In my view, Penny's narrative suggests that she still identifies with the association that being a low weight (as some of her anorexic clients are) is attractive, and this is perhaps because she was feeling more conscious of her own appearance due to illness and aging. Therefore I believe that Penny's narratives allude to her having some old 'disordered' ways of thinking that may be resurfacing when she admits in the following statement that she feels proud that she was at a low weight without intentionally starving herself: "*If I go to a deeper level of honesty, there was a feeling of pride 'cause I haven't had to try to be this, I just am*".

In these quotes, Penny describes feeling self-conscious with some clients who she saw as being more attractive than her, but was also aware of what they may think about her because she was slim, and therefore represented 'the ideal' for some. She also shared that she was trying to gain weight and improve her health after her physical illness; however I feel this indicates the complexity of her struggle with her body image, as there seems to be a part of Penny that also likes being this ideal low weight which she always strived to reach during her eating disorder, even though her weight-loss at present was due to a physical illness.

Nicola was open throughout the interview that body image concerns were still something she was working through and I consider this to be evident by the heightened sensitivity she had about her appearance, particularly when working with eating disorders and body image disturbance, and her concern about what they thought of her. For instance, with a client whom Nicola thought was more attractive than her, she noticed herself thinking, "*you look so wonderful, so what do you think about me as I don't look that wonderful*".

In contrast to Penny's experience, Nicola was a higher weight than her anorexic client and therefore felt her curvy body represented something negative for the client. She was worried how this was interpreted, as her client "*didn't want to be overweight, and then seeing me overweight, how did that make her think and feel about me?*". Similarly with an overweight client she also described her worry that they would assume she also had an eating problem because of her size: *"I just wondered if she was thinking that I have an eating problem because I'm overweight and she was overweight. [...] she must think I have an eating issue".*

In Nicola's narratives, it comes across to me that her self-consciousness about her body, and concerns about others thinking she's unattractive, overweight and has an eating problem, seem to be a shameful and painful experience for her

which I believe may often result in her over-identifying with her clients' body image issues.

Lauren similarly shared that she had felt self-conscious in the therapy room due to her increasing weight-gain during early pregnancy before this was officially announced to her clients. Like Nicola, I feel she conveyed a sense of discomfort that her clients may be thinking she was overweight:

> *Lauren: I think my pregnancy became quite obvious early on [...] as I put a lot of weight on [...], but I remember wanting to look pregnant in both pregnancies very quickly, rather than fat, so even though I didn't want to tell anyone before thirteen weeks, at work and in the therapy room, I think I often found myself rubbing my tummy or doing things that would obviously be associated with pregnancy. So [...] there was definitely discomfort around people thinking that I was fat.*

Bridget also spoke about her ongoing body image issues: "*If I'm honest, I'm still sort of worried about it all the time".* Echoing Penny, Nicola and Lauren, she described sometimes feeling self-conscious around attractive clients: "*If there's a girl sitting in front of me who's quite beautiful and slim, I mean I will find myself maybe covering my body with my arms".* Bridget also spoke of being aware of some of her clients' competitive behaviour around appearance:

> *Bridget: I often pick up from a client how they feel [...], how competitive they become in the room with how you look and how they look. There's always that eyeing you up and down, and saying, oh that's nice what you're wearing. So first of all there's the way they look at you, [...] and then there's the comments.*

In my view, Bridget's quotes serve to demonstrate the unspoken communication between therapist and client, particularly regarding the subtle cues about one's relationship with one's body. Bridget seems to use this as valuable information about her client and how they feel about their physical-selves in the room.

Some participants experienced a heightened awareness of their bodies when working with *difference* and body issues which were unique from their own experience. For instance, Megan reflected on an experience with a female client who presented with body dysmorphia about certain parts of her face:

> *Megan: It's interesting because I didn't relate so personally, [...] so then in a sense, any sort-of transference that I felt, I knew it was part of the client's process rather than part of something in me. And there was something about the invitation of that client to scrutinize [...] that part of her face [...] and of course that was her experience with a history of bullying, so I think then in the transference, there's the induction to agree with her and the induction to pull her down.*

In my view, Megan's narrative above conveys the unspoken communication within the therapeutic dyad as she had experienced a pull in the transference to criticise her client and collude with the client's negative views of herself. In this instance, I believe that as Megan's own body image issues were not present for her, she could acknowledge that this was the client's projection onto the therapist from her experiences of bullying.

Bridget also shared a humbling experience in her work with a disabled client who struggled to accept his body and its limitations. She became very aware of being 'able-bodied': "*I can walk, and I can go to the toilet, so many of the things he can't do".* For Bridget, this experience was significant in her own healing as she shared that it helped put her own body images concerns into perspective.

For Alice, a feeling of shame about her appearance was easily triggered with some clients: *"there are times when I sort-of felt ashamed",* and that this was *"usually with clients who have an issue with food themselves".* This contrasts with her experience of working with a male client who had body dysmorphia. Alice and her client were very different in appearance, in terms of their height and body

shape, and interestingly she noticed feeling very comfortable in her body with him: "*His problems are about being very tall and very thin, and body shape and issues around body are always present, and I felt very comfortable*".

In Alice's quote above it seems that as they were very different physically, her own body concerns were not triggered, however I believe she could still understand his feelings of shame and discomfort with his body, and they shared a similar experience of having absent mothers who were not very tactile:

> *Alice: ...the feeling that I never had it from my mother. So my basis is similar yet very different at the same time, because he didn't have it from mother. His mother's the same, his father's the same, his sisters are the same, the never hug, they never kiss, they never say they love each other face to face, so you can see where all these ideas about his body may stem from.*

In Alice's narratives above, I feel she demonstrates a very sensitive, shame-based relationship with her body; and at times she seems to become very self-conscious about her appearance if she over-identifies with certain clients with similar issues to her own. However, with her male client above, I get a sense that she grasps the complexity of his struggle in a deeply empathic way as she understands, from her own developmental trauma, how the lack of maternal attunement, touch, love and affection, may significantly impact a person and shape their view of themselves and their body image.

4.2.4 Feeling Ineffective

This theme captures the negative countertransference experiences described by participants of feeling ineffective in their role as therapists. This encompassed times when the therapist had felt deskilled or out of their depth; or had felt stuck or frustrated in their work with clients who were not moving forward.

For example, Bridget reflected on her work with her disabled client who struggled with body image problems, stating, *"I feel helpless because I can't change anything for him, I can only listen"*. This quote suggests to me that Bridget was perhaps experiencing a lot of projection from her client about how helpless and hopeless he felt about the limitations of his disabled body, and it was perhaps difficult for Bridget to just 'be with him' in his suffering as this was so painful for him.

She likened this challenge to her difficulty in supporting her daughter who also struggled with eating problems and body image issues: *"I suppose I can't fix it...I can walk beside her, which is her journey, and she's the one to choose whether to fix it or not"*. I believe that Bridget's struggle with bearing her client's pain, which in some ways resembles her daughter's struggle and perhaps also her own body concerns, is indicative of the feelings of ineffectiveness that she was experiencing. Although this was a challenge for her personally, it seems to me that she aware and able to bracket her own issues so she can be there with her client.

Another negative consequence of working with this challenging client group was the feeling of frustration that a number of participants expressed. For instance, Bridget had a client who was quite resistant towards change in therapy, and Bridget shared that she felt frustrated and was thinking, *"we're playing games...is this just a game for you*?". She went on to describe eating disorders as a type of addiction which was reminiscent of her frustration with her father's alcoholism, and a sense that "*you can't do anything*":

> *Bridget: ...they're not very committed and attached to the situation, and that's very frustrating for me. And that comes back to any addiction. It has a similar emotions attached, grandiosity, superiority, denial, and I suppose coming from a background where my father was an alcoholic, you recognise those.*

These quotes by Bridget paint a clear picture of what it was like for her living with her alcoholic father, and I get a sense that she has to work hard to manage her frustration when similar 'addictive' and resistant behaviours are manifested by her clients. Similarly, Leigh and Sandra shared that they had felt frustrated with their clients' resistance to change:

> *Leigh: I just thought, what's the payoff in you staying with this really persecutory place with your own self? What is the payoff? And we did make a bit of headway, but I felt like I was pushing her, so the resistance was huge.*

Here I believe that Leigh's narrative conveys her frustration with her client's resistance to letting go of her self-destructive behaviours. In this case I consider her intervention to be effective as her client was able to manage being challenged because of the strong therapeutic relationship. In contrast to Leigh's successful intervention, Sandra had experienced a lot of rejection and withdrawal from her anorexic client after Sandra had become frustrated and challenged her on her dysfunctional thoughts and behaviour:

> *Sandra: ...she was always trying to push me away, and in some ways she did it because I used to get frustrated with her, and maybe I thought [...] how can you look at yourself and see that you're not thin.*

In my opinion, these varied client experiences by Leigh, Bridget and Sandra convey the importance of the therapist discerning what the client's resistance may be about, and how to intervene appropriately to support the client.

At times with certain clients, some participants had experienced a sense of being deskilled or inadequate in their roles as therapist, particularly in the early stages of training when they were less experienced. For instance, in Candice's work with a difficult eating disorder client, she shared that she had felt "*quite useless and inadequate*" and sometimes "*found it difficult to remember that I was the*

therapist". Here my view is that Candice's countertransference reaction was perhaps in response to the client's projection of the insecure feelings she had about herself, which seemed to stir up Candice's own issues, as well as her lack of confidence as a new therapist.

Nicola similarly described an experience of feeling ineffective as a trainee therapist when she saw a severely underweight anorexic client briefly for therapy who was awaiting in-patient treatment. She expressed feeling "*really concerned and wary, and insecure about my ability to help her*". Essentially I get a sense that Nicola was feeling out of her depth:

> *Nicola: I felt quite lost and not knowing how to help her, but then realising it's not right that I help, or that my help is not good enough as she needs more than my help, a whole team supporting her to start eating more. So that was terrifying actually.*

In Nicola's narrative, she expresses her self-doubt and fear about being in-effective as a therapist to help this client. However, I believe she also seems aware that rather than this being her failure, that the client was perhaps not suitable to be seen by her due to being high risk and urgently needing a multi-disciplinary team to support her.

4.3 Master Theme 3: 'Self-Support Strategies: A Life-long Healing Process'

The third master theme encompasses the strategies used by participants to support and care for themselves in their professional and personal lives. This includes five super-ordinate themes: Self-Acceptance and Respect; Healthy Attitude to Eating and Exercise; Relaxation and Reflection- Sitting with Honesty; Recognising and Bracketing Own Issues; and Support in Supervision and Personal Therapy.

4.3.1 Self-Acceptance and Respect

This theme of developing greater self-acceptance and respect captures an important part of the recovery process described by participants in working through their personal body image problems. For example, Sandra shared that she felt more accepting of herself but without a pressure to be perfect: *"It doesn't mean I think I'm perfect or wonderful, it just means, you know what? I'm okay".*

It appears to me that the turning point in Sandra's journey of healing began when she decided not to let her family's criticisms determine how she felt about herself: *"I decided that I'm not gonna let my family [...] dictate to me how I feel about me".* Similarly, Candice expressed that she felt different about herself now: "*I feel more accepting of how I am, and my weight doesn't really change anymore. I don't feel like I have to exercise loads, [...] I just feel I can just be normal".* I feel that she echoes Sandra in no longer feeling a pressure to strive for 'perfection', but they have both come to a place of self-acceptance and a realistic view of themselves as being normal and 'good enough'.

Although Candice shared that she still felt self-conscious about her appearance at times, she said, *"I don't use how I feel about my body as an emotional punishment anymore*". Through her self-acceptance she had also become more comfortable and confident socially:

> *Candice: On a personal level I guess I feel more comfortable in friendships, and feel a bit more confident when I meet new people. [...] I always used to think people don't really like me, and didn't know what to say, now I just think well, you know, just be yourself...and it's easier to be yourself.*

In the quotes above it seems to me that Candice's self-acceptance has enabled her to be less critical and punitive towards herself, allowing her to be more relaxed and authentic with others. Penny also described how, despite having to adjust to the physical changes in her body through aging, her self-acceptance

meant that her self-worth and professional achievement was no longer defined by her appearance, compared to her days as a dancer:

> *Penny: I'm happy with myself to a certain extent [...]. There are changes in my body, slight signs that point towards menopause, yeah, I mean, I don't want to get too perfectionistic about myself at all, but I'd like my bottom and my boobs back a bit. It's not bad, but it's not good you know. It doesn't define who I am as much. My career doesn't depend on having this beautiful figure.*

Penny's words suggest to me that although she thinks there are parts of her body that aren't 'perfect', she also conveys that she is relatively content with herself. When asked how her body image impacts her personally, Leigh similarly spoke about being accepting, content and grateful towards her body:

> *Leigh: I'm honestly very happy in my own skin and I think that's what's happening to me. You know, I don't think I'm perfect or body-beautiful or anything like that, but I think I'm good enough, and I'm comfortable in my own skin. [...] what matters to me is that I'm content with what I see, and I'm content with my aging process. I'm accepting where I am in my life, and I'm really grateful that I was able to have children, as I really thought I wouldn't be able to. So I'm very grateful to my body.*

Leigh's words are similar to those expressed by Sandra, Candice and Penny, which I view as conveying a sense of feeling 'good enough' about one's body despite having some imperfections which no longer feel unacceptable.

Significant life events such as pregnancy and illness had challenged the negative views some of the participants held about themselves. This often represented the change moment in their recovery journey, when their view of themselves and their bodies was redefined. For example, Leigh had developed a new-found respect for her body during pregnancy along with nursing both a close friend as well as a parent who died from terminal illnesses in close succession:

Leigh: This just made me aware of how much I owed to my body, and that in time, anyway my body would become frail, and actually what I appreciated was the strength. So now-a-days when I think about my body, I think about what a gift it is to have a body that works and I don't think of myself in terms of body image at all, it's more what a wonderful organism it is, and just to appreciate what I've got.

Leigh's great respect for her body, its capabilities and her health becomes clear to me in her narrative above, and I consider this to be significant in maintaining her recovery process. Similarly, Alice's pregnancy and experience of becoming a new mother had profoundly impacted her perception of herself and her body in a positive way. This helped deepen her recovery process which had begun in personal therapy during her psychotherapy training. She said, *"I have a lot of thoughtful respect for my body after giving birth"* and shared that, *"I respected and loved my body because of it, not 'cause of what it looked like. Because of its potential and what it can give me".*

Here I feel that Alice's narrative conveys how she has developed a kind, respectful relationship with her body, and feels a sense of pride about her body's ability to create and bring new life into the world. Her self-respect and acceptance are also evident in her comment about still carrying extra weight from her pregnancy: *"I am at the most comfortable with my body that I have ever been, [...] but perhaps I'm also at the biggest I've ever been too, which is interesting".*

For some participants the process of self-acceptance and recovery was an ongoing journey and a life-long healing process as participants talked about their body image concerns resurfacing at times due to physical changes and weight fluctuations through pregnancy and aging. For example, Megan shared that during her pregnancy she *"didn't mind being bigger and pregnant"* and that she felt *"there's permission, you can enjoy it".* She had since lost the extra weight and

when asked how she felt about her body now, she talked about her old feelings resurfacing:

> *Megan: I feel good about my body now, but I'm also aware that I feel good about it because I'm thin, I'm slim at the moment. [...] so it's still around then that thin, or slim equals feeling good, do you know what I mean? That's the idea that's obviously still there for me, which is interesting.*

To my mind, Megan's narrative suggests she had only felt comfortable carrying extra weight because it was acceptable during pregnancy, but having since lost all the weight, she acknowledged that her association of '*thin or slim equals feeling good*' is reminiscent of her previous disordered thinking about her body. I therefore believe that Megan's self-worth may still be hinged at some level on her weight and appearance, and that her journey of recovery is ongoing.

Similarly, Lauren felt her body image concerns were an on-going struggle: *"I don't think this will ever end because it's so deep, [...] there's so many levels to it you know, so I need to be kinder to myself about it"*. These issues were also heightened after gaining weight in her recent pregnancy and by becoming aware of the changes to her body through aging. This created lots of anxiety for her, and she shared feeling *"fear and panic, and it's mirrored in my body. I guess my body is a reflection of that internal panic that I'm getting old"*. Although it is clear to me that Lauren still struggles with her body image, I feel that the next quote demonstrates that her acceptance, value and respect for her body has improved, and she is mindful of trying to be less self-critical:

> *Lauren: I feel like I have an acceptance of it to a degree, [...] much more than I had then, but it's a daily battle. [...] at least it's going in the right way, like I'm catching myself when I'm having bad thoughts about myself around food, like you shouldn't have done this and that, so I'm catching myself, and I have some respect for my body and [...] appreciate all the great things it does for me.*

Nicola shared that she also still struggled with self-acceptance, and her narratives suggest that her self-worth fluctuates with her weight changes: *"I'm struggling with the idea that this might be me for the rest of my life, that [...] maybe when I feel stronger I can lose some weight, but then quite easily I'll put it back on"*. She admitted that she is still seeking *"a breakthrough that will release me from this up and down"*. Although at times I view Nicola as coming across feeling quite defeated about her struggle, she also talked about her ongoing battle that she isn't quite ready to surrender to:

> *Nicola: ...part of me wants to just give up and surrender to it, and say okay, I'm gonna be overweight for the rest of my life, just deal with it. But yeah, I've not ever been happy with that. It's a big battle actually, a battle of two minds.*

4.3.2 Healthy Attitude to Eating and Exercise

This theme focuses on participants having healthier attitudes towards eating and exercise, with a focus on health and wellbeing as an important part of the recovery process. This was demonstrated by Penny who had suffered from poor health and exhaustion from a recent illness: *"I'm trying to take better care of my body to get better"*. She talked about eating and exercising for her health, and seemed aware of needing to continually manage her self-care: *"I eat normally, quite a lot, I need to exercise more, but for my health rather than weight"*. Participants were mindful of trying to manage this day-by-day; which was captured in Leigh's statement: *"I'm trying to be as caring for myself as I can, when I can, which is not nearly enough, but I try"*.

For many participants, it appears to me that the motivation behind managing their eating and exercise had changed, with the emphasis now being on trying to make healthy choices with their eating, enjoying food more, as well as keeping active with regular exercise as a support strategy for managing stress and looking after their bodies. For instance, Alice shared that her motivation for losing

weight and going to the gym after her recent pregnancy now felt different to her old critical drivers: *"It's not about vanity [...], the motives behind it are very different to what they were in the past".* Having always felt restricted by carrying extra weight, Alice said she now wanted to be "*bodily more able*" to enjoy her time with her child. She shared: *"It's not about depriving myself, it's about gaining something out of it".* In these previous quotes by Alice, I believe her experience of becoming a mother seems to have reshaped her views about herself and her body. Thus I feel that her more recent efforts to lose weight appear to be focused more on caring for her body rather than punishment, and a desire to be more comfortable in her body, in order to enjoy her time with her child.

A shift of focus was also conveyed by Candice who shared in the interview that she was newly pregnant. She was conscious of eating healthily to look after herself and her new growing baby, and although she had already stopped her disordered eating patterns for a number of years, it seems to me that this pregnancy enabled her to form a new relationship with her body, and consequently, a new view of food as nourishment and something to be enjoyed:

> *Candice: I'm thinking more about the need to eat well properly and nourish myself for the baby, so there are a lot of positive effects. And I've been feeling a lot more comfortable in my body over the last few years, and doing the course, and I've not consciously dieted or starved myself, but I don't think I'd enjoyed food or thought of it as nourishment before, so yeah, it has affected things.*

Other significant events in recent years had also challenged Candice's negative perception of food, namely her relationship with her husband and her previous work in the homelessness sector. She spoke about travelling abroad with her husband to visit his family who were quite impoverished. She had observed that for her husband and his family, food was something to be appreciated and enjoyed: "*I think he kinda helps me to put things into perspective. His family are [...] quite poor and their food is [...] something they treasure, and they sit down*

and have a family meal". Candice also shared the similar impact that her work with homeless people had made on her:

> *Candice: When you see people living in the streets and coming to the hostel, you can help them with practical things like giving them a hot meal, and you see actually it's just about keeping alive, food [...]. I think that's kinda shifted my perspective.*

Here I find Candice's narratives provide a very moving picture of her journey of healing and recovery. Her personal experience of being pregnant and becoming more focused on nourishing her body with healthy food, and her observation of others' poverty and their appreciation of food as a basic life-source, seem to have enabled Candice to develop a healthier relationship with eating and her body.

Sandra also talked about embracing a better attitude towards food and of making healthy choices with her eating: *"I think from mid-twenties onwards I had a much better attitude towards food, a much healthier attitude".* She identified that the *"legacy"* of her body image issues was that she was still mindful of what she ate:

> *Sandra: I am careful with what I eat [...] so I don't deprive myself, but for instance, I never eat anything sweet, and I do eat healthily, but that doesn't mean I won't have a pizza. [...] That is the lasting legacy of what has happened to me. I won't order fattening things. I went for lunch yesterday and I wanted to order something else, but I decided to order that. So I do eat good portions and I do eat well.*

In the above quote, I believe that a significant part of Sandra's successful recovery involved adopting a better attitude towards herself, her body and her health. Although she says that she doesn't deprive herself, she also seems aware that as a result of her history she still avoids or restricts certain things from her diet that are sweet or fattening, so there appears to be a regular, conscious decision-making process for her to make the 'correct' healthy choices with her diet. Sandra also talked about looking after her body by doing regular exercise at

home, and in the following narrative she emphasises that her recovery and self-acceptance as being evidenced by her not being obsessed with being in the gym for hours like some of her clients were:

> *Sandra: I do think I'm accepting of me, but I've never been to gym ever in my life. [...] There is something about me that thinks I must be alright 'cause I don't go do those things. I do exercise but I do it at home.*

Like Sandra, Bridget also spoke about her enjoyment of food and of not 'depriving' herself: *"I love food. I find it very hard to deprive myself. Even if I'm on a diet I like to be eating quite a lot of food".* She also shared how she was mindful of making healthy food choices to look after herself: *"I'm trying to be quite healthy I must admit, and I'm quite aware of that, and that I can eat quite a bit and it doesn't have to be fattening things, so I can have more salads and things".* Here I feel that Bridget communicates her enjoyment of food, and seems conscious of eating healthier, less-fattening types of food rather than restricting her eating. She was also aware of trying to exercise regularly to manage her weight, but this seemed to be a challenge at times:

> *Bridget: It's a little more of a struggle to keep the weight off, although I walk for an hour and a half every day and I do go to the gym and play tennis, but not doing it as constantly as I used to.*

Two of the participants reported sometimes using negative ways of coping when they felt overwhelmed after their sessions, for instance Megan shared that at times she restricted her eating: "*I think it's still a way of asserting control, controlling what I eat [...]. So by no means do I have an eating disorder now [...] but I still recognise some of the behaviours around managing what I eat".* Nicola also shared that she would sometimes comfort-eat: "*I think eating has become a soothing thing, and it's how I, wrongly in a way, take care of myself. And it's interesting how with some clients I'll come out and I'm very hungry".* Both participants acknowledged that their eating was sometimes reminiscent of previous patterns, however neither felt this was to an extreme of an eating

disorder as in their past experiences, and to me seemed mindful of trying to manage this.

4.3.3 Relaxation and Reflection- Sitting with Honesty

This theme demonstrates how participants include various activities in their personal lives which help them to relax and reflect, and as a way to manage stress or residual feelings after therapy sessions. In my view, this process enables the working through, or letting go of difficult or negative emotions, and was captured by Megan who talked about *"being really aware to take it slow and sit back with honesty".*

Participants spoke about consciously making time for personal reflection outside of the therapy room. For some this meant acknowledging and thinking about any residual feelings after seeing clients, and sharing feelings with those close to them; or by writing down thoughts and feelings after client sessions. I believe that this process also seems helpful in preparing to explore these issues in clinical supervision (discussed further in 4.3.5).

Megan shared that if she felt overwhelmed or low, it was helpful to share her feelings with those close to her: *"to some people occasionally I would say I feel really bad, you know, be honest to some people".* She would also make time to reflect on things after client work, particularly if she had experienced difficult feelings in a session:

> *Megan: If it's about me, I'll take some space to deal with it and reflect on it. What's happened to you? Why have you gone into this place personally and what's triggered that? I'd try manage it and make sure it doesn't go down some obsessive path.*

Here I feel Megan clearly indicates that by taking time to reflect on her feelings she can decide about how best to support herself. Candice also found it helpful

to write down her feelings after client work and was conscious of trying to make time to think and relax:

> *Candice: I think I write down a lot how I feel after sessions. Just trying to make space for doing things that are relaxing, and realising I can stop working and I can enjoy things. So things like going for a walk or having the space to kinda think.*

Here Candice emphasises giving herself permission to relax, '*stop working*' and to '*enjoy things*' as a way to restore herself. Similarly, Alice spoke about making time to reflect on her client sessions and write down her thoughts and feelings, particularly if she experienced strong countertransference reactions with a client. She talked about *"reflecting and writing down post-session, to really look at the dynamics of whether there was something in that session or material about my client that makes me feel a certain way"*. In her personal life, she shared that quality time spent with her child was important: "*spending time with my son puts things into perspective"*. In my view, the former quote by Alice demonstrates how her reflexive capacity supports her in understanding and managing her countertransference feelings; and the latter quote conveys how Alice's special bond with her child grounds her and gives her focus.

When asked how they support and care for themselves outside of sessions, a number of participants shared some of the activities they used, such as massage; fragrant baths; exercise; spending time with pets; and being outdoors. For example, Bridget said: *"I go for lots of massages, walking, playing with the dogs. Just being at one with nature. I feel quite calm talking about it actually"*. To me Bridget's words convey the restorative impact of these activities in her life, as it seems that just the thought of them had a calming effect on her.

Similarly, Leigh shared how she supports herself to relax. The following quote indicates how she is mindful of looking after her body and managing the tension she carries from her client work:

> *Leigh: I love long fragrant baths, so whenever I get the chance, but usually it's a quick power shower for me, but on occasion I get to have a long bath and I just lie there enjoying the water and the scent. And I don't get to do this often enough, and I know I've got a front-back body split, so I carry a lot in my back and shoulders, so something I love is to get a back and shoulder massage".*

4.3.4 Recognising and Bracketing Own Issues

This theme represents the capacity of participants to recognise and bracket their own issues that may come up in their work with clients suffering from eating disorders and body image disturbance. I believe that this tends to become easier with more experience, as expressed by Lauren who said, *"I think with time gone by and I'm more experienced I can see things a little more clearly I guess. I can discriminate a little bit more what's mine and what's the client's".*

Some therapists expressed that by reflecting on the changes to their emotional and embodied states before and during a client session, this helped discern what their subjective responses were about. For example, in the following narrative, I feel that Leigh conveys a deep level of self-awareness about her body and its stress responses, enabling her to slow down when noticing tension in her body and to reflect on the feelings evoked for her:

> *Leigh: The feeling always hits me in my stomach and I notice the tension very quickly. And I know I go to my head really quickly, and think, what do I do now? So I slow down and start breathing, and think okay, what belongs to me and what belongs to the client?*

Similarly, Bridget spoke about *"figuring out what's theirs and what's mine in the countertransference. Did I feel like this with that client again, did I come with these feelings or not?"*. She shared further that if she recognised that things were triggered for her she was conscious of bracketing her feelings: *"I'm aware that I need to put that back there, and put my professional hat on to give my attention to the client"*. She also made reference to awareness of 'ego states': *"I have to get into my adult then [...] if that's triggered emotions for me in the transference-countertransference cycle, so I always feel I have to detach from that, get into my adult and go from there"*. In this last quote, I feel that Bridget demonstrates her reflexive capacity and conscious self-support process in motion when her own issues are tapped into with clients.

In contrast, some therapists found it difficult at times to acknowledge and bracket their own material. I believe that this was the case for some of the less experienced therapists, as well as those whose issues were currently more present for them in their personal lives (for example, those currently trying to lose weight from their pregnancies). Candice and Nicola shared their experiences as new therapists of finding it challenging to bracket their own issues when working with clients who had similar problems to their own. Candice stated: *"I think it's pretty hard actually. I think I have to kinda be aware of my body"*.

Similarly, Nicola spoke openly throughout the interview about still struggling with insecurities with her body which could easily resurface when working with this client group: *"I was a very new therapist and I couldn't see past the issue, but now I'm better able to see past an issue, see around it and get to the route"*. Her narratives suggest to me that by gaining more experience as a therapist, she was better able to recognise and bracket her own issues:

> *Nicola: I have these thoughts in my mind, but it's about being able to put them to one side and focus on the client. So although it's there in the room, it's okay and I'm not gonna talk about it. But [...] every time I have to*

make a choice to talk about it or not, 'cause in my mind it comes forward and I have to push it back, and say, it's my issue so try keep it to the side".

For Alice and Megan who were both trying to lose their pregnancy weight, their awareness of their bodies was heightened. Alice shared that sometimes her countertransference reactions were very difficult to sit with, and she had to work hard to bracket her feelings so she didn't act on them with clients: "*there are times when I felt criticised, when I sort of felt ashamed. [...] Sometimes in my countertransference, I really have to try to hold myself back from not saying or doing something*". Although this was difficult for her, she also emphasised the importance of making space to address things in the immediacy of sessions if necessary:

> *Alice: You know, it's something about being aware of what it is that bothers you, and being very much aware of what is yours and what is theirs, and creating a space for it if they have issues about the way you look and what that means to them, and what makes it come up for them, as painful as it might be for both therapist and client.*

Megan shared a similar feeling that at times it was difficult to determine what was hers and what belonged to the client if things were familiar to her:

> *Megan: If I was sitting with a client, I'd start to feel more anxious about my own body and start to think about my own weight and that stuff, you know, and while attending to the client, I'd start to be aware that my own process was being tapped into [...]. And it was that, trying to sift through what's being projected here, and what's actually mine, where's the line, how can I separate them? And sometimes it helped me to...I guess, feel, or understand it more...what it was like for the client. [...] and sometimes it wasn't helpful because it went beyond that into me, being left with these*

residual feelings after the client had gone, these feelings of being hyperaware myself.

I believe that by Megan reflecting on her experience, she gains important insight into what it's like for her client, however a consequence is that she may be left with negative residual feelings about herself if her own issues are stirred up.

4.3.5 Support in Supervision and Personal Therapy

This theme is about the professional support participants get in supervision and personal therapy. All participants were in regular supervision for their client work, and all had been in personal therapy for their training requirements or for personal reasons, with some currently seeing therapists, and others open to the idea of returning to therapy if needed.

Most participants spoke of supervision as a supportive place to work through issues that came up in their client work. For instance, Penny spoke about first exploring things in supervision before using particular interventions with clients. Her narrative indicates how supervision facilitates reflexivity in her decision-making during sessions: *"I have raised with a client or two about my weight but not until I've taken it to supervision and not until I've felt a certain intuition, to bring it into the room".*

Megan also talked about using supervision for support, stating, *"I think probably I'd talk about it in supervision, and the impact it's had on me, and work out, well how much is it something in me, and how much of it is the process of the client".* Like Penny, I believe that Megan has developed an 'internal supervisor' to support and ground herself in the moment with clients:

> *Megan: I have the support for myself because I'm sorted enough to be able to do that, but definitely in the early days I wouldn't have been able to*

cope. I think being able to recognise what's happening is really helpful to do what you need to do to keep yourself grounded as a therapist.

Alice expressed a similar view to Megan that "*supervision really helps to discern what is yours*", and she found it helpful exploring difficult feelings with her supervisor: *"I feel more supported in supervision about this person, and it doesn't feel as chaotic, and difficult. It doesn't feel so competitive".* Alice also seemed open to the idea of "*going to therapy*" and exploring her issues with a personal therapist if it felt necessary.

For Lauren, supervision was an insightful process in exploring difficult client issues: *"My supervisor saw immediately what was going on so that was very helpful. So I guess supervision has been very helpful as well as being a bit more experienced".* She expressed her view about the importance of recovered therapists to be in personal therapy if necessary, saying*, "I suppose just my thought at the moment is how important it is to have ongoing therapy when you have these underlying issues, with a really good therapist".* It appears to me that Lauren also recognised her own need for ongoing support because of the depth of her personal struggles:

> *Lauren: I suppose at one level I'm thinking, for goodness sake, this is ridiculous, but I guess I'm thinking at a very superficial level, thinking this is about weight. It's not about weight, of course it's not about weight. But for me it's an indicator that therapy is ongoing, it needs to be ongoing, but at the same time, even with that, I don't think this will ever end because it's so deep.*

The general consensus of the participants was that supervision and personal therapy was a valuable resource for exploring personal issues evoked with their clients. In contrast, two participants (Candice and Nicola) expressed feeling unsupported in their personal therapy and a worry about being judged in

supervision. For instance, during Candice's training, she found personal therapy very challenging: *"I found it quite difficult trying to talk about how I felt and my own past".* Similarly she felt worried about opening up about her past and being judged in supervision:

> *Candice: She was my supervisor while I was training as well, which I'm not anymore. I somehow feel a little bit like she's assessing whether I'm adequate or [...] a safe practitioner, and that's sometimes at the back of my mind.*

In my view, this demonstrates Candice's worry about her supervisor judging her competence as a therapist if she were to disclose her eating disorder history. These concerns were however challenged after Candice had a positive experience with another supervisor who was more empathic and attuned to her struggle:

> *Candice: He understood something about me that I couldn't say to him, or there was something he didn't verbalise but there was some kinda understanding there, and I felt really supported by him. I think he realised, and he verbalised that he felt this was very painful for me, but he didn't go into great detail about why he thought that was, but he just touched on these things that I feel, that it was sometimes painful.*

For Nicola who was currently in personal therapy, it seems to me that she felt unsupported with her body image struggles: *"I've lost confidence that another therapist can help me with this problem".* Here I believe that her disillusionment about finding a resolution to her struggles appears to be stopping her talking about her body image issues in therapy: *"I think it's the most difficult part of my development, and I've almost [...] lost hope. I've stopped taking it to my personal therapy because it doesn't feel like there is a solution to it, if that makes sense".* She made some connections between her tendency towards avoiding her

feelings by swallowing them down with food, and avoiding looking at her issues in therapy:

Nicola: Avoidance is one of my favourite things, so in the same way that I avoid things by eating, I avoid thinking about it. I mean I was talking about it in therapy all the time but I just got tired of myself just repeating the same things, and still going up and down with my weight

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Consistent with Nicola's concern about others judging her, she shared: *"I don't bring it up in supervision",* thus it seems to me that she also avoids addressing her issues with her supervisor because they still feel quite painful and unresolved:

Nicola: It's something quite raw in a way, you know, so it doesn't have closure, and maybe I sound a bit chaotic at times but I haven't got supervision about this, and it's something that is there and bothering me, then it's not, so it comes and goes, but actually I've never been brave enough to address it in supervision. Maybe it comes down to that, to avoid that subject because it's raw.

Although Nicola was concerned about coming across to me as sounding 'chaotic', I feel that the experience of candidly speaking about her struggle during the interview, rather than 'avoiding the subject', appeared to have a positive impact on her. This was evident in her statement: *"I'm realising while I was talking that it's probably something that I should bring to supervision, rather than doing my avoidance thing because it's too ugly".*

5. DISCUSSION

5.1 Overview

The aim of this study was to gain an in-depth understanding of what it is like for recovered female therapists who have a history of body image concerns related to an eating disorder or body dissatisfaction, in their work with clients currently struggling with similar issues. The participants' subjective experiences and countertransference responses were explored, and the study also looked at how these reactions were managed with clients, as well as the strategies they use to look after themselves outside of the therapy room. Upon proposing this research, a review of the current literature indicated that there were very few qualitative studies on this subject, so it is hoped that this study will make a valuable contribution to the current knowledge-base. In this chapter the findings will be considered in relation to the literature and the research questions posed by the study. Thereafter I will discuss the limitations of the study and suggestions for future research; my personal reflections; and the implications of the results for theory and practice.

5.2 What are the Subjective Experiences and Countertransference Reactions of the Recovered Female Therapist in her Work with Clients Struggling with Issues of Body Image Disturbance and Eating Disorders?

It is widely acknowledged in contemporary psychotherapeutic literature that the countertransference of the therapist is inevitable and an invaluable source of information regarding the process of therapy (Casement, 2002; Clarkson, 1990; Evans & Gilbert, 2005; Maroda, 2004; Stolorow & Atwood, 1992). This first research question explores the recovered female therapist's subjective experiences and countertransference feelings that emerge with their clients with eating disorders and body image disturbance. Within the first two master themes ('Understanding the Struggle: A Shared Experience'; and 'Becoming Entangled: Old Feelings Resurfacing'), a number of sub-ordinate themes demonstrated some of the participant's experiences: 'Empathic Resonance'; 'Assumption about

Therapist being the Sorted One'; 'Over-identification with the Struggle'; 'Worry About Judgement and Exposure'; 'Heightened Body Awareness'; and 'Feelings of Ineffectiveness'.

5.2.1 Empathic Resonance

The participants all spoke of having a deep *'empathic resonance'* with their clients' experiences of body issues and the struggle to find healing. The findings showed that this high degree of empathy had positive and negative consequences for participants. For instance, negative consequences included the therapists over-identifying with their clients' stories, as well as having a heightened body awareness with certain clients. Some of the positive consequences of this empathic resonance included the level of hope that the therapists held about their clients' recovery; an understanding about their clients' resistance and reluctance to change; as well as a sensitivity to how challenging and painful it may be for clients to confront issues about their bodies in therapy.

Kearns (2005, p.116) suggests that therapists should pay careful attention to the implicit communication from clients in the room about their feeling-states and relational experiences; and says that "*managing, understanding, and using our emotional resonance is the most potent tool the therapist has for 'knowing' the inner world of the client as well as how other people in the client's life have treated them*". This theme of empathic resonance is consistent with the findings by Bloomgarden et al (2003); Bowlby et al (2012); Costin and Johnson (2002); Johnston et al (2005); Sovak (2011); and Warren et al (2013) in their respective articles related to the possible benefits, drawbacks and suitability of employing recovered therapists to work in the eating disorder and body image field. The united view of these writers, which is echoed in the findings of this study, is that recovered therapists may have a lot to offer in their work with this client group by having important insight into the healing process, and "*there may be greater compassion or greater desire to make a difference because of acute awareness of the suffering in that arena*" (Bloomgarden et al, 2003, p.166).

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By understanding these issues on a personal level, recovered therapists may offer understanding, hope and motivation to clients that recovery is possible, and could also encourage trust in the client who desperately fears change. These experiences may be described in Jungian terms as the archetypal energy of the 'Wounded Healer', whereby the therapist's "*own experience of being wounded is what helps her face the suffering client in simple relatedness*" (Larisey, 2012, par.3).

In this study, the participants' experience of deep empathic resonance with their clients is also indicative of the implicit nonverbal right-brain communications which occur in the therapeutic relationship. Current neuro-scientific research on 'mirror neurons' has been enabled through brain-mapping and neuro-imaging which indicates that similar parts of an observer's brain are activated to those activated in the individual who is performing particular actions, or experiencing certain sensations such as pain, touch or sound (Rankin et al, 2006). This phenomenon is also relevant to emotional processing as the parts of the brain associated with particular emotions become automatically activated when individuals observe those emotions in a person, or witness them experience situations which may cause those emotions (Preston & de Waal, 2002; Watson & Greenberg, 2011).

This has important implications to the therapeutic relationship, as it is suggested that mirror neurons enable the therapist to experience a combination of cognitive and emotional forms of empathy, yielding the most comprehensive form of empathic understanding. *Cognitive empathy* includes components such as perspective-taking; abstract reasoning; and cognitive flexibility, and is independent of emotional neural networks. *Emotional empathy* in contrast, is rooted in emotional neural circuits and includes the ability to recognise emotions in the other; emotional responsiveness; and the capacity to correctly recognise one's own emotional and cognitive states (Rankin et al, 2006).

It is suggested by Danziger, Prkachin and Willer (2006) that personal experience of pain is not needed to recognise the pain which others may be experiencing and to feel empathy. However in this study, the participants' personal experience of having body image issues and/or an eating disorder appears to deepen their capacity to empathise with their clients on a meta-level, as they can understand emotionally and cognitively what that struggle is about. As mentioned earlier in this section, this may have negative consequences for the therapist if they over-identify with the client's pain, potentially resulting in emotional contagion and undue distress. This emphasises the importance of the therapist having personal and professional self-support structures in place.

5.2.2 Assumption about Therapist 'Being the Sorted One'

A number of participants experienced the assumption and expectation from their clients that they were 'sorted', or without any body image problems, because of their role as therapist. In the transference dynamics, this may be seen as a projection from the client onto the therapist an image of one who is 'untroubled', or a 'perfect' person unburdened by the restrictions and frailties of being an ordinary human being (Adams, 2014). Subsequently these clients may often feel alienated and isolated in their relationships with themselves and others (Kearns, 2005). This relates to the Transactional Analysis concept of existential 'life positions', which reflect how people view themselves in relation to others, and an expectation of how life will be. In this case, the life position of the client is '*I am not Okay, You are Okay*', whereby the individual decides that as human beings they are not acceptable (not Okay) and expect that they will fail at something (Steiner, 2009).

A negative consequence of this projection was experienced by some participants who were of a healthy weight, as some of their clients viewed this factor as indicative of their 'wellbeing', as well as perceived evidence that the therapist could not understand what it was like to feel awful about one's body. Other participants who were either underweight or a slim, petite build, had a similar

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experience with their overweight and obese clients who also assumed that they couldn't relate to the their body struggles; whereas their anorexic clients demonstrated jealously and competitiveness in the therapy room by scrutinising the therapist's body or asking personal questions about the therapist's weight, eating and exercise routine. This echoes the findings by Rance et al (2014) regarding the assumptions that eating disorder clients often make about a therapist's capacity to understand and help them, based on the observations they make about the therapists' body shape and size. The issue of client assumptions was similarly portrayed by Lowell and Meader (2005), who describe themselves as 'thin therapists'. They had experienced clients using the therapist's thin body as evidence to explain and support their disturbed beliefs and assumptions, as an object for transference projections and fantasies, and as a target of envy. Therefore, Lowell and Meader (2005) encourage the inclusion of the therapist's body in the therapeutic dialogue with eating disorder clients as a means rather than an obstacle to recovery.

In some of the participant's accounts in this study, the projection and assumption of the therapist's wellbeing subsequently had positive consequences for some clients. For instance, Alice's client perceived her as being comfortable in her voluptuous body and with carrying extra weight, and saw this as an indication of her wellbeing and health. This correlates with Burka's (1996) experience of her rounder, softer body fostering positive maternal transferences in some clients; as well as Costin's (2009) view that it may be healing for clients to observe other women who feel comfortable with their bodies, who are able to live their lives free from disordered thoughts, behaviours, desires and restrictive eating.

Costin (2009) suggests that ideally, female therapists should aim to be positive, healthy role models who demonstrate self-acceptance, care and love for their own bodies. Thus the emphasis is less about whether or not the therapist has body image concerns, but rather about how they manage their feelings and behaviours without becoming destructive towards themselves. These findings

also relate to feminist literature about the importance of the relationship between female therapist and female client, in which the therapist may serve as a role model of a woman struggling to be comfortable with her discomfort (Eichenbaum & Orbach, 1983), and a model of a woman with her own subjectivity (Baker-Pitts, 2007).

5.2.3 Over-identifying with the Struggle

Rogers (1951) suggests that the provision of therapeutic empathy enables clients to explore and reflect on themselves, thus facilitating self-directed change. He is however careful to distinguish between the therapist's empathy and their identification with the client, the latter being an indication of a loss of boundaries. For recovered therapists who work with these very painful feelings about the body with their clients, it is inevitable that they may connect to some extent with their client's feelings as this was once their own experience. In some instances this may have a negative impact on the therapeutic process, and as suggested by Rogers (1951), may cause a loss of boundaries. In this study, a number of participants spoke about over-identifying with their client's body image issues and eating problems, resulting in a sense of 'entanglement', and their personal body issues –past or present- being triggered.

When this happened, some participants reported experiencing negative feelings such as insecurity; inadequacy; and becoming highly critical and punitive towards themselves. The findings in this study correspond with the literature on working in the body image and eating disorder field; for instance, Johnston et al's (2005) study found that some of the disadvantages of the recovered therapist working in this arena were over-involvement and enmeshment; therapist vulnerability; and subjectivity. This theme also correlates with the findings by Warren et al (2013) who found that recovered therapists saw the negative impact of their personal history on their client work as the risk of over-identifying with clients and feeling personally 'triggered'.

In this regard, Costin (2009) states that countertransference issues may cause personal consequences for recovered therapists if sensitive unconscious material is evoked, causing a vulnerability to being triggered into relapse. The feminist literature also demonstrates that in the course of working with this client population, it is common for female therapists to experience a heightened awareness of their personal embodied shame triggers, and they may become aware of their body imperfections, dread gaining weight, and be conscious of their own diet and exercise routines (Gutwill, 1994; Ruskay-Rabinor, 1995; Shure & Weinstock, 2009). This was evident with some participants in this study who spoke about feeling self-conscious about their weight gain (particularly after pregnancy).

Warren et al (2009) reported similar findings in their mixed-methods study, that therapists reported having a heightened awareness of their own and other's appearances after working with an eating disorder client group, which had a negative impact on them as it felt uncomfortable, intrusive and hypocritical. Many therapists in that study also reported feeling self-conscious and hypervigalent about their appearance, and described feeling offended, angry, vulnerable, self-critical and incompetent. Therapist over-identification with client's problems was also found in the countertransference research by Delucia-Waack (1999). In the current study, there seemed however to be an emphasis by participants that they were aware of trying not to let their own issues adversely affect the therapeutic process by being aware of 'what was theirs' and what belonged to the client.

5.2.4 Worry about Judgement and Exposure

Some participants expressed worry about being judged by clients on their appearance, and assumptions being made about their trustworthiness, stability, credibility and worth. This relates to Ruskay-Rabinor's (1995) statement that female therapists may feel fraudulent in their role as healer if they have not fully resolved their own body image issues. This was heightened when some of the participants' size and shape fluctuated (such as during or after pregnancy), or

through times in their lives when they were struggling with managing their weight and eating habits. This corresponds with the findings by Warren et al (2009) that 72% of eating disorder therapists reported feeling self-conscious and hypervigalent about their appearance with this client group, and 33% were also worried about their clients judging or envying them.

Some of the participants in the present study also worried that their body image issues, whether past or present, may be exposed or 'obvious' to clients and other colleagues and professionals, with many feeling a sense of shame and a desire to hide this painful part of their history from others. This correlates with the findings in the research literature, for instance Bloomgarden et al's (2003) study which found that 31% of staff at a national eating disorder treatment centre had experienced an eating disorder themselves; and the authors suggest this figure may be even higher as more therapists came forward afterwards and admitted to having an eating disorder, but they had felt too guarded to share this in the survey for fear of losing their jobs if 'discovered'.

Similarly, Rance et al (2010) found that the recovered therapists in their study made multiple claims to being 'normal', the absoluteness of their recovery, and the unlikelihood of any possibility of relapse. The authors question whether these positive assertions about how *little* impact their work had on their personal body image, weight and relationship with food, may be an avoidance of any question about their capability and fitness to practice as eating disorder therapists. This is indicative of the shame many therapists may feel about having their own personal difficulties, resulting in a desire to hide behind a professional mask in order to be seen by others as 'doing well'.

Consequently, it was evidenced in the study by Rance et al (2014) that eating disorder clients often *do* tend to scrutinise their therapists' bodies and make assumptions about their relationship with food, self control, and wellbeing; and as perceived evidence about the therapists' capacity to understand and help them.

Therefore, I believe this may be an inevitable challenge for the recovered therapist to learn to manage in the process of therapy with this client group, and Adams (2014) suggests that by accepting their own fragility, therapists are better equipped to support clients to accept their own.

5.2.5 Heightened Body Awareness

Some participants spoke of being acutely aware of their bodies with their clients presenting with body image disturbance or eating disorders; and expressed a heightened discomfort at times with issues of physical difference such as being a higher/lower weight than their clients, or seeing clients as being more attractive than themselves. With body image issues related to body dysmorphia or disability, where the participants did not relate personally to their clients' experiences, there seemed to be strong feelings of discomfort that came up for them. For instance, Bridget felt guilty for being more able-bodied than her disabled client, and for Megan there was a pull in the transference to criticise and scrutinise her client's perceived facial imperfections. These experiences may be indicative of 'projective identification' onto the participants from their clients who unconsciously aim to evoke "*the unbearable feeling state*" in the therapist which they cannot contain within themselves (Casement, 2002, p.137).

The literature suggests that eating disorder clients may predictably make powerful assumptions about the therapist's attitudes, morality, competence, and mental and physical health, including the therapist's body shape, size and appearance, to create an awareness of who the therapist is and how they should try to relate to them (Liebermann, 2000; Lowell & Meader, 2005; Orbach, 2003; Warren et al, 2009; Rance et al, 2014). This was experienced by some of the participants who were conscious of being either smaller or bigger than their clients, and the potential transference reactions that these contrasts and comparisons evoked for their clients (Sheehy, 2009).

Competitive feelings also seemed to surface for some participants, particularly when working with anorexic clients. For instance, Penny was a lower weight than some of her clients after suffering from a period of illness, and she admitted that there was a part of her that felt proud to be the weight that some of her clients desired to be. In contrast, Megan felt deeply uncomfortable being a weight which some of her overweight clients desired to be, and felt the urge to dull herself down to appear less attractive. Like Megan, other participants felt deeply uncomfortable with their bodies being scrutinised in the therapy room, for instance, Candice felt that her body was been "*watched and judged*". This relates to the research by Warren et al (2009) who similarly found that 83% of the eating disorder therapists interviewed felt that clients were monitoring, examining, or evaluating their appearance. In this regard, some participants in the current study were open to the idea of discussing their body as part of the therapeutic dialogue with these type of clients (Burka, 1996; Costin, 2009; Lowell & Meader, 2005; Orbach, 2003, 2004).

5.2.6 Feeling Ineffective

Participants in the study spoke of sometimes feeling ineffective with their clients presenting with eating difficulties and body image disturbance, which included times when they had felt helpless, deskilled, or out of their depth. The latter seemed to occur more often with the newly qualified participants who may lack confidence or experience in their clinical work. Others also spoke of feeling frustrated when experiencing their clients' resistance to change and the letting go of self-destructive behaviours. This theme is consistent with Delucia-Waack's (1999) view on the types of countertransference experienced by therapists working with eating disorders, namely a sense of helplessness, ineffectiveness and inadequacy.

The findings similarly echo Warren et al's (2009) research in which the participants also described some of the hardest aspects of working with eating disorder clients, such as the resistance of severe, chronic symptomology to

change (i.e. severe body image distortion; rigid thinking; lack of readiness to change); the nature of the illness and its prognosis (i.e. high rates of relapse rates; risk of death from health complications or suicide; slow recovery process); and negative personal impact on the therapist (i.e. worry; fatigue; sadness; frustration). Furthermore, similar results were identified in a study by Gorman-Ezell (2009) on eating disorder professionals and the relationship between countertransference, eating attitudes, body image, and self-esteem; where it was found that working with eating disorders evoked certain countertransference feelings in the therapist (i.e. helpless/inadequate; positive/satisfied; and parental/protective).

As experienced by the participants in the current study, Bloomgarden (2009) states that reluctance to change is relatively common and expectable in the treatment of eating disorders. Consequently this poses a challenge for therapists working with this client group as they find themselves in the uncomfortable position of taking responsibility for helping someone who is acting self-destructively and strenuously resisting therapy, leading to the therapist struggling with negative countertransference reactions such as feelings of sadness, disappointment, fear, panic, shame, incompetence, inadequacy, anger, frustration, disillusionment, hopelessness and impotence.

These feelings may be exacerbated if the recovered therapist's personal insecurities, traumas, wounds or current struggles are stimulated by the therapeutic dialogue, or are present independently of the therapeutic interaction. This may result in 'countertransference dominance' if the therapist unconsciously steers the therapy in a direction more in line with their own unconscious needs rather than those of the client (Moroda, 2004). Thus it is essential for the therapist to figure out how to manage these feelings so they don't damage the therapeutic relationship and threaten treatment outcomes. This will be discussed in the following section 5.3.

5.3 How are the Recovered Therapist's Subjective Experiences and Countertransference Responses Managed Therapeutically?

This second research question explores how the participants manage their subjective experiences and countertransference feelings in the therapy room, and was addressed by a number of super-ordinate themes within the first and third master themes: 'Conveying Empathy'; 'Exploring Embodied Experiences'; 'Authenticity and Self-disclosure'; and 'The Recognising and Bracketing of Own Issues'. When working with countertransference, O'Brien and Houston (2007, p.152) suggest that the therapist needs to monitor their internal mental processes and continually ask themselves: "*What does this person make me feel like, make me think about, make me want to do?",* thereby developing and honing their reflexivity. Bloomgarden (2009) also shares her view that it is the therapist's self-awareness which ultimately protects the client from the therapist's thoughtless or unconscious reactions to the influence of personal issues, or client's treatment resistance.

5.3.1 Conveying Empathy

Therapeutic empathy is described by Barrett-Lennard (1993) as a three-phase active, cyclical process: firstly, the therapist resonates empathically with how the client feels about their experiences and what this means to them; secondly, the therapist communicates their empathic understanding to the client (this will be discussed in more detail in this section); and thirdly, the client receives or perceives the therapist's empathy and becomes aware that they are being understood.

When the participants spoke of conveying empathy towards their clients, this meant being present, and to "*really hear them*" (Alice), which created a deeper relational experience through their spoken words, as well as their empathic attunement. Their personal understanding of the difficulty of managing body image concerns seemed to enable a more 'genuine' and authentic way of being

and relating, and some participants spoke of having an attitude of 'unconditional positive regard' (Rogers, 1951) with clients. This enabled them to be present in a non-judgemental way, with sensitivity and compassion about the personal obstacles and resistance to change which differed for each client. Decety and Jackson (2004) indentified three main components of human empathy in their examination of its functional architecture: the capacity to share the emotional experience of another; the cognitive ability to understand what they are feeling; and the ability to maintain a distinction between one's own and another's feelings, whilst simultaneously regulating one's own feelings.

One participant found that her empathic attunement enabled a deeper connection with her client, and this also had a positive impact on her own recovery, as this connection *"felt very healing, healing for me and healing for them"* (Megan). Her experience and the theme of 'conveying empathy' relates to Sovak's (2011) study which found that for some recovered therapists working with eating disorders, this empathic attunement supported and strengthened the therapist's own recovery; they experienced work as being both challenging and rewarding; and their understanding and empathy about the issue strengthened the therapeutic relationship and instilled hope in the recovery process.

As well as non-verbal empathic interactions, participants also spoke of sharing their countertransference feelings with clients to verbally convey their empathic acknowledgement and understanding of their struggle and suffering, but also as a means to gently challenge clients in a sensitive and caring manner about the client's resistance to recovery, and the impact of their eating disorder attitudes and behaviour on others. In this regard, Bozarth (2011) states that verbal empathic responding enables the therapist to readily determine, by their client's response, whether they feel understood, or whether they reject, or need clarification of the therapist's attempt to convey empathic understanding.

5.3.2 Exploring Embodied Experiences

Dialoguing about the therapist's body with eating disorder clients is discussed and encouraged by a number of writers (Burka, 1996; Costin, 2009; Lowell & Meader, 2005; Orbach, 2003, 2004), however the only study which mentions this concept was by Warren et al (2009). The study explored the experiences of eating disorder professionals and found that 73% of therapists interviewed had rarely received direct comments from clients about their body shape and weight, but 75% said they would address these comments in the session when they occurred. This supports the findings in the current study as a number of the participants spoke about exploring embodied experiences with their clients. This included discussing differences/similarities between the therapist's and client's bodies, and the feelings this evoked; and the use of body language and physical countertransference reactions as important information about the unspoken communication in the room. Alice described this as seeing "*what the unconscious had provided*", and viewed this as an important part of the work with her clients.

Of particular interest was the impact on clinical work of the therapist's weight fluctuations during and after pregnancy. Some participants admitted feeling more comfortable carrying extra weight during their pregnancies as it felt like they had more 'permission' to do so; furthermore this enabled them to feel more comfortable during pregnancy to draw attention to their own bodies and explore how this weight change impacted their clients. Warren et al's (2009) study similarly found that a third of the therapist sample had significant weight fluctuations through pregnancy, and 68% of this group felt that the impact of their pregnancy on clients included fear, envy, rivalry, anger, anxiety about maternity leave and increased body image issues. For example, one therapist in the above study was asked by her client how she felt about gaining so much weight and that she was 'lucky' that she was 'allowed' to eat anything and put on weight. Strobeck (2005) states that the therapist's pregnancy can impact therapy as it introduces the therapist as a real person, but also serves as an evocative stimulus for the client on a conscious and unconscious level. Therefore the

therapist's pregnancy may interfere with the natural course of the therapeutic process with eating disorder clients, but can also be used as a means to furthering psychological growth.

5.3.3 Authenticity and Self-disclosure

Most participants shared the view, to varying degrees, that they could be authentic without self-disclosing their history of an eating disorder or body image issues to their clients. For instance, some expressed strongly that they preferred *not* to disclose anything, whereas others felt more comfortable sharing selective information without being specific, to convey their personal understanding of their client's experience. There was however a general consensus among the participants about the potential analytic usefulness of self-disclosure as an intervention (Leibowitz, 1996), but the view was that therapists should be mindful that their disclosures were not a result of over-identifying with their client's issues which may appear similar on the surface, but may in fact be very different. This could potentially result in the therapist making assumptions and losing focus of the unique, subjective experience of the client. For example, Nicola had self-disclosed personal information to her client but this had unfortunately left her feeling vulnerable, exposed and uncertain about what her client now thought of her, and she felt this may have negatively impacted the work which ended soon afterwards.

Participants thus emphasised the importance of exercising caution and reflection before using self-disclosure as an intervention with clients; and the careful determination about whether this may help or impede the work, and the possible impact on the therapeutic relationship. This supports the current research findings on this issue, for instance Sovak's (2011) study indicated that half the participants interviewed were unsure whether self-disclosure is appropriate due to the possibility of this leading to the client comparing themselves and their recovery to the therapist. Similarly, Johnston et al (2005), found that most professionals (46%), with or without a previous history of an eating disorder,

were against the obligation to self-disclose, whereas the carers and those with eating disorders (43%) were in favour of it.

Bunnell (2009) suggests that therapist self-disclosure as an intervention should only be made at an appropriate time when one has a hunch, or plan in mind about how the disclosure may enrich the therapeutic process. An important aspect of self-disclosure is also how much trust and connection has been established in the therapeutic relationship to support the revelation, and whether it serves to further analytic exploration (Leibowitz, 1996).

One participant in this study (Leigh) shared an experience of self-disclosure which had impacted her client in a positive way. Although they had worked together for a long period of time and had a good therapeutic relationship, this intervention created a deeper relational exchange between them which enabled the therapy to progress in a more trusting and authentic way. This demonstrates the potential benefits of self-disclosure if used carefully and purposefully.

5.3.4 Recognising and Bracketing Own Issues

It is important for the recovered therapist to be able to acknowledge and 'bracket' their own issues and countertransference feelings when these surface with clients. Some participants expressed that by reflecting on the changes to their emotions, embodied experience, and ego states before and during a client session, this helped them make sense of what their countertransference reactions were about. It seemed to become easier for the therapists to discriminate what belonged to them or to the client as they became more experienced. Participants felt this required a deep level of self-awareness about one's body, its stress responses, as well as one's affective state and ego states. This correlates with Bunnell's (2009) proposal that *"ongoing self-exploration and self-awareness are the most powerful antidote for inappropriate countertransference reactions"* (p.91).

The theoretical literature on 'bracketing' comes predominantly from a relational, phenomenological Gestalt perspective. For instance, Joyce and Sills (2014, p.18) state that an important skill in phenomenological inquiry involves the therapist identifying and acknowledging their preconceptions, judgements and attitudes; and in the moment of bracketing they try "*as far as possible to put all these to one side and be open and present to this unique client in this unique moment*". Bracketing also supports the therapist "*to stay cognizant of the truth of multiple realities, and the lack of purely objective or purely subjective perception*" (Yontef, 1999, paragraph 9).

Some of the less experienced therapists shared how they could find it challenging to bracket their own issues at times when clients presented with similar body image problems to their own. Similarly, for the participants who spoke of trying to lose their pregnancy weight, their awareness of their bodies was heightened, therefore they had to work hard to bracket their feelings so as not to act on them with clients. In this regard, Shure and Weinstock (2009) emphasise the importance of therapists becoming aware of the complex dynamics of their countertransference reactions to avoid inadvertently shaming their clients, or becoming overwhelmed by their own shame. Gabbard and Wilkinson (1994) also stress the importance of the therapist containing their countertransference reactions until they develop some clarity about their source and significance; and Costin (2009) states that "*to process before responding is helpful*" (p.190).

This finding also correlates with the empirical literature by Schwimmer (2010, p.173) who suggests that "*as a potentially unresolved issue on the therapist's part (e.g. body image distortion) gets magnified in the treatment dyad with an eating disordered client, the therapist's countertransference management is compromised*". Schwimmer's study found significant positive correlations between three therapist variables (e.g. years of work experience; postgraduate training; and supervision), with their levels of countertransference management.

This was similarly demonstrated in the current study where some of the less experienced therapists struggled with managing their negative countertransference feelings. In some instances this may lead to 'burnout', and Warren et al (2012) recommend that the training of eating disorder professionals should incorporate management for burnout in order to maximise the wellbeing of both therapists and clients in the eating disorder field. The third research question in the next subsection (5.4) explores some of these self-support methods.

5.4 How Do Therapists Support Themselves Personally and Professionally?

The self-support strategies used by the participants were explored and demonstrated in the third master theme, 'Self-Support Strategies: A Life-long Healing Process'. These sub-themes include: 'Healthy Attitude to Eating and Exercise'; 'Self Acceptance and Respect'; 'Relaxation and Reflection- Sitting with Honesty'; and 'Support in Supervision and Personal Therapy'. These strategies are in line with theoretical and feminist literature (Bloomgarden et al, 2003; Costin, 2009; Ruskay-Rabinor, 1995) as well as recent empirical findings (Sovak, 2011; Warren et al, 2012; Warren et al, 2013; Williams, 2011) related to therapists working with eating disorders and body image problems.

The findings also support the recognition in the literature that recovery from body image disturbance and eating disorders is a multifaceted process, rather than just comprising behavioural changes and weight restoration (Bowlby et al, 2012; Noordenbos & Seubring, 2006). A study by Jenkins and Ogden (2012) indicates that the recovery process involves a resolution of dichotomies (i.e. between the mind and the body; the rational and the irrational; and cognitions and behaviour), with movement towards greater use of the mind, rational processes and cognitions to express psychological distress through language and relationships.

Sovak's (2011) study also demonstrates that for recovered therapists, their ongoing personal recovery process encompasses biological, psychological and

social factors in both past and present tense, and the author suggests that awareness and growth in these areas is important for lifelong wellbeing, rather than merely the cessation of their eating disorder behaviours and restoration of weight. Sovak's recovery categories may be applied to the support strategies used by participants in the current study: *physical factors* (i.e. healthy attitude to eating and exercise); *psychological factors* (i.e. self acceptance and respect; and relaxation and reflection); and *social factors* (i.e. support in supervision and personal therapy).

5.4.1 Physical Factors:

- *Healthy Attitude to Eating and Exercise*

On their journey to recovery, many of the participants had adopted a healthier attitude to looking after themselves, with an emphasis on making healthy choices with their eating, being able to enjoy their food more, as well as keeping active with regular exercise as a support strategy for managing stress and looking after their bodies. In a few cases the participants had been through significant life events (i.e. nursing their own or other's physical illnesses; pregnancy; observing homelessness/poverty), which had shifted their views of food to something of value, health and sustenance. This supports the findings by Warren et al (2009) that 54% of eating disorder therapists experienced a change in their eating behaviour (i.e. more healthy, mindful, moderate and deliberate eating); and 70% indicated that their view of food had changed (i.e. increased awareness of food; seeing food as a source of nutrition; increased enjoyment and appreciation of food).

In contrast, two of the participants in this study reported infrequently using negative ways of coping when they felt overwhelmed after their sessions, for instance Megan would sometimes restrict her food, and Nicola would 'comfort eat'. Both acknowledged that their eating patterns were reminiscent of previous patterns however both seemed mindful of trying to manage this. This echoes

Warren et al's (2009) study in which a few participants also reported engaging in disordered or unhealthy eating after sessions. In my view this serves as evidence that the recovery process from eating disorders and body image issues is an ongoing, lengthy process rather than an end point in time. Therefore this may be a life-long journey for some, which needs to be handled day-by-day in a mindful, caring manner, with an attitude of self-acceptance and respect (Garrett 1997; Petterson & Rosenvinge, 2002).

5.4.2 Psychological Factors

- *Self-Acceptance and Respect*

The participants described that a significant factor in their own recovery process, and an ongoing support strategy in their client work, was the development of greater acceptance and respect for themselves. This relates to Bowlby's (2008) study which demonstrates that long-term recovery requires comprehensive changes, involving learning to understand and value oneself and finding meaning and purpose in life. In the current study, significant life events such as pregnancy and illness had challenged the negative views some of the participants held of themselves. This often represented the change moment in their recovery, as their view of themselves and their bodies was redefined. Therefore the adjustment to physical changes in their bodies through aging, illness or childbirth, felt easier as many participants spoke about being more accepting, kind, content, respectful and grateful towards their bodies.

This theme correlates with Sovak's (2011) findings on the psychological factors of the recovery process (i.e. psychological wellbeing and identity development); as well as Lamoureux and Bottorff's (2005) study on recovery from anorexia which highlights a process of 'self-discovery' (i.e. seeing the danger of having an eating disorder; choosing to leave the eating disorder; learning to tolerate and cope with life without dysfunctional eating; work on changing a critical mindset; and discovering the self as good enough). Some participants in the current study

similarly described being able to hold a more realistic view of themselves as being 'good enough', rather than a distorted opinion of their perceived flaws, and a pressure and desire to be 'perfect'. For others, this meant they were less critical and punitive towards themselves, so they no longer felt their imperfections were unacceptable. For instance, Penny shared that her self-worth and achievement were no longer defined by her appearance, and for Candice, her self-acceptance had enabled her to be more authentic, relaxed and confident with others as she was no longer her own worst critic.

Some participants shared that at times their self-acceptance fluctuated, particularly those who had recently gained weight after pregnancy or stressful periods in their lives. This suggests that for these individuals, their self-worth is still hinged to some degree on their weight and appearance, and conveys the ongoing nature of their recovery and body issues which resurface at challenging times in their lives. In this regard, Bloomgarden et al (2003) highlight the responsibility of the therapist to look after their own physical and psychological wellbeing so they can truly be role models. I appreciated the honesty of some the participants in the current study about their ongoing body image difficulties, and although this was still challenging for them, they all seemed mindful of managing their issues appropriately in their personal lives so that this did not negatively impact them professionally.

- *Relaxation and Reflection*

The participants also shared that they supported themselves by including various activities in their personal lives which help them to relax, reflect, and to manage stress or residual feelings after therapy sessions. For some this involved enjoying life outside of work; having massages; fragrant baths; exercise; spending time with family and pets; and being outdoors in nature. These things appeared to give the participants grounding and focus. Others consciously made time for personal reflection by acknowledging and writing about any residual feelings after seeing clients. This process seemed helpful in providing clarity to the therapists

on how to support themselves in the best way, and preparing for discussions about these issues in clinical supervision.

These psychological support factors echo the feminist literature by Costin (2009, p.191) regarding the self-care of recovered therapists working with issues of the body:

> *Caring for oneself physically, reading and staying connected to feminist and spiritual ideas, and engaging in soul-nourishing activities will all help to keep one's head and heart in the right place when dealing with our own and our client's bodies and souls. Each therapist needs to find her own way to connect with what is truly important in life to be a conduit for that connection to take place in clients. Carefully tended and appropriately nourished, the therapist's embodied experience can be one of personal joy as well as a useful tool in the efforts to help clients navigate recovery.*

Similar results were found by Warren et al (2012), that 92% of the eating disorder treatment providers interviewed reported using self-care methods which were similar to those in the current study (i.e. exercise, social support; hobbies/leisure activities; time off/vacation; eating well; relaxation; detaching from work; maintaining work/life balance; personal time; sleeping; and meditation).

5.4.3 Social Factors

- *Support in Supervision*

All of the participants attended regular clinical supervision, and most described this as a supportive place to work through difficult countertransference issues, as well as discussing particular interventions before using them with clients. This supports the research literature which emphasises the importance of supervision as a source of support for examining countertransference issues related to body image, food, and weight that emerge for therapists working in the body image and eating disorder field (Delucia-Waack, 1999; Schwimmer, 2010; Sovak, 2011;

Warren et al, 2009, 2013; Warren et al, 2012). This also correlates with the theoretical literature that an essential support strategy for any therapist, and in particular recovered therapists, is the regular use of supervision in order to maintain reflective practice in one's client work (Bolton, 2005; Costin, 2009).

Evans and Gilbert (2005, p.133) consider the capacity for reflective practice as the most important characteristic of the psychotherapist that requires "*a delicate holding of an awareness of the therapist's own experience and that of the client, while simultaneously standing back and reflecting on the dynamic interaction between the two*". This was evident with the participants whose use of supervision seemed to facilitate reflexivity and the development of an 'internal supervisor' (Casement, 2002) to support them in their decision-making during sessions.

In contrast, this was not the case for two of the less experienced participants (Candice and Nicola), as they both shared how they had struggled to open up in supervision about their personal history of body issues out of fear of judgement or negative appraisal by their supervisors, particularly during training when supervisor reports were written. For Candice, her concerns subsided after a positive experience with another supervisor who was more empathic and attuned to her struggle, enabling her to feel safer about self-disclosing in supervision. Nicola identified that she avoided bringing her body image issues to supervision as they felt painful and unresolved for her, however she expressed that she found the interview process helpful in addressing the complexity of this struggle, and stated that she was more conscious of bringing things to supervision in the future rather than avoiding them.

This relates to the recommendations for practice by Williams (2011) on supporting recovered professionals in the eating disorder field. These include the provision of ongoing training and supervision on the complexity of ethical issues relevant to working with an eating disorder population; giving attention to

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therapist wellbeing and self-disclosure, which may otherwise result in ethical vulnerabilities in the early stages of their careers and/or recovery, potentially risking harm to clients; and professional environments which should ideally foster a safe, 'positive ethics experience' to support recovered therapists in their self-reflection and engagement with related ethical issues in order to practice safely and appropriately with their clients.

Furthermore, Warren et al (2012) found that along with using professional support (e.g. supervision; consultation; a treatment team; personal therapy), therapists working in the eating disorder field chose to limit their caseloads and broaden the types of clients they saw in therapy. The latter finding was similarly demonstrated in the present study, as all but one participant, chose to work with a *variety* of presenting client issues, rather than only eating disorders and body image issues.

- *Support in Personal Therapy*

On many psychotherapy and psychology training courses, trainees are required to experience personal therapy is a significant part of training and accreditation, providing the opportunity to explore and understand personal wounds and vulnerabilities, as well as address any unresolved issues which may resurface with clients (Hammersley, 2003). There are however still many training courses in mental health which either do not require personal therapy, or only require a brief period of attendance. Consequently, I believe this may have a deleterious impact on clinical work if the therapist has not explored their own issues enough to enable a suitable level of self-awareness and reflexivity.

All of the participants in this study had been in personal therapy for their training requirements or for personal reasons, with some currently seeing therapists, and others being open to the idea of returning to therapy if they needed to. It is interesting to note that the two participants who struggled to open up about their body image issues in supervision also expressed finding personal therapy very

difficult when it came to addressing these areas. For instance, during Candice's training she had initially found it challenging to open up about her past in therapy because of the shame she felt, however she eventually managed to work through this and slowly found healing and recovery.

For Nicola who was currently in therapy, she expressed feeling unsupported; and her disillusionment about finding a resolution to her struggles with her weight appeared to be stopping her bringing her weight and eating issues to therapy any longer. This seems to convey her resistance and reluctance to address and change some of these very painful issues related to her body and her self-worth. Although she was less experienced than some of the other participants in this study which may account for some of the heightened feelings and countertransference reactions (i.e. worry about judgement and exposure; feeling ineffective; self-consciousness; an over-identification with her clients), her ongoing struggle with her body image seems to compound these issues.

In this regard, Costin (2009) feels that it is essential for effective treatment that all therapists working with eating disorders should explore their own body-related issues and embodied experience, practice self-care, and engage in ongoing personal supervision for support. Delucia-Waack (1999) similarly states that a therapist's success in facilitating change in their clients may be based on how successfully they've examined these issues themselves.

5.5 Revisiting the Concept of Recovery

Current body image literature has indicated that recovery from an eating disorder and body dysmorphia encompasses more than merely reaching a healthy weight, and normalising eating and compulsive behaviours; and needs to include multi-dimensional factors such as psychological, social, biological and emotional dimensions of change to reduce the potential for relapse (Bloomgarden et al, 2003; Bowlby, 2008; Johnston et al, 2005; Noordenbos & Seubring, 2006; Sovak, 2011; Williams, 2011).

When initially starting this study, part of the essential inclusion criteria I had for the sample group was that the participants had a previous history of body image disturbance and/or eating problems and that they self-identified as being recovered from these issues. However, through the research process it became apparent that despite subjectively identifying as being 'recovered', a number of participants indicated that at times their body image fluctuated and they still struggled to varying degrees with how they felt about their bodies. This was usually in response to life events (e.g. pregnancy; illness; aging) or interpersonal experiences with others, which was particularly heightened in the therapy room with clients suffering with similar issues. For some this triggered negative feelings and coping behaviours such as restricting food or binge-eating, but for many they shared that they were always conscious of trying to eat healthily and exercising regularly to look after their bodies, along with other self-care strategies.

Therefore, in my view, the process of recovery appears to be a unique, subjective experience for each individual, which is significantly impacted by the quality of one's body image. I believe this highlights the question of whether it is really possible to 'fully recover' from the negative body image concerns which underlie an eating disorder or body dysmorphia, particularly within a culture which endlessly equates one's attractiveness with happiness, success, and acceptance. Therefore I consider the notion of 'recovery' as less of an end state to reach, and more of an ongoing journey which needs continual management through self care and a deep awareness of one's personal vulnerabilities.

5.6 Limitations of the Study and Suggestions for Future Research

There are a number of design limitations in the current study and it is hoped that future research may address some of these factors:

First, the recruitment of participants was challenging due to a refusal or lack of response from a number of eating disorder centres in the UK to advertise the

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study. Upon reflection, this may have been due to the nature of the research which addresses a sensitive and often shameful topic. Advertising yielded greater success on the 'BEAT' research webpage; as well as by directly contacting professionals who indicated that they worked with eating disorders and body image issues in private practice. As a result, seven of the nine participants worked with a *variety* of client presentations in private practice, including body image problems and eating pathology, and the remaining two worked primarily with eating disorders. While this provided valuable findings, future research could focus on recovered therapists working *predominantly* with eating disorders, body image issues, as well as body dysmorphic disorder. This may offer different insights as the therapists' subjective experiences and countertransference reactions may be more heightened due to the intensity of the treatment with these presentations.

Second, due to the small sample size in this study, and the need for a fairly homogenous group, the sampling criteria of the research design comprised female, Caucasian therapists as the literature has consistently shown that body image problems and eating disorders occur more frequently in these populations (Barbarich, 2002; Celio et al, 2004; Costin, 2009). As comparative studies, future research could expand on these findings by increasing the diversity of the sample by interviewing recovered male therapists to determine whether there are any gender differences that occur in their experiences of working with this client population. This would provide an interesting comparison as there appears to be no previous body image research on the experiences of recovered male therapists. Furthermore, the findings in this study, and the current literature on recovered female therapists, appears to all be focused on sample groups from White, Western cultural backgrounds. Therefore it may be beneficial for further comparative research to be done by investigating the experiences of recovered therapists from various non-Western cultural and ethnic backgrounds (e.g. Black; Latino/Hispanic; Asian) who work with body image disturbance and eating

disorders, in order to identify any similarities or differences that result across the various groups.

Third, the initial screening questionnaire was limited in that it did not ask about *duration* of recovery, and the amount of clinical experience post-qualification and 'post-recovery' the participants had. As indicated in the findings, some of the newly-qualified and 'less-recovered' therapists reported more negative experiences and countertransference responses compared to those who appeared more experienced in managing their personal responses in the therapy room. Future research could focus more clearly on these criteria to further address how more-experienced, recovered therapists manage their subjective experiences and countertransference reactions, and the recommendations they make for recovered therapists working with this client group. It may also be beneficial for future studies to address the question of *how* we might know when a therapist is *'recovered enough'* to work effectively with clients presenting with eating disorders and body image disturbance.

Fourth, although the screening questionnaire asked about the *type* of training and qualification the participants had, it may be informative for future research to investigate how the experiences of recovered therapists may differ by training modality, and to hear their recommendations for training programmes in terms of providing greater preparation and support to trainees in the management of embodied countertransference issues as addressed in this study.

Fifth, on reflection, I wonder what the lasting impact of being interviewed in this study was like for the participants because of the sensitive nature of the subject of body image. Although the participants were debriefed at the end of the interviews, it may have been helpful to conduct second follow-up interviews with participants after a period of time, involving a full discussion about the impact of the first interview on them, and whether this raised any issues, or changed anything in their professional outlook and clinical work with their clients. This

issue could be addressed in future research, and would enable a further deepening of the hermeneutic circle of the inquiry process (Smith et. al, 2009).

5.7 Personal Reflections on the Study

The notion of reflexivity is essential in conducting qualitative research (Willig, 2013) as the analyst can never remain entirely detached and impartial from their own assumptions and experiences to be truly objective in their interpretations. As the phenomenon of the recovered therapist working with eating disorders and body image disturbance has personal relevance to me as a researcher, it is important to share my reflections extracted from my reflexive journal to consider how I may have influenced and shaped the process of data collection and analysis.

Being a novice researcher, I found that the experience of conducting research interviews was initially difficult and required me to focus on finding a comfortable 'research persona' (Smith et al, 2009) for myself whereby I could remain attentive and focused on hearing the participants' experiences; whilst being careful not to respond 'as a therapist' to some of the sensitive, often painful, material the participants were sharing.

I was also mindful of the possibility for a 'parallel process' (Evans & Gilbert, 2005) to occur in the interviews, reflecting the participants' client experiences, as well as them being curious or making certain judgements and assumptions about myself, my appearance and whether I had a personal history of body image issues. For instance, I was aware of needing to manage my own countertransference feelings when a participant (Penny), who was noticeably a smaller build and lower weight than me, spoke about a desire put on some weight after her illness and made a comparative comment about my body-shape:

Penny: I sometimes think if I was a stone heavier, I feel...and I'll get a bit personal here...I sometimes get envious when I see someone with more your build and size, because there's something beautiful and womanly about that, and I still feel like this little fairy doll [...] and when I look at women my age, who are quite ethereal, unless they're dancing, I don't like the look of it.

Although her comment was intended as complementary rather than critical, I noticed feeling quite self-conscious having attention drawn to my body. With some of the other participants whose bodies were of varying sizes and shapes in comparison to myself, I also noticed my embodied experience fluctuating at times from feeling comfortable, relaxed and confident with my body, to the opposite experience of feeling awkward, uncomfortable and hyperaware of my appearance. Similar experiences were expressed by most of the participants in their client work, which resulted in the development of two super-ordinate themes, 'Heightened Body Awareness' and 'Worry about Judgement and Exposure'. I took time to carefully reflect on these two themes to ensure they correctly captured the participant's experiences rather than being an assumption I was making. Therefore I was mindful throughout the analytic process of the potential for researcher bias in the interpretation of the data, particularly the complex construct of countertransference.

Another factor I carefully considered was regarding the curiosity of the participants about whether I too was a 'recovered therapist'. I had chosen not to disclose anything about my personal history as I was mindful that this may impact the way in which the participants answered the questions. Regarding the issue of the interviewer disclosing personal experiences or perspectives, Smith et al (2009) state that this should be handled with care as it could potentially set up competitive, comparative dynamics, and may even result in a certain 'response bias' to answer questions in the certain way. However, they suggest that disclosure could be useful during the debriefing process. This was demonstrated in the current study, as two participants asked about my history during the

debriefing process and I felt more comfortable discussing this with them at this stage as I felt that they had been able to express themselves freely, and on their own terms in the interview. Upon reflection, this felt like an acknowledgement that I understood personally what their experiences were like, which echoed the findings in the research about empathic resonance and response.

At various stages of the analytic process, which was also new experience for me, I noticed feeling quite overwhelmed, frustrated and tired; and sometimes, that the end was nowhere in sight. After immersing myself in the data, particularly the participant's accounts of the methods they used to look after themselves, the importance of managing my own self care became apparent. At these points I allowed myself some breaks from the process while awaiting feedback from my supervisor, and by planning short holidays and enjoyable, relaxing activities with my loved ones. I was always grateful after these breaks and distractions to have a renewed sense of enthusiasm and insight upon my return to the data analysis and writing-up process. Furthermore, this research process has enabled me to develop a greater awareness and sensitivity to the implicit embodied relational aspects of my own clinical work with clients suffering from body image problems and eating disorders, and the importance of maintaining and managing my own personal self support processes as a psychological therapist.

5.8 Clinical Implications

This IPA study has utilised a small, purposefully-selected sample of nine participants to conduct an in-depth exploration of how particular experiential phenomena (i.e. subjective experiences and countertransference responses) have been understood from the perspective of particular individuals (i.e. recovered female therapists) in a particular context (i.e. working therapeutically with eating disorders and body image disturbance). The findings do not seek to develop theory, establish causality or make claims at the population level (Smith et al, 2009) however the results are consistent with the existing theoretical and

empirical literature, and thus provide additional support for a number of clinical practices. I therefore make a number recommendations for recovered therapists working in the eating disorder and body image field; and where appropriate, these recommendations will be extended to the clinical work of *all* therapists on the assumption that we all bring our personal imperfections, vulnerabilities, challenges, past traumas, and 'woundedness' into our professional lives as we are not above the very challenges that our clients seek our support with.

5.8.1 Reflexivity

It is well documented in the literature that countertransference issues are an inevitable element of the work with clients presenting with eating disorders and body image disturbance. If the therapist working in this field has a personal history of body image problems, their subjective feelings and countertransference reactions are likely to be magnified, which if unmonitored may result in negative consequences for the therapist and the therapeutic process. Therefore it is essential for all therapists, and recovered professionals in particular, to develop and nurture their capacity for reflexivity and self-awareness (i.e. through personal therapy, clinical supervision and peer support) in order to continually process countertransference responses, maintain integrity and manage ethical boundaries. This enables one's 'internal supervisor' (Casement, 2002) to guide difficult decision-making processes and therapeutic responses in the therapy room; as well as being able to recognise and bracket personal issues in order to manage them appropriately and avoid potentially impacting the therapy in a negative way.

5.8.2 Training Issues

Following on from the first point about becoming a reflexive therapist, it is recommended that *all* trainees should be required to enter into personal therapy during their training, as on some courses, trainees either experience a brief amount or none at all. Furthermore, psychology and psychotherapy training courses (not just those specific to eating disorders and more body-focused

therapies) should place greater emphasis on educating trainees on the impact and management of the therapist's embodied experience in the therapy room, particularly if they have a personal history of these problems. From my own experience and those of the participants, this knowledge seemed to be gained post-qualification through bringing these issues to supervision as they emerged in client work, rather than being explicitly taught during training in much depth (if at all).

5.8.3 Personal Therapy

It is essential that therapists have explored their own body image and/or eating issues in personal therapy before starting to work with individuals suffering from eating disorders and body image disturbance. Furthermore, personal therapy should also be used as a supportive resource if personal issues resurface to a significant level in the course of working with this client population, or potentially during times of stress or physical changes (e.g. from illness, pregnancy and aging). The lack of clarity in the literature about how we might define recovery from eating disorders and body image disturbance also has implications for 'recovered' therapists: how do we know when an individual is '*recovered enough'* to work with clients presenting with these same issues? Furthermore, what are the consequences if the therapist is *not* recovered enough?

There are very few guidelines offered in the literature to answer these questions, apart from Costin's (2009) recommendation that recovered therapist's should ideally have been recovered from the symptoms of an eating disorder for at least two years before working with eating disorder clients; and Sovak's (2011) suggestion that to avoid potential ethical errors, less experienced recovered therapists should also consider deferring seeing eating disorder clients until they can access safe supportive supervision. Although personal body image concerns may resurface at *any* time, regardless of the amount of clinical experience and number of years in recovery an individual has, these guidelines seek to minimise

therapist over-identification and entanglement with client issues, thus avoiding possible harm to the therapist and the client.

Guidelines for what equates to being 'recovered enough' should not be too rigid or quantitative as this may result in therapists feeling monitored, shamed and fearful about disclosing their personal histories (Bloomgarden et al, 2005). It is also important to acknowledge that each person's journey of recovery is unique, and a judgement of personal readiness to work with this client population should be carefully considered in supervision and personal therapy. Similarly, if a therapist 'relapses' due to personal material resurfacing, it is recommended that their clinical work with eating disorders and body image disturbance is reduced or temporarily put on hold for the therapist to seek support to get 'back on track'.

Based on the findings in this study, I consider the healing process from negative body image issues as being more of an *ongoing* 'journey of recovery' rather than an 'end state' to reach. In contrast to recovery from the particular symptoms of an eating disorder or body dysmorphic disorder as defined in the DSM-5 (APA, 2013) such as reaching a healthy body weight and cessation of 'disordered' behaviours; some individuals may still continue to have a negative body image by holding some residual beliefs and attitudes regarding eating, weight, body shape and appearance, despite relinquishing self-destructive behaviours (Johnston et al, 2005). Therefore this emphasises the need for ongoing management of these issues through self-reflection, personal therapy and supervision.

This point is also relevant to *any* therapist who has had a particular issue or disorder to a significant level, and often it is this very type of person with personal wounds who is drawn to training in the mental health field. It highlights that therapists need to acknowledge their personal wounds (regardless of what these are) and take care in establishing whether they are recovered *enough* to be working ethically and safely with clients. Thus there is a message for all

therapists here about whether we are really as 'recovered'/ 'untroubled'/ 'sorted' as we like to think we are, and perhaps we all need to revisit personal therapy from time to time when life becomes challenging to offer ourselves the very things we seek to give our clients: compassion, support and insight.

5.8.4 Supervision

The importance of using regular supervision and peer support is highlighted in this study and well-documented in the literature. It is recommended that recovered therapists and trainees should find a trusted supervisor with whom they can disclose their body image history, so they may be effectively supported in providing safe, ethical therapy to their clients struggling with eating disorders and body image disturbance (Sovak, 2011). Recovered therapists should also use caution before using certain interventions such as self-disclosure and discussing the therapist's body in the therapeutic dialogue. These interventions may be of great value in supporting clients with their body image problems, however their effectiveness should first be carefully explored in supervision, as well as considering how this exposure may personally affect the therapist (Costin, 2009).

The importance of attending regular supervision is equally important for *all* psychotherapists, psychologists and counsellors for professional support in creatively exploring the therapist's personal process in relation to client work, so that one does not lose sight of oneself or the client. Despite the number of years of clinical experience and level of training one has, nobody is immune from the vagaries of life; and all professionals bring their own pre-occupations, vulnerabilities and life experiences into the therapy room, which may inevitably be evoked with clients. Hence, it is simply about how these issues are admitted, understood and managed within the context of one's personal and professional lives that makes or breaks us as therapists (Adams, 2014).

5.8.5 Maintaining Recovery

An essential element of maintaining recovery and wellbeing involves the recovered therapist continually managing their personal triggers and body image issues through 'bio-psycho-social' self-support strategies. The methods used and recommended by the participants in this study include: adopting a healthy attitude to eating; enjoying regular exercise; greater self-acceptance and respect; relaxation (i.e. massage; relaxing baths; time spent in nature); reflection (i.e. writing; personal therapy; supervision; peer support); and spending time with loved ones and pets.

The importance of using self-support strategies outside of the therapy room is also relevant to *any* therapist working with the suffering of others. Anyone is susceptible to burnout from work, unanticipated life circumstances, current struggles or past issues re-emerging, therefore the inclusion of effective strategies, activities, rituals, and relaxation methods as a regular part of one's daily/weekly routine "*entails the choice of changing and the ensuing responsibility. It is the acknowledgement, the commitment, and the burden of replenishing yourself, professionally and personally*" (Norcross, 2000, p.711).

6. CONCLUSION

In conclusion, this chapter will present a summary of the findings and discuss the significance of the study.

6.1 Summary of the Findings

IPA analysis is a joint product of the participant and researcher, or the 'double hermeneutic', in which the researcher makes sense of the participant making sense of their experiences. Thus, the truth claims in this IPA study are tentative, and the subjectivity of the analysis in the current study has strived to be "*dialogical, systematic and rigorous in its application*" (Smith et al, 2009, p.80). Through an analysis and interpretation of the data, there were three master themes which emerged across the sample group, each including a number of sub-ordinate themes:

6.1.1 Understanding the Struggle: A Shared Experience

This first master theme captures the shared experience between therapist and client of having an eating disorder or body image disturbance, and the recovered therapist's personal understanding of what this struggle may be like for the client. This encompasses five super-ordinate themes: empathic resonance; conveying empathy; assumption about therapist being 'the sorted one'; authenticity and self-disclosure; and exploring embodied experiences.

6.1.2 Becoming Entangled: Old Feelings Resurfacing

The second master theme conveys the negative consequences for the recovered therapist of working with eating disorders and body image problems, when elements of their personal struggle are evoked and their own wounds became entangled with those of the client's. This includes four super-ordinate themes: over-identifying with the struggle; worry about judgement and exposure; heightened body awareness; and feeling ineffective.

6.1.3 Self-Support Strategies: A Life-Long Healing Process

The third master theme demonstrates the strategies used by participants to support and care for themselves in their therapeutic work and personal lives. This includes five super-ordinate themes: self-acceptance and respect; healthy attitude to eating and exercise; relaxation and reflection; recognising and bracketing own issues; and support in supervision and personal therapy.

6.2 Significance of the Study

The idiographic nature of this IPA study has given a voice to the individual participants about their personal experiences; and the findings have contributed to the growing evidence in the empirical literature by highlighting some of the negative and positive countertransference responses and subjective experiences of recovered therapists working in the eating disorder and body image field. Furthermore, the study also provides a number of recommendations for practice; effective methods for managing difficult feelings and countertransference experiences that arise; self-support strategies; and suggestions for training.

A significant issue raised in this study is regarding the relationship between how therapists have dealt with their own issues, and how they work with their clients in supporting them to confront their own struggles and conflicts. If an individual has had a personal experience around body image, weight and food, and they choose to work as a therapist in the field of body image disturbance and eating disorders, they need to be very attuned to their own issues to know *where* they are in their personal 'recovery process'. To facilitate this self-knowledge and insight, it is essential that recovered therapists access support through personal therapy and clinical supervision in order to track that they remain 'recovered enough' to work safely and ethically with clients, as well as to provide the therapist with an awareness of what they bring to the therapeutic encounter.

It is hoped that the findings have provided the reader with a sense of the value which recovered therapists have to offer in their work with clients suffering with eating disorders and body image disturbance, through their deep empathic resonance with these issues, and the instillation of hope about the journey towards healing and recovery. This is not without its potential pitfalls, and this study has explored various personal and professional support structures to put in place to manage this effectively. In closing I share Adams' (2014, p.17) sentiment which captures the importance of becoming a reflexive, self-aware therapist:

> *Working as a therapist is a privilege, and with it comes a profound responsibility to know ourselves as much as we hope to know others.*

7. REFERENCES

Adams, M. (2014) *The myth of the untroubled therapist: private life, professional practice.* East Sussex: Routledge.

Altabe, M. & O,Garo, K. (2004) Hispanic body images. In: T.F. Cash & T. Pruzinsky (eds.) *Body image: a handbook of theory, research and clinical practice.* New York: Guilford Press, pp. 250-256.

American Psychiatric Association. (2013) *Diagnostic and statistical manual of mental disorders: DSM-5.* Washington, D.C: Author.

Anderson-Fye, E.P. (2012) Body images on Non-Western Cultures. In T.F. Cash & L. Smolak (eds.) *Body image: a handbook of science, practice and prevention (2nd ed.).* New York: Guildford Press, pp244-252.

Baker-Pitts, C. (2007) Two bodies in the room: an intersubjective view of female objectification. *Psychoanalysis, Culture & Society*, 12, 124-141.

Barbarich, N. C. (2002) Lifetime prevalence of eating disorders among professionals in the field. *Eating Disorders, 10*, 305-312.

Barker, C., Pistrang, N. & Elliot, R. (2002) *Research methods in clinical psychology: An introduction for students and practitioners,* (2nd edition). Chichester: Wiley.

Barrett-Lennard, G.T. (1993) The phases and focus of empathy. *British Journal of Medical Psychology,* 66, 3-14.

Bloomgarden, A. (2009) Working with people who live dangerously: Perspectives on managing negative countertransference during the treatment of eating disorders. In: M. Maine, W.N. Davis & J. Shure (eds.) *Effective clinical practice in the treatment of eating disorders: the heart of the matter*. New York: Routledge, pp.221-234.

Bloomgarden, A., Gerstein, F. & Moss, C. (2003) The last word: a 'recovered enough' therapist. *Eating Disorders,* 11, 163-167.

Bolton, G. (2005) *Reflective practice: writing and professional development* (2nd edn). London: Sage.

Bowlby, C. G. (2008) Lessons learned from both sides of the therapy couch: a qualitative exploration of the clinical lives of recovered professionals in the field of eating disorders. *Dissertation Abstracts International: Section B: The Sciences and Engineering,* 68 (9B), 6290.

Bowlby, C.G., Anderson, T.L., Hall, M.E.L. & Willingham, M.M. (2012) Recovered professionals exploring eating disorder recovery: a qualitative investigation of meaning. *Clinical Social Work Journal,* 1-10.

Bordo, S. (1993) *Unbearable weight: Feminism, western culture, and the body.* Berkeley: University of California Press.

Bozarth, J.D. (2011) Rogerian empathy in an organismic therapy: a way of being. In Decety, J. & Ickes, W. (eds.) *The social neuroscience of empathy.* London: MIT Press, 101-112.

British Psychological Society (2009) *Code of ethics and conduct.* Leicester: British Psychological Society.

British Psychological Society (2014) *Code of human research ethics.* Leicester: British Psychological Society.

Bunnell, D. (2009) Countertransference in the psychotherapy of patients with eating disorders. In: M. Maine, W.N. Davis & J. Shure (eds.) *Effective clinical practice in the treatment of eating disorders: the heart of the matter*. New York: Routledge, pp79-93.

Burka, J.B. (1996) The therapist's body in reality and fantasy: a perspective from an overweight therapist. In: B. Gerson (ed.) *The therapist as a person: Life crises, life choices, life experiences and their effects on treatment.* London: The Analytic Press, pp.255-275.

Campbell, T. (1996) Technology, multimedia, and qualitative research in education. *Journal of research on computing in education*, 30(9), 122-133.

Casement, P. (2002) *Learning from our mistakes: beyond dogma in psychoanalysis and psychotherapy.* East Sussex: Brunner-Routledge.

Cash, T.F. (2008) *The body image workbook: an eight-step program for learning to like your looks. (*2nd ed.). Oakland: New Harbinger Publications, Inc.

Cash, T.F. & Fleming, E.C. (2004) Body image and social relations. In: T.F. Cash & T. Pruzinsky (eds.) *Body image: a handbook of theory, research and clinical practice.* New York: Guilford Press, pp.277-286.

Cash, T.F. & Pruzinsky, T. (eds.) (2004) *Body image: a handbook of theory, research and clinical practice.* New York: Guilford Press.

Cash, T.F. & Smolak, L. (eds.) (2012) *Body image: a handbook of science, practice and prevention (2nd ed.).* New York: Guildford Press.

Celio, A.A., Zabinski, M.F. & Wilfley, D.E. (2004) African american body images. In: T.F. Cash & T. Pruzinsky (eds.) *Body image: a handbook of theory, research and clinical practice.* New York: Guilford Press, pp.234-242.

Chapman, E. & Smith, J.A. (2002) Interpretative phenomenological analysis and the new genetics. *Journal of health psychology* 7(2), 125-130.

Clarkson, P. (1990) A multiplicity of therapeutic relationships. *British Journal of Psychotherapy,* 7 (2), 148-163.

Clarkson, P. (2003) *The therapeutic relationship (2nd ed.).* London: Whurr Publishers Ltd.

Costin, C. (2009) The embodied therapist: Perspectives on treatment, personal growth, and supervision related to body image. In: M. Maine, W.N. Davis & J. Shure (eds.) *Effective clinical practice in the treatment of eating disorders: the heart of the matter.* New York: Routledge, pp221-234.

Costin, C. & Johnson, C.L. (2002) Been there, done that: Clinicians' use of personal recovery in the treatment of eating disorders. *Eating Disorders,* 10, 293-303.

Cozolino, L.J. (2010) *The neuroscience of psychotherapy: healing the social brain (2nd ed.).* New York: WW Norton & Company.

Danziger, N., Prkachin, K.M. & Willer, J. (2006) Is pain the price of empathy? The perception of others' pain with congenital sensitivity to pain. *Brain, 129,* 2494-2507.

Decety, J. & Jackson, P.L. (2004) The functional architecture of human empathy. *Behavioural and Cognitive Neuroscience Reviews,* 3, 71-100.

Delucia-Waack, J.L. (1999) Supervision for counsellors working with eating disorder groups: countertransference issues related to body image, food and weight. *Journal of Counselling and Development,* 77, 379-388.

DeYoung, P.A. (2003) *Relational Psychotherapy.* New York: Routledge.

Eichenbaum, L. & Orbach, S. (1983) *Understanding women: a feminist psychoanalytic approach.* New York: Penguin Books Ltd.

Evans, K.R. & Gilbert, M.C. (2005) *An introduction to integrative psychotherapy.* Hampshire: Palgrave Macmillan.

Fallon, P. & Ackard, D.M. (2004) Sexual abuse and body image. In: T.F. Cash & T. Pruzinsky (eds.) *Body image: a handbook of theory, research and clinical practice.* New York: Guilford Press,pp.117-124.

Finlay, L. (2003) Through the looking glass: intersubjective and hermeneutic reflection. In L. Finlay & B. Gough (eds.) *Reflexivity: a practical guide for researchers in health and social sciences.* Oxford: Blackwell Publishing.

Finlay, L. (2006) Mapping Methodology. In: L. Finlay & C. Ballinger, *Qualitative research for allied health professionals.* West Sussex: Wiley, pp.8-29.

Finlay, L. (2008) A dance between the reduction and reflexivity: explicating the ''phenomenological psychological attitude''. *Journal of Phenomenological Psychology,* 39, 1-32.

Finlay, L. (2009) Debating phenomenological research methods. *Phenomenology & Practice*, 3, 6-25.

Finlay, L. and Ballinger, C. (2006) *Qualitative research for allied health professionals.* West Sussex: Wiley.

Franko, D.L. & Roehrig, J.P. (2012) In T.F. Cash & L. Smolak (eds.) *Body image: A handbook of science, practice and prevention (2nd ed.).* New York: Guildford Press, pp221-228.

Gabbard, G.O. & Wilkinson, S.M. (1994) *Management of Countertransference with Borderline Patients.* Plymouth: Rowman and Littlefield Publishers, Inc

Garrett, C.J. (1997) Recovery from anorexia nervosa: a sociological perspective. International Journal of Eating Disorders, 21 (3), 261–272.

Gerson, B. (ed.) (1996) *The therapist as a person: life crises, life choices, life experiences and their effects on treatment.* London: The Analytic Press.

Gorman-Ezell, K. E. (2009) Eating disorder professionals and the relationship between countertransference, eating attitudes, body image, and self-esteem. Doctoral dissertation. The Ohio State University.[Online]. Available from: https://etd.ohiolink.edu/!etd.send_file?accession=osu1257454991&disposition=inl ine [Accessed 9 January 2015].

Grogan, S. (2012) Body image development in adulthood. In T.F. Cash & L. Smolak (eds.) *Body image: a handbook of science, practice and prevention (2nd ed.).* New York: Guildford Press, pp93-100.

Gutwill, S. (1994) Transference and countertransference issues: The impact of social pressures on body image and consciousness. In: C. Bloom, A. Gitter, S. Gutwill, L. Kogel & L. Zaphiropoulos (eds.) *Eating problems: a feminist psychoanalytic treatment model.* New York: Basic Books, pp144-177.

Hammersley, D. (2003) Training and professional development in the context of counselling psychology. In R. Woolfe, W. Dryden, S. Strawbridge (eds). *Handbook of counselling psychology.* (2nd ed.). pp637-655.

Hargaden, H. & Sills, C. (2002) *Transactional analysis: A relational perspective.* East Sussex: Brunner-Routledge.

Herzog, D.B., Keller, M.B. & Lavori, P.W. (1988) Outcome in anorexia nervosa and bulimia. A review of the literature. *Journal of Nervous and Mental Disease*, 176, 131-143.

Hoepfl, M.C. (1997) Choosing qualitative research: a primer for technology education researchers. *Journal of Technology Education, 9(1), 47-63.*

Jarman, M. & Walsh, S. (1999) Evaluating recovery from anorexia nervosa and bulimia nervosa: Integrating lesson learnt from research and clinical practice*. Clinical Psychological Review*, 19, 773-788.

Jenkins, J. and Ogden, J. (2012) Becoming "whole" again: a qualitative study of women's views of recovering from anorexia nervosa. *European Eating Disorders Review*, 20, e23-e31.

Johnston, C., Smethurst, N., & Gowers, S. (2005) Should people with a history of an eating disorder work as eating disorder therapists? *European Eating Disorders Review,* 13, 301-310.

Joyce, P & Sills, C. (2014) *Skills in gestalt counselling and psychotherapy* (3rd ed.). London: Sage Publications Ltd.

Kawamura, K.Y. (2004) Asian American body images. In: T.F. Cash & T. Pruzinsky (eds.) *Body image: a handbook of theory, research and clinical practice.* New York: Guilford Press, pp.243-249.

Kawamura, K.Y. (2012) Asian American body images. In T.F. Cash & L. Smolak (eds.) *Body image: a handbook of science, practice and prevention (2nd ed.).* New York: Guildford Press, pp229-236.

Kearney-Cooke, A. (2004) Familial influences on body image development. In: T.F. Cash & T. Pruzinsky (eds.) *Body image: a handbook of theory, research and clinical practice.* New York: Guilford Press, pp99-107.

Kearney-Cooke, A. & Striegel-Moore, R. (1997) The etiology and treatment of body image disturbance. In: D.M. Garner & P.E. Garfinkel (eds.) *Handbook of treatment for eating disorders (2nd ed.).* New York: The Guildford Press, pp295-306.

Kearns, A. (2005) *The seven deadly sins: Issues in clinical practice and supervision for humanistic and integrative practitioners.* London: Karnac Books.

Krueger, D.W. (2004a) Psychodynamic perspectives on body image. In: T.F. Cash & T. Pruzinsky (eds.) *Body image: a handbook of theory, research and clinical practice.* New York: Guilford Press, pp.30-37.

Krueger, D.W. (2004b) Psychodynamic approaches to changing body image. In: T.F. Cash & T. Pruzinsky (eds.) *Body image: a handbook of theory, research and clinical practice.* New York: Guilford Press, pp.461-468.

Kvale, S. (1996) *Interviews: An introduction to qualitative research interviewing.* Thousand Oaks, CA: Sage.

Lamoureux, M. & Bottorff, J. (2005) "Becoming the real me": recovering from anorexia nervosa. *Health Care for Women International,* 26 (2), 170-188.

Larisey, K. (2012) The wounded healer: a jungian perspective. [Online]. Available from: http://www.jungatlanta.com/articles/fall12-wounded-healer.pdf [Accessed 21 November 2014].

Larkin, M. & Thompson, A. (2012) Interpretative phenomenological analysis. In A. Thompson & D. Harper (eds.) *Qualitative research methods in mental health and psychotherapy: a guide for students and practitioners*. Oxford: John Wiley, pp. 99-116.

Legard, R., Keegan, J. & Ward, K. (2003) In-depth interviews. In: J. Ritchie & J. Lewis (eds.) *Qualitative research practice.* Los Angeles: Sage, pp.138-169.

Levine, M.P. & Smolak, L. (2004) Body image development in adolescence. In: T.F. Cash & T. Pruzinsky (eds.) *Body image: a handbook of theory, research and clinical practice.* New York: Guilford Press, pp74-82.

Leibowitz, L. (1996) Reflections of a childless analyst. In B. Gerson (ed.) *The therapist as a person: life crises, life choices, life experiences and their effects on treatment.* London: The Analytic Press, pp 71-88.

Liebermann, J. (2000) *Body talk: looking and being looked at in psychotherapy.* New Jersey: Jason Aronson, Inc.

Lowell, M.A. & Meader, L.L. (2005) My body, your body: Speaking the unspoken between the thin therapist and the eating-disordered patient. *Clinical Social Work Journal,* 33 (3), 241-257.

Maroda, K. (2004) The power of countertransference: innovations in analytic technique (2nd ed.). Hillsdale, NJ: Atlantic Press.

McKinley, N.M. (2004) Feminist perspectives and objectified body consciousness. In: T.F. Cash & T. Pruzinsky (eds.) *Body image: a handbook of theory, research and clinical practice.* New York: Guilford Press, pp55-62.

McKinley, N.M. (2012) Feminist perspectives on body image. In: T.F. Cash & L. Smolak (eds.) *Body image: a handbook of science, practice and prevention (2nd ed.).* New York: Guildford Press, pp48-55.

Murnen, S. K. (2012) Gender and body images. In: T.F. Cash & L. Smolak (eds.) *Body image: a handbook of science, practice and prevention (2nd ed.).* New York: Guildford Press, pp173-179.

Noordenbos, G. & Seubring, A. (2006) Criteria for recovery from eating disorders according to patients and therapists. *Eating Disorders,* 14, 41-54.

Norcross, J.C. (2000) Psychotherapist self-care practitioner-tested, research-informed strategies. *Professional Psychology: Research and Practice*, 31 (6), 710-713.

O'Brien, M. & Houston, G. (2007) *Integrative therapy: A practitioner's guide. (*2nd ed.). London: SAGE Publications Ltd.

Orbach, S. (2003) There is no such thing as a body. *British Journal of Psychotherapy,* 20(1), 3-16.

Orbach, S. (2004) What can we learn from the therapist's body? *Attachment and Human Development,* 6(2), 141-150.

Oxford Dictionary. (2015). Available from: http://www.oxforddictionaries.com/definition/english/body-image [Accessed 1 April 2015].

Petterson, G. & Rosenvinge, J.H. (2002) Improvement and recovery from eating disorders: a patient perspective. *Eating Disorders: The Journal of Treatment and Prevention*,10(1), 61-71.

Phillips, K.A. (2004) Body image and body dysmorphic disorder. In: T.F. Cash & T. Pruzinsky (eds.) *Body image: a handbook of theory, research and clinical practice.* New York: Guilford Press, pp312-321.

Preston, S.D. & de Waal, F.B.M. (2002) Empathy: Its ultimate and proximate bases. *Behavioural and Brain Sciences, 25*, 1-72.

Rance, N.M., Moller, N.P., & Douglas, B.A. (2010) Eating disorder counsellors with eating disorder histories: A story of being "normal". *Eating Disorders,* 18, 377-392.

Rance, N.M., Clarke, V., & Moller, N.P. (2014) "If I see somebody, I'll immediately scope them out": anorexia nervosa clients' perceptions of their therapists' body. *Eating Disorders*, 22 (2), 111-120.

Rankin, K.P., Gorno-Tempini, M.L., Allison, S.C., Stanley, C.M., Glenn, S., Weiner, M.W., & Miller, B.L. (2006) Structural anatomy of empathy in neurodegenerative disease. *Brain, 129,* 2945-2956.

Ritchie, J. (2003) The applications of qualitative methods to social research. In: Richie, J. & Lewis, J. (eds.) *Qualitative research practice.* London: Sage, pp.24-46.

Ritchie, J., Lewis, J., & Elam, G. (2003) Designing and selecting samples. In: Richie, J. & Lewis, J. (eds.) *Qualitative research practice.* London: Sage, pp.77-108.

Rogers, C.R. (1951) *Client-centered therapy: it's current practice, implications and theory.* London: Constable & Robinson Ltd.

Rosen, J.C. (1990) Body image disturbance in eating disorders. In: T. Cash & T. Pruzinsky (eds.) *Body images: Development, deviance, and change.* New York: Guilford Press, pp. 190-216.

Rosen, J.C. (1997) Cognitive-behavioural body image therapy. In: D.M. Garner, & P.E. Garfinkel (eds.) *Handbook of treatment for eating disorders (2nd ed.).* New York: The Guildford Press, pp188-201.

Rothschild, B. (2006) *Help for the helper: self-care strategies for managing burnout and stress.* London: W.W. Norton.

Rubin, H.J. & Rubin, I.S. (2005) *Qualitative interviewing: the art of hearing data (2nd ed.).* Thousand Oaks, California: Sage.

Ruskay-Rabinor, J. (1995) Overcoming body shame: my client, myself. In: M.B. Sussman (ed.) *A perilous calling: the hazards of psychotherapy practice*. Oxford: John Wiley & Sons, pp89-99.

Saldana, J. (2009) *The coding manual for qualitative researchers.* London: Sage.

Schooler, D. & Lowry, L.S. (2012) Hispanic/Latino body images. In T.F. Cash & L. Smolak (eds.) *Body image: a handbook of science, practice and prevention (2nd ed.).* New York: Guildford Press, pp237-243.

Schore, A.N. (1994) *Affect regulation and the origin of the self.* New Jersey: Lawrence Erlbaum Associates.

Schore, A.N. (2001) The Seventh Annual John Bowlby Memorial Lecture; Minds in the making: attachment, the self-organizing brain, and developmentally-oriented psychoanalytic psychotherapy. *British Journal of Psychotherapy*, 17, 299-328.

Schore, A.N. (2005) Attachment, affect regulation, and the developing right brain: linking developmental neuroscience to paediatrics. *Paediatrics in Review*, 26, 204-211.

Schore, A.N. & Schore, J.R. (2008). Modern attachment theory: the central role of affect regulation in development and treatment. *Clinical Social Work Journal*, 36, 9-20.

Schore, A.N. & Schore, J.R. (2014) Regulation theory and affect regulation psychotherapy: A clinical primer. *Smith College Studies in Social Work,* 84, 178-195.

Schwandt, T.A. & Halpen, E.S. (1988). *Linking auditing and metaevaluation: Enhancing quality in applied research.* London: Sage. In A. Pickard & P. Dixon (2004) The applicability of constructivist user studies: how can constructivist inquiry inform service providers and systems designers? *Information Research* [Online] 9(3). Available from: http://informationr.net/ir/9-3/paper175.html [Accessed 28 June 2013].

Schwimmer, G. (2010) The influence of female therapist body image on the perceived management of countertransference in the treatment of female anorexic and bulimic clients: implications for practice. PhD Dissertation. New York University.

Shaw, R. (2004) The embodied psychotherapist: an exploration of the therapist's somatic phenomena within the therapeutic encounter. *Psychotherapy Research*, 14(3), 271-288.

Sheehy, J.E. (2009) Book review of F.S. Anderson (ed.) Bodies in treatment: The unspoken dimension. *Psychoanalytic Psychology,* 26(4), 447-450.

Shure, J. & Weinstock, B. (2009) Shame, compassion and the journey toward health. In: M. Maine, W.N. Davis & J. Shure (eds.) *Effective clinical practice in the treatment of eating disorders: the heart of the matter.* New York: Routledge, pp.163-177.

Skouteris, H. (2012) Body image issues in obstetrics and gynecology. In T.F. Cash & L. Smolak (eds.) *Body image: a handbook of science, practice and prevention (2nd ed.).* New York: Guildford Press, pp342-349.

Smith, J.A., & Osborn, M. (2008) Interpretative phenomenological analysis. In: J.A Smith (ed.) *Qualitative psychology: A practical guide to methods* (2nd ed)*.* London: Sage, pp.51-80.

Smith, J.A., Flowers, P. & Larkin, M. (2009) Interpretative phenomenological analysis: theory, method and research. London: Sage.

Soth, M. (2005) Embodied countertransference. In: N. Totton (ed.) *New dimensions in Body Psychotherapy.* Maidenhead: OUP. [Online]. Available from: http://www.wttn.org.uk/ecthandout.pdf [Accessed 28 June 2013].

Sovak, A.F. (2011) The experiences of recovered professionals in the eating disorder field. PhD Dissertation. University of Saint Thomas. [Online]. Available from:http://ir.stthomas.edu/cgi/viewcontent.cgi?article=1005&context=caps_grad psych_docproj [Accessed 28 June 2013].

Steiner, C. (2009) The Heart of the Matter: love, information and transactional analysis. [Online]. Available from: http://www.emotional-literacy-training.de/Medien/Buecher%20Claude/Steiner%20%20The%20Heart%20of%20 the%20Matter;%20Love,%20Information%20and%20Transactional%20Analysis. pdf [Accessed 15 December 2014].

Stolorow, R.D. & Atwood, G.E. (1992) *Contexts of being.* Hillsdale, NJ: The Analytic Press.

Stolorow, R.D., Atwood, G.E. & Brandchaft, B. (1994) *The intersubjective perspective.* Northvale, NJ: Jason Aronson*.*

Striegel-Moore, R.H. & Franko, D.L. (2004) Body image issues among girls and women. In: T.F. Cash & T. Pruzinsky (eds.) *Body image: a handbook of theory, research and clinical practice.* New York: Guilford Press, pp183-191.

Strobeck, L.N. (2005) The impact of the therapist's pregnancy on the eating disorder patient: Implications for object relations and self psychological treatment. Doctoral Dissertation. Widener University, School of Human Service Professionals. [Retrieved on loan from Wolfgram Library, Widener University, Chester, PA].

Tiggemann, M. (2004) Media influences on body image development. In: T.F. Cash & T. Pruzinsky (eds.) *Body image: a handbook of theory, research and clinical practice.* New York: Guilford Press, pp91-98.

Tiggemann, M. (2012) Sociocultural perspectives on human appearance and body image. In T.F. Cash & L. Smolak (eds.) *Body image: a handbook of science, practice and prevention (2nd ed.).* New York: Guildford Press, pp12-19.

Warren, C.S., Crowley, M.E., Olivardia, R., & Schoen, A. (2009) Treating patients with eating disorders: an examination of treatment providers' experiences. *Eating Disorders,* 17, 27-45.

Warren, C.S., Schafer, K.J., Crowley, M.E., & Olivardia, R. (2012) A qualitative analysis of job burnout in eating disorder treatment providers. *Eating Disorders,* 20, 175-195.

Warren, C.S., Schafer, K.J., Crowley, M.E., & Olivardia, R. (2013) Treatment providers with a personal history of eating pathology: a qualitative examination of common experiences. *Eating disorders*, 21 (4), 295-309.

Watson, J.C. & Greenberg, L.S. (2011) Empathic resonance: A neuroscience perspective. In J. Decety & W. Ickes (eds.) *The social neuroscience of empathy.* London: MIT Press, pp125-137.

Wertheim, E.H. & Paxton, S.J. (2012) Body image development in adolescent girls. In T.F. Cash & L. Smolak (eds.) *Body image: a handbook of science, practice and prevention (2nd ed.).* New York: Guildford Press, pp76-84.

Wertz, F. (2005) Phenomenological research methods for counselling psychology. *Journal of Counselling Psychology,* 52(2), 167-177.

Williams, M.A.L. (2011) The ethics experiences of eating disorder therapists who have a personal history of an eating disorder: An interpretative description. PhD

Dissertation. University of British Columbia. [Online]. Available from: https://circle.ubc.ca/handle/2429/39511 [Accessed 28 June 2013].

Willig, C. (2013) *Introducing Qualitative Research in Psychology: Adventures in Theory and Method* (3rd ed.). Berkshire: Open University Press.

Yardley, L. (2000) Dilemmas in qualitative health research. *Psychology & Health,* 15, 215-228.

Yardley, L. (2008) Demonstrating validity in qualitative psychology. In J.A. Smith (Ed.) *Qualitative psychology: A practical guide to methods* (2nd ed). London: Sage, pp.235–251.

Yontef, G. (1999) Awareness, dialogue and process. [Online]. Available from: http://www.gestalttherapy.org/publications/AwarenessDialogueProcess.pdf [Accessed 30 December 2014].

8. APPENDICES

Appendix 1: Ethics Approval Letter

Appendix 2: Participant Information Sheet

Appendix 3: Screening Questionnaire

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Appendix 6: Sample of Candice's Transcript with Exploratory Comments and Emergent Themes

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Appendix 9: Table of Master Themes across Participants

Appendix 10: Table of Themes and Extracts by Participant

Appendix 1: Ethics Approval Letter

13 North Common Road
Ealing, London W5 2QB
Telephone: 020 8579 2505
Facsimile: 020 8832 3070
www.metanoia.ac.uk

Linda Verbeek
DCPsych programme
Metanoia Institute

6th April 2011

Ref: *14/10-11*

Dear Linda

Re: Therapists who self-identify as being 'recovered': experiences working with body image disturbance and eating disorders.

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Institute Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please inform me as DCPsych representative for the Metanoia Institute Research Ethics Committee.

Yours sincerely,

Dr Patricia Moran
Research Subject Specialist, DCPsych Programme
Faculty of Applied Research and Clinical Practice

On behalf of Metanoia Institute Research Ethics Committee

Appendix 2: Participant Information Sheet

Therapists Who Self-identify as Being 'Recovered': Experiences Working with Body Image Disturbance and Eating Disorders.

Invitation

You have been invited to take part in a research study. Before you decide to participate it is important that you take time to familiarise yourself with the reasoning underpinning the study and what it will involve. Please read the following information carefully and if there is anything that you are not clear about, please contact me on the email address provided.

What is the purpose of the study?

This is a qualitative research project exploring experiences of countertransference by female therapists who have a personal history of body image concerns (and/or an eating disorder) when working with clients suffering from body image disturbance and dissatisfaction, (including eating disorders). The study seeks to explore the currently under-researched area of the impact on the therapist's personal and professional self when client and therapist suffer from similar concerns. The aim of this study is to explore the therapist's experience of countertransference, and how it is managed therapeutically. Furthermore, the study will explore the strategies which therapists use to support themselves personally and professionally.

Why have I been invited to participate?

I am interested in hearing about your experiences as female therapist with a personal history of body image concerns to contribute to the advancement of knowledge, treatment and management of countertransference when working with clients struggling with body image disturbance and eating disorders.

Do I have to take part?

It is your decision as to whether you participate in this study or choose not to. If you do decide to take part then you will be required to read and retain this information sheet and

sign a consent form indicating that you agree to take part. You may elect to withdraw your participation in this study at any time and without giving a reason.

What will happen to me if I take part?

If you agree to take part in this study, you will be invited to attend an individual interview lasting approximately one to one and a half hours which includes 15minutes for debriefing.

What happens when the interview has finished?

Your interview transcript will be analysed with the transcripts of other participants to look at the differences and similarities in experiences. From the analysis a written summary of themes will be produced.

What are the possible disadvantages and risks of taking part?

Due to the sensitive nature of the subject matter, it is possible that you may find it distressing to recall your clinical experiences. Should an in-depth exploration of your clinical practice raise difficult feelings that you wish to explore in more depth, I will provide a comprehensive list of support agencies offering confidential help in the debriefing information. If you appear distressed you or I may end the interview early without any pressure to continue.

What are the possible benefits of taking part?

It is hoped that you will find the interview process interesting and even useful. The information obtained from this research project may provide valuable information for therapist's working with clients suffering from eating disorders and body image disturbance, regarding countertransference evoked in the therapy room, and how this may be managed therapeutically and in terms of therapist self-support strategies.

Will my taking part in this study be kept confidential?

Yes. All information that is collected about you during the research will be kept strictly confidential. During the transcription and analysis stage your confidentiality and anonymity will also be maintained by altering any identifying personal characteristics. This process will include the use of pseudonyms for each of the participants. All recordings of interviews will

be stored, analysed and reported in compliance with the Data Protection Act (1998). As a participant you are asked to also extend confidentiality to your own clients by preserving their anonymity when referring to them during the interview.

What will happen to the results of the research study?

The findings will be included in my doctoral thesis and will be stored at the library at Metanoia Institute. I may also submit my report for publication in professional journals. If requested, you may receive a copy of the findings.

Who has reviewed the study?

The research has been reviewed and ethically approved by the Metanoia Research Ethics Committee.

What should I do if I want to take part in this study?

If you are interested in participating in this research, or require further information before deciding, please contact me on the details below. Following this, you will need to complete a screening questionnaire to determine whether you meet the participant requirements of the study, and if chosen to take part, you will need to complete a written consent form. The interview can then be arranged at a time and location that is convenient for you.

Contacts for Further Information:

<u>Name of Researcher</u>:
Linda Verbeek
linda.verbeek@hotmail.com

<u>Research supervisor</u>:
Dr. Janet Dutton, C. Psychol.
Metanoia Institute, 13 North Common Road, Ealing, London, W52QB.

Thank you for taking time to read this information sheet.

Appendix 3: Screening Questionnaire

Participant Identification Number: _____

Title of Project: *Therapists Who Self-identify as Being 'Recovered': Experiences Working with Body Image Disturbance and Eating Disorders.*

Thank you for showing an interest in participating in this research study. To establish whether you might be suitable to take part in this study, please answer the following questions as honestly as possible and provide any relevant details in the space provided. This questionnaire is confidential and no personal identifying information will be stored with this form.

1. How would you describe your ethnic origin?

2. What is your personal therapeutic approach?

3. Please name any Professional Bodies you are registered with:

4. Please describe the context of your client work:

5. Have you worked with clients struggling with eating disorders or body image disturbance? YES / NO (delete as appropriate)

Please provide details:

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6. Would you say that you've had body image concerns or an eating disorder in the past? YES / NO (delete as appropriate)

Please provide details and describe any treatment or support that you may have received:

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7. Would you say that you currently have body image concerns?

YES / NO (delete as appropriate)

Please provide details:

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8. Would you say that you currently have an eating disorder?
YES / NO (delete as appropriate)

Please provide details:

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Thank you for taking the time to fill in this questionnaire.

Please contact me if you require any further information about the study or this questionnaire:

<u>Researcher:</u>

Linda Verbeek

Email: linda.verbeek@hotmail.com

<u>Research supervisor</u>:

Dr. Janet Dutton, C. Psychol.

Metanoia Institute, 13 North Common Road, Ealing, London, W52QB.

Appendix 4: Interview Schedule

Personal Experience of Body Image Concerns

1. Can you tell me about your history of body image concerns?
2. How have you managed your body image concerns in the past?
3. How do you feel about your body now?
4. How does your body image impact you personally and professionally?

Professional Experience of Working with Clients with Body Image Disturbance/Eating Disorders

5. Can you tell me about why you've chosen to work with clients with body image disturbance and/or eating disorders?
6. How do you feel that your body impacts the process of therapy?
7. What do you think about the issue of self-disclosure about your past or present body image concerns with your clients?
8. If you reflect on your work as a therapist with this client group, can you describe any experiences of countertransference you've had?
9. If a client has openly commented on your body, how has this made you feel, and how did it impact the therapeutic process?
10. What are some of the ways that you manage difficult feelings that are evoked in the therapy room?
11. How do you support/look after yourself outside of the therapy room?

Appendix 5: Research Consent Form

Participant Identification Number: _____

Title of Project: *Therapists Who Self-identify as Being 'Recovered': Experiences Working with Body Image Disturbance and Eating Disorders.*

Name of Researcher: Linda Verbeek

Please tick each box to show that you agree with each statement:

1. I confirm that I have read and understood the information sheet provided for the above study and had the opportunity to consider this information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason. ☐

3. I understand that the interview will be taped and subsequently transcribed. ☐

4. I understand that the research will be submitted to academic journals and that no identifying information about me will appear in any report and/or publication. ☐

5. I am willing to take part in the above study. ☐

6. I agree that this form that bears my name and signature may be seen by a designated auditor. ☐

_____   _____   _____
NAME OF PARTICIPANT   DATE   SIGNATURE

_____   _____   _____
NAME OF RESEARCHER   DATE   SIGNATURE

1 copy for participant; 1 copy for researcher

Appendix 6: Sample of Candice's Transcript with Exploratory Comments and Emergent Themes

	Emergent Themes	Original Transcript	Exploratory Comments
L38		How do you feel about your body now?	
P38	More accepting and comfortable about her body now.	Um, I feel different, I do. I think I feel much more comfortable. I don't know whether it's training or what's happened over the last few years, getting married and...I don't know, I just do feel different now.	More accepting and comfortable about her body now possibly from her training, her marriage or other recent experiences.
L39		So what do you think has changed for you...in terms of your body image?	
P39	Doesn't punish herself emotionally anymore because of any negative feelings she has about her body. Feels better about her body and her weight is more constant. Okay to 'just be normal'.	I think I don't use how I feel about my body as an emotional punishment anymore. Sometimes I'll have my days and my moments when I think Uhhh...but I'm not, it's not my way of dealing with things now I think. I feel more accepting of how I am, and my weight doesn't really change anymore. I don't feel like I have to exercise loads, or, I don't know, I just feel kinda I can just be normal.	Doesn't punish herself emotionally anymore because of her the negative feelings that pop up occasionally about her body. Feels better about her body and her weight is more constant. Okay to 'just be normal'.
L40		So, a lot more self acceptance.	
P40		Yeah.	

L41		And how do you think your body image affects you personally and professionally now?	
P41	Improved body image helps her to feel more comfortable and confident with others. Easier to be herself and not worry about not being liked/not saying the right thing . Worry that others may pick up things about her past even though she's not disclosed anything. Uses the body a lot in therapy, can identify with their pain.	I think personally...on a personal level I guess I feel more comfortable in friendships, and feel a bit more confident when I meet new people and I feel more...I think I always used to think people don't really like me, and didn't know what to say, now I just think well, you know, just be yourself...and it's easier to be yourself. I think professionally, cos the last kinda year or so I've been working in eating disorder settings, I think sometimes it's perhaps quite difficult, so I think even though I feel okay about myself now, I still kinda think, I wonder if clients or staff will pick something up about me or how I used to feel. Well I haven't disclosed anything to anyone. But yes, sometimes at the back of my mind...it's like, sometimes, cos I'm kinda working with the body and very much using it in therapy, I can identify with how painful it is sometimes with the clients I'm working with, and really don't want to use the (*reality?*)...and how difficult it is to access that, so.	Personal: Her improved body image has helped her to feel more comfortable with friends and confident when meeting new people, easier to be herself and not so worried about not being liked/not saying the right thing. Professionally: working in eating disorder settings has been quite difficult for her, as although she feels better about herself, she worries that others (staff and clients) may pick up things about her and how she used to feel, even though she's not disclosed anything. Uses the body a lot in therapy, can identify with their pain.
L42		Is that through the understanding of what you've been through yourself in therapy?	
P42		Yeah.	

L43		What stood out for you from your own experience of therapy?	
P43	Awareness that what worked for her in therapy may not necessarily work for everyone.	I just, I guess knowing that it's helped and realising that it's not gonna be helpful for everybody, but may be more accessible to some people than others...Knowing how much it's helped me to get through some of my difficulties, makes me want to use it with people with similar difficulties, but I have to accept that it's not gonna be for everybody.	Awareness that what worked for her in therapy may not necessarily work for everyone.
L44		It sounds like it was a positive experience for you.	
P44		Yeah	
L45		And are there particular clients you've seen, when you've picked up that it is harder to do for them?	
P45	Varied recovery process for each individual.	Yeah. Yeah, I mean I think it's, even where I work they group people in different stages depending on their recovery. But even in the group I work with, there is such a variation in patients and where they're at.	Notices a big variation on how different people are in their personal recovery process.
L46		So everyone has quite a unique experience in their recovery.	
P46		Yeah.	
L47		And why do you think you've chosen to work with eating disorder clients in particular, and body image?	
P47		I think when I was doing my training I did like a...my second year was working with adults. But then I did some individual work with a young woman who was in recovery from anorexia, and just, I think I felt that she got something out of	

		the therapy, and then I started thinking about it and the whole possibility. I guess it's to do with my own interest in it and my own experience.	Drawn to working with body image and eating disorders from her own interest and experience.
L48		And how do you feel your body impacts the process of therapy with your clients?	
P48	Aware of clients distorted 'comparing' of sizes in the anorexia therapy group.	I don't know...I think it's...for some of the patients I work with, it does impact the work; It's like they still, even though they're painfully thin, they still saw themselves as the largest body in the room, and that was a theme that came up. So I guess there is a lot of comparing.	Noticed a lot of 'comparing' in the therapy room; lot of very thin clients saw themselves as being 'the biggest' in the room.
L49		Was that something that you were just conscious of or was there comments made?	
P49		Yeah, comments were made. And I don't know whether...I guess, I do take stuff about my work to clinical supervision, and I've had to stop personal therapy now, but I sometimes think... I'm aware of what I'm taking into the room obviously, as a therapist as well.	
L50		Can you describe the types of body issues you've worked with?	
P50		Most of the work I've done so far has been with underweight patients. I've done one kinda mixed group of patients with anorexia and bulimia, and I've recently relocated, so I've been trying to set up some work which I'm hoping to start, with a mixed group. It would also be nice to do some work with overweight patients as well. So I guess, just working with body image as a whole.	

L51		And what has been your personal experience of working with an underweight as opposed to a normal weight or overweight client?	
P51	Worry and tension in her body about her very underweight client. Groups hard as members may feel exposed, but beneficial in enabling communication with others.	Mmm...I haven't really worked with overweight patients, so the difference I'd feel when working with very underweight patients as opposed to normal weight patients is...don't know, I guess I worked with a girl individually with a very low weight, you know on the verge of going in as an in-patient. I guess I realised that there was a lot of anxiety that I'd feel in my body before and after sessions; I'd feel quite tense, and worried about her during the session, and the activity level, and just be mindful of not wanting her to use the movement as exercise. I don't know how it made me feel about my own body, but I just know that I had a very strong sense of anxiety. I think groups...I don't know it's quite hard because I've done group and individual work, but I think there's sometimes things that clients can gain from groups, from the work and the process, and they can relate to others, and enable a way of communicating with others, which ultimately can be helpful. But then, I know from my own experience being in groups, that they can also make you feel quite exposed and quite aware.	Noticed CT feelings of tension in her body and worry about her very underweight client. Groups can be hard in as they can make you feel exposed and very aware, but they also have the benefit of enabling communication with others.
L52		Would you say there's a lot of comparison in the group, as opposed to just you and a client?	
P52		Yeah, I think so. I think kinda looking at each other and looking at me. And sometimes I try encourage people to try develop their own idea of what they want to do with one of the props, and often I find everyone was doing exactly what I was doing *(laughs)*, so all eyes are on me.	Lot of comparison done by individuals in group work, often just copying her movements rather than making them their own.

L53		If we go back to a previous thing you said about, um, comments being made, are you willing to share some of those?	
P53		Yeah...oh you mean?	
L54		Yeah, from clients. And going back to the comparison issue, when clients have commented on your body, and what that was like for you?	
P54	Understanding clients' feelings. Aware of feeling 'sized up' by clients sometimes.	Yeah, I don't know...I think I meant to say is that they were saying that they felt like the biggest in the room, which I know what that feels like. And it's just a phrase, but literally for one client who was a lot taller than the other girls, said she felt absolutely huge. She was a lot taller than me as well. I never really thought about height and body image in that way. But yeah, I don't really think anyone's ever made any direct comments to me. I have kinda felt sized up a bit.	Client very aware of feeling 'huge' compared to rest of the group because of her height. Aware of feeling 'sized up' by clients sometimes.
L55		And do you notice you comparing yourself to the others? With clients in groups, or perhaps with certain individual clients?	
P55	Anxious with some clients and a responsibility to keep them safe.	Not really...I think just because some of them are so unwell, there's just an instinct to try keep the group safe, and feeling a lot of that anxiety as well about the body image they're projecting.	Aware of feeling anxious when with her clients and a responsibility to keep them safe.
L56		So, your experience of transference and countertransference, if you're familiar with those terms, (Yeah), can you talk a bit about this in your work?	

P56		Yeah, I don't know...sorry	I wonder if she felt confused and embarrassed by not knowing how to respond to my question?
L57		Perhaps thinking of certain clients who have made quite an impact on you?	This next question perhaps put her at ease as I clarified what I wanted to hear from her.
P57	Initially felt quite challenged with clients while working on her own body image issues.	Yeah...I think the first client I worked with individually was quite hard...had quite an impact, cause that was when I first started to really...when I was in therapy myself, and taking a pause and thinking about my own body image, and working with her and things like that, and writing about the work. She was younger than me but I still had that sense of us both being young women, and sometimes...she also knew I was a trainee, so I sometimes felt she wanted to be friends, and that would come up a lot in the themes of the work, about friendship. So there was quite a lot of stuff, and it took quite a long time for the body image stuff to emerge but then it did it was all kinda tangled up with stuff about her mum, her relationship with her mum, and then I became the mum really, or that's how I felt, and she became quite angry.	Felt quite challenged with her first individual client in therapy, as she was also working on her own body image issues in personal therapy, and was very aware of being a similar age to her client, and a desire by her client to be friends. In Countertransference became 'the mum'; client would become quite angry.
L58		So how did you feel towards her? What was your countertransference reaction to her, as it sounds like she was asking quite a lot of you.	
P58	Sessions confusing and difficult; lot of worry and anxiety about client outside the sessions.	Yeah, I felt quite confused sometimes *(Laughs)* about what I was doing and the difficulty of the sessions. I felt kind-of drawn into the chaos of what was happening outside and between the sessions, and kinda worrying if she's gonna be okay, and I had quite close contact with her care coordinator. Yeah, she did provoke quite a lot of anxiety	Found sessions confusing and difficult; lot of worrying and anxiety about client outside the sessions too.

		[laughs].	
L59		So this feeling of chaos and confusion, did that affect you in any way within or outside of the sessions?	
P59	Difficulty managing sessions and client's missed sessions left her feeling inadequate and useless -how client often felt.	Yeah, I think I found it quite difficult to hold the session and also found it difficult to talk about what had happened. I felt quite confused and I'd just go blank sometimes. Then she'd use a pattern of coming and then not coming the next week, and I'd kinda wait for her in the room and it's a huge room actually, just feeling quite useless and inadequate, which is I guess a lot of her feelings.	Found it difficult to manage the sessions and client would miss sessions leaving her to feel inadequate and useless which she identifies as being how her client felt quite often.
L60		So the body image themes that came up with her, how did that impact how you feel about your body?	
P60	Felt that her body was being 'watched', scrutinized and invaded upon by client's gaze.	I think working one to one with her was the first time I'd worked with body image. I think she'd either look completely down at the floor, or her gaze was really fixed on me all the time, which was quite difficult. I felt very watched. Sometimes I would kinda , you know, suggest some gentle movements to warm up, and we'd go into a process where she would explore and lead, but I found just even trying to lead her in a few gentle things in the chair, I felt very, very invaded upon with her gaze. My body was being watched and judged.	Noticed feeling that her body was being 'watched', scrutinized and invaded upon by client's gaze; but client would also sometimes avoid eye contact.
L61		Did you feel scrutinised in a way?	
P61		Yeah.	
L62		So was there a lot of pushing and pulling with her?	Here I name the push pull possible borderline process of her client, which she clarifies in P63 with talking about her boundaries being

			pushed.
P62		Yeah.	
L63		How did that impact you, this push and pull from her?	
P63	Controlling client was pushing the boundaries a lot, could forget she was the therapist.	I think sometimes I found it difficult to remember that I was the therapist. I felt she really would test the boundaries a lot. One day she just marched in and put some music on, and started moving around which was okay, but normally we'd sit and have some time for verbally checking in, and I would suggest how we began. It was like she perhaps wanted to...I don't know, it's something about control.	Sometimes felt client would push the boundaries a lot, making her forget she was the therapist; identifies this as the client needing to take control.
L64		And, how do you feel about self-disclosure with clients?	
P64	Self-disclosure helpful in homelessness/ addiction work.

Concern about self-disclosure of body image struggle and shift of focus onto their 'shared body image struggles'. | Yeah, um...I've kinda read a bit about this, and I guess in some ways it can be helpful, like very often a lot of people I worked with in the homelessness jobs, had been through the experience themselves, or through drug addictions, and they disclosed that to clients in their relationship, and that was helpful. But personally I've just always felt that as a therapist I can always keep that back, and if I told them it would become about me and them, and both of our body image struggles, rather than the focus being on theirs. | Acknowledges benefit of self-disclosure in addiction work or with homelessness work, however in her work she feels that this would take the focus off the client onto her and their 'shared body image struggles'. I think this is also about her desire to help others rather than focus on herself. |
| L65 | | So how do you manage your own body image issues in the room, some of which you may identify with in certain clients. How do you deal with that within the session? | |
| P65 | Managing personal issues in the therapy room has been difficult, has needed to be | Yeah, I think it's pretty hard actually. I think I have to kinda be aware of my body. I think I have to pay particular | Managing her own issues in the therapy room has been difficult, and she's had to |

	very aware of her body. Use of supervision if things surface so as not to impact her own recovery.	attention to...kinda realising, well, I guess I had my particular personal difficulties in the past, maybe outside, maybe separately *(laughs)* realising that I have got help with that, and things are a lot better. And you know if things do come up in the work, I can after a session go talk to somebody outside, so just trying to make sure it doesn't impact on the recovery.	become very aware of her body, and acknowledges that she's had her own difficulties and has got help so things are much better for her. She says she can talk to someone outside of sessions if things surface so as not to impact her own recovery.
L66		So have you had an experience of some of your personal concerns being evoked and being present for you in a session, and having to deal with that?	
P66	Often identifies strongly with feelings of inadequacy, anxiety and worthlessness of clients.	Yeah, I think, not so much physically, like physically comparing myself, or body image as such, but I think emotionally kinda identifying with what's happening in the group. Feeling kinda tangled up, worthless and a bit *(laughs)* inadequate, and anxious. I think that's quite a strong, powerful countertransference for me.	Notices often identifying strongly with feelings of inadequacy, anxiety, worthlessness that surface in her groups. Interesting to note that this is not tied to her body anymore as she doesn't compare herself to others in terms of appearance & self worth.
L67		And those were a lot of the feelings you described having before when you were restricting your eating. So if some of those feelings surface for you, how do you deal with them? How do you support yourself?	
P67	Writing feelings down; making time for relaxation; enjoying things and having space to think.	Through supervision. I think I write down a lot how I feel after sessions...just trying to make space for doing things that are relaxing, and realising I can stop working and I can enjoy things, so things like going for a walk or having the space to kinda think.	Copes with her CT feelings by speaking about them in supervision, writing them down, making time for doing relaxing things, realising she can enjoy things and 'stop working' to have space to think.
L68		And your relationship with your supervisor...	

P68		Yeah...	
L69		Do you feel you can trust your supervisor and open about your personal issues?	
P69		I still find it difficult. I can to a certain extent.	Hard to open up about her past.
L70		Do you still feel you need to edit yourself in a certain way?	
P70		Yeah.	
L71		What do you think that's about for you?	
P71	Feeling of being assessed by supervisor. Worry of opening up about her past and not being seen as a 'safe practitioner'.	Don't know...even though she was my supervisor while I was training as well, which I'm not anymore, I somehow feel a little bit like she's assessing whether I'm adequate or don't know...a safe practitioner, and that's sometimes at the back of my mind.	Feeling that she's being assessed by her supervisor who she was also with while she was in training. Aware of wanting to be seen as a 'safe practitioner', and perhaps worries that being open about her past may look bad.
L72		So it's something about the judgement of your capability.	
P72	Still hard to share her past with others, but telling some key people has been very supportive.	Yeah, I mean I haven't really told anybody apart from my supervisor, my therapist and one close friend, about my past and my body image issues. Actually talking to my friend was brilliant and a big help as she was quite supportive, but it's not something I tell people about, so it feels like a kinda hidden thing.	Still finds it hard to tell others about her past, but sharing it with some key people has been very supportive.

Appendix 7: Chronological List of Emergent Themes for Candice

Emergent Themes

Personal recovery from forming new perspectives on food as something to be treasured.

Views on food changed through working with homeless people: food and shelter as basic needs.

Personal experience prompted her starting training to help others.

Challenging focusing on herself and her past in therapy and training.

More accepting and comfortable about her body now.

Doesn't punish herself emotionally anymore because of any negative feelings she has about her body.

Feels better about her body and her weight is more constant. Okay to 'just be normal'.

Improved body image helps her to feel more comfortable and confident with others.

Easier to be herself and not worry about not being liked/not saying the right thing.

Worry that others may pick up things about her past even though she's not disclosed anything.

Uses the body a lot in therapy, can identify with their pain.

Awareness that what worked for her in therapy may not necessarily work for everyone.

Varied recovery process for each individual.

Aware of clients distorted 'comparing' of sizes in the anorexia therapy group.

Worry and tension in her body about her very underweight client.

Groups hard as members may feel exposed, but beneficial in enabling communication with others.

Understanding clients' feelings.

Aware of feeling 'sized up' by clients sometimes.

Anxious with some clients and a responsibility to keep them safe.

Initially felt quite challenged with clients while working on her own body image issues.

Sessions confusing and difficult; lot of worry and anxiety about client outside the sessions.

Difficulty managing sessions and client's missed sessions left her feeling inadequate and useless -how client often felt.

Felt that her body was being 'watched', scrutinized and invaded upon by client's gaze.

Controlling client was pushing the boundaries a lot, could forget she was the therapist.

Self-disclosure helpful in homelessness/ addiction work.

Concern about self-disclosure of body image struggle and shift of focus onto their 'shared body image struggles'.

Managing personal issues in the therapy room has been difficult, has needed to be very aware of her body.

Use of supervision if things surface so as not to impact her own recovery.

Often identifies strongly with feelings of inadequacy, anxiety and worthlessness of clients.

Writing feelings down; making time for relaxation; enjoying things and having space to think.

Feeling of being assessed by supervisor. Worry of opening up about her past and not being seen as a 'safe practitioner'.

Still hard to share her past with others, but telling some key people has been very supportive.

At times feels watched or judged by colleagues and 'not good enough' for them.

Revealing her past to other staff was not an option as she didn't feel close/safe enough to do so.

Felt understood and seen by supervisor who acknowledged that the work seemed very painful for her.

Sharing her feelings with her husband.

More accepting of her body as she is pregnant.

More mindful of what and how she eats. Eating for health and nourishment during her pregnancy.

Exploring in supervision how her pregnancy may affect her work.

Appendix 8: Super-ordinate and Emergent Theme Clusters and Quotations for Candice

Super-ordinate and Emergent Themes	Quotations
Fear of Judgement and Exposure	
Worry that others may pick up things about her past even though she's not disclosed anything (P41).	"the last kinda year or so I've been working in eating disorder settings, I think sometimes it's perhaps quite difficult, so I think even though I feel okay about myself now, I still kinda think, I wonder if clients or staff will pick something up about me or how I used to feel" (P41).
Aware of feeling 'sized up' by clients sometimes (P54).	"I have kinda felt sized up a bit" (P54).
Felt that her body was being 'watched', scrutinized and invaded upon by client's gaze (P60).	"I felt very, very invaded upon with her gaze. My body was being watched and judged" (P60).
Heightened Body Awareness	
Aware of clients distorted 'comparing' of sizes in the anorexia therapy group(P48).	"even though they're painfully thin, they still saw themselves as the largest body in the room, and that was a theme that came up. So I guess there is a lot of comparing" (P48).
Empathic Resonance	
Uses the body a lot in therapy, can identify with their pain (P41).	"I'm kinda working with the body and very much using it in therapy, I can identify with how painful it is sometimes with the clients I'm working with" (P41).

Personal experience prompted her starting training to help others (P29).	"I realised actually when I moved I could feel or express things that I couldn't really talk about, or feelings came about, and I thought there's something about this I want to explore maybe, and I found a course, and I thought this is something I can do" (P29).
Understanding clients' feelings (P54).	"they were saying that they felt like the biggest in the room, which I know what that feels like" (P54).
Over-identifying with the Struggle	
Initially felt quite challenged with clients while working on her own body image issues (P57).	"I think the first client I worked with individually was quite hard...had quite an impact, cos that was when I first started to really...when I was in therapy myself, and taking a pause and thinking about my own body image, and working with her and things like that, and writing about the work" (P57).
Often identifies strongly with feelings of inadequacy, anxiety and worthlessness of clients (P66).	"I think emotionally kinda identifying with what's happening in the group. Feeling kinda tangled up, worthless and a bit inadequate, and anxious. I think that's quite a strong, powerful countertransference for me" (P66).
Client was pushing the boundaries a lot, could forget she was the therapist (P63).	"I think sometimes I found it difficult to remember that I was the therapist. I felt she really would test the boundaries a lot" (P63).
Difficulty managing sessions and client's missed sessions left her feeling inadequate and useless -how client often felt (P59).	"feeling quite useless and inadequate, which is I guess a lot of her feelings" (P59).
Feeling Ineffective	
Worry and tension in her body about her very underweight client (P51).	"there was a lot of anxiety that I'd feel in my body before and after sessions; I'd feel quite tense, and worried about her during the session, and the activity level" (P51).
Anxious with some clients and a responsibility to keep them safe (P55).	"because some of them are so unwell, there's just an instinct to try keep the group safe, and feeling a lot of that anxiety as well about the body image

	they're projecting" (P55).
Sessions confusing and difficult; lot of worry and anxiety about client outside the sessions (P58).	"I felt quite confused sometimes about what I was doing and the difficulty of the sessions. I felt kinda drawn into the chaos of what was happening outside and between the sessions, and kinda worrying if she's gonna be okay" (P58).
Self Acceptance and Respect	
More acceptance of her body and more constant weight. Okay to 'just be normal' (P39).	"I feel more accepting of how I am, and my weight doesn't really change anymore. I don't feel like I have to exercise loads, or, I don't know, I just feel kinda I can just be normal" (P39).
More accepting and comfortable about her body now (P38).	"I feel different, I do. I think I feel much more comfortable" (P38).
Improved body image helps her feel more comfortable and confident with others (P41).	"on a personal level I guess I feel more comfortable in friendships, and feel a bit more confident when I meet new people" (P41).
Easier to be herself and less worry about not being liked/not saying the right thing (P41).	"I always used to think people don't really like me, and didn't know what to say, now I just think well, you know, just be yourself...and it's easier to be yourself" (P41).
Doesn't punish herself emotionally anymore because of any negative feelings she has about her body (P39).	"I don't use how I feel about my body as an emotional punishment anymore" (P39).
More accepting of her body as she is pregnant (P82).	"I think I feel more accepting than before, and I want things to happen. Quite exciting. It feels like a new phase for me" (P82).
Healthy Attitude to Eating	
View of food challenged through work with homeless people: food and shelter as basic needs (P24).	"when you see people living in the streets and coming to the hostel, you can help them with practical things like giving them a hot meal, and you see actually it's just about keeping alive, food and you know...I think that's kinda

	shifted my perspective" (P24).
Personal recovery from forming new perspectives on food as something to be treasured (P22).	"I think it's partly kinda to do with perhaps feeling guilty and ashamed of what I did and...I think he, I don't know, I think he kinda helps me to put things into perspective. His family are from XXX and we went there a few years ago. You know, they're quite poor and their food is quite, it's something they treasure, and they sit down and have a family meal" (P22).
More mindful of what and how she eats. Eating for health and nourishment during her pregnancy (P83).	"I'm thinking more about the need to eat well properly and nourish myself for the baby, so there are a lot of positive effects. And I've been feeling a lot more comfortable in my body over the last few years, and doing the course, and I've not consciously dieted or starved myself, but I don't think I've enjoyed food or thought of it as nourishment, so yeah, it has affected things" (P83).
Relaxation and Reflection- Sitting with Honesty	
Writing feelings down; making time for relaxation; enjoying things and having space to think. (P67).	"I think I write down a lot how I feel after sessions...just trying to make space for doing things that are relaxing, and realising I can stop working and I can enjoy things, so things like going for a walk or having the space to kinda think"(P67).
Support in Supervision	
Use of supervision if things surface so as not to impact her own recovery (P65).	"if things do come up in the work, I can after a session go talk to somebody outside, so just trying to make sure it doesn't impact on the recovery" (P65).
Felt understood and seen by supervisor who acknowledged that the work seemed very painful for her, but didn't push her to say anymore (P77).	"he understood something about me that I couldn't say to him, or there was something he didn't verbalise but there was some kinda understanding there, and I felt really supported by him. I think he realised, and he verbalised that he felt this was very painful for me, but he didn't go into great detail about why he thought that was, but he just touched on these things that I feel, that it was sometimes painful" (P77).

Exploring in supervision how her pregnancy may affect her work (P84).	"I guess I'm also just conscious of how it's going to affect the work (laughs).I discussed it with my supervisor" (P84).
Personal Therapy	
Challenging focusing on herself and her past in therapy and training (P30).	"I found it quite difficult trying to talk about how I felt and my own past" (P30).
Fear of Judgement by Professionals	
Feeling of being assessed by supervisor. Worry of opening up about her past and not being seen as a 'safe practitioner' (P71).	"she was my supervisor while I was training as well, which I'm not anymore, I somehow feel a little bit like she's assessing whether I'm adequate or don't know...a safe practitioner, and that's sometimes at the back of my mind" (P71).
At times feels watched or judged by colleagues and 'not good enough' for them (P76).	"I always felt like I wasn't really good enough for them, and slightly watched or judged" (P76).
Revealing her past to other staff was not an option as she didn't feel close/safe enough to do so (P76).	"Perhaps me popping in for one day a week, I felt that tension with the staff, and found it difficult to find my voice and tell people why I was there. Yeah, I was nowhere near close enough to anyone to reveal anything personal about myself" (P76).

Appendix 9: Table of Master Themes across Participants

Master Themes and Super-Ordinate Themes	Participant Name and Interview Number									
	1	2	3	4	5	6	7	8	9	
	Alice	Megan	Candice	Nicola	Lauren	Penny	Bridget	Leigh	Sandra	TOTAL
1. Understanding the Struggle: A Shared Experience										
11 Empathic Resonance	Y	Y	Y	Y	Y	Y	Y	Y	Y	**9**
1.2 Conveying Empathy	Y	Y	Y	Y	Y		Y	Y	Y	**8**
1.3 Exploring Embodied Experiences	Y	Y				Y	Y	Y	Y	**6**
1.4 Assumption about Therapist being 'the Sorted One'	Y	Y				Y	Y	Y	Y	**6**
1.5 Authenticity and Self-disclosure	Y	Y	Y	Y	Y		Y	Y	Y	**8**
2. Becoming Entangled: Old Feelings Resurfacing										
2.1 Over-identifying with the Struggle	Y	Y	Y	Y	Y	Y		Y	Y	**8**
2.2 Worry about Judgement and Exposure	Y	Y	Y	Y	Y					**5**
2.3 Heightened Body Awareness	Y	Y	Y	Y	Y	Y	Y	Y		**8**
2.4 Feeling Ineffective			Y	Y			Y	Y	Y	**5**
3. Self-Support Strategies: A Life-long Healing Process										
3.1 Self Acceptance and Respect	Y	Y	Y	Y	Y	Y	Y	Y	Y	**9**
3.2 Healthy Attitude to Eating and Exercise	Y	Y	Y	Y		Y	Y	Y	Y	**8**
3.3 Relaxation and Reflection- Sitting with Honesty	Y	Y	Y				Y	Y		**5**
3.4 Recognising and Bracketing Own Issues	Y	Y	Y	Y	Y		Y	Y	Y	**8**
3.5 Support in Supervision and Personal Therapy	Y	Y	Y	Y	Y	Y				**6**

Appendix 10: Table of Themes and Extracts by Participant

Themes	Participant and Line Number								
	1 Alice	2 Megan	3 Candice	4 Nicola	5 Lauren	6 Penny	7 Bridget	8 Leigh	9 Sandra
1.1 Empathic Resonance	P53	P19	P29	P45	P35	P52	P14	P20	P35
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		P41	P54	P63	P40			P24	
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	P61	P52	P43	P29			P46	P30	P19
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	P76		P51						P25
									P35
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