Effects of Similarities in Therapy: An Exploration of Changes to Therapists' Body

Image and Eating Behaviours When Working With Clients with an Eating Disorder

Thesis submitted to

To the University of Leicester,

School of Psychology, Clinical Section

In partial fulfilment of the degree of,

Doctorate in Clinical Psychology

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By

Rachel Swancott

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Declaration

I confirm that the literature review and research report are an original piece of work and

have been submitted in partial fulfilment of the degree of Doctorate in Clinical Psychology.

No part of the report has been submitted to any other degree or to any other institution.

Thesis abstract

Part one: Literature review

Objective: Similarities between patients and their therapist may facilitate engagement in therapy. The literature review critically appraised the evidence that sex matching between children and adolescents and their therapists influenced therapy.

Method: A systematic search yielded 16 papers that were then critically appraised.

Results: Findings were categorised into three areas: client preferences for a sex matched counsellor; the effects of sex matching during therapy; and the effects of sex matching on outcomes of therapy. A fairly consistent finding was that female clients preferred a female counsellor.

Conclusions: Sex matching between children and adolescents and their therapist has limited predictive value in therapy process and outcome. Future research may be better focused whether on client preferences to affect treatment uptake.

Part two: Research report

Introduction: Similarities between female therapists and their patients in eating disorder services may impact on the therapist. Previous research has suggested that therapists and other professionals can experience changes to their body image and eating behaviours whilst working in eating disorder services. Little is known about what sense therapist make of these changes.

Method: Semi-structured interviews were completed with eight clinical psychologists. Findings were analysed using Interpretative Phenomenological Analysis approach.

Results: Four super-ordinate themes emerged from the data: affirming one's identity'; 'close knit team'; 'protecting oneself'; and 'being influenced'. These related to participants professional identity and how they interpreted the changes in their body image and eating behaviours.

Conclusions: Findings indicated that the participants made sense of the changes to their body image and eating behaviours in different ways. The way the changes were perceived and discussed as a team was likely to have influenced how participants felt in the working environment.

Part three: Critical appraisal

The critical appraisal is a reflective account of the experiences encountered during the research process.

Word count

Word count for main text (excluding tables, figures, appendices and references)

Literature review	6510
Research report	11880
Critical appraisal	2422
Total	**20812**

Word count for tables, figures, appendices (excluding mandatory appendices)

Literature review	1143
Research report	1707
Critical appraisal	0
Total	**2850**

Word count total	**23662**

Contents

Part one:

Literature Review

A critical review of the effects of client-counsellor sex matching on therapy with

children and adolescents

Abstract

     Objective: Treatment such as psychological therapy has been recommended for mental health and behavioural difficulties in children and adolescents. Efficacy of therapy is believed to be influenced by the type of therapeutic relationship between the client and counsellor. Client-counsellor sex matching may facilitate a good therapeutic relationship, as the client may feel an immediate connection with the counsellor that initiates their engagement in therapy. Most research has focused on adults, and reviews have concluded that sex matching has little predictive value. It would be inaccurate to assume the findings would be similar in children and adolescents due to fundamental group differences, such as developmental processes. The aim of the current review was to critically appraise research on client-counsellor sex matching in children and adolescents.

     Method: A systematic search of five online databases identified 16 relevant papers that were included in the current review.

     Results: The findings were categorised into three areas looking at: client preferences for a sex matched counsellor; the effects of sex matching during therapy; and the effects of sex matching on outcomes of therapy. A fairly consistent finding was that female clients preferred a female counsellor. Other findings were more variable and overall it was deemed that sex matching does not have a strong effect in the process and outcome of therapy.

     Conclusions: Given the similarities with the adult literature, it may be accepted that client-counsellor sex matching has limited predictive value in therapy process and outcome. Future research may be better focused on client preferences to affect treatment uptake.

1 Introduction

The prevalence of mental health or behavioural difficulties in children and adolescents has been reported as $10 - 20\%$ worldwide (WHO, 2001), however, only a fraction of those who need a service, receive appropriate support. For example, services have been accessed by an estimated 18% of children and adolescents in community samples in the USA and Puerto Rico (Flisher et al., 1997); 18% of those with anxiety and 23% of those with depression across schools in Germany (Essau, 2005); and 20% of youth offenders in the community and 60% of youth offenders in secure settings from a sample in England and Wales (Barnett, Byford, Chitsabesan & Kenning, 2006).

Several studies have sought to identify reasons for reduced uptake of mental health service in children and adolescents. Barriers identified include: lack of information about services (Bingewatt & Gershoff, 2010); stigma; and issues with confidentiality and trust (Gulliver, Griffiths & Christensen, 2010). Studies that have examined what facilitates access to services for children and adolescents have pointed towards factors such as: positive previous experiences; encouragement from others; and trust in the provider (Gulliver et al., 2010). It is imperative to appropriately meet the needs of children and adolescents and ensure that suitable treatment is on offer. If this is not achieved, it can lead to chronic and severe difficulties later in life (Cosgrave et al., 2008) and an increase in crime, unemployment, violence and risky behaviours (WHO, 2003).

The relationship between therapist and client has been termed the therapeutic relationship and has long been regarded as essential in the therapeutic process. A good therapeutic relationship transcends the approach applied and communicates to the client that the therapist respects their point of view and believes they are worthy of care

(Horvath, 2005; Rogers, 1957). Research focusing on children and adolescents has shown that a good therapeutic relationship has been linked with outcomes (e.g. Karver, Handelsman, Fields & Bickman, 2005; Shirk & Karver, 2003). Conversely, a poor therapeutic relationship has been linked with premature termination of therapy (Garcia & Weisz, 2002).

An understanding of what contributes to the development of a good therapeutic relationship is essential in order to encourage good outcomes. The adult literature has suggested that factors such as appropriate body language, eye contact, tone of voice (Forrest, 2011); empathy and positive regard (Norcross & Wampold, 2011) are important.

Static visible characteristics of the therapist such as age, race/ethnicity and sex/gender may also influence the development of a therapeutic relationship. Clients may prefer therapists who are similar to them, which in turn could contribute to reduced premature termination in therapy (Jerrell, 1998; McCabe, 2002; Sue, Fujino, Hu, Takeuchi & Zane, 1991). The assumption behind this notion is that people tend to group their social world according to easily identifiable characteristics (Aronson, Wilson & Akert, 2010): people who are similar are deemed to have shared understandings and experiences (Robbins & Krueger, 2005) and are seen as more intelligent and moral than people who are dissimilar (Baron, Bransombe & Byrne, 2009). Thus, similarities may help foster an environment where the client has immediate positive expectations that encourage engagement in therapy and lead to better outcomes.

Research into client-therapist matching in mental health has most often explored sex/gender matching and racial/ethnic matching. Numerous articles have been published and several reviews have been conducted in an attempt to draw together the

findings. Prior to describing previous reviews it is important to clarify the meaning of sex and gender and also race and ethnicity, as these terms are often used interchangeably. Sex is based on the biological concept of genes/chromosomes, whereas gender refers to the socially constructed ideas of what is deemed masculine and feminine (Beutler, Brown, Crother, Booker & Seabrook, 1996). Both race and ethnicity are socially constructed concepts but race is often based on physical characteristics such as skin colour (e.g. white, Asian, black) and ethnicity is based on cultural and historical backgrounds (Khanna, 2011). [1]

1.1 Previous reviews

A recent meta-analysis of articles examining the effects of racial/ethnic matching on client preference, perceptions and outcome in therapy also considered the effects of client age (Cabral & Smith, 2011). They found that regardless of client age there was no overall effect of client-therapist race/ethnicity matching on treatment outcomes but some evidence that clients had a preference for, and a more favourable perception of therapists of their own race/ethnicity.

Flaskerud (1990) reviewed nine papers that explored sex matching and reported mixed findings. They also noted that previous research has had a number of methodological limitations that reduced the strength of the evidence, such as the use of unrepresentative samples or multiple presenting problems. Methodological flaws were accounted for in a later review by Bowman, Scogin, Floyd and McKendree-Smith (2001). Their meta-analysis of 46 published and 18 unpublished articles appraised the quality of studies to help determine what weight should be given to the conclusions. Several studies were rated 'below average' but the majority were 'slightly above average'. The findings indicated that sex matching had little predictive value in therapy

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[1] Sex has been used in the current review unless the article has referred to the social construct of gender. Both race and ethnicity have been used in line with the original articles.

outcomes and recommended that future research should not continue to examine this area.

Research into the effects of client-therapist matching has most often been carried out with adults, with the implicit belief that the findings can be applied to children and adolescents. Some authors have suggested that generalizing findings from adults to children and adolescents in this way is erroneous as there are important differences that make this problematic. For example, children and adolescents may not have the developmental capacity to understand and agree to tasks and goals of therapy or they may value features such as how much fun they deem their therapist (Shirk, Karver & Brown, 2011). In addition, children and adolescents may not have been given a choice as to whether they wanted therapy, and so may be more ambivalent about the therapeutic process and more difficult to engage (e.g. DiGiuseppe, Linscott, & Jilton, 1996; Oetzel & Scherer, 2003). Consequently, it is important to consider children and adolescents separately to adults. As Cabral and Smith (2011) accounted for age groups, this has been adequately examined. To the author's knowledge, no review to date on the effects of client-therapist sex matching in children and adolescents has been published.

1.2 Aims of current review

The aim of the current paper was to carry out a critical review of the literature into the effects of client-therapist sex matching in children and adolescents on the therapeutic process and outcomes of therapy. In line with previous research (e.g. Bowman et al., 2001), the effects of matching on preferences has also been reviewed. This may shed light on whether sex matching is a facilitator to therapy and should be considered when providing a service for young people.

2 Method

In November 2011 five online databases (Psycinfo, Medline, Embase, Scopus and Web of Science) were searched for relevant published articles to date. The earliest article coverage varied for each database with records dating from 1967, 1966, 1966, 1966 and 1970 for Psycinfo, Medline, Embase, Scopus and Web of Science respectively. Search terms were identified following an initial scoping search and are shown in Table 1 below. Terms were truncated where possible and each cluster was combined using the Boolean Operator AND. Terms were entered as keywords or as words appearing within the abstract.

Table 1. Search terms used in the online databases

Search term cluster	Search terms
Population	gender or sex* or male* or female* or girl* or boy*
Intervention	therap* or session* or counsel* or appointment*
Comparison	match* or similar* or same
Outcome	preference* or perception* or outcome* or process* or relationship* or alliance*

In order to manage the number of articles retrieved in each search, some terms were modified for each database. Within Psycinfo, the comparison terms were excluded; in Medline and Embase, the population terms were searched for as words in the title; and in Web of Science, the terms were searched for as keywords within social studies, education, psychiatry, and psychology based categories. Searches were limited to articles published in peer reviewed journals and those written in English.

Following this initial search, a total of 7040 articles were retrieved and were exported to the computer programme RefWorks. Duplicate articles were removed

electronically, giving a total of 4083 articles. The titles and/or abstracts were then searched by hand to decide whether or not the papers were relevant to the current review by looking for references to sex matching.   Following this, 54 articles remained. All remaining article abstracts were read, and where there was insufficient information, the full article was scanned for further details. The following inclusion and exclusion criteria were used to identify relevant articles:

Inclusion Criteria:

- Published in English

- Published in a peer reviewed journal

- Study aims explored sex matching on client perception, therapeutic process or therapy outcome

- Participants were children and adolescents up to the age of 18 years

- Quantitative data

- Focus on one-to-one sessions

Exclusion Criteria:

- Editorials, letters, dissertations, book chapters, reviews, case studies and qualitative articles

Fourteen articles met the above criteria.   To ensure a comprehensive search, the reference list of each article was read and the names of the first authors were used as search terms in the databases. This yielded an additional two articles. Google Scholar was searched using the following key terms: *gender, sex, match, therapy, children, and adolescents* and a total of 19, 400 results were retrieved of which the first 200 were searched. None of these articles met the inclusion criteria for the current review. Finally, where possible, key authors were contacted by email to ascertain whether they

had any relevant unpublished research but no additional articles were highlighted from this method. Therefore, sixteen articles were included in the current review. A flow chart of the process can be found in Appendix A. Each article was read and the relevant data removed using a data extraction form (Appendix B).

3 Results

Findings are presented as a critical appraisal of the literature looking into the relationship between client-counsellor[2] sex matching and therapy in children and adolescents. The quality of research and the strength of the findings were appraised using guidance from a previous review (Bowman et al., 2001). The areas focused on were: significance of the problem; clarity of the problem definition; adequacy of research design; control of variables; sample selection; psychometric properties of the instruments; analysis techniques; interpretations and generalisation from the data; and adequacy of the research report. Throughout, attempts were made to draw conclusions from the data. An overview of the study characteristics is provided below followed by a detailed description and critical appraisal of the evidence. A summary of the papers can be located in Table A in Appendix C.

3.1 Characteristics of the studies

Of the 16 articles under review, sex matching was explored in outpatient settings in nine papers and school settings in seven papers. The total number of participants was 8312, ranging in age from five to 18 years.

Findings were categorised into three areas: client pre-treatment preferences for a sex matched counsellor; effects of client-counsellor sex matching during therapy; and

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[2] The term counsellor will be used throughout the remainder of the paper, as this was used by 14 out of the 16 articles reviewed.

effects of client-counsellor sex matching on therapy outcomes. Some of the papers had

findings that crossed over areas, and thus have been discussed in all relevant sections of

the appraisal. Details of which papers have been grouped into each area of the review

can be located in Table 2 below.

Table 2. First author and year of publication of papers reviewed in each section

Sex Matching Category	Author	Setting
Client pre-treatment preferences	Bigfoot-Sipes (1993)	School
	Cooper (2006)	School
	Fowler (1992)	Outpatients clinic
	Fowler (1993)	Outpatients clinic
	Littrell (1982)	School
	Littrell (1989)	School
	Moon (1993)	Outpatients clinic
	Quinn (2009)	School
	Turner (1986)	School
Effects during therapy	Kilcrease-Fleming (1992)	Outpatients clinic
	Moon (2000)	Outpatients clinic
	Porter (1996)	Outpatients clinic
	Wagner (1993)	Outpatients clinic
	Wintersteen (2005)	Outpatients clinic
Effects on therapy outcomes	Fowler (1993)	Outpatients clinic
	Goldberg (1990)	School
	Hall (2002)	Outpatients clinic
	Wagner (1993)	Outpatients clinic
	Wintersteen (2005)	Outpatients clinic

3.2 Detailed description and critical appraisal

3.2.1 Client pre-treatment preferences for a sex matched counsellor

As detailed in Table 2 above, nine articles examined whether children and adolescents had a preference for a sex matched counsellor prior to any therapeutic intervention. Three papers used samples of sexually abused females aged between five and 17 and measured their preference for sex of counsellor as well their anticipated comfort levels with a male or female counsellor (Fowler, Wagner, Iachini & Johnson, 1992; Fowler & Wagner, 1993; Moon, Wagner & Fowler, 1993). In Fowler et al.'s (1992) study 35 participants completed a pre-counselling evaluation of psychological measures administered by a male or a female examiner. Nineteen participants were randomly allocated to a male examiner and 16 participants to a female examiner. After the evaluation measures were completed, the examiner asked participants to state (verbally or by pointing to a response) whether they would prefer to see a male or female counsellor. They also asked three 7-point Likert scale questions with regard to anticipated comfort levels if they were to speak to: their current examiner; a male counsellor; and a female counsellor about their abuse.

Fowler and Wagner (1993) and Moon et al. (1993) sampled 20 and 47 females respectively. They used a 7 item measure developed by Fowler and Wagner specifically to measure preference and comfort in sexually abused females called the Counselor Preference and Comfort Survey (CPCS) that had been shown to have reliability (Moon et al., 1993). This measure consisted of one categorical item for preference for a male or female counsellor, two 6-point Likert scale items for levels of preference for a male or female counsellor and four 6-point Likert scale items for anticipated comfort for talking to a male or female counsellor about their sexual abuse. Fowler and Wagner

(1993) also measured preference post counselling to examine if there had been any change, and these findings are discussed later in the current review.

The remaining six papers (BigFoot-Sipes, Dauphinais, LaFromboise, Bennett & Rowe, 1992; Cooper, 2006; Littrell, Hashim, & Scheiding, 1989; Littrell & Littrell, 1982; Quinn & Chan, 2009; Tuner & Manthei, 1986) examined students' preference for a male or female school based counsellor. BigFoot-Sipes et al. (1992) and Littrell and Littrell (1982) sampled from schools in the United States and had 242 and 366 participants respectively. Littrell et al. (1989) sampled 557 students from Malaysia and Tuner and Manthei (1986) sampled 430 students from New Zealand. The remaining two papers were closely linked to each other as one was an operational replication of the other. The original study sampled 584 students aged 11 to 16 from Scotland (Cooper, 2006), and the replication sampled 589 students aged 11 to 16 from Northern Ireland (Quinn & Chan, 2009).

All six school based studies used Likert scale questionnaires specifically designed for each study. No reliability scores were provided for the questionnaires. Three papers (Littrell et al., 1989; Littrell & Littrell, 1982; Turner & Manthei, 1986) used slides of counsellors to provide images for students to base their preferences on.

A fairly consistent finding reported in all but one of the papers (Littrell et al., 1989) was that females were significantly more likely to request a female counsellor, indicating that sex matching was an important feature for them. Findings with males were variable, with results showing that they were either likely to have no particular preference, or a preference for a female counsellor (Bigfoot-Sipes et al., 1992; Cooper, 2006; Littrell et al., 1989; Quinn & Chan, 2009). This implied that in both sexes, female counsellors were often preferred to male counsellors.

Despite the widely observed finding for clients to have a preference for a female counsellor, some results demonstrated that this relationship was not universal. Fowler et al. (1992) found that females were significantly more likely to state a preference for a male counsellor if a male examiner had administered the pre counselling psychological measures. Two possible reasons were suggested: a male examiner provided participants with a chance to have a positive encounter with a male and therefore, they were more willing to see a male in the future; or participants were responding to the demand characteristics of being asked by a male to state a sex preference. Nevertheless, Moon et al. (1993) also identified that females did not always prefer a female counsellor. Their results indicated that the older (12 to 16) non-sexually abused girls in their control group had a preference for a male counsellor, also implying that age might be an important factor.

The influence of age was supported by Cooper (2006) who noted that younger clients (11 to 13 years) had a stronger preference for a sex matched counsellor than did the older clients (15 to 16 years). Moon et al. (1993) suggested that the difference was related to developmental stages with younger clients being more concerned with the development of same sex peer relationships and thus, sex matched preferences were more pronounced. The scope of the findings were narrowed, given that Cooper (2006) did not always meet the chi square cell count criteria for the statistical analysis of the results and Moon et al. (1993) based findings on a small sample of 25 sexually abused and 22 non-sexually abused females. Furthermore, the appropriateness of the control group in Moon et al.'s (1993) study was questionable as the sample was obtained by asking two questions about abuse; if the responses were no, they were placed into the non-sexually abused group. Although it was necessary and ethical to trust the response

from participants, it is commonly believed that children and adolescents are reluctant to disclose abuse (Kellogg, 2011).

If taken at face value, Moon et al. (1993) also drew attention to the possibility that the type of problem experienced by the children and adolescents may have an influence on their sex of counsellor preference. This idea was examined in four other papers (Bigfoot-Sipes et al., 1992; Littrell et al., 1989; Littrell & Littrell, 1982; Turner & Manthei, 1986). Littrell and Littrell (1982) found that American Indians and Caucasians preferred to see a counsellor of the same sex when discussing academic or vocational issues, whereas the interactions were not significant when the topic was a personal concern. Littrell et al.'s (1989) study of Malaysian students pointed to a more complex picture as preference for counsellor sex was significantly influenced by the ethnic group of the counsellor (i.e. Malay, Indian or Chinese) and the type of problem (i.e. personal, social and drug concerns). For example, for personal problems, female Malay students had stronger preferences than their male students for a male Chinese counsellor but also stronger preferences than male students for a female Malay counsellor. Similar complex relationships were reported for Indian and Malay counsellors and for social and drug problems. Not all research demonstrated that strength of preferences differed between types of problems (Bigfoot-Sipes et al., 1992; Turner & Manthei, 1986).

Littrell et al.'s (1989) study was valuable as it attempted to address the complexity of sex matching, but a number of limitations somewhat reduced the confidence in the findings. In their paper it was stated that the attractiveness of counsellors used on the slides was controlled, but gave no indication of how this was done, unlike others studies using similar methods (Littrell & Littrell, 1982; Turner &

Manthei, 1986). Littrell et al (1989) also failed to make any interpretations for their findings.

The influence of client ethnicity on preferences was explored in two other papers. Bigfoot-Sipes et al. (1992) concluded that American Indians who had a strong commitment to the Indian culture rated having a sex match with their counsellor as the second most import characteristic, with ethnicity being rated as most important. Littrell and Littrell (1982) found that preference for same sex counsellor was present in both American Indian and Caucasian students, but that the strength of the preference was reported as being strongest in female American Indian students.

In summary, prior to therapeutic intervention, there seems to be a client-counsellor sex match preference amongst female children and adolescents, however, this varied with type of problem, age of the client, and ethnicity of the client and/or counsellor. A limitation across many of the studies was the reliance on participants' imagination of their preferences. This may have been too artificial as imagined ways of feelings and behaving do not necessarily correspond to actual feelings and behaviours (Turner & Manthei, 1986; DeHeer, Wampold & Freund, 1992). Although the papers that sampled from sexually abused females could be seen as having increased validity as their clients were awaiting therapy, the generalisability was reduced as the sample sizes were small (20, 35 and 47) and thus unlikely to have adequate sensitivity to draw valid conclusions (Barker, Pistrang & Elliott, 2002). Although it was legitimate to examine problem types of the clients, the categories were too broadly defined, and consequently lost their specificity and meaningfulness. What the findings did seem to indicate with more conviction was that the area is more complex than a match in a singular domain.

3.2.2 Effects of client-counsellor sex matching during therapy

Five articles examined the effects of client-counsellor sex matching on parts of the therapeutic process. All five papers obtained samples from outpatient clinics: four of the papers sampled from sexually abused females aged 7 to 17 years and one from a cannabis youth treatment project with a mean average age of 15.7 years.

Three papers investigated whether client-counsellor sex matching influenced 'verbalisation' during therapy: the degree to which sexually abused females engaged in conversations with the counsellor about their sexual abuse. Verbalisations were examined using video recordings of sessions that were assessed by trained raters. Porter, Wagner, Johnson and Cox (1996) modified the Client Behavior System (CBS) (Hill et al., 1992 as cited by Porter et al., 1996) for use with children. Raters observed recordings of the third session of a six session standardised psychoeducation programme for 27 female participants; eight of participants were also part of the Wagner, Kilcrease-Fleming, Fowler and Kazelskis (1993) study. This session was the first time clients were asked specifically about sexual abuse. Kilcrease-Fleming, Wagner and Fowler (1992) developed a Verbalization Rating Form that was also used by Wagner et al. (1993) which required observers to complete systematic observations consisting of a 5 seconds observation followed by a 10 second rating period. They also measured participation during sessions, willingness to return and disclosure of information about family, friends and school. These latter three areas were also measured in the study by Moon, Wagner and Kazelskis (2000).

Kilcrease-Fleming et al. (1992) focused on a 20 minute initial session when 18 females were asked to complete the Draw-a-Person test (Koppitz, 1968 as cited in Kilcrease-Fleming et al., 1992). Both Wagner et al. (1993) and Moon et al. (2000) followed the same six session standardised psychoeducation programme. Wagner et al.

(1993) took measurements for 21 females throughout each session and Moon et al. (2000) analysed the process in sessions three, four, and five for 35 females; 17 participants were also part of Wagner et al.'s (1993) study. Patient Participation and Patient Hostility subscales of the revised version of the Vanderbilt Psychotherapy Process Scale (VPPS) (O'Malley, Suh & Strupp, 1982) were used to measure the degree of client engagement in the therapeutic interaction. They all also used the Therapeutic Influence subscale to measure the overall relationship, how productive the session had been, how well the client was getting along and the degree of information shared by the client about family, school and friends.

Results from all three papers (Kilcrease-Fleming et al., 1992; Porter et al., 1996; Wagner et al., 1993) that examined verbalisation indicated that this was not influenced by client-counsellor sex matching. It appeared that clients were more likely to talk about abuse in response to the abuse question (Porter et al., 1996) and that the amount of abuse discussed increased as the sessions progressed independent of counsellor sex (Wagner et al., 1993).

No influence of client-counsellor sex matching was found in participation levels, willingness to return and disclosure of information about family, friends and school by Kilcrease-Fleming et al. (1992) or Wagner et al. (1993). As with verbalisation, Wagner et al. (1993) found that overall participation level increased as the session progressed. As with preferences, when age was considered, a more complicated picture emerged from the data. Moon et al. (2000) found a significant 3 way interaction for the Patient Participation and Therapeutic Influence subscales and observed that during session three, four and five of the six session standardised psychoeducation programme, participation fluctuated. Namely, the older females (12 – 17 years) with a male counsellor (11 of the 24 participants) had a decrease in their levels of participation and

therapeutic influence from session three to four, that then increased in session five. In contrast, younger females (7 to 11 years) with a male counsellor (6 of the 11 participants), had an increase in their participation and therapeutic influence from session three to four, that then decreased in session five. On the basis of this relationship, the authors suggested that older females had the cognitive ability to engage in hypothetical thinking and were more conscious of society's views on sexuality. This led them into being more reluctant to talk about their abuse, particularly with a male, suggesting that a client-counsellor sex match may be more beneficial for processes during therapy. Moon et al. (2000) acknowledged that the results needed to be interpreted with care due to the small numbers. In spite of this, the study supported the notion raised by Cooper (2006) and Moon et al. (1993) that age is an important variable to be considered when exploring client-counsellor sex matching in children and adolescents.

The final paper to explore client-counsellor matching examined alliance during the second or third manualised therapy session (Wintersteen, Mesinger, & Diamond, 2005) using the short version of the Working Alliance Inventory (WAI), which is a self completed 12 item scale with good reliability scores (Tracey & Kokotovic, 1989). The study was conducted with 600 adolescents, the majority of whom were male (81%), with a mean age of 15.7 years.

Wintersteen, Mensinger and Diamond (2005) found that client-counsellor sex matching was beneficial as participants with a sex matched counsellor rated higher levels of alliance. Nevertheless, as alliance can change over time (Horvath, 2005), a more reliable way to examine this would have been to monitor this throughout the sessions to give an indication as to whether alliance was fairly constant or if there was change over time. Also the WAI had not been designed for children and adolescents

and the language may not have been as accessible to all the participants (DiGiuseppe et al., 1996).

In summary, research into the effects of client-counsellor sex matching during therapy has found varied results. Interestingly the sex of the counsellor seemed to have some influence on in-session behaviour, but this was affected by the age of the participant. All studies, with the exception of Wintersteen et al. (2005) had small numbers and results may be more conclusive if larger sample sizes were used.

3.2.3 Effects of client-counsellor sex matching on therapy outcomes

The effects of sex matching on therapy outcomes with children and adolescents were researched in five papers. Wintersteen et al. (2005) and Hall, Guterman, Kaplan, Howard and Little (2002) explored whether client-counsellor sex matching led to higher levels of retention in therapy. Hall et al. (2002) examined data gathered from computer records from January 1983 to August 1988 in Los Angeles in the United States. A total of 4616 records of participants aged six to 17 years were analysed.

Wintersteen et al.'s (2005) results indicated that sex matching between counsellor and client improved levels of retention. Indeed, male clients had significantly higher retention rates when seen by a male counsellor, and female counsellors were more likely to retain female clients in therapy than male clients. Hall et al.'s (2002) retrospective examination showed that sex matching only influenced retention in treatment for Mexican Americans and not for White, Black, or Asian Americans.

Both Hall et al. (2002) and Wintersteen et al. (2005) provided useful findings with large samples. Hall et al.'s (2002) study benefits from being retrospective and thus not open to manipulation, but as the authors noted, the client-counsellor sex matching

information was only available for the initial consultation from the retrospective records. There were no subsequent data recorded to indicate whether or not the client received the same counsellor or a sex matched counsellor in future sessions and so findings were speculative. Wintersteen et al.'s (2005) study had less generalisability to females given the significantly smaller proportion of the sample (19%), but this was still a large number as it totalled 114 females.

Fowler and Wagner (1993) examined post therapy preference in 20 sexual abused females aged seven to 15. This was a follow up from the data gathered pre sessions and used the same CPCS measure. Items were reworded accordingly to reflect the change (e.g. "If you were to keep coming here to see a counselor, would you prefer to talk to a man counselor or a woman counselor?"). There was also an additional item added to the CPCS referring to the experienced comfort level with their male or female counsellor.

Prior to therapy, all females stated a preference for a female counsellor but were assigned equally between a male and a female counsellor. After completion of the standardised six session treatment programme, although the majority still responded to the categorical question with a preference for a female counsellor, three of the ten treated by a male counsellor said they would prefer a male. Furthermore, females seen by a male counsellor were also statistically more likely to have higher preference and higher anticipated comfort scores for seeing a male counsellor in the future. This suggested that preference and comfort ratings can change with experiences of counselling. Consistent with Fowler et al. (1992) it seemed to indicate that a male counsellor can provide females with a positive experience and the opportunity to challenge some of their assumptions. It is important to consider that, Fowler and

Wagner (1993) used a small sample of 20 females, with 10 seeing a male counsellor and 10 seeing a female counsellor.

Wagner et al. (1993) looked at sexually abused females' self reported adjustment after completion of a six session standardised psychoeducation programme. Thirty sexually abused females aged seven to 17 completed the Piers-Harris Children's Self Concept Scale (Piers & Harris, 1969 as cited in Wagner et al., 1993) and the Children's Depression Inventory (CDI; Kovacs, 1982 as cited in Wagner et al., 1993). The Piers-Harris is an 80 item scale measuring behaviour, intellectual and school status, physical appearance and attributes, anxiety, popularity, happiness and satisfaction. Wagner et al. (1993) cited good test-retest reliability scores. The CDI is a 27 item self report measure to capture mood levels.

Scores on the Piers-Harris and the CDI showed that there was improvement in participants' self esteem and a reduction in levels of depression, but this was not mediated by client-counsellor sex matching. Nevertheless, as the authors themselves recognised, generalisability was reduced as the study did not consider the influence of race/cultural factors. Also, as was common across the studies with sexually abused females, the sample size of 30 was small but fairly evenly assigned to male and female counsellors (16 and 14 females respectively).

The fifth study to look at the effects of sex matching post therapy was done by Goldberg and Tidwall (1990) with 116 students aged 15 to 17 (except for 18 participants for whose age was not provided). Students had a standardised 30 minute intake counselling interview by a trained counsellor. Afterwards, they completed three measures: two designed for their study called the Student Questionnaire to measure demographics and the Student Satisfaction Questionnaire; and one called the Counselor Rating Form – S (Corrigan & Schmidt, 1983 cited in Goldberg & Tidwall, 1990).

These were analysed to determine whether client-counsellor sex matching influenced students' perceptions of their counsellor's attractiveness and satisfaction with sessions.

Goldberg and Tidwall (1990) hypothesised that students would find school counsellors of the same ethnicity or sex more attractive and in turn, would be more satisfied with these sessions, but there results did not support this. They concluded the content of the discussion between client and counsellor was more important than matching on sex and ethnicity. Although this study used a 30-minute intake counselling session, and could be deemed similar in aspects to received counselling, generalising to other situations was narrowed as the sessions were to discuss the class schedule. Training of school counsellors was beneficial as it ensured a standard interview procedure, but during training, counsellors were informed of the experimental aim and this may have consciously or unconsciously influenced their behaviour and reduced the experimental rigour of the study.

In summary, the majority of studies into the effects of client-counsellor sex matching on outcomes have been inconsistent in both sample and variables measure. This made comparison and synthesis across all five papers difficult.

Summary of results

Findings across all 16 papers have produced a mixed picture. The most consistent findings were in the area of pre-treatment preference of counsellor sex especially for younger females, but even here variability was present. Results seemed to imply that client-counsellor sex matching did not have a robust effect on treatment process and outcome in children and adolescents.

4 Discussion

The aim of the current review was to critically appraise the evidence for children and adolescents' preferences for a sex matched counsellor, and for the effects of sex matching on therapeutic process and outcomes. A comprehensive search yielded 16 articles that were reviewed with the aims of establishing whether sex matching should be considered when providing services for children and adolescents, and to begin to understand whether this facilitates processes in therapy and positive outcomes.

To date, a minimal amount of research has explored this area for children and adolescents, particularly when compared to the adult literature where in a detailed review over 40 published papers were identified from only two databases (Bowman et al., 2001). The paucity of research and the variation in the areas investigated meant that the findings from the current review can only be deemed preliminary. Furthermore, all papers neglected to state whether or not their sample was sufficiently powered despite this being a prerequisite for determining whether the sample was sensitive enough to detect changes in variables and not overly susceptible to error (Cohen, 1992).

The most researched area was children and adolescents' preferences prior to receipt of counselling. A fairly consistent finding was females, and a large number of males had a preference for female counsellors. It seems possible that the general preference for female counsellors could be indicative of sex role stereotypes that females are the caring, nurturing sex (Speight & Vera, 2005), whereas once engaged in therapy, children and adolescents find out that both male and female counsellors had equality in therapeutic skills.

Many studies investigated sex matching alongside other client variables such as age, race/ethnicity, and type of problem. The results highlighted that rather than a simple relationship, sex matching can be seen as part of a combination of factors that

24

interact within the therapeutic domain. Few of the currently reviewed papers provided sufficient details about the counsellor over and above their sex, despite them being a key in the relationship. Some of the research took this into account and explored counsellor race, but other aspects of counsellors (e.g. age) were not considered as a variable. Papers also failed to account for clients' previous counselling history. Some papers stated that no previous therapy was received for the current concern (Fowler & Wagner, 1993; Moon et al., 1993) but it was not clear whether participants had previously sought therapy for any other concerns and if so, what was the sex of their counsellor. It was believed that a facilitator to therapy can be previous positive experiences of seeking help (Gulliver et al., 2010; Speight, 2005) thus, not knowing previous history of therapy affects the strength of the current findings.

The current review of child and adolescent literature appears to have similar findings to that of reviews of the adult literature. In line with Bowman et al. (2001), sex matching was not a good predictor of therapy outcome. Similarly to Cabral and Smith's (2011) findings with race/ethnicity matching, there was evidence for children and adolescents to have a preference for the same sex counsellor prior to starting therapy.

Many of the mixed results discussed in the review by Flaskerud (1990) were echoed in the current review. Comparison across studies was complicated by diversity in samples (e.g. school children, sexually abused girls), variation in outcome measures (e.g. satisfaction questionnaires, retention rates) and differences in interventions (e.g. standardised sessions, school intake sessions, hypothetical situations) making generalisability difficult. Not all of the limitations Flaskerud identified were supported in the current review, in particular Flaskerud noted that most of the studies sampled from a white population, whereas there was a range of ethnicities represented in the current review.

4.1 limitations

A key limitation to previous studies noted by Flaskerud (1990) that remained unaddressed in the updated literature was that of within-group differences. Samples were dichotomised into male or female without consideration of variability within those categories such as their perceptions of gender (i.e. how they constructed masculinity and femininity). This oversight in research on sex/gender has also been pointed to by others (Blow, Timm & Cox, 2008).

The current review was not without limitations. One key concern was that only published articles were reviewed. Despite contacting authors, no additional articles were identified, meaning the findings may be subject to publication bias. Another limitation was that only one author appraised the quality of the papers, thus increasing the possibility of subjective bias. Many of the findings were deduced from standardised sessions and therefore, cannot be extrapolated to sessions with different formats. Nevertheless, the current review provided a useful synthesis of the research focused on children and adolescents and highlighted the degree of attention the area of sex matching had received.

4.2 Clinical implications

Due to the variability in findings it was not possible to make generalisations from the current review; however, there were some interesting areas to consider. The area that received most attention was children and adolescents' preferences prior to receiving counselling. The findings indicated that females had a strong preference for female counsellors, and in some cases a large number of males also had a preference for female counsellors. It may be that young clients' initial engagement in therapy is affected by the sex of their counsellor. Consequently, it would be relevant to discuss this in the early stages of therapy to allow any concerns that clients had to be explored

as part of the therapeutic process. This discussion should occur irrespective of whether there is a sex match between the client and counsellor as the results also suggested that preference for sex of counsellor can be mediated by several factors such as the age and ethnicity of clients. The emerging evidence that seemed to suggest that both male and female counsellors have equivocal results with young clients could be used to inform discussions. Thus, if a young client's sex preference was not available, counsellors could feel confident that a therapeutic relationship could be developed with comparable outcomes. Even in areas one might assume sex of the counsellor would have more effect (e.g. sexual abuse), this does not appear to be the case.

4.3 Future research

Given that the preliminary findings of the current review suggest that there are several possible contributory factors to children and adolescents' counsellor preferences, the effects during therapy and treatment outcomes, it may be too difficult to design research that can identify and adequately control all of these factors. It appears that client-counsellor sex matching for children and adolescents in itself does not account for much variance in therapy process and outcome, and thus there may be little value in pursuing this area. It may be worthwhile to explore whether the actual or perceived availability of children and adolescents preference correlates to initial uptake of therapy. Future research should take into consideration within-group differences such as clients' views about gender, client age and also counsellors' age.

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Part two:

Research Report

An exploration of changes to therapists' body image and eating patterns when working

with clients with an eating disorder

Abstract

Introduction: Quantitative research has examined how work in eating disorder services can impact on professionals' body image and eating behaviours. Finding showed that whilst change is not inevitable, it frequently occurs. Research has suggested that any issues with body image and eating behaviours need to be explored to avoid collusion with patients and poor practice. Although supervision models that encourage reflection have been suggested, little is known about what sense professionals make of the changes they experience to their body image and eating behaviours.

Method: Eight clinical psychologists from eating disorder services were interviewed using a semi-structured interview format. Verbatim transcripts of the interviews were analysed using an Interpretative Phenomenological Analysis approach.

Results: Four super-ordinate themes emerged from the data: 'affirming one's identity'; 'close knit team'; 'protecting oneself'; and 'being influenced'. These related to the participants' professional identity and how they interpreted the changes in their body image and eating behaviours.

Conclusion: Findings indicated that the participant clinical psychologists made sense of the changes to their body image and eating behaviours in different ways: i) changes that related to assimilating into their own lives the ideals that they would encourage patients to adopt were seen as beneficial; ii) changes that were common amongst the team such as eating more snacks, were normalised as a group experience; iii) changes that were experienced on an individual basis and were incongruent with participants' beliefs about their identity created uncomfortable dissonance that participants' sought to reduce. The way changes were perceived and discussed as a team influenced how participants felt in the working environment. None of the participants felt that their own changes had any influence, positive or negative on their clinical practice.

1 Introduction

There are two main types of eating disorders: Anorexia Nervosa and Bulimia Nervosa, each encompassing a number of subtypes (World Health Organisation, 1992; APA, 2000). People with anorexia restrict their intake of food and consequently, it has the highest mortality rate of any mental health disorder (NICE, 2004). People with bulimia engage in regular periods of binge eating followed by behaviours in an attempt to purge the calories consumed (Beumont, 2002). Prevalence rates are highest in females, with anorexia and bulimia estimated at 0.3% and 1% of the population respectively (Hoek & van Hoeken, 2003).

People with an eating disorder typically have a number of physical health difficulties, such as irregular heartbeat, hypotension, muscle loss, tooth decay and dehydration (Seligman, Walker & Rosenhan, 2001; Ogden, 2010; NHS, 2010). Psychological difficulties are also present such as depression, anxiety, negative self evaluations and feelings of shame (Fairburn, Cooper & Shafran, 2003; Ogden, 2010). Due to the presence of physical and mental health needs, comprehensive assessment and treatment should involve a range of specialists including clinical psychologists, nutritionists, family therapists, and psychiatrists (Halmi, 2009).

Psychological therapies, such as cognitive behavioural therapy (CBT), interpersonal therapy (IPT), and family interventions are recommended alongside other care (NICE, 2004). A good therapeutic relationship between therapist and patient has long been regarded as essential in the therapeutic process and outcome (Horvath, 2005; Rogers, 1957; Shirk & Karver, 2003); however, the development of this relationship with people with an eating disorder can be difficult. In many cases, therapy has not

been sought and motivation to change is minimal (Casanovas et al., 2007; Goss &
Allan, 2009) as their eating disorder has functional aspects such as managing anxiety
and increasing their self esteem (Strober, 2004). Patients may have feelings of shame
about finding elements of their disordered eating rewarding (Palmer, 2002), and may
have become accustomed to hiding their thoughts and behaviours and therefore find it
hard to be open and honest during therapy (Harshbarger, Ahlers-Schmidt, Mayans,
Mayans & Hawkins, 2009). Despite the difficulties that can be present in the
therapeutic relationship, the benefits of therapies such as CBT and IPT have been
shown in treating bulimia (Shapiro et al., 2007) and suggestions made that enhancing
motivation to change is effective in anorexia (e.g. Treasure, Whitaker, Whitney &
Schmidt, 2005; Vitousek, Watson & Wilson et al., 1998).

In addition to patient related factors that may make therapy more challenging,
therapist related factors also have a role to play in the efficacy of treatment (Kaplan &
Garfinkel, 1999). The competencies deemed necessary for any professional working in
an eating disorder service are: relevant knowledge and skills (e.g. current knowledge of
evidence based practice); the ability for inter-disciplinary work (e.g. collaborating with
professionals from different disciplines); therapeutic relationship skills (e.g. building
trust); upholding professional responsibilities (e.g. seeking supervision); and several
therapist characteristics (e.g. addressing personal food and/or body issues) (Williams &
Haverkamp, 2010).

There is continual debate over the influence of the static therapist characteristic of
gender (e.g. Bilker, 1993; Frankenburg, 1984; Waller & Katzman, 1998). It has been
suggested that patients may prefer a therapist of the same gender as they may believe
that the therapist has a shared understanding (Robbins & Krueger, 2005). This may
encourage the patient to be more engaged in therapy and lead to better outcomes. As

therapists and their patients are exposed to the same cultural messages about the value of female thinness (Frankenburg, 1984) this may help facilitate empathy within the therapist (DeLucia-Waack, 1999).

Similarities between therapists and patients however, can also have a detrimental effect. Patients may see their therapist's body as competition and have feelings of jealousy or disgust towards their therapist (Lowell & Meader, 2005; Vocks, Legenbauer Peters, 2007; Zunino, Agoos & Davis, 1991). Similarities may encourage therapists to over identify with patients and make incorrect assumptions of shared understandings (Maki, 1990; Hamburg & Herzog, 1990) that could lead therapists into thinking that they know the right way for the patient to recover rather than helping the patients discover their own way (Costin & Johnson, 2002).

It is possible that therapists may feel dissatisfied with their body (Jacobs & Nye, 2010). This could be exacerbated in an eating disorders environment where patients place value on appearance. This notion has been examined by a small number of studies. The premise behind exploring this is that patients need a therapeutic environment that is containing and part of being able to provide that requires therapists to be aware of their own reactions to the work to avoid collusion with patients' irrational thoughts or behaviours (Hayes, Gelso & Hummel, 2011).

Some therapists have spoken about their experiences of changes in their perception of their body image and/or eating behaviours in response to working in eating disorder services. One such paper provided a reflective account of how, in providing therapy they had felt insecure and self conscious about their body, and made transient behavioural changes (Rabinor & Derenne, 2006).

40

Shisslak, Gray and Crago (1989) carried out one of the limited number of empirical studies into the effects on professionals' self views whilst working in eating disorder services. They obtained 71 questionnaires from participants (including psychiatrists, psychologists, social workers and nutritionists) with a mean average of three years experience in the field. Participants reported an increased awareness of: food; their physical condition; their clothes and appearance; and feelings about their body. The degree of the increase was linked to previous eating history, which had been categorised into: normal eating; binge eating; and anorectic or binging with purging symptoms. Twenty (28%) participants indicated that they had been 'moderately' or 'greatly affected' by their work, however, the meaning of these categories was not provided.

Developing on this research, Warren, Crowley, Olivardia and Schoen (2009) gathered responses from 43 professionals working in eating disorders from a range of health care backgrounds (e.g. social work, nursing, and medical) with experience ranging from six months to 31 years. Responses to a questionnaire indicated that thirty (70%) participants had noticed a change in their view of food that included an increase in awareness of food culture, nutrition and appreciation for food. Some participants had noticed a change in their eating behaviours that was reported as 'healthier' by 12 participants and 'unhealthier' by 8 participants. A total of 31 (72%) had felt self-conscious about their appearance and many had made changes as a result of this (e.g. hairstyle).

Both Shisslak et al. (1989) and Warren et al. (2010) implied that, whilst change in professionals' body image and relationship with food was not inevitable, it was not unusual. As the changes could have positive interaction (e.g. encourage empathy) or negative interaction (e.g. blurring boundaries) with clinical practice, it has been

recommended that regular exploration is beneficial to ensure that professionals can help patients check their beliefs against cultural norms and reality and maintain clinical effectiveness (Boie & Lopez, 2011; DeLucia-Waack, 1999; Natenshon, 2012).

In order to promote the exploration of historical views about body image and eating behaviours as well as potential changes, DeLucia-Waack (1999) created a model of supervision that focussed on countertransference issues when facilitating an eating disorder group. Personal experiences of working in the field and supervising others, along with findings from literature, were used for the basis of the paper. The model recommended that therapists meet weekly for co-facilitator supervision and weekly for team supervision to encourage exploration of beliefs about body image, food, weight and their coping styles. The model also suggested a guided imagery session where therapists imagined what it is like to have an eating disorder.

Although research had identified that changes in body image and eating behaviours might occur, and had suggested ways to explore this in supervision, understanding over and above descriptive terms and models was lacking in the literature. Furthermore, research has suggested that changes in clinicians' body image and eating behaviours can be advantageous or can have unfavourable effects on clinical practice, but had not explored whether this occurs in practice.

One of the few studies that addressed the lack of in-depth knowledge with regards to the interaction between working in eating disorder services and personal body image and eating behaviours was carried out by Rance, Moller and Douglas (2010). They interviewed counsellors with an eating disorder history and identified three themes: 'double-edged history'; 'emphasis on normality'; and 'selective attention'. 'Double-edged history' referred to counsellors' feeling that their own history

was beneficial in the therapeutic process as it increased their understanding and belief in recovery, but also had the potential for harm if their own experience were to become enmeshed with the patient. 'Emphasis on normality' encompassed counsellors' assertions that they had been unaffected by work, and 'selective attention' related to the cognitive techniques used to attend to information that justified their belief that they were separate from the patient group. For example, counsellors viewed certain aspects in a black-and-white way so that they positioned themselves at one point that was polarised from their patient. The researchers suggested that the themes 'emphasis on normality' and 'selective attention' were the counsellors' way of demonstrating that they were fit to practice.

Rance et al. (2010) provided a valuable insight into therapists' experiences and suggested that they viewed their professional ability as linked to maintaining stability in their body image and eating behaviours. The current research developed on this by focusing on therapists who had identified that work in eating disorder services had changed their body image and/or eating behaviours.

1.1 Aims of current study

The aim of the current research was to develop on previous findings and provide greater understanding of the experiences of therapists within eating disorder services who had identified changes in their body image and eating behaviours as a result of their professional role. Given that previous research (Rance et al., 2010) implied that stability in body image and eating behaviours was linked to evaluations of ability to practice, a secondary aim of the current study was to explore how those who acknowledged changes had appraised their experiences and whether they believed this influenced their clinical practice.

The specific research questions were:

- What are therapists' experiences of changes to their body image whilst working in eating disorder services?

- What are therapists' experiences of changes to their eating behaviours whilst working in eating disorder services?

- What sense do therapists make of the changes and does this interact with their clinical practice?

2 Method

2.1 Design

As the research aims were to explore experiences in-depth, a qualitative methodology was deemed most appropriate. This allowed for experience to be analysed based on what arose from the data rather than being restricted by pre-existing theory (Barker, Pistrang & Elliott, 2002; Braun & Clarke, 2006). As the core aim of Interpretative Phenomenological Analysis (IPA) is to understand an individual's lived experiences and personal perception of their world (Smith, 1996), this method was chosen. Lived experiences are immersed with complexities and often people do not express themselves coherently, or make a choice to avoid certain areas. Thus, IPA encourages exploration of the data to see whether there was more to the accounts than what was said by participants (Smith & Osborn, 2008).

Semi-structured interviews were carried out with all participants focusing on their overall experiences whilst working in eating disorder services, their experiences of changes to their body image (namely their body shape and size) their experiences of

changes to their eating behaviours, and any clinical impact resulting from the changes. The researcher took guidance from Smith, Flowers and Larkin (2009) and the academic and field supervisor when creating the Interview Schedule (Appendix D).

2.2 Participants

The rationale for the inclusion and exclusion criteria for participants was developed following a review of literature and was consistent with a homogeneous sample recommended for IPA. The decisions made are summarised below.

The current study focused on female therapists with a qualification in Clinical Psychology who had current or recent experience working in an eating disorders service. As some of the processes in individual and group therapy differ, for example group cohesion (Burlingame, McClendon & Alonso, 2011), participants were included if a significant amount of their clinical role was in one-to-one therapy. A minimum of a year's experience was chosen as this was deemed a sufficient amount of time for participants to have processed any changes. Table 1 below details the recruitment inclusion and exclusion criteria used in the current study.

Table 1. Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Female trained in Clinical Psychology	Unable to meet the inclusion criteria
Current or recent experience working in an eating disorder service	Primary role not in eating disorders services
Working primarily with female clients	
Significant proportion of their role involved providing one-to-one therapy	
Minimum of one year's experience specialising in an eating disorders service	

Eight female Clinical Psychologists[3] took part in the current research. Table 2 below provides details of their age groups, ethnic background and their cumulative years working in eating disorder services. One participant identified herself as previously having had an eating disorder over 10 years ago.

Table 2. Participant demographics

Participant	Age Group	Ethnic background	Years of Experience
1	36 – 40	White British	7
2	51 – 55	White British	4
3	36 – 40	White British	7
4	36 – 40	White British	2 ½
5	41 – 45	White British	2 ½
6	51 – 55	White British	12
7	46 – 50	White British	7
8	51 – 55	White British	7 ½

2.3 Procedure

The research was approved by the University of Leicester Psychology Research Ethics Committee (Appendix E). Following approval, a pilot interview was completed that lead to an additional question being added that allowed participants to describe their overall experience of their work.

An electronic recruitment poster (Appendix F) and Information Sheet (Appendix G) were placed on the Division of Clinical Psychology (DCP) Research Notice Board

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[3] Hereafter, clinical psychologists will be referred to as psychologists

website. The DCP is an organisation for Clinical Psychologists who are members of the British Psychological Society. Within the DCP there are branches for those working in, or with a special interest in specific areas and the branch relevant for this study was the Faculty for Eating Disorders (FED). The researcher contacted the chair of the FED who agreed to email to all members of the Faculty to notify them of the research and also invited the researcher to present at a FED conference. After the presentation at the FED conference nine psychologists volunteered to participate. The researcher sent an email to each of the participants to clarify their willingness to participate and ensure they met the criteria for inclusion. At this stage, two decided not to continue: one advised that her main role was not in eating disorders and the other decided to withdraw with no reason given, leaving seven participants. One person volunteered in response to the poster on the DCP Research Notice Board website, giving a total of eight participants.

2.4 Ethical considerations

Prior to commencing the interview, participants were given a verbal description of the research and a copy of the Information Sheet. Once any questions had been answered, the participant and the researcher signed two identical Consent Forms (Appendix H) and each kept a copy.

At the start of the interview, the researcher tried to create a safe space for open and honest responses without biasing the conversations and so declared that she was interested in the interaction between therapists and the work environment, but gave no indication about her view. Interviews lasted between 45 and 71 minutes and were audio recorded using a digital voice recorder and then transcribed by the researcher. Field notes of non-verbal aspects and any discussions after the recorder had been stopped were made immediately after each interview. At the end of each interview, the

researcher debriefed participants and gave them a £10 gift voucher to thank them for their time and contribution. Participants were given the option of reading their transcript for accuracy. Two participants opted for this and were emailed their transcripts as agreed, however, no response was received from either participant despite two follow up emails.

Audio recordings were converted onto a memory stick and stored in a locked cabinet in the researchers study. Participants were given pseudonyms in their transcripts and the files were saved on password protected Word Document files.

2.5 Researchers

The principal researcher[4] was a 29 year old female Trainee Clinical Psychologist at the University of Leicester. She was born in England and was of Black Caribbean ethnicity. She was approximately a UK dress size 10 which may have been of relevance to participants given the nature of the topics discussed. All interviews were conducted and transcribed by the researcher.

The academic supervisor was an academic tutor on the Leicester DClinPsy training course and a Consultant Clinical Psychologist working in a drugs and alcohol service with past clinical experience of an eating disorder service. The field supervisor was a Clinical Psychologist with 5 years experiences of working in the field of adolescent eating disorders. Both supervisors were involved in designing the study and assisted in developing emergent themes.

2.5.1 Position of the researcher

The research was conducted as partial fulfilment of the Doctorate in Clinical Psychology. The topic area was developed from a suggestion made by the field

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[4] Hereafter the principal researcher will be referred to as 'the researcher'

supervisor during a presentation of research ideas. The area matched closely with the researcher's interest which originated during undergraduate studies when the topic was first covered. The researcher adopted the epistemological stance of a contextual constructivist (Appendix I). The researcher kept a reflective diary so that the potential impact of the data collection process was monitored.

Due to starting the background literature review before conducting the interviews, there were some ideas about what topics may be raised. These were that therapists would discuss the ways they had managed changes such as the use of supervision and self reflection.

2.6 Quality issues

Yardley (2000) provided a comprehensive description of factors that were considered throughout this research to ensure that it was methodologically rigorous. These were: sensitivity to the context; commitment and rigour; transparency and coherence; and impact and importance. For example, to maintain transparency and allow the reader to judge the credibility of the research, the reasons for the decisions made in the current study have been clearly delineated.

2.7 Analysis procedure

Interviews were transcribed verbatim by the researcher and contained information that enhanced the meaning of the conversations (e.g. pauses, laughter, and emphases) (Bailey, 2008). It was decided to exclude encouraging noises such as 'mmm' or 'uhmm' as this can make text more difficult to read (Tilley, 2003). The transcription key was adapted from Bailey (2008) and can be located in Appendix J.

The process of analysis was guided by Smith et al. (2009) and followed six stages that involved identifying themes in each transcript and then looking for links across transcripts. Details of the stages and an example extract from a transcript can be

found in appendix K. One anonymised transcript was read by the field supervisor and an additional two anonymised transcripts were read by the academic supervisor. These were discussed to help the researcher explore areas not previously considered.

<p align="center">3 Results</p>

From the analysis of the transcripts, four super-ordinate themes emerged: 'affirming one's identity'; 'close knit team'; 'protecting oneself'; and 'being influenced'. Themes included convergent and divergent responses so that they represented the complexity of the participants' experiences. Quotes from transcripts have been used throughout the analysis to evidence the emergent themes[5]. The most salient sections of the transcripts were selected with the recognition that this act in itself is a form of interpretation (Bailey, 2008; Smith et al., 2009; Tilley, 2003). For details of the transcription key please refer to Appendix J. Table 3 below provides details of the contributors to each super-ordinate theme.

Table 3. Contribution to themes across the transcripts

Themes	Phoebe	Sandra	Lucy	Jodie	Maxine	Phillipa	Anne	Claire
Affirming one's identity	✓		✓		✓	✓	✓	✓
Close knit team		✓	✓	✓	✓		✓	✓
Protecting oneself	✓	✓	✓		✓			✓
Being influenced		✓	✓	✓	✓	✓	✓	✓

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[5] To protect the identity of participants and ensure confidentiality pseudonyms have been used throughout the report and potentially identifying details have been modified. The changes made do not detract from the meaning of the quotes.

3.1 Analysis of themes

The themes across transcripts were organised into a thematic map as shown in figure 1 below.

Figure 1. Thematic map
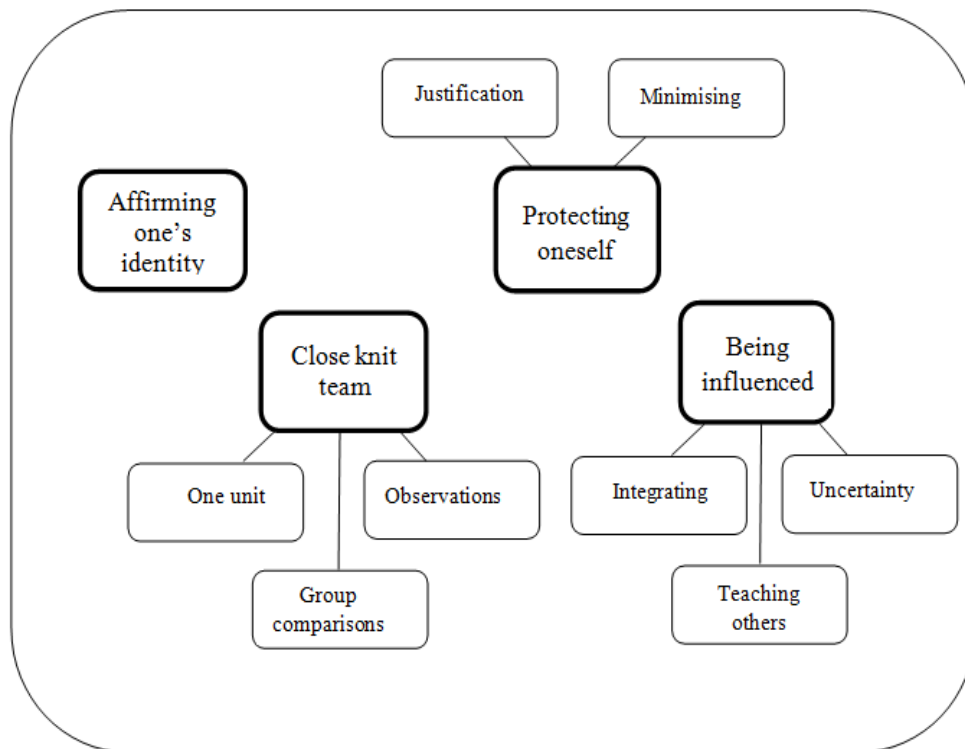
3.1.1 Affirming one's identity

The super-ordinate theme of 'affirming one's identity' captured the way that the participant psychologists positioned their identity as partly related to their relationship with food. One of the ways participants achieved this was to speak about their lack of knowledge about the calorie content of food prior to working in eating disorder services.

Erm, well I really didn't know calories at all, I had no, I'd never looked

at the labels, [omitted data] I would go shopping based on what do I

fancy eating today, and if something looked nice I would buy it and eat

it, erm and I wouldn't be thinking what else have I eaten today you know

can I, you know what will happen if I keep eating like this if I fancy

something I'll have it erm, and so, I was <u>quite</u> wary of learning about

calories in case, it made me, (?) or you know worry or concerned about

what I was eating in case it spoiled my enjoyment of food (Maxine 245 –

256)

Maxine described a sense of freedom and pride in her relationship with food that allowed her to choose what to eat on the basis of taste. This relationship with food was the polar opposite to patients with an eating disorder, thus placed her identity as fundamentally different to her patients prior to starting work, and was an identity she wanted to hold onto whilst working in the service.

Many of the participants had incorporated their relationship with food into their sense of self; the development of this identity sometimes occurred in line with their family. As can be seen in the quote below, Phoebe talked about her family prioritising food.

Well we were lucky because, we had structured meals, we had erm,

healthy foods, we had erm my parents <u>erm</u>, fed us on food was very

important [omitted data] so we'd always have a balanced meal of

protein carbohydrate and vegetables (Phoebe 449 – 454)

For Phoebe, this identity was natural and contributed to the reason why food did not present her with any difficulties. She later went on to state,

I think I always had that early inbred kind of awareness of the

importance of food (Phoebe 632 – 634)

As well as aligning with the family and having a shared view towards the meaning of food, some participants developed their relationship with food as a result of being different from others within the family. This was demonstrated by Claire,

there were times certainly as I was grew older that I felt a bit, am I a bit

of a greedy person erm, I eat way more than my mum does-, but it

didn't, stop me from, it didn't make me think oh I should eat less I must

eat less I must be, smaller or whatever so erm, I think in a way my

enjoyment of food just overrode any of those kind of, awarenesses

(Claire 486 – 491)

Claire showed that she was ultimately guided by her appetite and not what others around her were doing.

Many participants spoke spontaneously about enjoying a range of foods as a way to demonstrate that they were not governed by food groups.

I'm not bound by types of foods, I eat you know I've got preferred things that I eat, I eat relatively healthy but I also eat chocolate I eat out I eat take-aways so all the things we would like people to be able to do (Lucy 238 – 241)

The range often included foods that were considered high in fat and sugar, therefore further separating themselves from their patients. In the quote below, the use of the term 'huge' and her use of humour emphasised Phoebe's ease with eating cake.

erm I'm working here till probably six and I've got a huge piece of cake to have with a cup of tea in a minute [laughs] (Phoebe 616 – 618)

The sense of having a relaxed relationship with food was not shared by all participants, however, for the majority, they viewed themselves as being a 'foodie' and had pride in this position. A typical response from participants illustrated that food was more than a way to fuel the body, and that enjoyment was paramount.

I think I've always had an interest in <u>food</u> in itself I'm a bit of a foodie, I

like cooking I <u>love</u> food and I love erm, I think eating a wonderful meal

and enjoying it and then, three or four hours later being hungry again

[laughs] and being able to experience that all over again, is actually one

of life's greatest joys, and I think that's always stayed with me (Phillipa

41 – 46)

In summary, although not stated by the participants, the researcher believed that in sharing these elements of their characters, they were demonstrating how their experiences both past and present were linked to their enjoyment of food and not having any disordered eating characteristics.

3.1.2 Close knit team

The super-ordinate theme of a 'close knit team' encompassed three subthemes: 'one unit'; 'group comparisons'; and 'observations'.

One unit

The subtheme of 'one unit' referred to the way that participants viewed their team members and the team ethos as important and in some cases, one of the reasons that attracted them to the role. When Sandra described what encouraged her to work in the eating disorders field, she firstly talked about the team, drawing attention to its importance.

I think orig- it'd be partly because of the colleagues that I work with I

have to say [omitted data] and so I like sort of the ethos of the team and

how the team work psychologically (Sandra 25 – 29)

Participants found that eating disorder teams were likely to include people who were passionate about their role and for many, the values of the team corresponded with the values they had as individuals.

it feels like a good and dynamic, and people who work in the area seem

quite, passionate? erm and I think I quite like that as I feel some other,

placements that I did in my training and erm, the other work I did in the

CMHT it felt like, it didn't have quite as much passion, erm for the topic

or the area or the patient group than I felt in this service (Claire 48 –

54)

Furthermore, they were seen to work as one unit when managing the inherent risk of mortality with the patient group. In the following quote, Anne highlighted the benefit of having a team response to risk that allowed her to lessen her own anxiety by sharing the responsibility amongst the team.

the anxiety 'cos you know there's a huge amount of anxiety that's

attached to somebody who's potentially is, wasting away, erm but is

suppose wh- what we do <u>again</u> in supporting each other in this erm we

<u>know</u> that it's important for the client to carry the anxiety so as long as

we've got a really clear, process that we follow should weight start to

drop, then that alleviates a lot of staff anxiety (Anne 330 – 337)

The closeness of the team created an environment where participants felt that they were one unit working towards a shared goal for patient improvement and sharing the decision making and risks.

Group comparison

As well as the closeness of the team creating an atmosphere of one unit working together, it also provided an environment in which 'group comparison' occurred when participants compared themselves to others and looked to other members of the team for guidance. In the following quote, Claire was describing her general experiences of what she had found helpful with the changes experienced whilst working in the eating disorder service (e.g. transient changes in the eating behaviours and thoughts that parts of her body were fat).

Hmm (…) well I suppose supervision, and that kind of build up of

supervision over time, but having said that I think, I probably haven't

talked about it <u>that</u> much in supervision, erm, so it's not made a huge

difference I think maybe modelling by more senior clinicians, and seeing

how they, erm how they are, and erm, around food and their weight

around patients and how they kind of deal with that and, erm that's

helpful it's kind of very normalising (Claire 340 – 347)

57

Claire initially indicated that supervision was valuable in helping her to understand her changes in eating and also her feelings about her body but, then modified this by stating that modelling by more senior clinicians was the most helpful. The researcher believed this highlighted that supervision was seen as a place where topics such as body image and eating behaviours should be discussed but that this does not always occur. What was more likely and influential was that participants reflected and evaluated changes in their eating behaviours by comparing themselves with colleagues.

Observable aspects were compared as this offered participants the opportunity for self evaluation without disclosure. It also allowed participants to be more accepting of a change in themselves if the change was congruent with others, and thus normalised.

I would feel <u>really</u> hungry, so one of the things I [laughing starts] started doing [laughing ends] when I worked in an eating disorders team I hadn't done previously, was the bottom drawer of my desk, erm has crisps chocolate <u>snacks</u> in it, so that if I am hungry, er after an appointment, I just eat something <u>erm</u> and several of my colleagues have joked that since on an eating disorder team they feel they've gained weight, erm because for exactly that reason (Maxine 281 – 289)

As Maxine showed, the team response reinforced the notion that the eating disorder environment was different to other mental health settings and also normalised the changes in her behaviour. Furthermore, it is likely that 'in jokes' created by the shared experience had developed cohesion amongst members.

In the quote below, Anne described a shared experience that encouraged the team to bond together. She described how food was used to communicate, such as disputing the message that certain foods are bad.

as a team we have all stayed the same size, even though, you know

people bring in food and it's always cakes never, fruit [laughs], it's kind

of like we want to to go against, the idea that certain foods are, bad, it's

often after an assessment when we eat, it reinforces (...) erm what does it

reinforce (...) just that it's okay, erm if you eat things in moderation

(Anne 385 – 391)

The sense of cohesiveness created by shared experiences was beneficial to most participants and helped to foster a good team environment where people had shared ideals. With shared experiences held by the majority, there can be the situation of being in the minority and having a differing experience. Being in the minority group may make it difficult to express a dissimilar view and face the judgement from others. One participant had experienced this when sharing an experience with the team about taking her new exercise regime.

other people's reactions were very, "are you sure this is a good idea"

erm (...) so I don't, I don't talk about how much exercise I do

particularly because I think people would be like "oo that's quite a lot"

(Jodie 475 - 479)

Although only experienced by one participant, Jodie illustrated how an unexpected response can lead to feelings of shame and future non disclosure for fear of similar responses.

Observations

Due to the close knit nature of the team and the shared views within the team, norms were formed against which others were evaluated. This evaluative environment was experienced by participants as being one of 'observations'.

> *team members did scrutinise a bit how other members ate, so if it was,*
>
> *thought that someone was on a diet or there was a bit of kind of (...) food*
>
> *avoidance going on you know you could see people being very alert to it*
>
> *(Claire 266 – 270)*

Claire illustrated that there was an expectation that colleagues would behave in a certain way towards food. The closeness of the team environment meant that it was evident when there were colleagues who did not adhere to this norm. This was also expressed in the quote below when Maxine and the team noticed a student nurse was not eating cakes. As she was not adhering to the expected behaviour, this was deemed unusual.

> *she didn't eat anything, everybody else may not have a <u>big</u> slice of the*
>
> *cake that's on offer, or may have cake one week but not the next but she*
>
> *<u>never</u> <u>ate</u> <u>anything</u> (Maxine 1059 – 1061)*

The identification of a different behaviour was beneficial as it led to a discussion with the colleague where other difficulties were explored. Although not stated there was an impression that the team felt responsible for this particular colleague's wellbeing as she was in a junior role. This sense of responsibility was not as clearly delineated in relationships amongst qualified members of staff. Therefore, observations about others' behaviours and/or changes to the work environment were less likely to be discussed as evidenced in the quote below.

I'm aware the colleagues that I work with for example diet, and I never never would say anything about that, people can do what they like, but deep down I'm thinking can you really do that, can you rea- be funny about your own eating and then work with people, with eating disorders (Lucy 410 – 415)

Here Lucy described noticing another person's eating and had questions about how the colleague managed to diet and also work in the role. Although this could have potentially been a useful discussion (e.g. by allowing the colleague to talk about their experience and explore how she was managing) Lucy was reluctant to raise this as she did not want to pathologise behaviours.

I don't want to intrude, I don't think it's my business to intrude on people's own eating and pathologise them when it's quite normal to have those issues (Lucy 478 – 480)

Lucy's description highlighted the difficulty that presents when making judgements between what is a genuine curiosity and what crosses a boundary into intrusion. This was further complicated by being in an environment in which the extremes of eating behaviours were prevalent in the patient group and thus more difficult to maintain a view of reality.

In summary, the close knit team seemed to provide participants with an experience of unity, comparison and observation. This was seen as beneficial for most, but potentially a difficult experience for those who felt they did not fit in with the group norms.

3.1.3 Protecting oneself

The super-ordinate theme of 'protecting oneself' captured participants' responses to the changes that they had encountered whilst at work. Within this super-ordinate theme there were two subthemes of 'justification' and 'minimising'.

Justification

The subtheme of 'justification' referred to times when participants spoke about certain behaviours that could be interpreted as being a result of their work and their eagerness to explain why this was not the case.

I like intense exercise which is a bit sort of mad anyway so, erm but I kind of think my motivation is a bit different from, an eating disordered person (Sandra 163 – 166)

Here Sandra used justification as a way to pre-empt any questions about the reasons for her behaviour and demonstrated that she was not influenced by work. The quote below from Phoebe occurred whilst she was talking about a period in her life when she lost weight following a bereavement. Unprompted, she began to talk about being in the normal weight range, and using the scales whilst at work. As weighing herself was incongruent with being unaffected by work, she used justification to explain her behaviour.

> *I am actually in the normal BMI range, and the reason I probably know*
> *that is we have to do check the scales, very often before we weigh*
> *patients, so it doesn't mean I weigh myself, twenty times a week, it*
> *actually means that I, each clinic I do I just check, check the* scales
> *because obviously when the patients, although they're calibrated*
> *patients may state that the scales aren't working, which is, and another*
> *problem is we usually have, different scales, so it's important just to*
> *weight the patients (?) to remind them and you that the scales do weigh*
> *differently (Phoebe 244 – 255)*

In the above quote, Phoebe's use of terms such as 'obviously' to make the act of weighing herself seem so straightforward that no one would question whether there were any other factors that influenced her behaviour.

Minimising

The subtheme of 'minimising' encompassed the way participants reduced the extent of the influence of work. This was demonstrated in the quote below from

Maxine's interview. Here she was describing an experience following on from two female colleagues commenting on her shape.

> *interestingly I was wearing the same, I was wearing the same dress both*
>
> *days and so, I kind of I looked at that dress this morning and thought,*
>
> *it's a nice dress, er it's a nice dress and two people have asked me if I'm*
>
> *pregnant in it maybe I won't wear it today, erm but I will wear it again*
>
> *(Maxine 571 – 576)*

As can be seen in the above quote, Maxine noted that she was wearing the same dress when she received the comments about her appearance and that she decided based on this not to wear the dress that day. It was apparent that she remembered what she was wearing and therefore it can be assumed that this held meaning for her. As this was not how she perceived herself she immediately stated that she would wear the dress again as a way to demonstrate that she was not influenced by others' observations. She reinforced this at a later stage as can be seen in the quote below when she contradicted the fact that she chose not to wear the dress.

> *I know that some people have taken <u>massive</u> offence when people have*
>
> *asked them, you know if they're pregnant, but I'm not somebody that's*
>
> *particularly cares that much, you know I might have a fleeting thought*
>
> *about, oh maybe I look a bit fat in this dress, but I wouldn't change what*
>
> *I was wearing (Maxine 590 – 595)*

'Minimising' was also used to manage the emotional impact of the work as highlighted in the following quote from Sandra. Initially she spoke about her early experiences of being on an eating disorders ward and feeling bigger than her patients, but at a later stage, when asked about the feeling in more depth, the strength of the feeling was reduced.

certainly when I started in the service but I don't feel it so much now, I would just have a great awareness of, particularly the ward patients, that physically I took up more space in the room than they did and that would be a strong feeling in the room (Sandra 276 – 280)

I think it didn't feeling <u>wise</u> it didn't feel, it didn't come as a strong emotion (Sandra 296 – 297)

Participants' oscillation between description of changes and then subsequent minimisation can be seen in the following quote from Lucy when she described her experience of being pregnant whilst at work.

there could have been times when if you'd've talked to me that I wouldn't have said such positive things [omitted data]gaining weight weight gain and having to come back to work and work with people who are obsessed with eating and weight, probably wasn't that great but I can't remember it being something that was particularly a problem, you know it's probably not great, erm how was it a times when you know (…) being pregnant and er that wasn't great <u>er</u> because I was very aware

that I was self conscious of people watching me change I didn't feel

good (Lucy 731 – 744)

Lucy's initial emotional reaction was later reduced.

(...) it was never that bad to be honest [omitted data] I would be

thinking, yeah you know, get over it my body's changing, I'm making a

baby, here, it's all good it's all good stuff (Lucy 746- 762)

The participant psychologists' use of 'justification' and 'minimising' of changes
to their body image and eating behaviours, potentially brought about by the work
environment was useful and allowed participants to continue to work effectively as
therapists with patients with eating disorders. One participant spoke about her
experience of being unable to maintain the boundary between herself and her patients.
In the following quote, Claire captured the sense of disappointment and frustration that
was felt when boundaries were breeched and provided an insight in to the emotions that
other participants were guarding against feeling.

Erm, [sighs] in some ways it feels really frustrating, because it sort of

feels like, a bit of (...) irrationality whether that's theirs or mine or a bit

of both I don't know, has kind of got under my skin erm, and there's a

little bit of me that feels like that shouldn't, and I kind of feel myself a bit

want to just say, I'm not going to be bothered by that, you know and

want to just push it away and, being a bit cross with myself that I've let

them even come into my head or even a little bit of times angry at

patients (Claire 178 – 186)

In summary, participants used techniques to help them to explain changes in their views and behaviours related to their body image that allowed the reasons for the changes to remain unexplored. This was useful for them as it assisted in their ability to continue to work effectively.

3.1.4 Being influenced

The super-ordinate theme of 'being influenced' related to the participant psychologists' experiences that work had influenced their lives. This included the subthemes: 'integration'; 'teaching others'; and 'uncertainty'.

Integration

Often, participants spoke about 'integrating' the principles that they were trying to support their patients to learn into their own lives. This was demonstrated in the quotes below from participants incorporating regular eating into their lives.

what's really changed for me than before I worked in eating disorders

are that, erm I probably do have breakfast more than I would've done

beforehand and er I probably eat more regularly throughout the day

(Maxine 959 – 963)

I'm much more aware of eating regularly, I don't like being hungry

(Anne 157 – 158)

The researcher believed that these changes were seen as acceptable, as they were based on information that they were conveying to their patients and were presumed valuable. One participant demonstrated that when the relationship between information provider and recipient were reversed so that the patients were conveying messages to the therapist, the acceptance of change encouraged the blurring of boundaries.

I always feel here, at my waist sort of, just to see if that's getting flabby or not [laughs] erm which I don't think I ever did before I came here, and I don't think most people would do erm, but that kind of thing is normal for us the people that I work with will do that constantly erm, so I think that's a change, being kind of more [laughing starts] I suppose having more techniques to working out [laughing ends] (Jodie 196 – 202)

Acknowledging this and accepting the change without questioning had led to Jodie identifying herself with the patient group and interpreting the behaviour as normal within their context. Although when she spoke about her clinical work, she made no mention of this influencing her ability to challenge patients' views about their body size; this could potentially cause difficulties if it meant that she felt hypocritical when questioning the thoughts her patients had about their body fat and the behaviour they used to monitor their levels of fat.

Participant psychologists' applying the advice that they had provided to their patients, such as regular eating throughout the day was generally seen as a positive,

however, a couple of participants also spoke about the times when abiding by their own advice had proved difficult. In the quote below, Sandra talked about being unhappy about putting on weight but was restricted in options available to lose the weight as she did not advocate dieting.

> *Well given that kind of you know I'd advocate dieting is not a healthy*
> *way forward, then that does make it a bit difficult when you realise you*
> *know you have put on pounds yourself and you want to kind of <u>lose</u>*
> *them, erm, so it's kind of how to marry I guess what I advise and say*
> *and want other people to feel sort of, body confident, and yet kind of I*
> *know I'm a bit of a hypocrite in that, <u>I</u> would like to lose a bit of weight*
> *and there are parts of my body that I'm not all that ha- highly happy*
> *with, so it's kind of finding that balance I guess (Sandra 148 – 156)*

Conversely, the recommendations of healthy eating had been helpful for one participant, who acknowledged openly that she was on a diet, but that work had taught her the 'right' way to do this.

> *right I'm going to do this properly, I'm going to do it the way that I*
> *would recommend someone else to do it (…) and so very consciously,*
> *I've lost a bit of weight (Phillipa 322 – 324)*

It was possible that she was able to openly say she was dieting as she was able to legitimise this by stating that her BMI was out of the healthy range. Also she was

choosing to adopt a healthier lifestyle by reducing her intake of high fat and high sugar foods.

Teaching others

The subtheme of 'teaching others' reflected participants' experiences of having a role to educate others about body acceptance and healthy eating outside of work. This occurred either directly through conversation or through modelling appropriate behaviours. In the quote below from Anne, she described the way that she considered what appropriate language to use when talking to her daughter and the messages she was conveying.

my daughter probably does, have to watch her weight erm and I find

that, it's made me a lot erm, I've always been quite careful about sort of

the way I talk to her about her weight, erm but more so since working in

this, field erm, <u>so</u> you know just being encouraging [omitted data] <u>so</u> it's

made me much more sensitive I suppose to the language I use with her

(Anne 169 – 182)

The quote above has a sense of responsibility to be sensitive towards her daughter's needs. This was echoed by Lucy as can be seen in the quote below.

I would never diet, if I had no children I suppose I would be freer to do

all sorts of things but if you're a model, role model to your daughter

then you know, I really take that seriously I feel it's really important that

I've got <u>extra</u>, positive attitude to food and eating and erm so I would

you know, <u>be</u> <u>very</u> <u>aware</u> of modelling er, good attitudes to eating (Lucy

299 – 305)

The responsibly to educate others was mostly felt for family members, and in particular daughters of participants. On occasion, however, this responsibility was broader, as can be seen in the quote below from Sandra and her position around friends.

you become <u>more</u> sensitive to people talking about diets <u>and</u> <u>erm</u> (...)

feel as though you've got a role in trying to, educate people about faddy

diets (Sandra 132 – 134)

The quote above, illustrated that the role of educating others transcended the work environment and meant that participants were continually in the role of educator about body acceptance and healthy eating.

Uncertainty

The last subtheme of 'uncertainty' captured the questioning participants had about whether their work and the working environment had influenced their body image or eating behaviours. This was mentioned briefly by most, with the exception of Jodie, but was an important theme as it gave a glimpse into participants' difficulties in deciding whether it was possible to keep work and their lives outside of work as distinct categories.

Jodie spoke on several occasions about her uncertainty. In the quote below she described her concerns about putting on weight and trying to make sense of what has influenced this change.

I would be wary about putting weight on, and going back up to how I used to be,

which is [laughing starts] still really slim [laughing ends] and I don't know if

that's because you have so many conversations about putting on weight, and

expecting you know if you eat this many calories then you'll put on this much in

a week, it's kind of hard to know if it's a here thing or a woman thing or just a,

thing (Jodie 123 – 130)

This was a typical example of the way in which Jodie tried to understand the changes that she has experienced with her reluctance to gain weight. The use of laughter was also characteristic and seemed to be indicative of her uncertainty about what she was saying and also feeling uncomfortable in how she might be perceived by the interviewer. Towards the end of the interview when the researcher summarised the topics covered, she remarked that the interview had helped her begin to process the potential impact of work.

I suppose it's highlighted for me actually quite a lot of things that, we just kind

of take for granted and actually, probably, this work does have an impact but I

suppose one of the other things that it's highlighted is that I don't know what's

normal anymore, so perhaps I need to have a look at [laughing starts] normal

stuff [laughing ends] (Jodie 578 – 583)

Other participants also spoke about the uncertainty of the influence of their role as psychologists, but in less depth. The lack of clarity as to whether a change was

beneficial or has unwanted effects was illustrated in the following quote from Anne's interview when she described a change in her browsing behaviour whilst out shopping.

Anne: I wonder if I'm more, the other day I went to the supermarket and noticed the scales, I remember walking down the aisle and erm stopping to look, I never bought anything but you know, I don't know if I would've even noticed them before so (...)

Interviewer: Okay, so what do you think about that?

Anne: Well (...) I guess it's a balance because on the one hand I'm more sensitive to, body image and erm the importance of, I'm more compassionate with myself and, er liking myself, and on the other hand I, I don't want to be bothered or aware of it, [laughs] you know because that's so much of my life, already (Anne 435 – 445)

In summary, the theme of 'being influenced' referred to the changes that participants had accepted into their lives. Some changes they were happy to acknowledge and others they felt a responsibility towards. Finally, it also captured participants' 'uncertainty' about other ways that work may have influenced their lives such as changes in their views about their weight.

Overall, most psychologists who participated in this study positioned themselves as enjoying food and had experienced some changes to their body image and eating behaviours. Changes were interpreted in different ways dependent on whether the change was experienced on an individual or group level.

4 Discussion

The research questions for the current study were to explore through qualitative interviews, psychologists' experiences of changes to their body image and eating behaviours when working in an eating disorder service. The research also looked at whether psychologists felt that this had any influence on their clinical practice. Four super-ordinate themes emerged from the data analysis: 'affirming one's identity'; 'close knit team'; 'protecting oneself'; and 'being influenced'. Each theme described an aspect of psychologists' experience in relation to changes in their body image and eating behaviours and will be discussed in turn and linked to the research questions and relevant existing literature.

In line with both Shisslak et al.'s (1989) study and Warren et al.'s (2009) study with health professionals from various disciplines, the participant psychologists in the current research had noticed a change in their body image and eating behaviours since working in an eating disorders service. The themes identified from the current research provided further details about the types of changes participants experienced and how these were interpreted by them, as discussed below.

Affirming one's identity

The theme of 'affirming one's identity' related to participant psychologists' description of themselves with regards to their eating behaviours and their love of food. For many, this was discussed in response to questions asked about what had led them into the area of eating disorders. The participant psychologists spoke about their pre-existing love of food before working in the field of eating disorders, and how this enjoyment of food had continued. They often emphasised that they would enjoy eating high fat and high sugar foods such as cake and chocolate. This was interesting when

one thinks about how a person forms their identity. Marcia (1966, 1993 as cited in La Guardia, 2009) identified two stages to the formation of an identity: identity exploration that occurs when a person evaluates a range of beliefs and values; and identity commitment that occurs when a person makes a decision to adopt the characteristics of a particular identity and behaves in accordance with this identity. Much narrative research has examined how people describe themselves and that the stories they choose to tell often reflect the way they want others to perceive them (Bamberg, 2011). It was assumed that the psychologists in the current research chose to share these aspects of their characters to position themselves as comfortable with a range of food particularly high fat and high sugar foods.

The identity of being at ease around food was often discussed by the psychologists with a sense of pride. It was possible to interpret this as the participants' way of creating a 'them and us' distinction that served to position the patient as the unhealthy 'other' so that they could view themselves as the healthy 'us' (Richards, 2010). The researcher however, felt that a more appropriate interpretation of the theme was that this distinction was made to demonstrate that the psychologists in the current study had no elements of disordered eating, and thus had maintained their professional distance. This could be seen as similar to the finding of Rance et al. (2010) who studied counsellors with a history of an eating disorder. Rance et al. (2010) identified two themes that were linked to the notion of professionalism. Firstly, 'emphasis on normality' that captured counsellors' assertions that their work had not affected them and secondly, 'selective attention' that related to the cognitive techniques used to attend to information that supported their belief about being 'normal'. These two themes were seen as counsellors' attempts to affirm that their eating disorder history had not influenced their therapeutic competence.

75

Participants' desire to affirm their identity provided a basis on which to interpret subsequent themes. Given that the current research questions were to explore the experience of change, the assertion of their identity being one where they were comfortable with a range of food, gave an indication that changes discussed with regards to food would not distract from their enjoyment of it. Interestingly, this theme focussed on food, and little given to their relationship with their body image, suggesting that for them, their relationship with food formed more of their identity.

Close knit team

The super-ordinate theme of 'close knit team' encompassed the way participant psychologists viewed the teams they worked in as being one that they fitted in with and matched their own beliefs and ways of working. This theme was interpreted in line with theories of social identity and influence in groups. Groups can form when members share a common factor (e.g. goal or skin colour) that is different from a comparison group (Postmes, Spears, Lee & Novak, 2005). In eating disorder services, the common goal could be improving the quality of lives for patients. Groups form social identities in which it is assumed that members have similar beliefs and understanding (Hogg & Vaughan, 2011). The view of the participant psychologists that the team was part of a social identity was captured in the subtheme 'one unit'. Participant psychologists identified that eating disorder team members had a passion for the field that matched participants' passion, and that this similarity had not been their experience in other mental health teams they had previously been a part of.

The subtheme 'group comparison' captured the way participant psychologists' compared their behaviour to the rest of the team. For example, the psychologists spoke about discussing with other team members about an increased awareness that patients

were scrutinising and judging the psychologist's body shape and size. They also discussed a change in their eating behaviours in that they were eating more snacks (e.g. crisps and chocolate) throughout the day and how this was a shared experience amongst the team. When interpreted as related to social identity, it was clear that the presence of others with a shared experience of change influenced the way psychologists interpreted their own behaviour. Indeed, research has suggested that one will compare their behaviour to others within a social group to see if their behaviour is within the group norm (McKimmie et al., 2003).

Social identity defines what behaviours are appropriate (Postmes, Haslam & Swaab, 2005). As such, the majority of group members will conform to the thoughts and behaviours deemed appropriate. Given that most people will think and behave in a similar manner, being different can be challenging, as others may notice the difference and make judgements (Postmes, Spears et al., 2005). This experience was captured in the subtheme of 'observations' where the psychologists spoke about the experiences of noticing others' behaviour that did not conform to the group norm.

The 'observation' of others and 'group comparison' can be taken to show how the participant psychologists made sense of the changes in their body image and eating behaviours. The themes demonstrated that change that can be shared within a group was interpreted as acceptable, whereas change that was experienced on an individual level, can lead to judgements from others and feelings of isolation and difference.

The super-ordinate theme of 'close knit team' highlighted the importance of considering the team environment and the dynamics within the team. Whether the participants perceived themselves as sharing in a team experience or whether they felt their change in body image and eating behaviours were in isolation influenced how the changes were interpreted.

77

Protecting oneself

Another clinically relevant super-ordinate theme was that of 'protecting oneself'. This theme described the way that during the interview the current participants avoided discussion of certain changes in their body image or eating behaviours.

At times, participant psychologists would talk about a change in their behaviours that had occurred since working in eating disorders, such as weighing themselves more often, but would not attribute this to their role as therapists or the working environment. They would spontaneously use 'justification' to explain why the change in behaviour had occurred and provided reasons why it was not related to their work in eating disorders. The subtheme of 'minimising' related to the way that the participant psychologists initially spoke about their work in eating disorder services influencing a change in eating behaviours and in their perception of their body image (e.g. feeling bigger in size when they compared themselves to their patients), and then when later asked questions about this, subsequently minimised the degree of change experienced.

When the participant psychologists justified or minimised changes, they positioned the changes as insignificant and not worthy of exploration. Given that the focus of the interviews were to explore the experiences of changes in body image and eating behaviours, it was incongruent for participants to avoid discussing certain changes. The reason for this reluctance could be explained by the theory of cognitive dissonance that refers to the discrepancy between a person's attitudes and beliefs and their behaviour (Cooper, 2007). This discrepancy is aversive and people will be motivated to reduce it. It was likely that the psychologists in the current study believed that it was not professional to be influenced in this way by their clinical work, and this

was not part of their professional identity. Consequently, when they spoke about

changes in their eating behaviour and body image as a result of their work, this created

dissonance. One of the easiest ways to reduce dissonance is for people to change either

their attitudes and beliefs or their behaviour (Cooper, 2007). In the current study,

justifying and minimising the behaviour changes was used to resolve this dissonance.

Reduction of dissonance in this way provides a relatively easy method to avoid

questioning inconsistency in beliefs and behaviours (Barkan, Ayal, Gino & Ariely,

2012). One might assume that these experiences of change in attitudes or behaviours

related to food have not been thought about by participants as the application of

'justification' and 'minimising' have been applied without conscious thought and have

prevented them from acknowledging the presence of the changes.

Being influenced

The super-ordinate theme of 'being influenced' encompassed the times when the

participant psychologists either had a clear idea, or were uncertain that work had

influenced changes in their body image and/or eating behaviours. It also captured the

way participants tried to share the specialist knowledge they learnt at work with others

out of the work environment.

Within the super-ordinate theme of 'being influenced' there was the subtheme of

'integration'. This encompassed the changes in body image and eating behaviours that

were willingly discussed such as regularly eating throughout the day, and accepting

their body shape. A possible reason why these changes were accepted and often

spontaneously discussed in the interviews was that these changes were based on advice

the psychologists were giving to their eating disordered patients. Research has shown

that when people do not follow advice they give to others, they can feel hypocritical

(Stone & Focella, 2011). Thus, the participant psychologists integrated their own advice into their lives outside of work to avoid unpleasant hypocritical feelings.

Showing conviction in their beliefs and the ways they were advising their patients to behave was related to the theme of 'teaching others'. This theme captured the way participants tried to educate others about what they believed was healthy eating and body image. For example, participant psychologists would advise friends and family about healthy eating. This may have been another way to show conviction in their beliefs. Participants also demonstrated good body image and healthy eating behaviours to others. This may have served to improve their credibility and their professional identity with regards to being an appropriate person to listen to in reference to body image and healthy eating (Colon-Ramos et al., 2009).

The final subtheme related to the 'uncertainty' that participant psychologists had about the extent of the influence of their clinical work on their own body image and eating behaviours. For example, participants spoke about being uncertain about whether being in an environment where patients scrutinise the appearance of others had affected the participant psychologists' view on their body image and eating behaviours. One participant psychologist expressed significant uncertainty and regularly laughed during her interview. This was interpreted as her being unsure about how to make sense of her own behaviour, and also feeling discomfort with the interviewer exploring these personal issues and the judgements the interviewer might make. The 'uncertainty' present made it difficult for participants to know how to make sense of the situation.

In summary, most of the participant psychologists held an identity that positioned themselves as enjoying food and gave them professional distance from disordered eating. Team members were viewed as similar by most of the participants

which created a group identity of shared experiences. For one participant, however, they had feelings of being different to others team member and had feelings of discomfort. To avoid uncomfortable feelings of hypocrisy and to increase credibility, participant psychologists assimilated their clinical knowledge about body image and healthy eating behaviours into their own lives. Changes that were incongruent with their beliefs about themselves created cognitive dissonance and were managed through dissonance reducing techniques.

4.1 Limitations

The findings from the current research need to be interpreted with care due to a number of limitations. The sample was selective as all but one of the psychologists was recruited via the DCP FED conference. Members of the FED are those with an interest in the area of eating disorders and one might reasonably assume that those who attended the conference were likely to have high levels of motivation and interest in their therapeutic role. Another consideration of recruiting in this way, may have been that psychologists who volunteered and participated were those who felt comfortable in their therapeutic role, whereas those who perhaps found they were unable to manage the changes to their eating behaviours and thoughts and feelings around their body image may have left the field or simply not volunteered. This does not discount the value of the current research, as the aim was not to find a representative sample of all therapists but a deliberate attempt to get a sample that was homogenous as required for IPA methodology.

Another area that needs consideration when interpreting the current results was the interaction between the researcher, who was a trainee clinical psychologist, and the participants, who were qualified clinical psychologists. As noted previously, the

findings were seen as contextual to the situation and as such, the fact that the participants were being interviewed by someone in a junior role in the same discipline was likely to have contributed to the topics discussed. The researcher noted in her reflective diary that she often wondered how the interviews were perceived by participants and whether they thought that she was asking the right types of questions. It may also be that the participants wanted to be portrayed in a way that maintained professional competence.

A benefit of semi-structured interviews is that they allow the interviewer to follow up with topics that are raised by the participants, but this may have also been a limitation of the study. This level of flexibility was open to bias and inevitably some topics raised were given priority over others.

4.2 Clinical implications

Despite the limitations, the current research offers some interesting areas to consider with implications for clinical practice for therapeutic staff within eating disorder services. The majority of scientific research to date has focused on emotional reactions of professionals working in eating disorder services such as anger, frustration, helplessness in response to the resistance to treatment that the patient group present (e.g. Franko & Rolfe, 1996; Satir, Thompson-Brenner, Boisseau & Crisafulli, 2009; Toman, 2002). This may have created an illusion that professionals tend not to react to working with the patient group with changes to their own body image or eating behaviours. The current research suggested that changes in body image and eating behaviours were present but the changes that were discussed by the participants were mitigated by whether they were shared amongst the team or whether they matched with what they

were telling their patient group. Other changes that were mentioned were disregarded using 'justification' and 'minimising'.

The absence of discussion of changes to professionals' body image and eating behaviours in the literature, and the selective discussion by the current participants may have unintended consequences, in that only changes that were categorised as acceptable were acknowledged. Consequently a norm may have been created making professionals reluctant to discuss any changes in body image and eating behaviours which are outside of the accepted group norm. In such an environment, individuals are unlikely to single themselves out as experiencing change in their body image and eating behaviours that is considered outside of the socially accepted norm as this might exacerbate their feelings of being different.

The research suggested that team working was important. It may be beneficial to have specific time, such as a reflective practice group, to allow team members to discuss as a group how the work in eating disorder services exposes professionals to knowledge of healthy ideals and also extreme views about body image and eating behaviours held by their patients. It is likely that there will be some interaction with one's life outside of work given that one way that eating disorder services are different to other services is that it is difficult for one to distance oneself from their clinical role when not in the work environment. A person working with people with an eating disorder may be reminded of their work context throughout the day when anything arises that is relevant to food, weight or body image.

The role of the facilitator in a process such as a reflective practice group would be paramount given that those who feel in the minority would be unlikely to single themselves out as being different. The facilitator would need to be vigilant and notice those who were contributing less. This may indicate that a discussion needs to occur in

supervision. At these times, it may be useful to refer to the supervision model

suggested by DeLucia-Waack (1999) to help guide the process of supervision.

4.3 Future research

Given that previous researchers in the area (Shisslak et al., 1989; Warren et al.,

2009) obtained their findings from a range of professionals in eating disorder services,

one might expect that other disciplines also experience changes in their body image

and/or eating behaviours. It would be beneficial to explore the experience of change for

other disciplines as it would be presumptuous to assume that the current findings would

be the same across disciplines due to fundamental group differences in their clinical

roles. For example people admitted to inpatient wards are often of very low weight and

have the immediate goal of weight restoration (Wright, 2010). Much of the immediate

care is provided by nurses who need to ensure that patients are getting an adequate

intake of nutrition (Ryan, Malson, Clarke, Anderson & Kohn, 2006). In contrast,

psychological interventions are likely to focus on working with individuals or families

to understand the causes of the eating disorder and work with the patient and family to

improve well being, highlighting one of the differences between the roles.

Future research may want to compare models of reflective practice and examine

what effects these have on individuals and/or the team as a whole with regards to what

sense they make of changes in their body image and eating behaviour. It may be useful

to examine whether the experiences of staff new to the field of eating disorders differs

to the participant psychologists in the current study who had experience ranging from 2

½ to 12 years.

4.4 Conclusions

The participant psychologists seemed to have experienced two types of changes

related to their body image and eating behaviours. They had made changes that

included body acceptance and adopting healthy eating patterns. These changes corresponded with the beliefs around body image and food that they encouraged their patients to adopt. It was believed that this helped to reduce feelings of hypocrisy and improve professional credibility. Other changes that had occurred such as eating more snacks and using weighing scales more often were made sense of through the use of techniques to reduce the dissonance, or by normalising if the change was common amongst the team. None of the participants felt that their own changes had any influence, positive or negative on their clinical practice; however, the way the changes were perceived and discussed as a team was likely to have influenced how participants felt in the working environment and that team cohesion was key to this process happening.

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Part three:

Critical Appraisal

Critical Appraisal

This critical appraisal focuses on the experiences of being the lead researcher in a doctoral study and is based on comments and reflections made in my research diary. The topics covered are: the development of the research idea; process of conducting the research; learning outcomes and future research. Throughout the appraisal, the personal challenges and rewards the research entailed are explored.

1 Development of research

During a presentation of ideas for research, a clinical psychologist (hereafter referred to as the field supervisor) presented several ideas that would be relevant to the field of eating disorders service. This was an area that I had been interested in since first covering the topic in my undergraduate degree. A suggestion that was particularly appealing was what females with an eating disorder thought about their therapists' body shape and size, and whether this impacted on therapeutic process.

Whilst considering the research questions further, I began to wonder about a different perspective on the research. This led me to thinking about what it might feel like for therapists whose appearance is scrutinised by their clients. I wondered what type of body image therapists held, and whether or not any elements of this were disclosed during the therapeutic process, perhaps as a way to normalise clients' behaviour. A scope of the literature highlighted that changes to how professionals working in eating disorder services viewed their body image and changes to their relationship with food were sometimes experienced. Research also highlighted that there were no clear guidelines on therapist disclosure of their thoughts and feelings

about their body image and eating behaviours, but there was some research on the benefits of disclosure.

After careful consideration about what was feasible within the time frame of a doctoral thesis, and what questions the research would be able to address, it was decided to focus solely on therapists' experiences of changes to their body image and/or eating behaviours since working in eating disorder services. It was thought that disclosure could be an area for future research. The research aim therefore, was to explore the types of changes around body image and eating behaviours and what sense had been made of the changes. This would provide greater understanding of the therapists' experiences, and whether changes influenced their clinical practice.

2 Process of conducting the research

Choice of methodology

As the nature of the research was to explore in-depth descriptions of participants' experiences and develop an understanding of the way in which participants constructed their world, phenomenological approaches were considered. There are a number of different types of phenomenological methods (e.g. Interpretative Phenomenological Analysis (IPA), Grounded Theory and Consensual Qualitative Research), each with their own approach to research and analysis (Barker, Pistrang & Elliott, 2002; McLeod, 2001). As the current research questions focused on similarities as well as the differences across experiences and the aim was not to provide a theory or framework to explain the participants' data, IPA was the most suitable approach. The core aim of IPA is to understand an individual's lived experiences and personal perception of their world (Smith, 1996).

The word 'experience' has a specific meaning in IPA; it is more than a day to day occurrence, and occurs when a person becomes aware of something happening and begins to reflect upon it. These experiences are usually linked to something of significance to the person. For the current study, gaining an understanding of lived experiences was achieved by analysing participants' verbal accounts of their personal experiences.

IPA allowed me to be critical of the data and explore whether there was anything more to the accounts than what the participants had said in the interview. This process required double hermeneutics as it involved two levels of interpretation; firstly, the participants reported interpretation of their experiences, and then my interpretation of their accounts. Due to the nature of interpretations, an exact understanding of experiences was not possible but can still be closely represented (Smith, Flowers & Larkin, 2009). This degree of interpretation could be perceived as a limitation of this methodology. It could be argued that whilst making interpretations in one transcript, I was primed to make similar interpretations in subsequent transcripts. If this was the case, shared themes across participants would be an artificial finding. I was cognisant of this problem, but found that the analysis process detailed by Smith et al. (2009) encouraged me to remain close to the data and ensure that the themes that emerged were relevant to each individual transcript.

Recruitment

Prior to seeking ethical approval, I had agreement from the Chair of the Faculty for Eating Disorders (FED) that I would be able to email all of the members of the Faculty with details of the study. The FED is one of the branches within the Division of Clinical Psychology (DCP) which is an organisation for Clinical Psychologists who are

members of the British Psychological Society. Unfortunately, at the time of emailing, I was informed by a DCP administrator that this method would no longer be possible. Changes in policy had meant that using the Faculty membership list to recruit participants for research was no longer deemed an acceptable use of the membership list. I felt frustrated that I had been informed of this at a late stage and also overwhelmed with uncertainty about how I would recruit participants. The Chair of the FED was very helpful and suggested that I place the advert on the DCP Research Notice Board website and also invited me to present my research at the next FED conference in four months time. I was grateful for her help, but was acutely aware that at the point when I planned to be analysing data, I would be presenting at the conference and hoping to obtain participants.

Up to the point of the presentation at the FED conference, I had managed to recruit one participant via the poster on the DCP, thus felt pressure to recruit participants from my presentation. Those at the conference were very supportive of the project idea; I recruited several volunteers and was also invited to return to present the findings. I was pleased with this for two main reasons: firstly, that I had managed to recruit an adequate amount of participants to conduct the research; and secondly that they valued the idea, adding to my confidence that the research would be beneficial to those in the field.

Interviewing

Not having completed qualitative research from start to finish, and also being aware that the standard for doctoral work would extend my research skills, I had trepidation about using qualitative methodology. My main fear was about getting the questions 'right' without which, I could not hope for meaningful findings. Although

creating the questions in the interview schedule was reasonable as I had the support from both my academic and field supervisor, I was concerned about the questions I would be asking throughout the rest of the interview, and whether these questions would be suitable.

Qualitative research can be criticised for being subjective and open to bias from the agenda of the researcher, and thus being less trustworthy than quantitative research (Meyrick, 2006). In order to maintain transparency for the reader, I acknowledged that I expected therapists to talk about the changes they had experienced and how they managed this so that boundaries were maintained. Even though I had some thoughts on what might arise, this did not affect the questions asked. In fact, the topics raised were not as I had expected and in my reflective diary and with my supervisors, I openly discussed this initial feeling of disappointment with regards to this.

An area of difficulty in the interviewing process was the challenge of stepping out of the therapist role and into a researcher role. This challenge persisted throughout the interviews, and was particularly heightened when participants shared something that was clearly emotional or difficult to discuss. I felt that not offering a reflection might be interpreted as though I was not listening to the content and would be disrespectful. After experiencing this a couple of times in the early stages of the interviewing process, I decided that thanking participants for sharing the information with me seemed an appropriate way to acknowledge their honesty and show that I had heard the emotional aspect behind what they were sharing with me.

Transcribing

The process of transcribing was an arduous task as it was very time consuming. I had originally planned to pay for someone to transcribe two interviews, but abandoned

this idea as decisions made about what to include in the transcripts is a type of interpretation (Smith et al., 2009). Therefore, I chose to complete all the transcriptions to ensure that this interpretative process was consistent across all data (Tilley, 2003). Although this was difficult, I believe this also had a secondary gain of allowing me to immerse myself in the data.

Analysing

The analysis stage of the research also presented me with challenges but was an overall rewarding experience. I was anxious about making interpretations that might be viewed as 'incorrect'. I was initially reluctant to analyse too far and was informed by my field supervisor that my initial analysis of the themes were too descriptive. This was a particularly difficult time for me as the thought of looking through the transcripts again not only seemed daunting with regards to the amount of time it would require, but I also doubted my capacity to interpret the data further. A fear remained that there was a 'right' way to do this, and that my interpretations would be 'wrong'. This feeling persisted for a long time, but when I returned to the transcripts, I decided that I needed to spend more time than I had originally done, thinking about why people had chosen to speak to me about certain things, particularly if they had discussed something spontaneously. When I began to think more deeply about the meaning in the transcripts, the process of analysis was more enjoyable than I had expected. The development of themes were read by the field supervisor who said that she found them interesting and believed they would be clinically relevant. I realised that her honesty was necessary and helped me to interpret the data in a meaningful way. The detailed analysis of the data and the emergence of unexpected themes demonstrated the value of

qualitative research and not being constrained by pre-existing theories (Barker et al., 2002).

3 Learning outcome and future research

A key theme in my reflective diary was about getting things 'right'. I believe that this was partly inevitable as I was doing a project that was considerably more intellectually demanding than anything I have done previously. This was exacerbated as I was particularly anxious about interviewing people who worked in the same discipline and were more qualified than I. I was nervous about judgements they might be making about my interviewing style. In order to try to manage this, I held on to the thought that interviewing psychologists might be beneficial as they might be more aware of qualitative interviewing styles, and be expansive and detailed in their responses.

As well as reflections on my academic abilities, the research also made me question my thoughts about my own body image and eating prior to starting this research, and how these changed throughout the process. Prior to starting the research I always considered myself to be someone who ate fairly healthily and felt okay about my body image, although there were aspects that I did not like as much. As the interviews progressed, I became increasingly aware that many of the thoughts that the participants were describing that the clients had chimed with my own thoughts. Of particular resonance was the worry about whether or not I could eat something deemed unhealthy, dependant on what I had already eaten that day. I also had similar experiences to the participants in that I was uncertain about what was influencing my eating behaviours during the research. I was aware of eating more throughout the transcription and analysis process of the research, and found myself fluctuating between thinking this was

because I was researching food and therefore thinking about it more, and also whether the increase in weight was due to studying and a pre-existing habit of regular snacking whilst completing academic work. Using my research diary was invaluable in helping me acknowledge and reflect on the personal impact of the research.

Looking back through my reflective diary brought back to mind the difficulties I encountered whilst conducting the research with the foreboding deadline. In retrospect, my schedule was unrealistic and based on the expectations that there would be consistent progression and that no unforeseeable events would occur. It also highlighted that others can be crucial in the success or failure of research. This dependence on others and reduction in control was something I had to learn to tolerate.

The process of research has been full of challenges and rewards and encompassed a range of emotions. Despite initial reservations, I found the process of analysis fascinating. Now with the research completed my feelings have shifted to one mainly encompassed with pleasure with having produced a clinically relevant piece of work.

Although challenging at times, this has been an invaluable learning experience and has helped me develop my skills as a researcher. Despite the time constraints that were present, I believe that a series of small goals with time limits are imperative as without a timeframe, it can be difficult to retain momentum and motivation.   Incorporated into this however, there needs to be a contingency plan as unforeseen events can occur at any time during the process. My ability to critically appraise literature, write academically and most significantly my analysis have improved with the support of my supervisors. Throughout the process of the research, I have valued the principles of reflexive practice, especially as being the interviewer and interpreter meant that I was the main 'instrument' in data collection and analysis.   A reflexive approach was
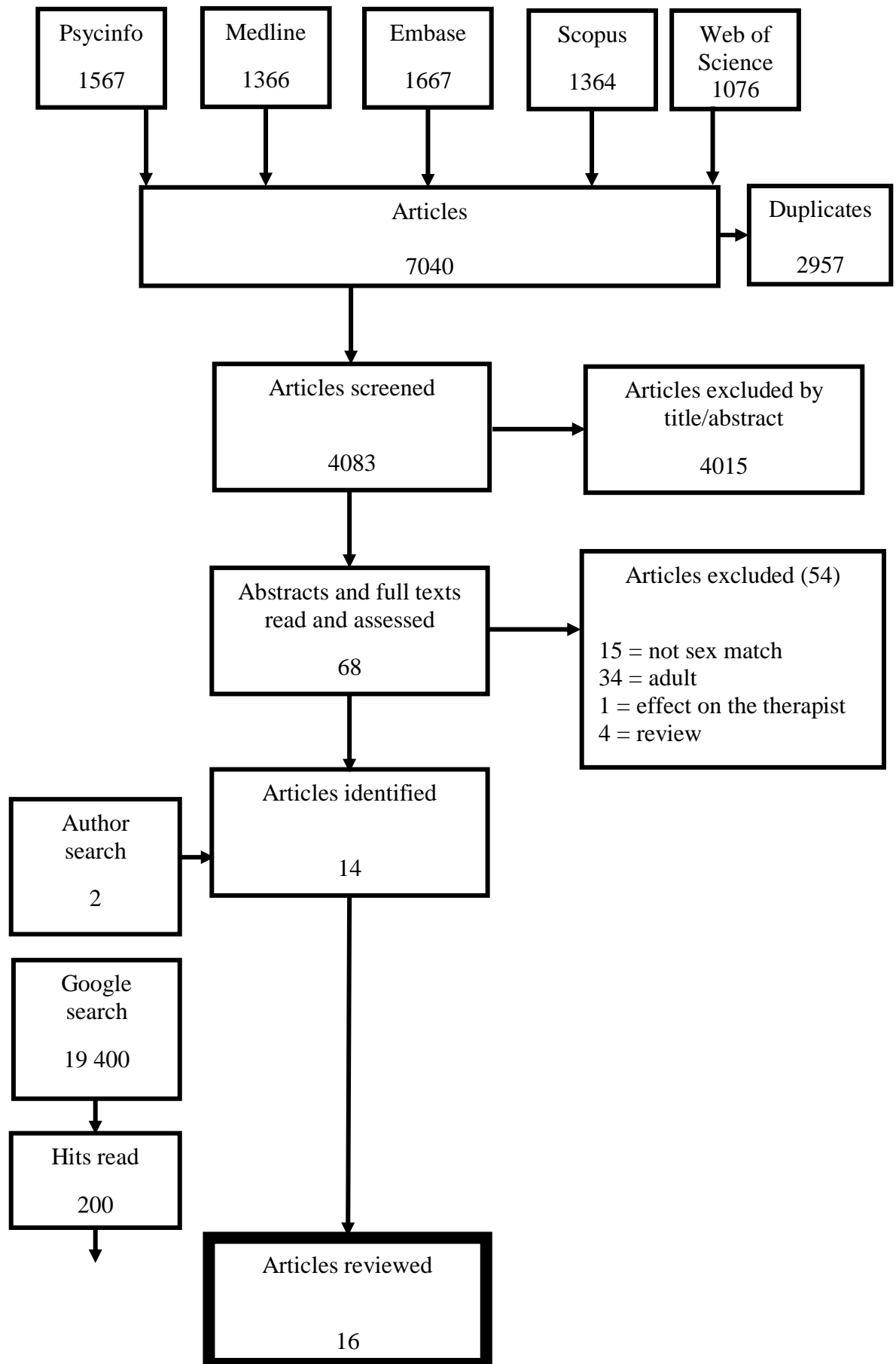
especially useful in helping me to maintain perspective on the personal impact of the research and also what I was bringing to the research.

I would like to conduct future research along the lines of staff teams as it is suggested that staff morale affects clinical effectiveness and a supportive team environment with good managerial leadership and supervision can improve staff wellbeing (Gilbody et al., 2006). I think that qualitative research could explore some of the taken-for-granted assumptions about what staff teams find supportive.

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Appendix A: Flowchart for article searching

Appendix B: Data extraction form

Study number		Year	
Title			
Researchers			
Journal			

Aims of study/ hypotheses

Research design

Sample
Number of Pps
Age
Sex
Ethnicity

Variables measure
What outcome? How is it measured?

Intervention *Type*? *Duration?*

Findings   *What type of stats*

Conclusions

Study Quality - a) sig of problem   b) clarity of prob definition
c) adequacy of research design   d) control of variables
e) sample   f) psychometric properties   g) analysis
methods   h)interpretations and generalisability
i) adequacy of research report

Positives

Critiques

Appendix C: Summary of papers

Table A Summary of papers

First Author	Client sample				Clinician sample			Intervention (Type and Duration)	Variable measured	Source of data
	No.	Age	Sex	Ethnicity	No.	Sex	Ethnicity			
Bigfoot-Sipes (1992)	242	13 – 18	111 (46%) M 131 (54%) F	AI and Metis (mixed Indian and Anglo American)	N/A			Hypothetical situation – school counsellor	Preference for counsellor sex dependent on whether concern was personal or career related	Client completed preference questionnaire
Cooper (2006)	584 (566 valid for sex match	11 – 16	283 (48%) M 274 (47%) F 27 (5%) missing	487 (83%) Br 39 (7%) NBr	N/A			Hypothetical situation – school counsellor	Preference for counsellor sex	Client completed preference questionnaire
Fowler (1993)	20	7 – 15	20 (100%) F	13 (65%) W 7 (35%) B	7	4 (57%)M 3 (43%) F		Psychoeducation using standardised procedure. 6 sessions	Preference and anticipated comfort for counsellor sex pre and post treatment	Client completed preference and comfort questionnaire
Fowler (1992)	35	5 – 17	35 (2005) F		2	1 (50%) M 1 (50%) F		Evaluation stage - Prior to treatment	Preference and anticipated comfort of counsellor sex	Client completed preference and comfort questionnaire

Study	N	Age	Sex	Ethnicity	N	Sex	Ethnicity	Setting/Duration	Focus	Measure
Goldberg (1990)	116	15 – 17 (except 18 partici-pants)	52 (45%) M 64 (55%) F	53 (46%) W 63 (54%) B	8	4 (50%) M 4 (50%) F	2 (25%) W M 2 (25%) W F 2 (25%) B M 2 (25%) B F	Intake for school counselling. 1 session	Sex matching effect on client's view of counsellor attractiveness and satisfaction	Client completed attractiveness and satisfaction questionnaire
Hall (2002)	4616	6 – 17	Not stated	1219 (26) B 903 (20%) A 1498 (32%) M 996 (22%) W	Not stated			Outpatient service No stated duration	Effect of sex matching on dropout rates	Archival data on automated information system
Kilcrease-Fleming (1992)	18	7 – 17	18 (100%) F		Not stated			Psychoeducation using standardised procedure. 6 sessions	Effects of sex matching on in session behaviour	Rated videotapes of sessions
Littrell (1989)	557	Ave 16 Ave 17.5 M 16.8 F Ave 16.3	Not stated Not stated Not stated	193(34.5%) Ma 193(34.5%) Ch 171 (31%) I	6 – slides	3 (50%) M 3 (50%) F	2(33%) Ma 2(33%) Ch 2 (33%) I	Hypothetical situation – school counsellor	Effects of sex of counsellor and ethnic group on students preferences for personal, academic, career, social and drug concerns	Client completed Sharing Problems Scale
Littrell (1982)	366	students	67 (48%) M 73 (52%) 119 (53%) M 107 (47%) F	140 (38%) AI 226 (62%) C	12 - slides	6 (50%) M 6 (50%) F	100% C	Hypothetical situation – school counsellor	effect of sex of student, sex of counsellor, race of student on student preference for personal, academic and vocational concerns	Client completed preference questionnaire

Moon (1993)	47 in total 25 SA	7 – 17	47 (100%) F 14 (56%) C 11 (44%) AA		N/A		Not stated	Preference and anticipated comfort for counsellor sex for SA and NSA F	Client completed preference and comfort questionnaire
	22 NSA	7 – 16	15 (68%) C 7 (32%) AA						
Moon (2000)	35 in total		35 (100%) F	28 (80%) C 7 (20%) AA	22	11 (50%) M 11 (50%) F	Psychoeducation using standardised procedure. 6 sessions	Sex matching and age effect on clients in session behaviour	Client completed counselor preference and comfort survey Rated transcripts and videotapes of sessions
	11 (32%)	7 – 11							
	24 (68%)	12 – 17							
Porter, (1996)	27	7 – 17	27 (100%) F	17 (63%) C 10 (37%) AA	20	18 (90%) C	Psychoeducation using standardised procedure. 6 sessions	Effects of sex matching on in session behaviour	Client Behaviour System questionnaire. Rated videotapes of sessions
Quinn (2009)	589 (586) for sex match	11 – 16	313 (53%) M 276 (47%) F	Not stated	N/A		Hypothetical situation	Preference for counsellor sex	Client completed preference questionnaire

112

Turner (1986)	430[*]	15 – 16	74 (21%) M 109 (30%) F 90(25%) M 87 (24%) F	183 (51%) M/P 177 (49%) P	4 – slides	2(50%) M 2 (50%) F	2(50%) M/P 2 (50%) P	Hypothetical situation – school counsellor	Preferences for counsellor dependent on whether concern was personal or career related	Client completed preference questionnaire Choosing counsellor questionnaire
Wagner (1993)	21	7 – 17	21 F	Not stated	17	10 (59%) M 7 (41%) F	17 (100%) W	Psychoeducation using standardised procedure. 6 sessions	Effects of sex matching on in session behaviour	Rated videotapes of sessions
	30	7 – 17	30 F		Not stated				Effects of counsellor sex on post abuse adjustment	Client completed self – concept questionnaire and depression questionnaire
Wintersteen (2005)	600	Mean 15.7	486 (81%) M 114 (19%) F	366 (61%) C 192 (32%) AA	14	5 (36%) M 9 (64%) F	7 (50%) C F, 4 (29%) C M 1 (7%) AA F 1 (7%) AA M 1 (7%) L	Manualised treatment 2/3 motivational 1/6 behavioural 1/6 family therapy 2 or 3 sessions	Sex matching effect on alliance and retention	Client completed Working Alliance Inventory

[*] The author was aware that the numbers for the client population did not correspond to the total number, however, this was the information given in the report. The percentages provided are for the 360 students for which there was information.

Appendix D: Interview Schedule

Background information

- Can you tell me which age range you currently fall into?

- Which of the following ethnic backgrounds would you most closely identify with?

- How long have you worked within the eating disorder service?

- What has led you to working with clients with an eating disorder?

Prompts - Are there any particular personal experiences that may have informed your decision? Did you know anyone with an eating disorder before working in this area?

- What has your experience been?

If it's okay, I'd like to talk about your body shape and size now...

Impact on body image

- What is your experience of your current body shape and size?

- What has shaped your feelings about your body shape and size

- *Prompts - Why do you think that is? When did you start to notice the changes? Does the diagnosis or physical presentation of the client have any impact? Is it particular topics discussed in therapy sessions? Does the environment you work in have any impact?*

- How do you feel about the changes?

Eating behaviours

- What are your thoughts about food and your eating behaviours?

 Prompts – have you noticed any changes since working in the eating disorder

service? How do you feel about the changes? What sense do you make of this?

Clinical impact

- What is your experience of change and your clinical work?

Prompts – Does it impact on how you choose to work with clients? Does it impact on the types of discussions you have? How do you respond if a client talks about your body shape or asks what you eat? Does it impact on who you work with?

- How do you feel about the impact on yourself that you have described?
- Tell me how you manage the impact

  Prompts –What kind of support is available? Do you discuss these issues with colleagues or in supervision? Do you discuss these issues with anyone outside of the health service? Does this have any effect on relationship others?

Other impacts

- Are they any other changes you have noticed since working with clients with an eating disorder?

Additional comments? Is there anything else you would like to say? Thank you for taking part. Would you like a copy of the transcript to verify the accuracy of this interview?

University of Leicester Ethics Review Sign Off Document

University of Leicester

To: **Rachel Swancott**

Subject: Ethical Application Ref: **rlc27-51fc**

          (Please quote this ref on all correspondence)

10/03/2011 04:43:41

Psychology

Project Title: **An exploration of changes to therapists' body image and eating patterns when working with clients with an eating disorder**

Thank you for submitting your application which has been considered.

This study has been given ethical approval, subject to any conditions quoted in the attached notes.

Any significant departure from the programme of research as outlined in the application for research ethics approval (such as changes in methodological approach, large delays in commencement of research, additional forms of data collection or major expansions in sample size) must be reported to your Departmental Research Ethics Officer.

Approval is given on the understanding that the University Research Ethics Code of Practice and other research ethics guidelines and protocols will be compiled with

- http://www2.le.ac.uk/institution/committees/research-ethics/code-of-practice

- http://www.le.ac.uk/safety/

The following is a record of correspondence notes from your application **rlc27-51fc.**
Please ensure that any proviso notes have been adhered to:-

Jan 13 2011 9:23PM   A summary of this research has been sent to the
service user reference group for their reference and their feedback.

Mar 1 2011 11:40AM   Dear Rachel, Your proposal has been reviewed
by the School of Psychology Research Ethics Committee. I am reporting on this
application on behalf of Dr. Ray Randall. The Committee has required minor
amendments to your application, which are listed below: Please make it clear that the
paraphrasing of the data will be for presentation only and will happen after the data
are analysed. The sensitive topic item on the checklist should be checked and the
financial inducement box checked as the compensation is not thought to be beyond
reasonable).   On the information sheet, the email address of your supervisor needs to
be added (perhaps instead of the phone number). On the first page of the information
sheet under Procedure - the committee has requested that you add the word 'your' in the
italicised section so that this statement reads 'changes in your awareness of body image'.
Please revise the wording under 'What if there is a problem'□ to 'if you would like to
discuss the research' (rather than using the word complain). The correct name for this
committee is the University of Leicester Psychology Research Ethics Committee. Please
correct the name on your information sheet. Please address how your data will be
stored, on the information sheet. Please make the signposting for participants who are
upset or may wish to have further support around the topic clearer on the information
sheet. Please make these changes on the original form, and summarise the changes you
have made in the note section of the application. You may wish to discuss your revisions
with your supervisor prior to resubmission. As the Departmental Ethics Officer assigned to
your application, I will review your revisions. Please be aware that this process can take
approximately a week following submission.   Best wishes, Melanie

Mar 7 2011 9:19AM   Dear Melanie,   A list of the changes I have made
are detailed below. The information sheet has been amending in the following ways:
How data will be stored - All information will be kept confidential. Consent forms will
be kept in a locked cabinet at the University of Leicester. Audio recordings will be
converted onto disc and kept in a locked cabinet in my home study. Audio recordings
will be destroyed once they have been transcribed and the study is completed.
Transcripts will be anonymised using pseudonyms and will be saved in password
protected Word Document files. Anonymised transcripts may be seen by research
supervisors as a way of validating the findings and progressing the analysis.   Once the
research is completed the transcripts will be kept securely at the University of Leicester
for five years. After this time, they will be destroyed. Paraphasing - Extracts from the
interviews may be included in the final report. These extracts will be anonymised and
may be paraphrased to reduce identification through dialect or phraseology. Any
paraphrasing of the transcripts will only occur after the data has been analysed. Where
participants will be signposted for further help and support - However, should you
encounter any unexpected upset or require further support you will be encouraged to
seek appropriate help and support from your supervisor, employee counselling service
or your GP surgery. The committee name has been corrected. Wording has been
changed under 'What if there is a problem', and the academic supervisor telephone

number has been substituted for her email address. The word 'your'• has been added in the procedure section. I have also added in details about the consent form under the topic 'I would like to participate' and I have altered the ordering of information sheet, as it seemed to flow better.   Also the sensitive topic item on the checklist is checked and the financial inducement box is checked.

--- END OF NOTES ---

University of Leicester

An exploration of changes to therapists' body image and eating patterns when working with clients with an eating disorder

How has working in an eating disorders service affected you?

Do you believe that your body image and eating patterns have changed because of your work?

Do you think that this has any impact on your clinical practice?

I am a Trainee Clinical Psychologist who is interested in interviewing female therapists with a qualification in clinical psychology or psychotherapy in order to explore these questions.

I would like to carry out semi-structured interviews to explore how these changes occur, how this is managed and whether it has any impact on clinical practice. As a thank you for your time, you will be given a £10 Debenhams voucher.

What are the clinical implications?

There are a number of clinical implications to this research. These are;

a) Increasing the body of knowledge about the experiences of therapists when working in an eating disorders service.
b) Developing an understanding of the strategies used by therapists to manage changes they experience.
c) An increased understanding of how changes experienced by the therapist may impact on clinical practice.

Further information

If you are interested in finding out more or participating in this study, please read the information sheet below or contact me at rlc27@le.ac.uk

Rachel Swancott, Trainee Clinical Psychologist, University of Leicester

Research title

An exploration of changes to therapists' body image and eating patterns when working
with clients with an eating disorder

I am a Trainee Clinical Psychologist at the University of Leicester and would like to
invite you to take part in my research exploring changes to your body image and eating
patterns.
Before you decide whether or not to participate, I would like you to understand what the
research involves for you, and the clinical implications. Please take some time to read
through this information.

Purpose
The purpose of this research is to explore the process and thoughts around the changes
in awareness of body image and eating patterns, how therapists feel about the changes,
how these are managed, as well as whether this has any influence on clinical practice.

I am focusing on female therapists with a qualification in Clinical Psychology or
Psychotherapy who have a minimum of one year current experience of working in an
eating disorders service, and work predominantly with female clients on an individual
basis. I am particularly interested in therapists as I would like to investigate if the
development of a therapeutic relationship and the discussions that take place within
therapy have any impact on body image and eating patterns.

At present there is a limited amount of qualitative research which explores these areas
in depth and therefore the ways in which therapists make sense of their experiences is
not well understood.

It is anticipated that this research will help develop our understanding about the
experiences of therapists, and how what ways these experiences are managed.

Right to Withdraw
Participation in this is research is voluntary. If you decide to take part, you still have
the right to withdraw at any time during the interview and afterwards until data analysis
begins in September 2011. Your withdrawal will have no impact on your role.

Procedure

I would like to meet for approximately one hour for a confidential interview. The interview will be semi-structured and will use open ended questions covering *changes in your awareness of your body image and eating patterns and how this is managed as well as whether this impacts on clinical practice.* As a thank you for your time and taking part in the research, I would like to offer you a £10 Debenhams voucher.

The interview will be audio recorded so it can be transcribed verbatim at a later date. If you wish, you can read a copy of your transcript to verify that it is an accurate record of our discussion. Once the interviews have been analysed, the audio recording will be deleted and the transcripts will be submitted with the final report.

Risks
It is not anticipated that taking part in this research will present any risks. However, should you encounter any unexpected upset or require further support you will be encouraged to seek appropriate help and support from your supervisor, employee counselling service or your GP surgery.

What if there is a problem?
If you would like to discuss the research you can contact my academic supervisor, Dr Marilyn Christie at the University of Leicester at mc110@leicester.ac.uk

Ethical approval
This research has been approved by the University of Leicester Psychology Research Ethics Committee.

I would like to participate
If you would like to take part in this research, please contact me on **rlc27@le.ac.uk** to discuss a convenient time for the interview. We can then arrange whether to carry out the interview at your work base, or in a local NHS room if this is preferred. Ideally, I would like to recruit from the Midlands area to keep travel costs at a minimum. When we meet, you will be asked to read and sign two copies of a consent form; one copy for your reference and one will be kept by me.

I live outside of the Midlands, can I still take part?
Yes. If additional participants are required I am happy to travel outside of the Midlands area. Please contact me on rlc27@le.ac.uk and I will inform you as soon as possible whether or not I will be able to interview you.

Confidentiality
All information will be kept confidential. Consent forms will be kept in a locked cabinet at the University of Leicester. Audio recordings will be converted onto disc and kept in a locked cabinet in my home study. Audio recordings will be destroyed once they have been transcribed and the research is completed. Transcripts will be anonymised using pseudonyms and will be saved in password protected Word Document files. Once the research is completed the transcripts will be kept securely at the University of Leicester for five years. After this time, they will be destroyed.

Anonymised transcripts may be seen by research supervisors as a way of validating the findings and progressing the analysis. Anonymised extracts from the interviews may be included in the final report. These extracts may be paraphrased to reduce

identification through dialect or phraseology. Any paraphrasing of the transcripts will only occur after the data has been analysed.

Dissemination of findings
The research will be submitted as partial fulfilment of the degree of Doctorate in Clinical Psychology and will also be submitted for publication to a peer reviewed journal. A summary of the findings will be sent to participants and also emailed to the Chair of the Division of Clinical Psychology Faculty of Eating Disorders for dissemination throughout the membership. A poster will be created for conference presentations on behalf of the University of Leicester.

Further information
If you would like any further information please contact me on rlc27@le.ac.uk

Thank you for your time and help in this research

Rachel Swancott
Trainee Clinical Psychologist

University of **Leicester**

Consent to participate

<u>Research title</u>: An exploration of changes to therapists' body image and eating patterns when working with clients with an eating disorder

<u>Name of researcher</u>: Rachel Swancott

You have been invited to take part in a research study exploring therapists' body image, and eating patterns when working with clients with an eating disorder. Before you agree to participate, please ensure you have read the information sheet, that it has been discussed with you, and that you have had the opportunity to discuss any questions or concerns you may have.

Please read the statements below and circle the appropriate response

I have been given a written information about this research and it has been discussed with me	Yes / No
I have been given the opportunity to ask any questions	Yes / No
I understand that the interview will be audio recorded so that it can be analysed at a later date	Yes / No
I understand that the information I provide will be kept confidential	Yes / No
I understand that if quotes from my interview are used in the research write up they will be anonymised and may be paraphrased	Yes / No
I understand that participation is voluntary and I have the right to withdraw at anytime prior to the analysis in December 2011 and that this will not affect my role	Yes / No
I agree to take part in the research	Yes / No

Participant Name (please print): …………………...
Participant Signature: …………………………………………………………….……..
Date: ……………………………….……

Researcher Name (please print):……………..
Researcher Signature: ………………………………………………………….……….
Date: ……………………………………………………………………………………

Contact details:
Rachel Swancott
Trainee Clinical Psychologist
rlc27@le.ac.uk

Appendix I: Epistemological position

The researcher adopted the epistemological stance of contextual constructivist. Constructivism posits that there is no one reality and accordingly individuals are involved in constructing their own reality (Hansen, 2004). The contextualism element adds that participants' descriptions are influenced by the context in which the interviews are collected (Madill, Jordan & Shirley, 2000). Accordingly, all findings were contextual to the situation. Thus the interaction between the interviewer and the interviewee were paramount as both influenced each other in what topics were raised and explored, creating a relationship of mutual influence (Yardley, 2000).

References

Hansen, J. T. (2004). Thoughts on knowing: epistemic implications of counseling practice. *Journal of counseling and development, 82,* 132 – 138.

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology, 91*, 1 – 20.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15*(2), 215 – 228.

Appendix J: Transcription key

Transcription Conventions adapted from Bailey, (2008)

Key	Meaning
,	Pause
(...)	Pause that is over 2 seconds
[sighs]	Notes/comments
(?)	Inaudible
[	Overlapping between speakers begins
]	Overlapping between speakers ends
four	Lengthening of a sound
becau-	Cut off, interruption of a sound
<u>she</u> says	Emphasis
?	Rising intonation
"what"	Speaking from the perspective of another in their voice

Appendix K: Stages of the analysis process and an example extract from a transcript

Although the stages are described as discrete steps, in practice, there was merging of steps, particularly step one and two.

Step one – Reading and re-reading

This first step involved reading the transcript several times to obtain initial impressions of the data. The first reading of the transcript was carried out whilst listening to the audio recording and subsequent readings were completed using the transcript alone.

Step two – Initial noting

During this step, descriptive, linguistic and conceptual comments were made in the right hand column of the transcript for each sentence.

Step three – Developing emergent themes

Exploratory notes were analysed to identify emergent themes and were written on the left side of the data. (See example page from transcript below).

Step four – Searching for connections across emergent themes

This step entailed looking for connections between the themes, such as variations amongst the same theme and noting the frequency of the evidence to support

the theme (although this does not make a theme more or less relevant). Connected

themes were grouped together into super-ordinate themes.

Step five – Moving to the next case

Once step four was completed with the initial transcript, the process was

repeated with subsequent transcripts.

Step six – Looking for patterns across cases

During this step, themes were analysed to identify patterns across the data sets.

It was decided that a theme needed to be present in at least half the sample for it to be

discussed in the research.

	162	try and erm pour it into a glass and then that glass would
Difficult to be physically evaluated	163	then go in the wardrobe she'd throw it out of the window,
	164	And I guess kind of <u>that</u> experience was helpful at a later
	165	stage but then was obviously quite difficult because of my
	166	first exposure to the condition and, erm (...) quite hard to
	167	kind of erm manage when the patient actually said to me
	168	maybe I should have one of those drinks because I didn't
	169	look that (...) I didn't look that <u>erm</u>, well and I probably
	170	needed to be fed up like she was being forced to be, well
	171	she perceived force fed,
	172	I: Can you remember how that made you feel?
minimising difficult emotion intellectually	173	P: erm (...) I think, probably at the time quite anxious, I was
	174	able to talk it through with the ward staff but there was
	175	only one patient of a ward of probably, twenty five thirty
	176	female patients because in those days they were single sex
	177	wards so erm (...) it was, it was just something that kind of,
	178	I think (...) the exposure and the experience was not until
	179	at a later point that I was to remember kind of just perhaps
Denial of own body in the risk?	180	how, much how that did have an impact on me, erm, I'm
	181	not saying that it made me think about, that you know my
	182	own body weight or my image was impacting on her
	183	difficulty to be challenged to, kind of restore her own
	184	weight erm I just think it kind of made me <u>alerted</u> to
	185	perhaps how the patient, was perceiving the nurses who
	186	helped who were there to treat her but we were part of a
	187	multidisciplinary team then

Appendix L: Chronology of research process

Date	Stages
May 2010 – November 2010	Development of research Peer review at the University of Leicester Developing interview questions
January 2011	Submitted to ethic
March 2011	Ethical approval received Pilot completed
May 2011	Placed recruitment advert on DCP Research Notice Board
July 2011	Interviewed first participant Transcribed data Analysed data
September 2011	Recruitment at FED conference
September 2011 – December 2011	Interviewed seven participants Transcribed data
December 2011 – January 2012	Analysed data Looked for emergent themes across transcripts First draft of results
February – March 2012	Analysing the data Writing second draft of results
February – May 2012	Writing up findings
July 2012	Research Viva
	Dissemination of findings – summary to be sent to participants and the chair of Faculty for Eating disorders, a poster will be created for conference presentations, submitted for publication in a scientific journal.

Appendix M: Guidelines to authors for journal targeted for literature review

The target journal for the literature review is the Journal of Consulting and Clinical Psychology. This journal was chosen as it is publishes articles that have clear implications for clinical research and practice and welcomes submissions of critical analyses of approaches relevant to the field of clinical psychology.

The submission details for authors indicate that the abstract should be no longer that 250 words and should clearly indicate objective, method, results and conclusions. There is no maximum word length but papers should not exceed 35 pages in length, however, the paper has been formatted and written in accordance with the University of Leicester DClinPsy Coursework Guidelines and Assessment Regulations. This allowed 300 words for the abstract and a maximum of 7,000 words for the review. For More Detail about the submission criteria for the Journal of Consulting and Clinical Psychology see the website at: http://www.apa.org/pubs/journals/ccp/index.aspx