

**Counselling for Eating Disorders:
Above and Beyond Cognitive Behavioural Therapy**

Stephanie Golds

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Supervisor: Aisling Hearn

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Abstract

Western culture today favours masculine, linear, and strategic opportunities, approaches, and answers, in many aspects of life, leaving little room for guided intuition, spiritual vision, or feminine energy. It is from personal experience, through therapy, conversation, education, and conducting research, that it became quite clear that this linear, strategic approach is also favoured in the treatment of eating disorders; a phenomenon that is without doubt multi-faceted and multi-dimensional. The counselling approach that is most-favoured and most-documented for the treatment of eating disorders, is cognitive behavioural therapy (CBT). CBT incorporates tasks, strategies, and exercises in order to obtain results, leaving aside the more abstract, intuitive techniques. It is the opinion of the author that while CBT has proven to be successful in treating eating disordered thoughts and behaviours, it falls short. As beings, we are much more than the sum of our actions and so, counselling needs to incorporate other elements above and beyond CBT techniques if true change is to occur.

The body of the thesis will contain three main chapters which will provide (1) an overview of elements for consideration with regard to eating disorders, (2) a detailed description of a number of treatment paradigms for eating disorders; and (3) the missing puzzle pieces that could compliment the CBT approach for a more successful outcome. The purpose of this overview is to provide a greater understanding of eating disorders and how they might be better treated in the counselling setting.

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Introduction

Eating disorders have long been known as “difficult” cases across all modalities of treatment. People suffering from or experiencing an eating disorder, particularly anorexia nervosa, can seem incessantly defiant, and their symptoms, elusive. And this perception is not just limited to, or solely based on, the experiences of the family members or loved ones of sufferers, but it also aligns with the beliefs of professionals in the field. Hilde Bruch, a German-American psychoanalyst, who’s life work was centred around treating people with eating disorders described the condition as, “...an enigma, full of contradictions and paradoxes” (Bruch, 1978). More recently, Professor Christopher Fairburn of Oxford University, who has also spent a many number of years researching and studying both the nature and treatment of eating disorders, was asked, “Is evidence-based treatment of anorexia nervosa possible?”, and his response was, “barely” (Skårderud, 2009).

Over the decades, eating disorders have been understood and treated quite differently, from being considered a type of hysteria in the times of Freud and Jung, to undergoing electroconvulsive therapy, modified insulin therapy, being administered with large doses of antipsychotic medications such as chlorpromazine, to more modern attempts such as inpatient refeeding programs, family based therapy and cognitive behavioural therapy (Roche, 2010). Although our knowledge of eating disorders has improved significantly over the years with an abundance of literature now readily available, it is as if the cure still remains to be seen as simply a mirage on the horizon, as ambiguous as the disorder itself.

Considerable amounts and varieties of research have been conducted, yet the National Institute for Clinical Excellence (NICE, 2004) treatment guidelines still advises us that there is no definitive evidence that describes the preferred method of treatment for eating disorders (Bezance & Holliday, 2013). The extensive research also implies that if someone has been suffering from an eating disorder for seven years or more, that there are no treatments available to them that are backed up by any ironclad scientific evidence (Conti, Rhodes, & Adams, 2016). This harsh reality is extremely disheartening and disappointing, for sufferers and professional alike, to hear that, over the last 30 years at least, no real improvements have been made for this population. Eating disorders can be pervasive and life threatening, severe and enduring, and chronic. They infuse hopelessness into the lives of those whom they encapsulate and they sever most of the relationships between sufferers and their outside world.

As is the truth for all physical and mental health conditions, there is a vast spectrum wherein eating disorders may take up residence. Not all cases are comparable therefore; we should not be approaching every case in the same manner or with the same technique, simply because that is the approach that has been most broadly researched (Touyz & Hay, 2015). Cognitive behavioural therapy (hereinafter referred to as CBT), has been referred to as the “gold-standard” method of treatment for bulimia nervosa and binge eating disorder which in itself is contradictory because not only do approximately 50% of cases report that they maintain binge eating behaviours, both following treatment, *and* at a 5 five year follow up, but there is also a 25% treatment abandonment rate (Woolhouse, Knowles, & Crafti, 2012). “Gold-standard” has been defined as “a supreme example”, “a model of excellence”, and “the best, most reliable, or most prestigious”. If the statistics above represent a “model of excellence”, this is concerning.

Another factor worth noting about the current literature is that the primary source of information is coming from the perspective of the researcher. While researchers and clinicians provide unquestionably invaluable knowledge, it would be beneficial to incorporate the experiences and insights of those who are living with the condition and who have perhaps attempted different treatment modalities and been unsuccessful to date (Musolino, Warin, Wade, & Gilchrist, 2016). While reviewing the literature for this thesis, it was the opinion of the author that, while the therapeutic relationship was spoken about and emphasized, its importance seems to remain overlooked. In all cases of counselling and psychotherapy, the quality of the relationship between the client and the therapist is paramount to achieving a successful outcome.

Furthermore, in particular with eating disorders, it has been documented that a collaborative and supportive connection must be established to deepen our understanding of our clients' experiences and needs so that they may begin to rebuild their sense of self, rather than simply focusing on their symptoms (Malson, Bailey, Clarke, Treasure, Anderson, & Kohn, 2010). Malson et al. further discuss Fardella's Recovery Model in which he encourages professionals to continue to work with clients on restoring their sense of self even past the point of symptom elimination (Fardella, 2008). To further support the imperativeness of the therapeutic alliance in the treatment of eating disorders, neuroscientific research shows positive changes in the right side of the brain when someone is engaged in a quality therapeutic relationship. It would seem that in applying Carl Rogers' core conditions of empathy, congruence, and unconditional positive regard, along with using reflection as a main tool, the brain as a social organ actually responds and changes form (Hershberg, 2011). It has been suggested that this right brain to right brain connection provides a sort of simulation or reenactment of the mother-child connection,

providing that safe environment that allows for exploration and growth, and laying a foundation for the development of self-trust and the restoration of a sense of self (Wylie & Turner, 2011).

Cognitive and family-based approaches are favoured and have maintained their positions as the “best” treatment methods and while challenging irrational thoughts (a main focus of CBT) and advising parents how to maintain control in refeeding their children (a component of family-based therapy) are important, they shouldn’t be believed to be solitary factors in attaining recovery nor should we settle on these methods and stop searching for better, more successful possibilities. To echo and further develop the previous point regarding the therapeutic relationship, Strober and Johnson refer to a “basic truth” that, fundamentally it is the therapist’s knowledge and wisdom of eating disorders, their treatments, and the lived experiences of sufferers, that will build the bridge upon which hope and faith can be transported to their clients during therapy. “Without this,” they state, “the bond that tethers our patient to our treatment is a fragile one” (Strober & Johnson, 2012).

If the current “gold-standard” treatment only “barely” offers a 50% success rate for only *some* of its participants, we simply need to do more. Literature pertaining to Alcoholics Anonymous and their methods ascertains that addicts must pursue recovery with a certain desperation; that of a drowning man. It describes desperation as the motivation to move forward and fight. Perhaps professionals could take heed of this advice in the pursuit of a cure. There should be no half-measures, shortcuts, or middle-of-the-road solutions. Half-measures will never allow anyone, client or therapist, to lay down the robust foundations that are required for self-trust, self-determination, self-belief, and self-worth to emerge (Iliff, 2008). Cognitive approaches have

dominated the fields of psychology and psychotherapy for the past three decades and it is believed that researchers are coming to a realization that while it is very researchable (hence its ability to produce the most data), the long term efficacy of these cognitive methods is limited. It might do us all no harm to allow ourselves to be swept along with what the neuropsychological scientists and therapists are calling the “emotional revolution” and see what wisdom it brings with it (Schoore, 2011).

In line with the above introduction, this piece of work aims to provide a deeper understanding of eating disorders and how best they might be psychotherapeutically treated, taking into account different elements of the literature that is currently available. Successful methodologies will be explored and explained and in turn suggestions as to how we might improve treatment modalities will be highlighted. As previously mentioned, not all eating disorder cases are comparable, and the same fact can be applied to treatment methods; they each operate from a different belief, with a different goal in mind, and a different opinion on what “recovery” looks like, therefore it is the author’s belief that no singular treatment can be truly effective or sustain long term success without the support of other treatments.

Chapter 1 – An Overview of the Disorder

The development of an eating disorder

Eating disorders are a complex mental health condition. According to the DSM (Diagnostic and Statistical Manual of Mental Disorders), they can be described as, “an illness that manifests itself in a variety of unhealthy eating and weight control habits that become obsessive, compulsive, and/or impulsive in nature.” The DSM recognises three main types of eating disorders; Anorexia Nervosa (AN), Bulimia Nervosa (BN), and Binge Eating Disorder (BED). The DSM-V now also recognizes additional categories such as avoidant/restrictive food intake disorder (ARFID), orthorexia (an obsession with eating foods one considers to be healthy), and what used to be referred to as EDNOS, (Eating Disorder Not Otherwise Specified), can now be found under OSFED (Other Specified Feeding and Eating Disorder), or UFED (Unspecified Feeding and Eating Disorder), (American Psychiatric Association. (2013).

The term *anorexia* refers to “loss of appetite” and *nervosa* comes from the Latin word for nervous. Anorexia nervosa has been defined as a psychiatric disorder characterized by an unrealistic fear of weight gain, self-starvation, and distorted body image. The individual is obsessed with weight loss, limits their food intake, and over-exercises while becoming increasingly unaware of the dangers of their behaviours or the effects they are having on their body. They refuse to reach or maintain a normal body weight. Although the sufferer is obsessed with weight loss, they continue to feel overweight. This “feeling of fat” is what keeps them striving to lose even more weight (Costin, 2007). This feeling also becomes an umbrella under

which all of their difficult emotions are housed. In someone experiencing anorexia, “feeling fat” can be decoded and understood as meaning, scared, lonely, stupid, or unloved, amongst a whole host of other unwanted negative and overwhelming emotions. Their bodies become the vessels through which they communicate and in maintaining extreme thinness they believe that they have mastered life; communicating to the world that they need nothing from anyone now that they have reached this superhuman level of functioning. Contradictorily however, they feel worthless (Bruch, 2001).

An eating disorder manifests and develops into a coping mechanism that the sufferer becomes intertwined in, and with. The disorder causes the sufferer to live a life in isolation, denial, deceit, and fear; a fear that prohibits them from asking for help, and from accepting assistance or guidance even from family and friends. They are gripped by an illness that is helping them to cope with life; it becomes their companion, they trust it, and they begin to believe that they cannot live without it. Therefore, a lot of sufferers can live their entire lives without seeking treatment (Bryant-Waugh & Lask, 2004).

Two personality traits are thought to be particularly common in people who develop eating disorders - perfectionism and low self-esteem - and typically both will have been present well before the eating disorder begins (Fairburn, 2008). People suffering from anorexia struggle against feeling enslaved, exploited and not permitted to lead a life of their own. In this blind search for a sense of identity they will not accept anything that their parents or the world around them, has to offer. The underlying psychological need behind anorexia is to gain a sense of self; it is a quest for autonomy (Bell, 1985). Children who grow up learning to seek validation

externally, will learn to value themselves on accomplishments rather than who they are and so can find great accomplishment in goals such as weight loss (Costin, 2007).

The two most common precipitating factors with anorexia nervosa are dieting and exercise. Most cases, with hindsight, begin with a seemingly innocent change in eating patterns in that someone will begin to eat healthier or undertake a certain diet in an effort to lose weight. They may or may not at this stage also begin exercising. However, due to the perfectionist characteristic that is present, he/she must be better than him/herself each day, therefore less and less is eaten, and more exercise is taken. Food groups are eventually omitted and labelled “dangerous” while just a handful of foods are considered “safe”. Sufferers become obsessed with diets, food plans, cookbooks, and most dominantly, calories. Numbers begin to rule their life and they become entrenched in counting and calculating every item that passes their lips, if they allow it (Kalodner, 2005).

The main perpetuating factor of anorexia nervosa is that it becomes the person’s coping mechanism. It usually develops in a time of need, when a person is unable to cope with life or a certain situation, and they become totally reliant upon it. While they are engrossed in the eating disorder behaviours, they avoid real life and miss out on developing normal coping skills. Other perpetuating factors include poor body image, low blood sugar, low self-esteem and worth, stress, anxiety, malnutrition, poor assertion skills, cognitive baggage, habit, lifestyle, and the ego-syntonic features i.e. I feel safe, I feel powerful, I feel strong, I feel special, I am happy, I have control (Jade, 2009). As opposed to ego-dystonic; where a person is aware of their illness and is distressed by its symptoms; ego-syntonic disorders are when the person suffering doesn’t

necessarily think that they have a problem in fact they think that other people are overreacting to their behaviours. Anorexia nervosa is described as such because patients experience their symptoms as the truth. Most patients will respond negatively and defensively to suggestions that they are ill (Fairburn, 2008).

Eating disorders have been misunderstood for most of their history. It wasn't until the 1930's that researchers finally understood that self-starvation was caused by psychological and emotional disturbances. Today, eating disorders are best understood as a combination of emotional factors interacting with biological and physiological imbalances in a vulnerable individual living in a cultural climate that places an emphasis on external appearance and thinness. Over time it appeared that dealing with underlying issues however, may not be enough to break serious behavioural patterns. Specifically, CBT seeks to change the dysfunctional beliefs and attitudes associated with eating disorders in order to facilitate a return to normal eating (Costin, 2007).

Eating disorders are certainly not a lifestyle choice. Nor are they a fad diet. They are a psychological illness that can result in death. Like with other mental illnesses, as humans we might display some form of behavior around food, exercise, or weight control from time to time, but an eating disorder includes a host of extreme and irrational behaviors and beliefs that negatively affect the sufferer and their ability to function in the world (Jade, 2009). There is no single cause that determines why someone might develop an eating disorder; rather it is a combination of many contributing factors (genetics, developmental factors, environmental factors, family, personality, neurobiological, cultural, and trauma). As Dr. Francis Collins, Director of the National Institutes for Health (NIH) once said, “Genes load the gun, the environment pulls the trigger”.

The connection between eating disorders and genetics is something that is still being researched today. In fact, as part of the global AN25K initiative, Genetics of Eating Disorders in Ireland (GEDI) are currently looking for data to aid this research. In her article linking eating disorders to an evolutionary hypothesis, Shan Guisinger (2003), offers a very interesting viewpoint; that the symptoms of anorexia nervosa, particularly, food restriction, hyperactivity, and denial of starvation, are in fact emulating the natural responses of our ancestors who were fleeing famine stricken lands. In order to survive, they had to muster up boundless amounts of energy even though they were severely malnourished, in order to move forward and locate food elsewhere and in essence; they would “deny” the fact that they were starving so that they could proceed. The research suggests that the genetic predisposition to eating disorders is present in all of us and that it has maintained a place in our genetic make-up because once upon a time, it did in fact save our lives (Guisinger, 2003).

Research to find a connection between genetics and eating disorders has been ongoing since the 1980’s, drawing from studies conducted with identical twins and also from studies pertaining to the chain of familial anorexia, in an effort to prove that it is indeed a hereditary disorder (Dring, 2015). Links have also been made between the parent-child relationships and the development of eating disorders; some look to the mother-child relationship while others focus on the father’s role within the family. From a psychodynamic perspective it might be viewed that a young girl who develops an eating disorder, is expressing an unattended trauma belonging to the mother (Vlahaki, 2012). With more limited studies conducted on the father-child relationship, there is less content but eight studies did find some core themes around managing conflict, communication, control, emotional regulation, self-esteem, and perfectionism, all of which

influence a child's autonomy, attitude, and overall psychology (Gale, Cluett & Laver-Bradbury, 2013).

Is it, or is it not, about food?

Of all the personal accounts found in the research, certain themes have emerged that are consistent with the idea that eating disorders are not simply about food; a holistic approach to treatment that focused on emotions rather than just food and weight was highly valued by participants (Munro, Thomson, Corr, Randell, Davies, Gittoes, Honeyman & Freeman, 2014); the eating disorder provided them with strength, safety, control, happiness, guidance, individuality, achievement, and success (Tierney & Fox, 2010); treatment paradigms that were inclusive of both the physical and psychological realms were most beneficial (Bezance & Holliday, 2013); the eating disorder behaviours posed as a projection of inner, emotional disturbances and anxieties (Brady, 2011); that if weight restoration was the primary focus of treatment, then relapse would most certainly follow shortly after discharge (Tierney, 2008); self-esteem, self-respect, allowing emotions, and being part of an active and supportive social circle, were important factors of recovery (Bjork & Ahlstrom, 2008); while all narratives expressed dieting behaviour initially, the eating disorder became a way of coping with their external world (Przybyl, 2010); and finally, through his extensive work on the connection between eating disorders and metaphors, Skårderud (2007) provides with a fine array of reasons as to why eating disorders are about more than food – control, protection, self-worth – to name just a few (Skårderud, 2007).

Costin and Grabb (2013) also speak about this in their book, *8 Keys to Recovery from an Eating Disorder*. Key number 3 is titled, “It’s Not About the Food”, however, key number 5 is titled, “It is About the Food”. Again, personal accounts within the book express that while they may have gained control over food and their weight, it was simply not enough because the underlying issues had never been addressed. Food is not the issue, nor is it the cause of the issue. It is well-documented that eating disorders are multi-faceted in nature and develop from the contribution of many varying factors but food itself is never listed as a primary cause. Some of the issues that can contribute to the development of an eating disorder are listed as, poor self-esteem, a need for distraction, perfectionism, superstition, a need for control, a need for power, a desire to be special, lack of self-belief, lack of trust, a need for safety, and difficulty expressing needs and emotions.

Conversely, one would be naïve to hope for change or recovery without appreciating the need to address the client’s relationship with food which is what key number 5 discusses. Costin and Grabb, in an interesting contrast to most other personal accounts, go so far as to say that recovery is possible without ever gaining any insight into the underlying issues, but unless the relationship with food improves, one will never be able to recover. As therapists, we can assist our clients in healing this vital relationship through a range of exercises; examine the current state without making it the focal point of any session; elicit any and all rules and beliefs that are held around food and eating; introduce mindful eating; and suggest the diarizing of food to include the emotional issues that arise around food and eating (Costin & Grabb, 2013). More important than any of these exercises however, is to not tip the equilibrium of power, or become directive, authoritarian, or instructive. The client must be allowed to feel a sense of control and

collaboration around any changes that are suggested or they will simply retract and possibly regress (Strober, 2004).

The anorexic voice

An extremely significant factor for therapists to not only be aware of, but to be wholly understanding of and compassionate towards, is the “voice” of the eating disorder, specifically in the cases of anorexia. What seems to be most difficult for outsiders of the disorder to understand is the obstinacy of the sufferer; that they are defiant, difficult, and persistent in their quest for starvation, in the midst of the obviousness that they are dying. If therapists could understand what it is like to live inside the disorder with the constant hum of a drill-sergeant voice, they might be able to see through the defiance and connect with their clients. It has been documented that this inner voice elicits mistrust in others’ offers of assistance and immobilizes those whom it inhabits. It has also been noted that when attempts are made to weaken the voice, it fights harder and continues to enforce its dominance over the healthy mind (Tierney & Fox, 2010). This can be extremely frustrating and disheartening, for client and therapist alike, and what might be helpful for clients who experience this particular phenomenon, could be some psychoeducation around the notion of extinction bursts; that in times of frustration or perceived threat, some behaviours can increase and escalate before decreasing and eventually subsiding (Goldstein, Schwade & Bornstein, 2009).

Not only should the authoritarian nature of the voice be considered, but also the relationship the sufferer has with their voice. Links have been made between those who are susceptible to severe and enduring cases of anorexia, or those who continue to relapse for many years, and a strong

bond with the inner voice. In research that was conducted to develop a quantitative measure (the P-CAN), participants were asked to list the pros and cons of their eating disorder; the most common advantage to having an eating disorder was that it made them feel safe and that their inner voice was their “guardian” (Serpell, Teasdale, Troop & Treasure, 2004). Further personal experience descriptions have conveyed a sense of loss in sufferers when they think about recovery; they felt saddened, a sense of abandonment, and a loss of direction, when contemplating life without their inner voice (Tierney & Fox, 2010). Sufferers can feel extremely dependent on their inner voice and truly believe that they will be unable to function without it. If they have been ill for a long number of years, this will be even more evident as they will have built up a strong attachment to it, therefore this is something quite profound that therapists should be cognisant of (Gale, Gilbert, Read & Goss, 2014).

On the contrary to sufferers relying and depending on their inner voice, they can also be in a constant battle with it. Rationally and cognitively they may know that the voice is just a collection of falsehoods and misconceptions and so they go to war in an attempt to extinguish it. In the same research which elicited the notion of “voice as guardian”, participants named a desire for their eating disorder to “go away” and leave them alone but that it was inescapable. Other participants expressed hatred towards the disorder and its symptoms and consequences such as depression, guilt, and shame (Serpell et al., 2004). This traumatic, daily, lived experience should not be ignored; in fact, in therapy it could be beneficial for the therapist to explore this present trauma and to provide solace and compassion. In addition, the therapist could give prominence to the client’s ability to battle against their voice (or even the consideration to battle) as a visceral strength that could be harnessed, bolstered, and further developed.

In 2014, Anderson Cooper, a well-known CNN host, underwent an experiment derived by Pat Deegan, a clinical psychologist and researcher, in order to better understand the experiences of those living with mental health illnesses. The experiment involved a schizophrenia simulator in which Cooper donned headphones that were rigged with a “schizophrenic voice” and wandered around the streets of New York. Cooper himself described the experience as harrowing, unpleasant, isolating, and incredibly distracting. It is not the author’s suggestion that every therapist undergo this type of simulation in order to work with clients but to at least meditate on the fact that they battle with a harsh inner critic daily, and to put themselves in the shoes of those who are at the mercy of such a voice.

Chapter 2 – Therapeutic Approaches

Cognitive behavioural therapy

Cognitive behavioural therapy (CBT), in similarity to anything or anyone who becomes popular and successful, has come under much scrutiny from opposing schools of thought. Some might view CBT as an authoritarian, overly directive, and controlling therapy that replicates the relationship between teacher and pupil. Others who are advocates of CBT might see it as the answer to all of their clients' issues and begin to disregard the importance of the unconscious mind. That is why it is important for us to become educated about what CBT really is, what function it serves within the field of counselling and psychotherapy, and what issues it does and doesn't work for (House & Loewenthal, 2008).

CBT is one of the most widely used and successful treatments for eating disorders and it can be provided on a one to one basis between a therapist and a client. Other successful treatment approaches include CBT-E (Cognitive Behavioural Therapy-Enhanced) CBT-E, DBT (Dialectical Behavioural Therapy), CRT (Cognitive Remediation Therapy), Narrative Therapy, CAT (Cognitive Analytical Therapy), FBT (Family Based Treatment, Maudsley), and Psychodynamic Therapy. All of these counselling based treatments can provide long term, solid results and enable the patient to actively partake in their treatment and recovery (Fairburn, 2008).

CBT was founded on the belief that an individual's affect and behaviour are largely determined by the way he or she structures the world, through cognitions based on attitudes or assumptions (Costin, 2007). In other words, our feelings and behaviours are a direct result of how we think about something. CBT became a widely used and common form of therapy, its key attraction being its brevity. Through the use of different techniques, clients can learn to observe and manage their thoughts, and in turn, change the behaviours linked to those thoughts (Ross, 2009). Beck's Cognitive Therapy (CT) model places an emphasis on negative thoughts, maladaptive beliefs, and cognitive distortions, affirming that an individual will make inaccurate interpretations of reality based on these thoughts, beliefs, and distortions. CT therapists will provide psychoeducation and will aim to enable clients to become their own therapist. The therapeutic process involves a lot of collaboration, challenges, structure, setting goals, and completing homework (Corey, 2013).

Eating disorders and CBT could be seen as a perfect match because eating disorders are fundamentally cognitive disorders and CBT was designed to produce cognitive change. Eating disorders have a core psychopathology of over-evaluation of shape and weight and their control. Clients are driven by irrational thoughts and rules, distorted and faulty thinking, catastrophisation, and extremist behaviour. The theory that underpins CBT is concerned with such processes that maintain the eating disorder rather than those responsible for its initial development (Fairburn, 2008).

Establishing a collaborative working relationship and engaging the client is of huge importance; the goal being that the client and the therapist work together as a team to help the client overcome their eating difficulties. The therapist needs to ensure that the client is aware of the

treatment plan and that they feel they are an active participant. Self-monitoring and the successful accomplishment of personalised homework tasks are also of huge importance. The focus is on the client's present state and the factors maintaining that state so that a treatment plan can be created. Creating a personalised visual representation of the processes keeping the client stuck in their illness will help to distance them from the disorder. By making the problem visual, the client can step outside of their mind and look at the disorder from a different angle; it will give the client breathing space. Through collaboration, education, and tasks, the client can successfully overcome their eating disorder. Although eating disorder clients have a reputation for being difficult to treat, the great majority can be helped and many, if not most, can make a full and lasting recovery (Fairburn, 2008).

However, although CBT is proven to work well with eating disorders, it primarily and solely focuses on the behaviours, as mentioned above. For someone to truly recover from anorexia, they would need to learn how to; listen to their body, listen to their feelings, learn to trust, accept and love themselves, and enjoy life again. Therapy would require the client to open up, allow themselves to be vulnerable, learn to fully experience every emotion, be open and accepting of all of those emotions, learn to use people to comfort them instead of focusing on food, and let their emotions come and go as they please without fear. This dimension of therapy and recovery would call for a more person-centered or humanistic approach because although CBT is effective with treating the behaviours, the underlying issues are of a deep emotional nature and need to be addressed by the client and their therapist. Also, if the trigger for the onset of an eating disorder was from a trauma or abuse that occurred in childhood, this would also need to be addressed and could have a great deal of therapeutic power (Corey, 2013).

Another factor that must be addressed when treating eating disorders is the diagnosis that is being presented. Clients with bulimia nervosa are known to have a more successful outcome with CBT than those with anorexia nervosa. There have been further developments of CBT specifically targeting the psychopathology of eating disorders; CBT-BN for bulimia nervosa and CBT-E for anorexia nervosa, with EDNOS (eating disorder not otherwise specified) requiring an even more specific treatment plan depending on their symptoms. A research trial carried out in the United Kingdom in 2013 asked participants about their experience with CBT in relation to bulimia nervosa and it was found that just over half clients who received specialist CBT treatment (CBT-BN), reported a preferable treatment outcome over those who received standard CBT (Serpell, Stobie, Fairburn, & van Schaick, 2013).

A promising development in the field of CBT and the treatment of eating disorders has been documented in recent research on the severe and enduring form of anorexia nervosa. Touyz and Hay (2015) refer to a new model, CBT-SE (cognitive behavioural therapy, severe and enduring) whereby the focus is not solely placed upon eliminating the eating disorder symptoms but rather on improving the client's overall quality of life. While restoration of weight was encouraged, it wasn't the main goal of the "recovery model" and interestingly, the participants were contacted 12 months after the trial and those who had received the CBT-SE treatment, had much improved levels of motivation to continue working towards recovery (Touyz & Hay, 2015). Perhaps a similar model could be utilized even when cases aren't severe and enduring; as Malson et al. (2010) advised us, to reinforce a position of looking at the client as a whole person rather than just their external symptoms (Malson et al, 2010).

Schema therapy

While it had been tried, tested, and proven that CBT could be successfully applied to a wide range of disorders, it was also recognized that CBT was not as successful with people who had been struggling with longer term disorders and illnesses and specifically with eating disorders, there is a large group of people that remain unaffected by CBT methods (Boone, Braet, Vandereycken & Claes, 2012). In order to address the wider issue, Jeffrey Young, an American psychologist, established a new method that built upon Beck's CBT model. This new method became known as Schema Therapy (ST) and it amalgamated a number of components from a variety of different theories; psychoanalysis, Gestalt, attachment theory, object relations theory, and constructionism (Cucchi, 2015).

There are four key elements to ST: (1) early maladaptive schemas, (2) schema domains, (3) coping styles, and (4) schema modes. ST is based on a hypothesis that people can develop maladaptive and dysfunctional patterns of thinking, known as schemas, about themselves and their environment in early childhood in order to make sense of their world. Schemas are thought to be mostly unconscious and drive how one might behave. For example, if a child is rejected, neglected, or lonely in their early years, they may develop a schema or belief, that others will always reject or neglect them. Young proposed that there are eighteen of these schemas, grouped into five subgroups, or domains; (1) disconnection/rejection, (2) impaired autonomy and/or performance, (3) impaired limits, (4) other-directedness, and (5) overvigilance/inhibition; and that these schemas are developed when a child's core emotional needs are not met (Corey, 2013).

To digress for a moment, when the needs of a child clash with the needs of their parent or caretaker, or when their needs are unrecognized due to an overwhelmed, sick, or uninterested parent or caretaker, this can cause a serious issue for the child. Limited perspective goes hand in hand with childhood; they simply don't have the knowledge or experience to understand that the fault is not theirs and so they may begin to believe that they have done something, or not done something, which results in a lack of parental care and attention (Katherine, 1991). It's known that in adolescence, girls who feel the unmistakable signs of development may regress to the comforts of childhood in an effort to hinder their development (Bell, 1985). When the "best little girl in the world" who has always pleased her mother and father, reaches puberty, she may suddenly rebel and in doing so, destroys her own blossoming femininity (Woodman, 1982). In his book, *Holy Anorexia*, Rudolph Bell explains how suppressing physical urges and basic feelings such as sexual drive, hunger, and pain allows the body and soul to reach new highs. With eating disorders there is also a deep psychological need to develop a sense of self (Bell, 1985). These developmental issues are examples of how and when such maladaptive schemas might manifest.

Further to the schemas and domains described above, an individual may develop any of the three main coping styles; (1) overcompensation, (2) surrendering, or (3) avoidance, in response to their schemas. In overcompensation an individual will battle with the schema and try to live their life in a way that opposes it. In surrendering, they will literally give their power over to the schema and believe it to be their truth. And in avoidance, they will try to avoid experiences that would activate their schema (Masley, Gillanders, Simpson, & Taylor, 2012). Further to an individual's coping style, they may develop a cluster of schemas, known as a schema mode, which can cause

them to foster a very rigid state of mind in response to certain triggers or events that stimulate their schemas. Young categorized these modes into the following; vulnerable child, angry child, impulsive/undisciplined child, happy child, compliant surrenderer, detached protector, overcompensator, punitive parent, and demanding parent (Young, Klosko & Weishaar, 2003).

Boone et al. found that overvigilance, impaired autonomy, and perfectionism were synonymous with eating disorder patients and suggests that treatment be centered on these prevalent factors, particularly seeking to address a reduction in perfectionist traits and behaviours. Further to that, and citing Jeffrey Young's book, *Schema Therapy: A Practitioner's Guide*, Boone et al. note that if CBT continues to be favoured over the deeper, more intense and profound approach of schematic therapy, then we might be at risk of overlooking a critical factor that might aid a deeper recovery for someone. If these core childhood themes remain outside the sphere of what we address in therapy, we might indeed have an explanation as to why some sufferers remain victims of their eating disordered thoughts and behaviours because their dysfunctional cognitions are operating at a level much more complex than the misconceptions they have about their bodies (Boone et al. 2012).

6 reflections

In a reflective piece of work, Johan Vanderlinden (2008) explores why CBT approaches remain ineffective in certain people who experience eating disorders. He notes that in the more traditional CBT model, the therapist will focus on the replacement of powerful, irrational thoughts and behaviours, and the client is also encouraged to challenge these thoughts and behaviours between sessions. But if it was as simple as replacing irrational thoughts with rational ones, why are some people still unable to change? Vanderlinden offers us six “critical reflections” from his time spent working with eating disordered clients and their families, in an effort to highlight what’s currently missing from our approaches.

(1) Basic Conditions; the therapeutic alliance and the timing of strategic intervention will have a direct impact on the progress of the therapy. A trustworthy, authentic relationship between the therapist and the client is paramount to attaining progress and it ultimately becomes the precursor for all of the client’s relationships, setting the tone for how healthy human connections are made and maintained (Natenshon, 1999). In terms of the timing of strategies, Vanderlinden refers to the motivation levels of the client in that, if he or she is still in the denial phase, admittance and acceptance must be established prior to attempting any therapeutic interventions.

(2) Cognition Content; as therapists, it is suggested that we should move from a place of focusing on the *content* of the irrational thoughts, to a place of focusing on why our clients get caught up in cycles of *rumination* with such thoughts. This would take on a more mindfulness-

based approach whereby a *witnessing* of a thought is first encouraged, followed by a detachment from the thought.

(3) Family and Peers; while family-based therapy does endeavour to involve the family and use the family unit as a tool for recovery, it doesn't necessarily look at the dynamics of the family, the intricate relationships therein, or how parents' beliefs are, or have been in the past, communicated to their offspring. Similarly with peers, while they might have been one of the many contributing factors to the onset of unhealthy eating habits, negative peer comments can have a lasting, sometimes traumatic effect on those whom they are aimed at.

(4) Genetics; Vanderlinden refers to neuropsychological studies from 2004 (conducted by Tchanturia, Breceelj, Sanchez, Morris, Rabe-Hesketh, and Treasure), which have indicated that the inflexible, rigid thinking styles associated with restrictive, chronic anorexia, are most probably genetic and in turn have found that these thinking styles can in fact be receptive to change through cognitive remediation therapy (CRT) which encourages flexibility through daily practice.

(5) Cognitions versus EMDR; again, with traditional CBT, cognitions and attempting to change them is the main goal. However, it is suggested here that until the emotional work has been done, the cognitive work must wait. Eye movement desensitisation and reprocessing therapy (EMDR) has been researched and proven effective for post-traumatic stress disorder and could perhaps be adapted for those eating disordered clients who have also experienced trauma. Vanderlinden, citing the work of Shapiro from 2001, indicates that as therapists, we can only

begin to foster newer, healthier, more rational thought patterns, once the emotional experience that is associated with the irrational thought patterns has been addressed, or desensitised.

(6) Emotional Arousal; in support of his fifth reflection above, Vanderlinden stresses the importance of the underlying emotional schemata and that, similarly to the CBT model of replacing old thoughts with new ones, we can restructure old emotional schemes with new ones through a sort of provocation of emotional experiences and furthermore it is implied that this step is essential in order for alternate cognitions to be established (Vanderlinden, 2008).

Of course, these are only a number of hypotheses for a better outcome for those who are unresponsiveness to traditional CBT methods and require further research, as indicated by Vanderlinden himself, but nevertheless they attempt at bridging the gap between hopelessness and recovery which is both notable and commendable.

Chapter 3 – Elements for Consideration

A Jungian perspective

Costin and Grabb (2013) refer to sufferers having a *healthy self* and an *eating disorder self* and at the beginning of treatment, the following anecdote is offered to clients, “...the battle you have to fight is not between you and me...the battle you have to fight is between your healthy self and your eating disorder self.” Personal accounts from clients who were offered this portrayal of two distinctive selves, confirm that they found this imagery beneficial and helpful. For some it didn't make sense, for others it resonated immediately, and for others they denied it to be true, but for all, eventually, it became a tool which allowed them to approach recovery in a much more meaningful way. An important piece to this offering however, and a disclaimer which therapists must follow with, is that the eating disorder self must not be conceptualised as evil, bad, or the enemy, in fact, we need to encourage our clients to accept, honour, and take responsibility for this other self. Although most eating disorder behaviours are self-destructive and ultimately life-threatening, they can also comprise of important hidden narratives that can assist in the unfolding of therapeutic progress therefore to view the eating disorder self as an adversary could have negative implications on long term recovery. In addition to this, as therapists, we want to humanise and validate the experiences of eating disorder sufferers, rather than creating hatred, disgust, or shame towards their thoughts and behaviours (Costin & Grabb, 2012).

Botha (2015) refers to a deconstructive process of “externalizing conversations” which echoes Costin and Grabb’s concept. The theory behind these externalizing conversations is that the client can begin to see their problems as separate to who they are as a person. Eating disorders tend to be insidious illnesses that isolate their victims and so, if one can set themselves apart from its grasp and view it as outside of themselves, then this would allow them a certain breathing space to look *at it* rather than be engulfed *by it*. Botha also cautions that this deconstructive process is not a demolition, rather a careful unveiling of the false truths that a sufferer has been subjected to, in an effort to diminish and replace those false truths with a new vernacular (Botha, 2015).

This idea of two contrasting selves is reminiscent of Jung’s view of the mind; the conscious ego and the unconscious shadow. Jung would have advised that in order to be balanced individuals, we must maintain a steady balance between these two polarities, never siding too much with either of them, but allowing and accepting both equally. As therapists, if we choose to introduce Costin and Grabb’s model, we must remain aware of the possible reactions within our clients; (1) over identification with the healthy self and therefore exclusion of the eating disorder self, (2) over identification with the eating disorder self and therefore exclusion of the healthy self, or (3) alternative over identification with both. All three outcomes pose different risks. As mentioned above, if the eating disorder self is excluded (as described in 1) or viewed as the enemy, this can create shame and hinder the sufferer from opening up about her behaviours. In cases where the healthy self is excluded (as described in 2), this would be most common among anorexic clients still in the denial phase of the illness where they are under obligation to and enmeshed with their eating disorder self and have yet to accept that there is an issue. Thirdly, if the client alternates

between the two without any stability (as described in 3) this might result in a pendulum between recovery and relapse, and perhaps would also suggest as to why some clients move within the diagnostic criteria of eating disorders and experience a crossover from anorexia to bulimia or vice versa (Monbourquette, 2001). To further support this idea that the eating disorder self, or shadow side, can indeed be harnessed as a tool for growth and recovery, it is also believed that if someone can make it to a place of honour and acceptance, and utilise their shadow side rather than banish it to the depths, then they will be able to break old habits and patterns with a seemingly miraculous vitality because they are able to release a vigourous energy that would have been constrained within the shadow side for some time (Johnson, 1993).

Marion Woodman wrote extensively from a Jungian perspective about eating disorders. In her book, *The Pregnant Virgin*, she explains that most of the women she worked with came from so-called “good homes” and in order for those “good homes” to run effectively and live the affluent middle class life, everyone was expected to take responsibility and perform accordingly. The father is typically a hard-worker with a need for power and control while the mother is intelligent and ambitious but hung up on appearance; busy ensuring this family was a work of art and perfection. No one ever mentions that the mother may be prone to depression or that the father may be keen on alcohol to regulate his emotions. For a sensitive child, witnessing this type of silent pain can be debilitating. No matter what they do or how hard they try to make their parents happy, the sadness never goes away and can become part of the child’s experience. Woodman states that a young girl in this situation will be a silent witness to her mother’s resentment of her father, and she will consciously decide that whatever her mother is, she will not be (Woodman, 1985).

While family background can of course vary greatly, Woodman states that there is one constant that she sees; the feminine element seems to be missing in the family system. Woodman says that children of such family systems may develop eating disorders in rebellion so as not to become like their parents. And as they witness the media associating thinness to happiness, sexuality, respect and acceptance, they buy into this, driven by the same need for power that their parents had. Woodman speaks at length about the polarizing masculine and feminine energies; attraction and repulsion, solar and lunar, darkness and light, unconscious and conscious, the yin and yang. To heal, we need to accept both aspects of our being. Our stance should fall somewhere in between the two, strong enough to balance both energies; an ebb and flow, a sort of yielding to the power of both sides (Woodman, 1985).

The metaphorical mother, or the mother complex, is another element that is documented to a certain extent and one that could be incorporated into the counselling model in the treatment of eating disorders. In her book, *Eating in the Light of the Moon*, Anita Johnston, Ph. D., describes eating disorders through beautiful metaphorical and mythical stories. She purports that, women who struggle with body, weight or food issues, have been disconnected from their archetypal mother; the inner, wise feminine spirit that provides guidance and care. The notion of the internal mother is that it is a reflection of what the child experienced from her real, external mother during her earlier years and to which makes up her mother complex. However, we must be cautious when using such terminologies in therapy and not place blame on the physical, biological mother, regardless of the history of the relationship. As therapists, we need to remind our clients that they have within them, the strength and ability to develop a strong inner mother. For women who have been disconnected from their internal mother, negative emotions are

unnerving and unsettling and should be extinguished, especially anger and sadness. They learn to put on a brave, happy face to please and appease others; they learn to shut themselves off, through disengagement and isolation; they become a faint representation of themselves, but hollow, unfulfilled and unsatisfied, turning either to food or starvation for a sense of accomplishment and wholeness. For these women, learning to identify, accept, and connect with their emotional system, is what will guide them back to their full form. They must develop a strong and mature inner mother that will care for, love and support them (Johnston, 2001).

Clarissa Pinkola Estés, Ph. D., has written some similar narratives about the mother archetype through the use of metaphor and storytelling and describes how certain mother constructs within the psyche can transcend into being. Dr. Estés illustrates three specific constructs; (1) the ambivalent mother, (2) the collapsed mother, and (3) the unmothered mother or child mother. The ambivalent mother is one who is confused and torn between the needs of her child and her own needs and for someone with this archetype, they will find themselves giving in easily to others, unable to stand up for or assert themselves, and unable to express their needs. The collapsed mother has given up and lost herself; overwhelmed and tormented, she regresses back to being a child herself. With little to no self-worth, she feels lost and hopeless. Finally, the unmothered or child mother refers to a construct whereby she is fragile, young, and naïve, portraying a lack of intuition and instinct. Echoing Katherine (1991) in a previous chapter, the unmothered mother has yet to find her identity and can then come upon it just as her daughter does and so the daughter will feel unsupported because the unmothered mother's needs are put forward and first (Estés, 2008). These three constructs are core issues within eating disorder causation and psychopathology and might prove to be invaluable when offered to clients in terms

of their understanding of the disorder. Object relations theory offers another interesting perspective in that, relating to the biological mother, anorexia can develop because at the differentiation stage of development, the child was not ready to separate from the mother and wanted to remain a part of her. Separation would have required her to develop the ability to cope with negative emotions and conflict, and the creation of her own identity for which she has no longing, and so she attempts to remain where she is, immobilized by fear and invisible through starvation, as a cry for help (Brady, 2011).

The mother complex is believed to go back to infancy and if the biological mother was ambivalent, collapsed, unmothered, or otherwise distracted, she may have responded to all of the baby's needs with food. Marion Woodman quoting Hilde Bruch reminds us that the inability to correctly read one's own bodily sensations and emotions is a core feature of those who suffer from eating disorders. All of the authors above take care to point out that it is not the fault of any singular mother, rather a consequence of our culture, and that for centuries women have had to diminish themselves to be less than, and to disconnect from their true natures and so we are left with generations of women and girls who can't even comprehend what the divine feminine is, never mind learn to embrace it to find freedom. Instead, they desperately hold on to control and play the good girl, daughter, mother, wife, in an effort to stay safe from harm (Woodman, 1980).

Culture

The existence of certain cultural or societal behaviours around food and weight can be one of the main obstacles in sufferers seeking or accepting treatment; they might believe that these behaviours are normal because they are socially acceptable, if not encouraged (Musolino et al., 2016). It's difficult to speak about culture and society without mentioning the effects that the media, be that social media, print media, radio or television, has had and continues to do so, on body image and behaviours around food and weight control. There is a continuous and consistent bombardment of images, ideals, suggestions, and offers, to make women and girls in particular, feel better, become leaner, look stronger, seem happier, more beautiful; ultimately, more acceptable and in line with current fad and norms. For decades now, body dissatisfaction among women and girls (mostly) has been juxtaposed with a societal dieting mentality that is supported by ideals where being thin equals gaining power and happiness, while being fat equates to being lazy and wretched (Levine & Murnen, 2009).

In her book, *The Body Project*, Brumberg documents the history of body image among women and girls by comparing and contrasting personal accounts from the 1830's and the 1990's. While women in the nineteenth century, including a young Queen Victoria and American poet Lucy Larcom, left indications of their extreme self-consciousness and self-criticism towards their bodies, the societal structure was different in that it weighed more heavily on moral character and becoming a better person allowing for their focus to shift from themselves to others. A century later however, the body was deemed as something that needed to be controlled, manipulated and maintained; the body became a platform, a stage, a vessel for communication

through which its owner conveyed their conformity to society's expectations. Brumberg, recounting Margaret Mead's, *Coming of Age in Samoa*, also refers to the fact however, that self-consciousness among women and girls is not common across all cultures (Brumberg, 1997).

Echoing that fact is the research that was conducted in a rural community in Fiji in 1998, where television was introduced for the first time to test the impact that media exposure would have on body image. Interviews were subsequently conducted 3 years after the introduction of television and found that it profoundly redefined what they considered to be beautiful and successful; it stimulated an admiration towards television characters and even went so far as to evoke needs to increase physical activity and adjust eating patterns in an effort to modify their body shape so that they could impersonate those television characters. While other factors contributing to the increase of disordered eating were certainly evident at that time, such as extensive changes to the economic and social structures in Fiji, the introduction of television and the negative impact it had upon young women and girls cannot be argued (Becker, 2004). Fast-forward almost 20 years from that study, and we are living in a different world still. With the advent of smart phones, increasing social media platforms, and ever-changing visual technology, as a human race our brains simply haven't had an opportunity to catch up or adjust. Our society has moved from a place where information was only obtainable by the wealthy, to a place where we are drowning in information, which makes for mass confusion about what is right and wrong.

Therapeutic alliance

“Sine Qua Non”

Definition: an essential condition; a thing that is absolutely necessary.

The importance and quality of the relationship between the client and the therapist is well-known to those in the field but it could be said that it is of the utmost importance when dealing with those with eating disorders, anorexia nervosa in particular. The underlying perfectionist personality trait is associated with an inherent hostility towards change and inconsistency and this is something that therapists must be aware of; that until the ultimate trust has been secured, any attempts, even with the best intentions, made towards encouraging the client to change their habits, will be received with suspicion and doubt and will be perceived as a threat. Should the therapist ever grow weary or impatient with the lack of progress and decide to push their client too hard, this could not only sever all possibility of ever being able to work with them, but also cause the client to retreat further into eating disordered behaviours as they look for safety from the perceived threat (Strober, 2004).

Generally, with cognitive and behavioural approaches, the symptom of the disorder is the main focal point and therefore the therapy is at risk of overlooking, or worse, diminishing, the importance of the underlying issues (Healey & Craigen, 2010). This act itself – looking at the client on a deeper level – may allow them to feel entirely seen and heard rather than partially. Not unlike most clients who come for counselling, people who are experiencing an eating disorder are extremely insightful and intuitive and a connection at this deeper level, would lend

itself to the creation of a stronger bond. The underlying purpose of the eating disorder must be elicited from the client's own perspective and a mutual awareness of that function should be the cornerstone of the therapy. Therapists must also be aware of the possibility that their client, while perhaps not necessarily in denial, may view the disorder and its behaviours as a form of self-care and to remain cognizant of the fact that such attachments and associations can in fact pose as windows of opportunity where therapeutic healing can take place (Musolino et al., 2016). Finn Skårderud (2007) reiterates this fact when he talks about "minding the functions of symptoms" whereby the therapist creates an atmosphere of open inquiry. In doing so, the client is encouraged to talk openly and freely about the perceived advantages of having an eating disorder without feeling ashamed. The therapist remains curious and inquisitive, as opposed to assuming the role of expert or authority figure. This not only validates the client's experience and liberates them from unspoken shame, but it also bodes well for creating that quality alliance that is so necessary for change (Skårderud, 2007). As Thich Nhat Hanh cleverly informs us, "understanding means throwing away your knowledge", and it is through assuming this stance, that the barriers can be removed and we can invite the client to open up (Hanh, 2005).

All of these elements play an important role in developing a robust therapeutic alliance. We simply must understand, almost on a cellular level, what it is like to live in our client's world, if we want to gain their trust and work collaboratively and successfully with them and for them. Not only that, but we should feel obliged to inform them about the multi-faceted, multi-dimensional nature of their illness. Eating disorders are complex and layered and require much uncurling and unlearning. The journey we set out to join them on must incorporate the whole person, masculine and feminine, ego and shadow, eating disorder self and healthy self. Drawing

on the cultural and gender issues that influence eating disorder behaviour in our society can bring an immense awareness and understanding to sufferers, and can add another therapeutic layer where growth and development can take place.

In a study observing treatment for self-injury, two main themes were found; (1) an integrative, holistic approach is essential – that is, incorporating a feminist framework into the therapy; (2) the relationship between the client and the therapist becomes the foundation upon which treatment begins. While admittedly Healey & Craigen (2010) state that an integrative approach is not necessarily a new concept, they found during their research that the value of the therapeutic alliance was undervalued and requires reexamination. People who self-injure, similarly to those who experience eating disorders, encounter great difficulty when it comes to dealing with negative emotions; they become extremely overwhelmed and consumed, almost physically, and in an effort to release their tension, their skin becomes their outlet (Healey & Craigen, 2010). If we as therapists continue to address and treat just the symptoms of eating disorders, we may miss the whole point, because ultimately, it is not the stage, nor the platform, nor the canvas that requires to be seen, but the production that is going on in the background.

Conclusion

“How bold one gets when one is sure of being loved”

Sigmund Freud

Both the medical model and the current favoured CBT model seem to imply that we as therapists don't have the time to treat the eating disorder population. They allude to having a strategy that works, and that once certain boxes are ticked, the patient should in theory “recover”. Like with all of our clients, no two are the same, yet the research suggests that one strategy should work for all eating disorder sufferers. If we don't have (or don't want to have) the time to treat this illness, then we are validating an already inherent and incessant belief that these particular clients are not worthy. And not only do we confirm their unworthiness, we extinguish any remnants of hope that they might have still possessed.

The current literature, with the exception of a few, seems misguided in terms of how to achieve recovery and what recovery is specifically. We seem to have over the years, blindly relied on data and numbers, much like someone experiencing anorexia nervosa, rather than asking the very person who is suffering what would be most helpful for them and attempting to foster a genuine, caring relationship with them. Online questionnaires that were completed as part of a research project not surprisingly found that one of the main factors that left anorexia sufferers feeling unsupported was that of “not being heard or understood”. Equally, when they felt most supported was when they experienced “hopefulness and being listened to”. These components are directly related to the quality of the therapeutic alliance and nothing else (Fogarty & Ramjan,

2016). Former patients who had completed and subsequently been released from inpatient treatment programs but continued to relapse, expressed that they had relapsed because there was a lack of depth to the treatment and that it only focused on the physical aspect of getting well (Tierney, 2008).

Our aim should not be to circumvent recovery just to get a quick-fix or in an effort to save time. Nor do we, or our clients, want to achieve a temporary or partial recovery. Full recovery is possible but it takes a little longer to get there and should go beyond the realm of the current or favoured treatment model to incorporate psychodynamic elements and should also be adapted for each client rather than applying a general approach to all (Espíndola & Blay, 2015). People experiencing eating disorders should not have to accept an attempt at treatment, or a partial state of recovery where they are forced to accept that some symptoms may always follow them. They are entitled to experience life at the very best possible frequency and this can be achieved through a deeper level of therapy than is offered through CBT. By incorporating elements such as integration of the shadow side, education around the mother complex, and expression of the repressed feminine in our society, we are offering our clients more avenues toward freedom; more lenses through which to view their illness which in turn will provide them with access to numerous channels toward recovery.

Transcending all treatment approaches, skills, and tasks however, remains the importance of the quality of the bond between the therapist and the client. “*Love*” as the person-centered school of thought might refer to it. “*Unconditional positive regard*” as Rogers himself named it. “*Compassion*”, as is now being incorporated into the more modern, integrative approaches such

as compassion-focused therapy. But whether it be love, unconditional positive regard, or compassion that you wish to label it, all are alluding to the same notion that the client must be valued, first and foremost, for *who they are*, not what they present with, and the focus throughout therapy should remain to be, *who they are*, and not their symptoms. Furthermore, they should not be dismissed once their symptoms have been reduced or eliminated, for that would only reinforce a notion that that was all we really cared about. Eating disorder sufferers themselves have expressed throughout the research, that they were given strength, hope, confidence, and courage to face the uphill climb towards recovery, simply by being heard, and this cannot be underestimated.

“The Wind and the Sun were disputing which was the stronger. Suddenly they saw a traveller coming down the road, and the Sun said: “I see a way to decide our dispute. Whichever of us can cause that traveller to take off his cloak shall be regarded as the stronger; you begin.”
So the Sun retired behind a cloud, and the Wind began to blow as hard as it could upon the traveller. But the harder he blew the more closely did the traveller wrap his cloak around him, until at last the Wind had to give up in despair. Then the Sun came out and shone in all his glory upon the traveller, who soon found it too hot to walk with his cloak on.

Kindness effects more than severity”

Aesop

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Cognitive-behavioural therapy (CBT) is a type of psychotherapy that tries to improve your mental health by modifying dysfunctional emotions, behaviour and thoughts. It is an evidence-based practice that helps you to change your perceptions and behave for treating certain problems in your behaviour. The course illustrates the concepts of CBT approach with a special focus on "eating disorders". Throughout the course, you will learn to treat "eating disorders" by applying CBT approach. Students interested in psychology and/or counselling. Individuals interested in career (work) related to "eating disorders". Individuals who want to use knowledge of CBT and "eating disorders" in their work. Individuals who want to work as professional "counsellors" or "therapists". PDF | Cognitive behavioral therapy (CBT) is the leading evidence-based treatment for bulimia nervosa. A new "enhanced" version of the treatment appears | Find, read and cite all the research you need on ResearchGate. not be frequent enough to meet criteria for BN or weight may be just above the threshold in. AN); the second and largest subgroup comprises cases in which the features of AN and BN. occur in different combinations from that seen in the prototypic disorders"these states may. The empirical status of cognitive behavioral therapy for eating disorders. Consistent with the current way of classifying eating disorders, the research on their treatment. has focused on the particular disorders in isolation.