

**PSYCHOTHERAPISTS' EXPERIENCE: WORKING WITH DISORDERED EATING FROM A
HUMANISTIC PERSPECTIVE - A PHENOMENOLOGICAL STUDY**

By

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Abstract

Disordered eating is considered to be one of the most prevalent mental health conditions, yet there is a lack of adequate support for individuals with such concerns. This research focuses on how psychotherapists work with disordered eating from a humanistic perspective. The aims were to enhance the limited existing research on the spectrum of disordered eating and humanistic therapeutic approaches. Data collection involved semi-structured interviews with four qualified psychotherapists with experience of working with disordered eating and who use humanistic approaches in their client work. The data were analysed using interpretive phenomenological analysis. Four group experiential themes and several sub-themes emerged from the analysis: application of therapeutic elements, aspects of disordered eating, inhibitors of change and influencing factors. The findings highlight the value and necessity of the humanistic approaches when working with disordered eating, allowing flexibility and client autonomy. The study thus bridges the gap and offers greater understanding of working therapeutically with disordered eating. Suggestions for further research are outlined and include focusing on traumatic experiences as well as humanistic approaches that are under-researched in regard to disordered eating.

Keywords: Disordered eating, Psychotherapists, Humanistic, Phenomenology, Psychotherapy

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Chapter 1 Introduction

Disordered eating is considered to be one of the most prevalent mental health concerns (Galmiche *et al.*, 2019). Despite its high prevalence, access to psychotherapeutic support for individuals experiencing disordered eating remains limited (Kazdin, Fitzsimmons-Craft and Wilfley, 2017). The term ‘disordered eating’ refers to a broad spectrum of maladaptive eating behaviours, ranging from irregular eating patterns to behaviours resembling clinically diagnosed eating disorders (American Psychiatric Association, 2006). Common behaviours include restrictive eating, compulsive eating and dieting; which is the most frequent, and also considered to be the highest risk factor for the development of clinical eating disorders (National Eating Disorders Collaboration [hereafter NEDC], 2024).

Eating disorders, by contrast, are severe and often fatal psychiatric conditions characterised by significant disturbances in eating behaviour, as well as persistent concerns related to body weight, shape, and food. The most common eating disorders include anorexia nervosa, bulimia nervosa, and binge eating disorder (BED); (National Institute of Mental Health, 2024), although other conditions such as avoidant/restrictive food intake disorder (ARFID), night eating syndrome, rumination disorder, purging disorder, and other specified feeding or eating disorders (OSFED) are also recognised (Fuller, 2024).

In the UK, an estimated 1.25 to 3.4 million people are affected by eating disorders, which have the highest mortality rate among all psychiatric conditions (Priory, 2024). A primary distinction between disordered eating and eating disorders lies in diagnostic criteria. Eating disorders meet formal classifications, for instance in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or the International Classification of Diseases (ICD-11) whereas disordered eating encompasses problematic behaviours that do not necessarily meet diagnostic thresholds. These behaviours may mirror those

seen in eating disorders but typically occur with less severity or frequency (Fuller, 2024).

The rationale for this study arises from the researcher's personal and professional interest in supporting individuals along the disordered eating spectrum, particularly those who fall outside the diagnostic criteria and often lack access to support. Preliminary research revealed a notable gap in the literature surrounding psychotherapeutic interventions for disordered eating. While a substantial body of research exists on clinical eating disorders, there is a relative scarcity of studies examining how therapists work with disordered eating, especially from a humanistic perspective.

This research aims to explore the lived experiences of psychotherapists working with clients who present with disordered eating difficulties, using in-depth semi-structured interviews. Furthermore, it will identify effective therapeutic elements, highlight barriers within current practice and offer possibilities for future changes. The findings intend to contribute to limited knowledge about disordered eating and inform not only the counselling field on working with such difficulties but also the researcher's future practice as a psychotherapist.

The research project will be structured into five chapters, to allow the research question of 'how do psychotherapists work with clients with disordered eating from a humanistic perspective?' to be adequately answered. Chapter two will review existing literature on disordered eating and psychotherapy. Chapter three will outline the study's methodology and methods of data collection and analysis. Chapter four will present findings, supported by interview excerpts. While chapter five will discuss these findings in relation to existing research, consider study's strengths, limitations and implications, propose directions for future research, and conclude the study.

Throughout the project, other terms such as 'counsellor' and 'therapist' will also be used interchangeably with 'psychotherapists', to reflect the broader psychotherapeutic field. For clarity, the term participant refers to an individual

contributing to the research through the semi-structured interview, all of whom are qualified professionals working therapeutically with clients experiencing disordered eating.

The subsequent literature review will critically examine current research on disordered eating, including its contributing factors and common therapeutic approaches. Given the scarce literature specific to humanistic approaches and disordered eating, the discussion will particularly draw on literature that is focused more broadly on eating disorders.

Chapter 2 Literature Review

This research investigates how therapists use humanistic approaches with clients experiencing disordered eating. To contextualise this, the literature review explores contributing factors towards disordered eating: dieting culture, social media, and sexual trauma. Given the limited literature on humanistic approaches for disordered eating, this section also examines existing therapeutic interventions, most of which focus on clinically diagnosed eating disorders rather than disordered eating. This highlights a significant gap in current research on disordered eating.

Literature was sourced from databases including ScienceDirect, ProQuest Central, Academic Search Premier, and APA PsychArticles, as well as The Journal of Eating Disorders. Keywords included 'disordered eating' OR 'eating disorders', 'psychotherap*', 'therapy', AND 'counselling'. Search criteria focused on peer-reviewed journal articles from the last five years. ProQuest's 'recent searches' feature was used to refine results. Credible websites from government and independent organisations were used for definitions and statistics.

2.1 Disordered Eating and Dieting Culture

According to the NEDC (2024), dieting is among the most harmful disordered eating behaviours and a significant predictor of eating disorder development. The Diet Cycle (Figure 1) illustrates how restrictive eating can initiate and perpetuate disordered eating. Initial food restriction leads to physical and psychological consequences, such as fatigue, irritability, and heightened cravings due to slowed metabolism. These factors often result in individuals overeating followed by feelings of guilt, negative body image, and low self-esteem. In response, an individual may revert back to food restriction, thereby repeating the cycle.

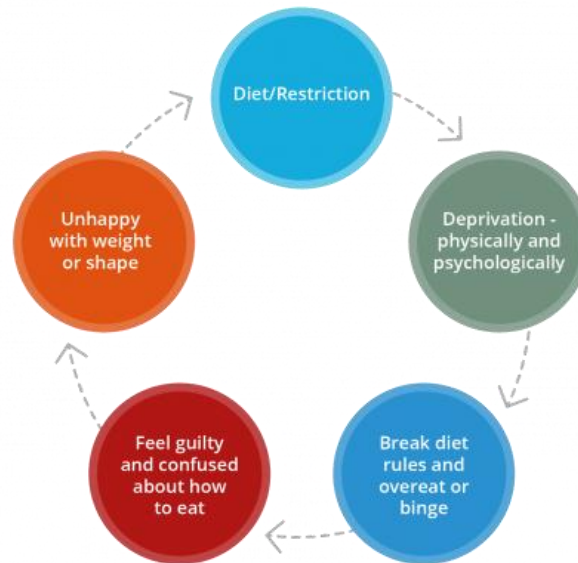


Figure 2.1. The Diet Cycle (NEDC, 2024)

Weiss, Miller, and Chermak (2023) note that adolescents in the US are frequently exposed to dieting culture from an early age, influenced by cultural norms, mass media, and familial pressures. Neumark-Sztainer *et al.* (2011) similarly found high prevalence of disordered eating and dieting among both male and female adolescents, with these behaviours not only persisting but also increasing into young adulthood. Comparable findings were reported by López-Gil *et al.* (2023) through a global meta-analysis, showing disordered eating increasing with age. Moreover, Hooper *et al.* (2021); White, Sharpe, and Plateau (2023) also found a strong correlation between disordered eating in young adult females and family body culture. Weight teasing and “fat talk” were particularly identified as contributing factors. However, a major limitation of the studies was their sole focus on females, underlining the need for future research to include male participants. Males comprise approximately 25% of those affected by eating disorders in the UK (Priory, 2024), hence it is pertinent to include both genders.

On the other hand, Puhl *et al.* (2022) reported that 61% of parents comment on their child's weight, aligning with earlier findings by Dahill *et al.* (2021) and Lydecker, Riley, and Grilo (2018), which highlight parental weight-talk as a common practice.

Nonetheless, Puhl *et al.* (2022) also found that positive comments were more frequent than negative ones, suggesting that weight talk alone may not be the primary reason for disordered eating in adolescents. Furthermore, they noted that boys received more weight-related comments than girls, which is consistent with Lydecker, Riley and Grilo's (2018) findings. In contrast, Dahill *et al.* (2021) found that daughters received more negative comments about eating, particularly from mothers. This contradiction emphasises the need for further research to clarify gendered patterns in parental influence on disordered eating.

2.2 Disordered Eating and Social Media

Among many influences, social media has been widely associated with disordered eating among adolescents. Lessard and Puhl (2021) identified that 53% of adolescents reported increased exposure to weight-stigmatising content on social media during the COVID-19 pandemic. Similarly, Wilksch *et al.* (2019) reported disordered eating behaviours in 51.7% of adolescent girls and 45.0% of boys, with meal skipping and excessive exercise being the most common. Furthermore, their study revealed a positive correlation between the number of social media accounts (Facebook, Instagram, Tumblr and Snapchat) and elevated scores on the eating disorder examination questionnaire. This shows a pattern between social media usage among younger individuals, and increased thoughts and behaviours associated with disordered eating. However, Roberts and Brown (2024) note inconsistencies across studies regarding the relationship between time spent on social media, disordered eating, and body image. Sanzari *et al.* (2023) further argue that the nature of the content consumed rather than time spent online, is more influential in shaping body image concerns.

Kinkel-Ram *et al.* (2022) examined the impact of viewing low-calorie food images on Instagram among female undergraduates at two US universities. Their findings suggest

that viewing such content can increase the risk for disordered eating behaviours among female university students, though this association was only observed at one site, limiting generalisability. Further research across diverse university populations, including both genders and international samples, is needed to strengthen these findings. Additionally, incorporating newer social media platforms such as TikTok may offer broader insights. While prior studies have largely focused on adolescents and young adults, comparisons with middle-aged individuals have been identified and consequently investigated.

Thompson *et al.* (2023) states that the social media platform rather than usage frequency, is linked to disordered eating behaviours in middle-aged women. Instagram showed the strongest correlation with bulimic symptoms, dietary restraint, and eating concerns. Furthermore, the author noted that the top four social media platforms used by middle-aged women in their study were all highly-visual platforms (Snapchat, Instagram, Facebook and Pinterest) as opposed to more text-based platforms such as Twitter (now X). This supports prior findings by Ryding and Kuss (2020); highly visual platforms pose a greater risk of body dissatisfaction compared to text-based platforms. Moreover, a more recent narrative review by Williams *et al.* (2024), highlighted mid-life as a particularly vulnerable period for the onset or relapse of body image issues and eating disorders in women. This emphasises the need for clinicians to recognise the early signs for timely intervention. However, future research should compare these findings to middle-aged men, as this is a particularly under-researched population.

2.3 Sexual Trauma and Disordered Eating

Research has consistently demonstrated a significant connection between sexual abuse or trauma and the onset of disordered eating behaviours and eating disorders (Dubosc *et al.*, 2012; Dworkin *et al.*, 2017; Heilman and Bright, 2022). Furthermore, individuals who have experienced at least one instance of sexual abuse are at increased risk of engaging in disordered eating behaviours or developing an eating disorder (Breland *et al.*, 2018). Sexual trauma can not only lead to post-traumatic stress (PTS) but also to internalised feelings of blame, shame, and guilt (Heilman and Bright, 2022). Male survivors, in particular, are especially prone to experiencing these feelings in response to sexual abuse (Dorahy and Clearwater, 2012). Difficulty coping with PTS increases the likelihood of developing post-traumatic stress disorder (PTSD) (Breland *et al.*, 2018; McTavish *et al.*, 2019). PTSD is a mental health condition that arises from significant psychological distress following a traumatic event such as sexual abuse. Common symptoms include emotional dysregulation, detachment from others, dissociation and intrusive memories (NICE, 2024).

While PTS is a known predictor of disordered eating, its association is even stronger when linked specifically to sexual abuse (Calugi *et al.*, 2018; McTavish *et al.*, 2019). Many individuals with eating disorders and a history of sexual abuse, report using disordered eating behaviours as coping mechanisms for PTS (Moulding, 2015). This suggests that disordered eating can be a direct response to sexual trauma. Moreover, individuals who developed PTS in childhood or adulthood due to sexual abuse, are also more likely to experience self-blame. This is often accompanied by low self-worth and social withdrawal (Ullman, Peter-Hagene and Relyea, 2014). McElvaney (2021) further adds that shame is especially prevalent and stigmatising among young survivors of childhood sexual abuse. Guilt can also manifest as self-blame, which can be understood as an implicit form of shame. Kennedy and Prock (2018) similarly note that stigma and victim-blaming contribute to internalised shame and self-blame. While these studies highlight the connections between childhood sexual abuse, shame, guilt and self-blame, further research is needed to clarify how these emotions contribute to disordered eating.

Latzer *et al.* (2020) found that individuals with eating disorders such as bulimia nervosa, BED, and night eating syndrome reported a higher prevalence of childhood traumatic events and higher childhood maltreatment including sexual abuse. Comparably, Wolf and Elklit (2020) reported that participants with histories of childhood abuse, including sexual trauma, exhibited significantly higher levels of disordered eating and lower self-esteem compared to non-abused individuals. Their study also showed a strong association between high symptoms of PTSD, lower self-esteem and disordered eating. Kiefer *et al.* (2021) found similar results; childhood sexual abuse was positively correlated with disordered eating with high levels of PTSD symptoms. Collectively, these studies underscore the high comorbidity between PTSD and disordered eating in individuals with childhood trauma, whereby self-esteem is often adversely impacted.

Additionally, there is growing evidence that disordered eating behaviours may serve as coping mechanisms for low self-esteem or the emotional distress associated with traumatic experiences (Malet-Karas *et al.*, 2022; Wolf and Elklit, 2020). While these studies offer valuable insights into the relationship between childhood sexual abuse and disordered eating, they are limited by their predominantly quantitative methodologies, relying on self-report questionnaires. This method can lead to subjective interpretations of childhood abuse due to recall bias, response bias influenced by shame or social stigma and sampling bias, particularly in terms of gender representation. Although Kiefer *et al.* (2021) included a more diverse sample in terms of participant race, ethnicity, and gender, there seems to be an apparent pattern of research continuing to disproportionately focus on female participants, often overlooking the experiences of males.

On the other hand, Roer *et al.* (2021) conducted a qualitative exploratory focus group study examining how experiences of traumatic stress influence eating behaviours. The study involved both female and male inpatients from a psychiatric clinic in Norway, although the sample size was limited (13 females and 2 males). Key themes emerged, including “eating behaviours controlled by stress and emotions” and “eating

behaviours as coping strategies”, aligning with findings from Moulding (2015). While the study offers greater understanding of the complex relationship between trauma and disordered eating, it did not specify the types of trauma being explored. Although some participants mentioned sexual trauma, the researchers intentionally allowed for a broad, subjective interpretation of trauma, which limited specificity. Furthermore, the study is yet to be replicated in other cultural contexts, restricting opportunities for comparative analysis.

2.4 Therapeutic Interventions for Disordered Eating

Russell *et al.* (2023) note that current clinical practice is primarily informed by research on behavioural therapies; with the Cognitive-Behavioural (CBT) having the strongest evidence base for treating bulimia nervosa, BED, and anorexia nervosa. Therefore, CBT and other behavioural approaches are often regarded as the most effective treatment for eating disorders.

Paphiti and Newman (2023), in a systematic review, highlight the efficacy of a brief ten-session CBT protocol (CBT-T) for individuals who are not underweight but are on the disordered eating spectrum and reported findings comparable to standard-length CBT for eating disorders. However, they advised that the included studies were of limited quality and argued for more rigorous research to strengthen the evidence base for CBT-T. Similarly, Butler and Heimberg (2020) reviewed the efficacy of exposure therapy among behavioural therapies for eating disorder treatment, finding preliminary effectiveness but deeming current evidence inconclusive. They stress the need for larger studies isolating exposure therapy from other interventions.

Joshua *et al.* (2023) conducted a systematic review suggesting schema therapy may offer a promising behavioural therapy alternative to CBT for eating disorders. Schema therapy aims to modify deep-rooted, early maladaptive schemas (EMS) that foster unhelpful beliefs and ideas about the world. Schema therapy thus aids people to

understand their patterns of EMS and focuses on developing more adaptive schema patterns to support healthier coping strategies. Although the reviewed studies were limited and methodologically diverse, findings indicate schema therapy may be particularly effective for individuals with severe or enduring eating disorder symptoms.

Moreover, Tilstra-Ferrell *et al.* (2024) explored the use of combined Written Exposure Therapy and Dialectical Behaviour Therapy to treat simultaneous comorbidity between eating disorders and PTSD through two case studies. Both female participants reported reduced eating disorder and PTSD symptoms at six to eight-week follow-up. While the findings are promising, the study's small sample size and differing eating disorder diagnoses (OSFED and BED) limit the feasibility of the results. Future research should employ larger, more diverse samples with a controlled measure of one classified eating disorder across participants. On the other hand, Vrabel *et al.* (2024) explored the comparative efficacy of CBT and a humanistic approach; compassion-focused therapy for eating disorders (CFT-E), in adults with and without histories of childhood trauma.

Findings from Vrabel *et al.* (2024) showed that both CBT and CFT-E were equally effective at reducing eating pathology among participants, however, CFT-E demonstrated superior long-term outcomes for participants with trauma histories. Whilst these findings require replication, they suggest that humanistic approaches can not only be as effective as CBT for clients with eating disorders but also more successful for treating comorbid childhood trauma. Likewise, Goss and Allan (2014), in a narrative review, highlight CFT-E's potential in addressing shame, self-criticism, and self-directed hostility in individuals with bingeing and purging presentations. CFT-E aims to foster self-compassion through practices of wisdom, validation, kindness and emotional support. Currently, research is now extending to examine the use of CFT-E on individuals with low-weight eating disorders and obesity. Mindfulness is another significant therapeutic approach that gained popularity among recent literature.

Roos *et al.* (2021) note that although mindfulness-based interventions display promising preliminary effectiveness for eating disorders, they still remain under-researched. Mindfulness consists of two components: awareness of the present

moment and acceptance of that experience. Authors propose that mindfulness may allow individuals to tolerate distressing experiences such as urges or fear triggered by cues, thereby reducing engagement in disordered eating behaviours over time.

In a qualitative focus group study with 23 university students, Altair *et al.* (2021) found general acceptance of mindfulness-based interventions for disordered eating, particularly those emphasising intuitive eating. Participants expressed preferences for various mindfulness techniques, including sitting and moving meditations. While the findings support the applicability of mindfulness for individuals with disordered eating behaviours, the authors suggest it may be more effective when combined with other approaches. Moreover, Osborne *et al.* (2023) discovered mindfulness improved emotional regulation at two months and reduced preoccupation with weight and shape in participants at seven months. These findings suggest mindfulness may not only support individuals with disordered eating, but also acts as a preventative intervention for those who are at high risk of developing eating disorders. However, the role of emotional regulation within mindfulness needs to be explored further.

Other humanistic therapies have also demonstrated effectiveness for disordered eating. For instance, Heilman and Bright (2022) and Scott, Hanstock and Patterson-Kane *et al.* (2013) highlight the potential of narrative therapy to help individuals externalise disordered eating behaviours. This approach known as "storying", enables clients to express their experiences through personal narratives, encouraging separation between the self and the disorder as if they were a third party. The results showed reduced emotional and cognitive symptoms, including self-blame associated with disordered eating. Furthermore, narrative therapy was found to be especially beneficial for individuals with histories of both sexual abuse and disordered eating as it facilitates the construction of cohesive memories through written or verbal expression, promoting psychological growth and healing.

Additionally, another humanistic modality such as emotion-focused therapy (EFT), has shown positive outcomes as a treatment for BED. Glisenti *et al.* (2021) found that participants who received 12 weekly one-hour EFT sessions over three months

targeting maladaptive emotions, demonstrated greater improvement in binge eating symptoms compared to a wait-list control group. Similarly, Hibbs, Pugh, and Fox (2021) explored a brief form of EFT for anorexia nervosa and reported that participants perceived it as a feasible and acceptable intervention, particularly for addressing the 'internal anorexic voice'. These findings provide initial evidence for the effectiveness of humanistic models of working with eating disorders. Although many existing studies are limited by small sample sizes and quantitative design, it is a way forward to bridge the gap on the lack of research focusing on humanistic approaches. Future research should aim to address these limitations and expand the scope to include disordered eating more broadly.

Having explored the literature pertaining to some factors influencing disordered eating as well as therapeutic interventions, the next chapter will turn to methodology and methods used to conduct the study.

Chapter 3 Methodology and Methods

This chapter will focus on the methodology and methods employed to carry out the research and thus answer the research question of ‘how do psychotherapists work with clients with disordered eating from a humanistic perspective?’. The methodology refers to the “general logic and theoretical perspective” of the research project, while the methods focus on the specific techniques used to collect the data (Bogdan and Biklen, 2007, p.35). The methodology used for this research project is qualitative research, phenomenology and interpretive phenomenological analysis.

Phenomenology is also a philosophical approach that underpins this study. Semi-structured interviews were used as a method to collect the data. The methodology and methods will be discussed and justified separately. The section on participants will include: the sampling method, sample size, recruitment of the participants, method of data collection and data analysis. The ethical considerations as well as inclusion of trustworthiness and rigor will conclude the chapter.

3.1 Methodology

3.1.1 Qualitative Design

Denzin and Lincoln (2011, p.3) define qualitative research as “interpretive, naturalistic approach to the world” that studies individuals’ phenomena in their natural settings and attempts to understand the meanings behind them. Creswell (2013, p.44) further explains that qualitative research employs interpretive or theoretical frameworks to inform the study, using both inductive and deductive analysis to identify themes and patterns. It emphasises participants’ voices and researchers’ reflexivity to provide a complex description and interpretation of the studied problem. Given that the research explores how psychotherapists work with clients experiencing disordered

eating, a qualitative approach is more appropriate than a quantitative one, as it enables exploration of the 'how' and 'why' questions that cannot be numerically measured (Tenny, Brannan and Brannan, 2022).

3.1.2 Phenomenology

Phenomenology is a philosophical approach centered on the study of experience (Smith, Flowers and Larkin, 2022, p.7) and grounded in a constructivist epistemology (Mohapatra and Satpathy, 2022). According to Creswell and Poth (2018, p.241), phenomenological research seeks to understand the shared meaning of individuals' lived experiences of a particular phenomenon. Bogdan and Biklen (2007, p.25) add that it aims to understand how ordinary people interpret events and interactions in specific contexts, while Moustakas (1994, p.97) emphasises the importance of what individuals experienced and how they experienced it. Consequently, phenomenology was selected as the most suitable qualitative methodology for this study as it enables unique in-depth exploration of therapists' personal experiences in working with clients with disordered eating.

Phenomenological research aims to explore both convergence and divergence in individual experiences, prioritising depth over generalisability to the wider population. As an interpretive process, it requires the researcher to set aside preconceptions and personal biases around the researched topic to wholly focus on the participants' experience (Smith, Flowers and Larkin, 2009, p.4,12). Comparably, Moustakas (1994, p.22) stresses the importance of systematically setting aside preconceptions of the phenomenon, to ensure the study remains free from preconceived beliefs and prior professional knowledge or experience. This openness enables the researcher to engage with participants' accounts in a receptive, unbiased, and reflective manner.

3.1.3 Interpretive Phenomenological Analysis

Interpretive Phenomenological Analysis (IPA) is a methodology focused on the detailed examination of human lived experience, allowing participants to express their experiences in their own terms rather than through predefined categories, which is central to its phenomenological nature (Smith, Flowers and Larkin, 2009, p.34). IPA facilitates the identification of experiential statements from significant statements, enabling the development of composite descriptions that deepen understanding of participants' lived experiences (Creswell and Poth, 2018, p.82). It was selected as an appropriate methodology for the data analysis due to its dual process of exploring how participants make sense of their experiences and engaging the researcher in an interpretative activity to make sense of those meanings (Smith and Osborn, 2008, p.53). Thus, IPA integrates phenomenology, hermeneutics, and idiography.

Hermeneutics is the theory of interpretation which underpins the analytic process in IPA by guiding how the researcher makes sense of how a phenomenon is experienced. In IPA, analysis is iterative rather than linear, involving the researcher's back and forth movement with various perspectives on the data as opposed to a step-by-step process. This is described as the hermeneutic cycle; a dynamic interplay between the parts and the whole at a series of levels, where understanding each element requires consideration of the whole and vice versa. The hermeneutic theory acknowledges that one's relationship to data is shifting according to the hermeneutic cycle, in turn generating rich data from the participants' accounts (Smith, Flowers and Larkin, 2022, p.17, 26). Smith and Osborn (2008, p.18) further add that hermeneutics aims to discover suspicion behind something being analysed, seeking deeper interpretation beneath the surface and challenge the account.

Idiography refers to a concern with the particular; it emphasises detailed understanding of "grasping the meaning of something for a given person", thus highlighting the depth of analysis (Smith, Flowers and Larkin, 2022, p.24). According to Pietkiewicz and Smith (2014), the idiographic approach involves examining each case individually before any general statements are made. In IPA, this means the researcher

conducts a thorough analysis of one participant's account, before moving on to the next and so forth. The final analysis highlights key themes supported by individual narratives, allowing for both shared and unique aspects of experience to emerge.

3.2 Methods

3.2.1 Semi-Structured Interviewing

In IPA studies, data is usually collected through semi-structured interviews, as it allows flexibility in responses and for participants to have a decisive impact on the direction of the interview (Smith, Flowers and Larkin, 2009, p.4). Smith and Osborn (2008, p.57) further highlight that to understand how participants make sense of their experiences, a flexible data collection method is essential. Semi-structured interviews thus enable an engaging dialogue between the participant and the researcher, where the initial questions can be modified based on participant responses. Additionally, the questions aim to guide rather than dictate the course of the interview (Eatough and Smith, p.205). Consequently, semi-structured interviewing was chosen as the most suitable method of collecting data for this research, to allow participants to introduce new areas and ideas of interest that have not been previously considered. It also provided opportunities for the researcher to probe and clarify responses, leading to richer, more detailed accounts of lived experiences. Moreover, Bogdan and Biklen (2007, p.104) emphasise that semi-structured interviews attain “comparable data across subjects” whereby key themes from the analysis can be identified.

An interview schedule comprising of key open-ended questions was developed to flexibly guide the interviews. Participants received the interview schedule (Appendix D) via email prior to returning their signed consent forms, thus allowing them to make an informed decision to take part and gain insight on the topics for the interview. The interview schedule was used flexibly with participants and any emerging areas of

interest were explored further. According to Smith, Flowers and Larkin (2009, p.60-61), this type of schedule facilitates a comfortable open dialogue and encourages participants to speak freely at length hence offering rich, detailed accounts. Eight open questions with potential prompts were created, following the recommendation to use six to ten open-ended questions to guide interviews lasting 45 to 90 minutes. The schedule worked well and the researcher was able to employ the funnelling technique; the first few questions were broad to ease participants into the topic before asking specific and more detailed questions. This technique not only facilitated participant comfort about the subject, but also helped reduce researcher bias of prematurely obtaining specific responses due to prior assumptions (Smith and Osborn, 2008, p.62).

The interview schedule was piloted, whereby the interview questions were trialled and discussed with peers and supervisors. This piloting process ensured the clarification and effectiveness of the questions and allowed potential adjustments to be made prior to participant interviews (Malmqvist *et al.*, 2019).

3.3 Participants

3.3.1 Sampling Method

To remain consistent with the idiographic focus of IPA, purposive sampling was used rather than probability-based methods. The sample was intentionally homogeneous; participants who share similar characteristics (Smith, Flowers and Larkin, 2009, p.49). This comprised of qualified therapists who use humanistic approaches and have experience working with clients with disordered eating. This purposive homogenous sampling ensured that participants could offer in-depth insights into the specific phenomenon under investigation, representing a perspective rather than a general population. While the group shared key characteristics, psychological variability allowed for the exploration of both convergence and divergence across participant

accounts (Smith, Flowers and Larkin, 2009, p.49). Similarly, Creswell and Poth (2018, p. 447) stress that it is essential in phenomenological research that all participants have direct experience of the phenomenon being studied. Thus, the selection criteria ensured that each participant had relevant experience of working with disordered eating and actively applied humanistic approaches in their therapeutic practice.

3.3.2 Sample Size

The primary aim of IPA is to provide rich, detailed accounts of individual lived experiences. Given the complexity of human phenomena, IPA prioritises quality over quantity, making smaller sample sizes more appropriate. For student projects, a sample of three to six participants was recommended, as it provides sufficient and manageable data for detailed analysis without overwhelming the researcher (Smith, Flowers, and Larkin, 2009, pp. 51–52). Based on this guidance, a sample size of four participants was deemed appropriate for this study.

3.3.3 Recruitment Method

Four participants were recruited for this study using a range of purposive recruitment strategies. These included advertisements within local counselling communities, posts on the National Counselling and Psychotherapy Society noticeboard, counselling-focused Facebook groups, direct contact through Counselling Directory and Psychology Today as well as professional contacts and snowball sampling. Facebook groups, the Counselling Directory and snowball sampling proved to be the most effective methods of recruiting the participants for this study. As Smith, Flowers and Larkin (2009, p.177) note, IPA studies often involve purposive sampling which can be challenging compared to other samples when recruiting participants. This difficulty was also encountered in this study.

The advertisement included a brief overview of the study, participant inclusion criteria, participation details, and the researcher's contact information for further information. All participants were females between the ages of 30 to 70 years.

3.4 Data Collection

Data collection took place over five months. Each participant was interviewed once either face-to-face or online via Microsoft Teams. Interviews lasted between 40 to 60 minutes and were audio and video recorded. Consent to record the interviews was revisited with the participants at the start of each interview. Audio and video recorders were provided by UWTSD and used for in-person interviews, while the Microsoft Teams 'record meeting' option was used for online interviews, with the audio recorder being used as backup. Audio recordings were transcribed verbatim for analysis and video recordings served to capture relevant non-verbal communication. As IPA focuses on the interpretation of meaning rather than prosodic details, aspects such as exact length of pauses and all non-verbal utterances were not transcribed (Smith, Flowers and Larkin, 2022, p.112).

Two participants requested for their face-to-face interviews to be conducted at their workplace therapy rooms rather than at the university due to availability and convenience concerns. The researcher obtained approval from the research supervisor before agreeing to this change of location. As Smith and Osborn (2008, p.63) note, participants are generally most comfortable in familiar settings and the location of the interview is significant. Glesne (2016, p.109) advises selecting locations that are physically comfortable, private, quiet, and convenient. Consequently, participant-chosen locations adhered to these recommendations. Online participants took part in interviews from self-selected, appropriate environments, thus also following the guidance. Choosing suitable interview locations also supported rapport-building between the researcher and participants.

Flick (2022, p.179) underscores that establishing rapport with the participants can be really challenging, while King, Horrocks and Brooks (2019, p.188-203) stress that trust and rapport are vital for successful participant engagement in qualitative interviewing. A strong rapport encourages openness, allowing participants to share their experiences more freely. Rapport can be established before the interview by providing clear information about the study, obtaining informed consent and being flexible with interview arrangements. During interviews, rapport can be maintained through thoughtful probing and questioning, researcher's active listening, genuine interest in experiences and exhibiting positive body language. The researcher employed these strategies to foster trust and elicit rich, in-depth data from participants.

3.5 Data Analysis

The transcribed interviews were subsequently analysed using the IPA framework. This qualitative analysis process was a step-by-step approach guided by Smith, Flowers and Larkin (2022, p.120-196) as detailed below. The researcher used the new terminology to describe the analytical process as advised by the authors. An example of the undertaken analysis is illustrated in Appendix G.

Step One: Reading and Re-reading

The researcher firstly immersed themselves in the original data. The phase begins with the active engagement with the data to enter the participant's world. This usually occurs during the transcription process; the researcher listened to recordings numerous times whilst writing the transcript. The researcher also initially recorded the most striking observations and reflections from the interviews to capture prominent

points for later analysis. This ensured that the focus was solely on the participant at this stage and helped the researcher limit their assumptions about the phenomenon.

Step Two: Exploratory Noting

In second stage of IPA analysis, step one and two are often merged to produce exploratory comments on the transcript. This involves the researcher being open-minded while re-reading the transcript multiple times to note points of interest, attending not only to content but also to the language use such as pauses, repetitions, and metaphors. Exploratory comments were descriptive, linguistic, and conceptual, requiring both attentiveness and interpretive engagement with the data. Through this process, the researcher developed a deeper familiarity with each transcript and began to identify how participants articulated and made sense of the phenomenon under study.

Step Three: Constructing Experiential Statements

The comprehensive exploratory comments were then developed into experiential statements by formulating concise phrases that represent connections, interrelationships and patterns between exploratory notes. At this stage, the researcher worked primarily with the exploratory comments rather than the full transcript, allowing for a manageable yet complex interpretation of the data. This synergistic process involved a higher level of conceptual abstraction, integrating both the participants' original expressions and the researcher's interpretations in line with the hermeneutic cycle. The researcher remained grounded in the participants' accounts to maintain the psychological essence of the piece whilst capturing the crucial but succinct statements of the transcript.

Step Four: Searching For Connections and Producing Personal Experiential Themes

The next stage involved identifying connections among experiential themes and grouping them based on conceptual similarities or contrasts. Experiential themes lacking sufficient strong evidential base or coherence within the cluster structure were excluded at this stage. The experiential themes were tabulated into personal experiential themes (PETs) and sub-themes, each assigned a descriptive label. An additional column included page numbers and time stamps to link themes back to specific transcript excerpts. This facilitated cross-referencing with the original data to ensure connections remained consistent and in context of the original transcript (Smith and Osborn, 2008, p.72).

Step Five: Continuing Individual Analysis for Other Cases

Steps one to four were subsequently repeated for each participant account; each case was analysed individually in line with IPA's idiographic focus. The researcher was actively bracketing off any insights from prior case analyses to minimise bias and maintain focus on the unique perspective of each participant.

Step Six: Looking for Patterns Across PETs to Develop Group Experiential Themes

PETs from each case were then compared to identify shared characteristics of experience across participants. PETs that were recurrent in at least half of the participant interviews were clustered together to form group experiential themes (GETs). PETs that did not fit the pattern of GET became sub-themes. Labels for GETs and sub-themes were modified to reflect interconnections between cases more accurately.

Step Seven: Presenting Findings

The ultimate step of the analysis involved writing a narrative account of the findings. GETs and sub-themes were organised in the subsequent findings chapter (Table 4.1) and discussed at greater depth, presenting researcher's analytical commentary supported by verbatim quotes from the participants.

3.6 Ethical Considerations

Several ethical considerations were addressed throughout this project. Ethical approval was obtained from the UWTSD Research Ethics Committee prior to drafting of the research documentation and data collection. Due to recruitment challenges, an amended version of the ethical form was later submitted and approved to permit online interviews, as the original approval only covered face-to-face interviews. This amendment enabled the inclusion of non-local participants.

Participants were aware that participation in the study was free and entirely voluntary. A covering letter (Appendix A) and participant information sheets were emailed to participants before signed consent forms were obtained (Appendix E) and returned prior to the interviews. Participants A and B received the first version of the information sheet (Appendix B), while Participants C and D received a revised version (Appendix C), which included details about conducting, recording, and storing online interviews, along with expanded information on data protection. All participants had the opportunity to ask questions before providing informed consent. Upon receiving the signed consent forms, interview dates and times were arranged accordingly.

At the start of each interview, participants were reminded of their right to withdraw, the use of recording and anonymity policy. The right to withdraw without penalty up

to a cut-off point of one month after the interview, aligned with Smith, Flowers and Larkin's (2009, p.54) suggestion, to allow participant withdrawal up until the beginning of data analysis. During the debrief process, the participants were given the opportunity to discuss any potential distress regarding the interview. A copy of debrief form (Appendix F) was provided to the participants, containing signposting information on organisations for additional support and advice in case of further distress.

A key ethical priority in this study was to ensure participant anonymity. As Smith, Flowers and Larkin (2009, p.54) note, qualitative research can offer anonymity rather than full confidentiality. General participant labelling was used in transcripts and analysis and pseudonyms to describe the findings, ensuring that participants cannot be identified from the data included in the project. Some transcript excerpts were modified for greater anonymity and any personal information was stored separately from the research data.

3.7 Trustworthiness and Rigour

To ensure the trustworthiness and rigour of the research, several strategies were employed. Central to methodological rigour was adherence to systematic steps and idiographic commitment of the IPA for each individual case (Smith, Flowers and Larkin, 2009, p.100).

Additional strategies were employed to enhance the trustworthiness of the study, in line with Glesne's (2016, p.53) recommendations. Member checking was conducted by emailing participants their interview transcripts, allowing them to provide feedback and make any adjustments. Although none of the participants chose to make any changes, this process supported credibility of the research (Smith, Flowers and Larkin, 2022, p.251). Furthermore, the first draft was submitted for feedback to the research supervisor and peer feedback was sought on GETs and the description of non-verbal communication, contributing to the accuracy and reflexivity of the analysis.

An audit trail was maintained throughout the research process, including organised documentation such as analytical process, transcripts and a research journal. The journal was particularly valuable for supporting reflexivity, enabling the researcher to reflect on and monitor potential subjectivity and bias prior to conducting interviews.

This chapter explored the methodology and methods used to collect and analyse the data. The following chapter will portray findings, supported by excerpts from the participant interviews.

Chapter 4 Findings

This study aimed to explore psychotherapists' lived experiences of working with disordered eating using in-depth semi-structured interviews. The collected data was subsequently analysed using the IPA framework. The findings from the analysis are outlined in table 4.1 below. Each theme is then explored in detail as demonstrated by excerpts from verbatim interview transcripts with inclusion of researcher's analytical comments.

Table 4.1. Summary of Group Experiential Themes (GETs) and Sub-Themes

	GETs		Sub-Themes
GET 1	Application of Therapeutic Elements	a.	Therapeutic Relationship
		b.	Client Directed and Autonomy
		c.	Humanistic Techniques
		d.	Integrative and Pluralistic Approach
		e.	Psychoeducation
		f.	Trauma Exploration
		g.	Private Practice versus Public Sector

GET 2	Aspects of Disordered Eating	a.	Definition
		b.	Comorbidity
		c.	Complexity
GET 3	Inhibitors of Change	a.	Knowledge and Education
		b.	Society
		c.	Economy
		d.	Support from Public Sector
GET 4	Influencing Factors	a.	Familial Relationships
		b.	Societal Norms
		c.	Social Media

GET 1. Application of Therapeutic Elements

The theme examines key therapeutic components and techniques prioritised by participants when working with disordered eating.

(a) Therapeutic Relationship

Analysis revealed the importance of a strong therapeutic alliance with clients to effectively work with their difficulties, emphasising unconditional positive regard and empathy (Rogers, 1961). This was noted by Bella, *“Feeling heard and being non-judgmental are the two main things”* and stressed by Daisy, *“The counsellor's role is to hold the client unconditionally and compassionately”*.

Trust and patience were also seen as crucial. Given the shame and discomfort clients may feel when discussing body image and food, therapists must foster a safe, understanding environment that encourages openness over time, as evidenced by Alice and Caroline:

“that you can kind of build that relationship up because it-- it-- it kind of takes a long time... for somebody to open up about their eating disorder. It's, um, something usually that somebody's kept private for quite some time or hidden.” (Alice)

“There's a lot of shame tied up in all of this. So, umm, that trust and a therapeutic relationship really have to be there. So in that terms, in sense of my approach, like, that's the core of it.” (Caroline)

(b) Client-Directed and Autonomy

Participants stressed the significance of client-led therapy and respect for autonomy. There was apparent recognition that clients should guide the process and choose which issues to explore, as reflected in Daisy's account:

"I was there for-- for the client and they were in charge. So they took, you know, they-- they led" (Daisy)

Client awareness was seen as essential, while counsellors may identify issues, progress depends on the client's readiness to explore them, as evidenced by Bella. The insight from Alice suggests therapy will be ineffective if clients feel pressured. Caroline's excerpt underscores the value of working in the present moment and aligning with the client's needs.

"If somebody comes to therapy because they wanna work at something, that's down to them. I can work with it if they think it's a problem, but if they don't think it's a problem, that's absolutely fine." (Bella)

"with therapy, it's always about the client being ready to have that support, isn't it? It's about y-- you. We all say it's not going to work unless the person wants to be sitting in front of you, with an eating disorder" (Alice)

"it sometimes it just goes in different sessions depending on what they need and what they wanna-- what they wanna, what they, what is best to get out of that session at that time for them [laughs]." (Caroline)

(c) Humanistic Techniques

The person-centered approach (PCT) was recognised as a core therapeutic modality. The key elements were active listening, reflection and exploring client experiences; expressed by Bella, Caroline, and Alice.

Caroline's strong assertion that PCT is essential in therapeutic practice alludes to the perception that a lack of PCT will result in therapy being ineffective. Her emphasis on *"so-- so much of it is rooted in shame"* implies that shame is deep-rooted and underlines difficulties with body image or eating.

"So being person-centred in listening and reflecting back." (Bella)

"I did an initial course that was very person-centred / humanistic and then my degree was integrative. So I feel like that mirrors my person-centred humanistic basis because I feel like that is the basis of this work. So with anyone, of any presentation that is gonna be the main thing, because if you haven't got that, you haven't got anything really [laughs], have you... humanistic approach is really needed because so-- so much of it is rooted in shame" (Caroline)

"I think it's about kind of exploring really, initially, it's about kind of exploring, um... [sighs], what is going on for them." (Alice)

Bella's statement of *"what are you hear [sic], isn't quite the same as what other people are saying"*, indicates gravity of clients' inner voices shaping their experiences. It further suggests client's negative assumptions due to distorted interpretations. Her comment, *"it's allowing them to maybe see that a bit differently"*, underscores the value of reflection in helping clients gain insight and shift perspectives.

Daisy frequently highlighted Internal Family Systems (IFS) as a valuable complement to PCT, noting its effectiveness in *"helping [clients] connect to their core self through the configuration of self."* In IFS, the core self represents authenticity, while the configuration of self refers to the various inner parts within an individual (Schwartz, 2021). Obvious similarity can be seen between IFS and PCT; particularly in fostering empathy and congruence. There is an implication that a therapist's compassionate presence in PCT can help clients approach their inner parts with similar understanding. Caroline's remark suggests that IFS can be used to explore client's conflicting narratives around food:

"parts work, that's another one that I [laughs] haven't mentioned as well I do. So yeah, like the eating disorder part, like the compassionate part, the logical part of them, will be these ones that have these different narratives that often argue, umm, in their head." (Caroline)

Daisy's mention of using Transactional Analysis (TA) to explore clients' parts, relates to ego states (parent, child and adult) and their interconnection between differing thoughts, feelings, and behaviours (Berne, 1961). It leans towards combining TA with IFS approaches to explore disordered eating behaviours:

“I introduced TA as a way of introducing parts... when I work with food, then I use parts work as well, because, umm, it's sort of an IFS informed way of work.” (Daisy)

Daisy exemplifies this within this quotation, *“TA may help them realise that there is a younger part, the child part, that uses food as a way of soothing their inner child or dimming the critical parent.”*. Daisy's example illustrates a transaction between the adapted child and critical parent ego states, where the fearful child uses food to self-soothe in response to internalised criticism. This dynamic may reflect childhood experiences that contributed to difficulties with food.

Bella noted the benefit of incorporating mindfulness practices to help clients build self-awareness and self-compassion in relation to their disordered eating behaviours, *“mindfulness, that's, you know, it can be really helpful, being kind to themselves in the moment... it's just, being aware of the behaviour... with self-compassion”*. Mindfulness encourages present-moment awareness of arising thoughts and behaviours. Bella further explains *“It doesn't matter what you used to do... what you're going to do, but right in this moment, is this the best thing for me?”*, implying mindfulness can be a useful tool for clients to shift the focus from past or future and to help them make more intentional, self-directed choices.

The present moment is also illustrated through somatic and Gestalt therapies as exemplified by Daisy, *“it's more like a soma—somatics sort of way, sort of feeling. Feeling where-- where-- where the stuckness is or where that sort of unfinished business if you want sort of is-- is there. And-- and what happened afterwards, how-- how that was managed.”*. Here, there is an emphasis on the connection between bodily sensations and emotions. *“The stuckness”* infers lingering feelings held in the body thus causing difficulties.

The Gestalt concept of ‘unfinished business’ refers to unresolved feelings derived from previous negative experiences that significantly impact present life, cause distress and prevent full engagement in the present moment (Joyce & Sills, 2018). It can be deduced from this, that difficulties surrounding food or body image appear as

suppressed, unprocessed negative emotions that are 'stuck' in the body hindering emotional healing. Consequently, somatic and Gestalt approaches can help clients become more aware and process those suppressed emotions, supporting positive change.

Practical humanistic approaches such as motivational interviewing and narrative therapy were revealed to be potentially useful to clients. Motivational interviewing is expressed in Bella's statement, *"Whether it's utilising motivational interviewing... to empower clients. And sometimes you know looking at who they value in themselves... all the different parts of them that make them who they are, can be really powerful, because they forget sometimes"*. There is an implication that motivational interviewing with the therapist's encouragement, prompts clients towards positive change, while emphasis on clients' values strengthens their internal motivation and sense of empowerment.

Caroline demonstrated narrative therapy through creative writing methods, allowing clients to express their feelings towards their difficulties, *"if it's helpful to them, they could write like an unsent letter or a letter to their younger self... I've had people write stories like fiction, before about like-- like the metaphor of what the eating disorder voice might be"*. Her expression *"if it's helpful to them"* implies prior discussion with the client and collaborative decision-making in utilising these techniques.

Caroline further voiced *"it's usually been something they've done outside of session. So if someone's a writer then I usually like tap into that."*, highlighting the value of incorporating clients' interests into therapy. Analysis indicated that her focus on writing may reflect a personal preference, suggesting potential bias in the choice of medium.

Narrative therapy has also been articulated by Bella, *"I...try to use...an imagined avatar... if you say to a client.., "we're gonna watch a film of somebody else that's living exactly the same, and you watch that person with these behaviours... what would*

you say to that person?... Sometimes that distance gives them clarity". Bella's emphasis on *"somebody else"* reflects the use of third-person perspective to separate the problem from the client's identity. There is an indication that this externalisation aids clients to gain greater insight and understanding about their eating difficulties and supports them in re-authoring their experiences in the preferred way.

(d) Integrative and Pluralistic Approach

Besides employing humanistic approaches, participants discussed combining different modalities in integrative and pluralistic ways.

CBT and solution-focused therapy (SFT) were commonly mentioned. SFT is a therapeutic model that underscores brief, goal-oriented interventions (Iveson, 2018). These approaches are articulated by Daisy *"I worked... in a solution... focused, umm, way... Quite a lot of CBT, thoughts"*. Within this excerpt, her use of past tense suggests she no longer employs SFT in her current practice but still frequently applies CBT techniques to address clients' thought processes.

Integration of CBT and SFT has also been voiced by Caroline *"But then integrating other things as well. So that would be like CBT, solution- focused ways... Depending on how long I'm working with them for as well, depending on what they need"*. It is inferred, that Caroline uses pluralistic and integrative approaches to adapt to clients' diverse needs, which is dependent on the number of sessions available with clients.

Caroline précises further, *"maybe use CBT techniques to like challenge, umm, thoughts around that, challenge things, thoughts about, umm, what their body should be, what they should eat like, or those shoulds and musts"*. This implies that CBT may be useful for clients to examine external expectations around body image and eating habits.

Bella highlighted Acceptance and Commitment Therapy (ACT) as a helpful integrative approach for disordered eating in her statement:

“ACT is very good when it comes to working with, er, eating disorders because it's mindful. It does work with the cognitions and the behaviours. So again, giving clients, ways of, looking at their thoughts, being kind to themselves, and then maybe choosing a different action, even if it's just for 10 minutes.”

ACT emerged as Bella's preferred approach for addressing food-related issues. Throughout the interview, she underlined its benefits in fostering mindfulness, self-compassion and empowerment to help clients shift unhelpful thoughts and behaviours around food.

(e) Psychoeducation

Psychoeducation has been greatly highlighted as a supplementary therapeutic intervention that helps clients enhance understanding of their mental wellbeing.

Caroline exemplified psychoeducation with her clients, *“the kind I find kind of the most helpful for people is around binge cycles... it's normally when people are restricting as well as part of that... they often haven't thought about it being connected to the restriction because often what they're trying to do, is the very thing driving it.”* Her quote indicates that clients are not usually aware that restriction can trigger and sustain bingeing, thus by highlighting this connection, it can be beneficial in potentially stopping or limiting the cycle's recurrence.

Caroline further states: *“Body mass index (BMI) as well. That's another one that sometimes I will ask if it's okay if I tell them a little bit about the history of the BMI that it was made in the 1830s and it's basically useless... that can be quite helpful.”* Her emphasis that BMI *“was made in the 1830s”* and is *“basically useless”* reflects her

strong frustration and belief that it is an outdated and ineffective measure still used in healthcare.

Another application of psychoeducation is voiced by Bella:

“I love neuroscience. I think that when we explain how we work physiologically. Allowing clients to work with maybe the thought processes of the urges, of a-- the behaviour. Understanding that dopamine, that drives us to do something, when we know that it only really lasts 10 minutes. Explaining to a client that, they can hold the urge. That is often very empowering.”

Bella’s enthusiasm for incorporating concepts of physiology, neuroscience and dopamine in her practice is clearly evident. There is an inclination here that body, thoughts and behaviours are interconnected and the awareness of that can promote meaningful change towards food.

Daisy’s approach to psychoeducation focuses on explaining the theoretical foundations of approaches, as illustrated in this account:

“possibly psycho-- psychoeducation comes into plays in working with, you know, explain-- explaining Gestalt...once they understand that there's an unfinished business... there's issues there that-- that can-- can, in a way so that cycle can be closed somehow then.”

It can be deduced that psychoeducation can be a propelling intervention for Gestalt therapy, helping clients to identify and process their lingering feelings quicker.

(f) Trauma Exploration

Participants identified that previous trauma or negative experiences can significantly contribute to disordered eating.

Sexual abuse was specifically highlighted as a major factor contributing to food-related issues, as evidenced by Daisy, *“Sexual abuse... mainly... that's a massive one”*.

Similar sentiments were shared by Caroline, *“I know that research has shown particularly like binge eating, I think there's an overlap with sexual abuse”*. Caroline's example of binge eating suggests agreement towards a link between disordered eating and sexual trauma. The connection between bulimia and sexual abuse has also been identified by Alice, *“with the bulimia, I've worked with quite a lot of, um, clients that have been sexually abused”*.

Other traumas have been expressed by Daisy:

“an instance there was war. Umm, another instance was trafficking, it's all like that kind of stuff, so quite-- quite deep and quite ma—massive... modern slavery, that's another one”.

It can be deduced that trauma from war, trafficking and modern slavery can impact disordered eating as severely as sexual abuse. Daisy's emphasis on *‘quite deep and quite massive’* indicates the profound impact of these experiences.

This is further articulated within this statement, *“a few of my clients who had issues with weight... abuse or trauma, traumatic experiences that had led to, umm, in a way sort of using food as a way of coping mechanism.”* (Daisy). This highlights over-eating being exhibited as a direct consequence of a traumatic experience, acting as a coping mechanism, providing comfort and outlet for complex emotions.

Daisy stressed further that the counsellor should, *“avoid triggering past traumatic events by keeping them safe within the 'corral fence' or 'garden walls'.”* Daisy's metaphor of horse *‘corral fence’* and *‘garden walls’* reflects her responsibility to keep clients within emotional boundaries during trauma work, preventing further distress or re-traumatisation.

Caroline identified another traumatic experience in her succinct statement, *“What I find is that also domestic abuse and abusive relationships, come into it quite a bit... that kind of intergenerational type kind of trauma... parents with difficult relationships with food perhaps as well... abuse in the family”*. It can be seen that domestic abuse can predispose individuals to disordered eating, with psychological effects sometimes persisting across generations. There is an impression that Caroline observed this pattern frequently. She précises further:

“the trauma impacted by things like racism, transphobia, umm, weight stigma. Because I think just experiencing weight stigma and being, I mean they call it just teasing and bullying, but like, it’s-- it’s abuse for your weight”

There is a clear leaning towards Caroline’s social injustice perspective, linking marginalisation trauma to disordered eating. Her repeated emphasis on ‘weight stigma’ implies her anger towards how it is minimised and habitually labelled as bullying or teasing.

Bullying has also been articulated by Bella, *“I think 90% of anybody coming to therapy [laughs] is because they’ve had something in their childhood that hasn’t been right for them, whether it’s in the family home, or whether it’s school, and bullying, and negative experiences”*. Bella’s emphasis on ‘90%’ highlights the high prevalence of childhood bullying and its lasting impact into adulthood. Alice shares a similar view, *“I would say 90% of the-- the cases I’ve worked on... tends to be some type of childhood trauma”*.

During this discussion, Caroline also voiced, *“often for neurodivergent individuals, they’ve gone through a school system, which has been quite traumatic for them because it hasn’t understood their needs”*. This extract indicates trauma can present for neurodivergent individuals who lacked adequate school support and that there is insufficient acceptance or understanding of non-neurotypical learning styles.

(g) Private Practice versus Public Sector

This theme explores participants' experiences working in public sector organisations (charities and National Health Service [hereafter NHS]) contrary to private practice.

Alice conveys the heavy focus on the medical model used in the NHS eating disorder services, *“so it's about monitoring, it's about weighing, it's about, um, their stats, it's about blood pressure, it's about their bloods. So it, everything is geared around, it's very medical model... to get them to a safe place. Then you can look at the therapeutic side of it”* .

It is evidenced that NHS prioritises physical health and safety before offering therapy. Alice mentions *“we kind of follow the Maudsley, um, model”*, referring to cognitive-interpersonal treatment for adults with anorexia nervosa (MANTRA); which involves family to help sufferers understand their difficulties within wider social context (Bryson, Douglas and Schmidt, 2024). Her phrasing of *‘kind of follow’* suggests partial, flexible use of the model rather than strict adherence.

Moreover, Alice strongly voices the issue of client autonomy within the NHS:

“the clients that come and see me here, they have more autonomy to make their own decisions. You know, I'm not going to make a safeguarding referral... if a-- a young person doesn't come to see me... Whereas if a young person is-- is coming to see me with anorexia in the NHS and they miss two appointments, it's a safeguarding issue”.

There is an indication here that NHS limits client autonomy, enforcing strict rules such as treating two missed appointments as a safeguarding issue. This infers a lack of trust in clients' ability to manage their wellbeing. Alice adds, *“I have been in-- in positions where the young people, and adults have been sectioned and, um... tube fed against their will”*, indicating her discomfort and unhappiness with removing client's autonomy in light of safety.

Caroline offers a different perspective, noting differences in her approach with charity-referred clients versus those in private practice:

“So I have my own clients in private practice, but I also take, umm, clients referrals on to my private practice, but from an eating disorder charity. And so they have 10 sessions, so I might be inclined to be a little bit more CBT also because that's like a little bit more of their remit, I suppose. More closely aligned with what the NHS would be doing”

Caroline highlights the constraint of having only ‘10 sessions’ with charity-referred clients, prompting her to be *“a bit more solution-focused a bit more psychoeducational to kind of speed up the process as it were”*. This indicates that she needs to use more goal-oriented approaches to achieve better therapeutic outcomes. Her emphasis on *“I might be inclined to be a little bit more CBT”*, suggests she seems pressured into using CBT as a therapeutic approach to satisfy the public sector. *“More closely aligned with what the NHS would be doing”*, implies that CBT is the preferred and expected method for addressing disordered eating difficulties.

Daisy equally address the challenge of limited sessions in the public sector, as shown in this extract, *“when you've got six sessions, there's no time to, so you have to really speed up... in that kind of circumstance... you haven't got time and space to allow the client to be, umm, their own expert, or to have the time to explore things”*. There is an implication here that time constraints limit her ability to use client-directed approaches, her phrase *“so you have to really speed up”*, alludes to pressure to move quickly through clients' difficulties.

GET 1 identified seven key therapeutic considerations in addressing disordered eating: building a strong therapeutic relationship, respecting client autonomy, integrating humanistic and pluralistic approaches, using psychoeducation, recognising the impact of trauma and adapting to differences in public sector settings.

GET 2. Aspects of Disordered Eating

This theme centers around participants' views on the meaning and origins of disordered eating in clients, with particular attention to its complexity and frequent comorbidities.

(a) Definition

There was a general consensus that disordered eating differs from clinical eating disorders in several ways, as illustrated by Bella, for example:

"So disordered eating isn't quite the same as an eating disorder, that it's used more sporadically. It's used more, as and when, and, hmm, yeah. It's not, the same in--, uh [sighs], I was going to say, it's not intensity, it's just not as continuous, I guess".

This statement gives an impression of Bella's hesitation, implying some uncertainty and lack of confidence in articulating understanding and distinction of the two terms. Similarity can be seen with Alice's comment, highlighting control as a key aspect:

"If a client comes to see me with disordered eating... it's usually around kind of control or lack of control... but in a nutshell, I guess it's-- it's around, um, yeah, an unhealthy relationship with food."

A longer pause within Alice's quotation, along with the use of 'umm' and 'I guess', equally suggests hesitation and uncertainty around the term.

Caroline offered a slightly different perspective on the distinction between eating disorders and disordered eating:

"I tend to think of it as broader than the eating disorder diagnostic. Umm, so sometimes I'll use it as a term to encompass it all. Sometimes it's like, you know, gap, but basically broader, umm, broader than eating disorders, but still different kinds of eating distress".

Caroline's repeated use of the word 'broader' suggests she views diagnostic criteria for eating disorders as limiting, not accounting for varied eating distress. Caroline's choice of the word '*gap*' indicates that she considers disordered eating to fill the space where eating-related distress does not meet clinical thresholds.

Daisy provides an alternative perspective on her understanding of disordered eating: *"I had clients who had, umm, bulimia... Anorexia... but there were people who were struggling to keep weight-- weight. Umm, you, their desired weight anyway, umm, as well. Umm, they had issues with controlling food, whether that was too much or too little, basically, so not eating and drinking as well"*.

Here, it seems that she previously has worked with eating disorders such as bulimia and anorexia as well as disordered eating. The latter being more about issues with sustaining desired weight and control over food and fluid intake. This view is also echoed by Alice.

Nevertheless, despite a general consensus on the distinction between disordered eating and eating disorders, there was a noticeable leaning towards participants using the terms 'disordered eating' and 'eating disorders' interchangeably. For example, Alice states, *"when somebody's got an eating disorder..."*, suggesting natural inclination towards eating disorders becoming a default term for food and body image difficulties, overshadowing the nuance of 'disordered eating'.

(b) Comorbidity

Participants noted that disordered eating frequently co-occurs with other issues, as Bella succinctly summarised, *"Disordered eating normally comes with, a plethora of other things"*.

A prominent identified comorbidity was obsessive compulsive disorder (OCD), as evidenced by Daisy, *“it was kind of an OCD type of thing and really sort of becoming a way of controlling, what was going on deep down within her”* and Alice *“it’s a form of control as well, and so it’s like moving the cup so if the eating goes then-- then OCD might appear or self-harm might appear so it is really difficult to kind of... I guess, just eradicate it”*. Daisy’s comment implies that controlling food reflects client’s coping mechanism for repressed emotions. Conversely, Alice’s metaphor of ‘moving a cup’, suggests other difficulties might be revealed during the process, complicating recovery.

Caroline and Alice both identified depression and anxiety as common comorbidities with disordered eating:

“often people with eating problems have other things, anxiety, depression, like there’s such an overlap with other stuff as well”. (Caroline)

“with eating disorder, I found... it’s kind of comorbid, so there’s usually depression, anxiety... if somebody’s got an eating disorder, but also, they’re having suicidal ideation”. (Alice)

Caroline’s emphasis on *“there’s such an overlap with other stuff”* indicates that disordered eating is often intertwined with other mental health issues. Similarly, Alice’s statements support this and highlights suicidal ideation and self-harm as other comorbid difficulties.

Caroline also noted a powerful comorbidity that can exacerbate individual’s disordered eating:

“health anxieties and like ageing and like death anxiety, I think plays a big part of this as well for some people. Because our society is also quite obsessed with not getting old, and I can only think that that is not only death anxiety. And yeah, for many people who’ve had people in a family who’ve died, especially if they’re like obesity related things, [air quotes] “obesity related things” that they’ve died of, then this can be, umm, another, like, massive fear factor in when they desperately want to not go down that same path. But then by doing that, that’s also driving their disordered eating”.

Caroline strongly underscores that health and death anxieties can significantly contribute to individuals' struggle with food. Her striking remark that *"society is also quite obsessed with not getting old"*, implies people are taught that older age is bad and something to be feared, which fuels these anxieties. Her reiteration and gesticulation of *"obesity related things"*, suggests disagreement with using obesity as a common explanation for death. This implies that fear of obesity and mortality are used as a way to shape individual's eating habits in ways that lead to disordered eating.

(c) Complexity

Participants highlighted the complexity of disordered eating, as evidenced by Alice's succinct, yet telling statement, *"it's such a complicated, complex disorder, and it's not as simple as getting somebody to eat"*.

She adds that, *"it's real-- really difficult because there are some, um, things that you might look out for and you might kind of jump to the conclusion it's disordered eating and it-- it might not be"*. This implies that disordered eating is often subtle and can be mistaken for other difficulties, hence careful observation is essential to prevent misconceptions.

Alice expands on the complexity of disordered eating within her statement, *"my experience is the longer the disorder goes on, the harder it is to beat. So if the earlier you catch it, then the-- the likelihood of kind of, um, being able to kind of, manage it and get over it is much higher"*. Here, the emphasis on early detection and intervention infers prolonged disordered eating tends to make recovery more difficult.

Bella takes a different perspective:

"Well, everybody's different. And disordered eating isn't, all that common when it comes to, clients revealing themselves in the therapy room. They might say "I have an eating disorder". But disordered eating not so much. It's-- it's not as easy to spot".

Bella emphasises that disordered eating manifests uniquely in each individual and can often be hidden or masked by other difficulties. She adds another point:

“Because, you know, it's that question, what's the difference between, an eating disorder that's been paused and then reused and a disordered eating behaviour? Trying to, for me sitting here, trying to differentiate the two. I don't know”.

It is evident that Bella's uncertainty about distinguishing between a re-emerged eating disorder and disordered eating behaviours, highlights the complexity of disordered eating and signifies a lack of clear recognition and awareness of its presentation in therapy.

The characteristic of disordered eating being hidden in clients is shared and re-iterated by Daisy and Caroline:

“for people who-- who may not have the weight on... it's different because that's hidden and that's-- that's the part that you try to discover. That's the part that you sort of need to explore. Umm, because you never, nobody can tell, nobody can say that there's an issue” (Daisy)

“So I just think this is why disordered eating is so like, subtle and kind of quite insidious in the world, because it's hidden amongst actually being normal and actually being praised. How much-- how much do we praise disordered eating? like so much. How much should we praise weight loss? It could be really somebody has an eating disorder and they'll still get praised for losing weight” (Caroline)

Daisy's statement infers that some eating difficulties are not visible through body size, emphasising the need for gentle, in-depth therapeutic exploration to uncover internal and invisible struggles. It also indirectly implies the necessity of moving beyond weight-centric assumptions and towards more active inquiry to understand individual's pain.

Caroline's quote critically reflects on how disordered eating is often seen as positive and virtuous. Her striking emotional response to society's celebration of weight loss implies personal experience, bearing negative connotations. There is a further

insinuation that weight loss and disordered eating should be questioned, not ignored or rewarded.

This theme presented participants' varying views on the definition, comorbidity and complexity of disordered eating.

GET 3. Inhibitors of Change

GET 3 encapsulates obstacles affecting therapeutic work and participants' suggestions on improving client support for disordered eating.

(a) Knowledge and Education

Lack of knowledge and education on disordered eating was strongly highlighted to pose difficulties for the counselling field.

This has been voiced by Bella in her statement:

"It's not highlighted. Nobody's talking about disordered eating. It's all lumped in. It's like when people talk about anxiety, it's all lumped in. It's like, well, no, we could be nervous. We could be a bit apprehensive. We could be worried. There's other things. It's not just all anxiety and it's not the same with eating disorders. It's all kind of lumped in. But there's, it's more intricate than that. But there isn't anybody out there talking about it, discussing it"

It is inferred that disordered eating is often overlooked or mislabelled as another issue. Bella's reiteration of 'lumped in' implies that it is frequently undifferentiated. She exemplifies this further with "It's like when people talk about anxiety". Her comparison of anxiety suggests a tendency towards over-pathologising certain feelings.

Caroline articulated similar perspective:

“I think, the people who don't know very much about eating disorders often just think anorexia and they think very serious eating disorders and they're not considering disordered eating and binge eating and, all the other stuff that is actually what most of it is, [laughs] like”

Here, Caroline poignantly captured the common misconception that all food-related difficulties are classified as eating disorders, particularly anorexia. Her laughter alludes to her astonishment at this oversimplification and lack of understanding around disordered eating.

She also offers a suggestion on improving knowledge about disordered eating within the counselling field:

“I think it's important that therapists have specific, erm, training on disordered eating, because sometimes there's a sense of people just being able to work with it because it's just another thing and it's, you know, not the route problem or something. But the context of stuff is really important”

This statement suggests that improving knowledge about disordered eating in the counselling field could be achieved through enhanced training and education. Caroline further specifies, *“so that there isn't harm caused because there can be accidental colluding, and risk of harm caused by that really”*, implying that it can lead to maleficence if not considered.

(b) Society

Current societal views on disordered eating were identified as a major barrier to individuals receiving adequate support.

Alice reflected upon current over-dependence of BMI as a diagnostic tool for eating difficulties:

“I think we need to get away from this BMI. You know, I've come across a lot of people that I've gone to the doctor and they're struggling and they're struggling to eat or they're struggling with bulimia... if they don't hit the-- the BMI criteria, then they're turned away”

Alice's statement implies that relying on BMI to classify food-related difficulties creates unnecessary restrictions, suggesting that help should not be contingent on a person's weight.

Another perspective is illustrated by Caroline:

“in a capitalist society that sort of thrives off having to sell stuff like this, I do feel like maybe we can't make too many changes, but I do on that such a big level, but I do appreciate the amount of people that are out there doing really good work like, umm, anti-diet kind of work”

Caroline expresses cynicism about potential systemic change. Her implicit critique of capitalism highlights society's commercialised ways in fueling body image insecurities and diet culture. However, she recognises individual advocacy and resistance to mainstream narratives as a path toward change.

(c) Economy

The current economy has been emphasised to exacerbate disordered eating in individuals.

Alice underscored the substantial effect that fast food can have on issues with food:

“it doesn't help that, um, our economy doesn't help, um, you know, it's-- it's a really-- it's really sad that the cheaper the food, the-- the fast food...it's cheap and so it's, it just, it's just really, really difficult”

Alice's statement reflects economic inequality, implying that food pricing can limit access to more nutritious food. Therefore, this drives individuals towards cheaper, less healthy options, reinforcing disordered eating. Her repetition of 'really' conveys frustration and a sense of a deeply-rooted issue that cannot be easily resolved.

Daisy emphasised a different element of the economy in her excerpt:

“ in the past we-- we didn't really see so many places where you can eat or so many things that you can eat. Now we every corner in every single corner there's, food, food, food. It's advertising about food all the time”

Daisy's remarks suggest discomfort with the overexposure and constant temptation derived from relentless marketing and food availability, that promotes greater consumption. Her comments also imply a critique of the commercial capitalist system that profits from overconsumption at the expense of health.

Caroline's contribution revealed another economic barrier:

“I think a barrier is finances because not many options for people to be able to get free or cheap therapy anyway, especially when it's based on like eating disorders and eating disorder practitioners are specialised and probably charge extra [laughs] because of that as well so”

Here, the intersection of economic inequality and mental health care is highlighted, signifying that high costs limit access to therapy and that affordable alternatives are scarce. There is an essence of money being a big obstacle to adequate care which delays treatment for disordered eating.

(d) Support from Public Sector

Participants voiced concerns about the limitations of the NHS and charities in supporting individuals with disordered eating.

Alice succinctly articulates this limitation, *“there are less and less kind of services to kind of refer into, which is really sad”*. Alice’s statement has an underlying tone of disappointment and concern regarding the growing scarcity of referral services for individuals with disordered eating.

She further acknowledges the issues of the limited six sessions that the NHS permits:

“it's six sessions, so there's only so much that you can do and unpack and you have to ensure that you don't leave somebody vulnerable, so you're kind of-- kind of containing it [makes a round shape with hands] rather than unpacking it”

Alice’s metaphor of *‘containing it rather than unpacking it’*, vividly illustrates how short-term therapy within the NHS prioritises managing emotional distress over exploring its root causes. Her remarks also highlight the therapist’s ethical responsibility to prevent harm, underscoring the challenging balance of safety at the expense of therapeutic depth.

While Daisy also identifies six sessions as problematic, she notes a marginal flexibility within the NHS:

“unless there's a case where the client... will benefit by having extended sessions and sometimes that client would be given like you know, maybe two more sessions or six more sessions or 10 more sessions”

Her statement acknowledges the possibility of additional sessions. However, it implies that these are rationed and granted selectively, often prioritising clients who are either highly responsive to therapy or experiencing greater distress.

Caroline offered an alternative perspective:

“barriers to getting into services as I mentioned before like neurodivergent people trying to do rigid CBT, it sometimes doesn't really work for them, doesn't work for other people, only having the option of CBT through the NHS, umm, which is difficult. That's where the charity tends to pick up the fall out of that. Umm, so it's good that we can help, but there's very few charities as well, for eating disorder work”

Caroline's excerpt highlights issues of accessibility and suitability of therapy. Her strong declaration of CBT, mainly being the sole approach offered by the NHS implies that it is seen as a default model of therapy that overlooks individual needs. There is an indication that charities bear the burden of care, resulting in a dual challenge of NHS rigidity and an insufficient availability of alternative services.

GET 3 identified key barriers influencing disordered eating, including knowledge gaps, societal factors, economic challenges and insufficient public sector support.

GET 4. Influencing Factors

This final theme centers on participants' perceptions of main influences on disordered eating.

(a) Familial Relationships

There was an overall agreement from the participants that family members can significantly contribute towards development and continuance of disordered eating.

Alice describes this influence in terms of familial pressure to achieve high levels of success, *“it does tend to follow that anorexia tends to be high achievers... a family*

background where there's a lot of pressure whether that's through exams or whether it's, um, sport, whether there's kind of that push to be the best, and so they're very high achievers".

Alice's statement clearly alludes to food restriction being driven by family expectations to succeed. Her emphasis on 'tends' indicates a strong belief that familial influence is a common pattern among individuals with anorexia.

Bella offers another perspective, *"Narcissistic mothers are massive when it comes to things like that"*. This suggests parental narcissism, particularly maternal influence. She elaborates further:

"Narcissistic mothers who just don't make their children feel good enough. That constant not quite good enough, constant not feeling heard". Bella's reiteration of 'constant' implies chronic emotional invalidation, where love is conditional on meeting certain standards, as reflected in her statement linking this connection to body image: *"Because the fear of disappointment, makes them want to strive harder and then the approval isn't given, so they want to strive harder... often it can come into looks."* (Bella)

Daisy's statement shared similarities to Bella's, *"there was a lot of childhood unmet needs, not been, seen and heard, but possibly not been seen and heard in a way that she may have needed if she was neurodiverse"*. This underlines how childhood unmet needs and emotional invalidation contribute to client's later food-related issues. The recurring thread of a child not being 'heard' appears central to family dynamics negatively impacting body image.

Caroline describes how family narratives surrounding food and eating can be profoundly damaging, *"sometimes the way that I'm finding it is that people have societal expectations or family narratives of eating [air quotes] "normally". And when they don't eat normally, that brings about distress"*. Caroline's gesticulation and emphasis on 'normally' suggests criticism towards socially-constructed notion of 'normal' eating. It further implies an individual's sense of failure, if they are not able to

conform to familial eating expectations, underlining deeply social and emotional nature of eating behaviours.

(b) Societal Norms

Social perspectives of what is acceptable in the society and its impact on disordered eating has been highlighted numerous times by the participants.

For instance, Alice voiced a powerful perspective on how societal pressures have a negative impact:

"I feel that there's a lot of pressure on how we should look and how we should kind of conform and, um, what an ideal weight is... I have kind of a--you know a (daughter in her 20s) and kind of--it's a lot more pressure now than there was back then"

Alice's emphasis on the word 'is' in relation to ideal weight gives an essence of a hiss indicating bitterness and disapproval towards the term 'ideal weight'. She makes poignant comment on the negative generational shift towards beauty standards and intensified pressure to adhere to what the society considers acceptable appearance.

Bella's striking reflection on disordered eating, *"I think it's normalised to a certain degree"*, implies that societal perceptions on weight and body image has led to frequent occurrences of irregular eating behaviours, which is becoming acceptable and regular among the population.

This has been highlighted by Caroline, *"the pressures on that can be can be-- can be societal... in terms of eating a normal or healthy diet. Umm, particularly pressures maybe of diet culture as well of not being, erm, like it may be to do with body image and weight, or it may just be about being able to eat normally"*. There is an indication

here that diet-culture is valued in the society and considered to be a trend that should be followed in order to appear healthy.

Daisy, on the other hand offered a different view, *“So you lose... connections... with time and stuff and then just, yeah. So that-- that these are the things that, you know, modern society has [laughs]. These are the issues that, you know, young people have, and that's really sad”*.

It seems that Daisy underscores the relationship between social disconnection and the negative impact on disordered eating. Her choice of words ‘modern society’ accompanied by laughter implies frustration and disapproval towards current society. There is also an essence of helplessness that anything will change systemically as inferred in *“that's really sad”*.

(c) Social Media

There was an evident consensus that social media has a negative impact on disordered eating as evidenced by participants.

Bella poignantly points out that disordered eating is massively portrayed on social media with her comment *“it's all over social media”*. She expands further with, *“I mean, gosh, when you see some of the images that are out there, it's just shocking”*. Bella’s use of the words ‘gosh’ and ‘shocking’ gives the essence of disturbance and disbelief at the social media content that is present online. There is an indication that the uploaded images are heavily focused on unrealistic appearance and body ideals which promote disordered eating.

Alice’s perspective highlights how pressure exhibited from social media can lead to someone’s preoccupation with body image, *“I think there's just so much pressure and so much pressure on social media and how we're supposed to look”*. It can be deduced

for this that social media encourages comparison and self-scrutiny and excludes diversity, thus directly impacting individual's self-perception.

Similar thoughts were shared by Daisy:

“these models there that have maybe been photoshopped, but then they appear to be perfect in perfect shape”. Her statement implies that many images portray flawlessness and idealised body shapes, but are often edited and not real, creating toxic standards.

Caroline, on the other hand, approached the impact of social media from the more positive angle while still acknowledging the negative impacts that it has:

“although it's often seen as, like social media causes these problems, which there is the negative aspect. There's also like lots of, you know, body acceptance communities and lot of really helpful stuff... often people can change up their social media so that they're, if they were following things that weren't very helpful for them, then they could follow more diverse people. Follow maybe plus size activists who might be quite helpful if it's someone in a larger body who wants to work on accepting themselves”.

Her statement suggests that social media can have a powerful effect towards body positivity and representation of varied body shapes. There is an emphasis here that individuals have agency and can curate their social media feed more intentionally to remove harmful content. Furthermore, her extract highlights that social media can be used as a tool in creating supportive content that helps individuals towards empowerment and healing.

This last theme explored three major, often negative influences contributing to disordered eating: familial relationships, societal norms, and social media.

The findings are further discussed in relation to the existing literature in the final subsequent chapter.

Chapter 5 Discussion and Conclusion

The four themes and sub-themes that have emerged from the IPA analysis have been explored in the previous chapter. This chapter will focus on the following: relating findings to the existing literature and research, strengths and limitations of the study, implications of this research for practice, recommendations for future research and an overall conclusion.

5.1 Discussion of Findings

The findings from the GET1 emphasised the importance of therapists building good therapeutic relationship with their clients when working with disordered eating. This is consistent with Muzi *et al.* (2024), highlighting therapeutic alliance as being a reliable factor in achieving positive treatment outcomes for various mental health difficulties, especially in early stages of psychotherapy. Moreover, a vast amount of research also suggests that therapeutic relationship is a vital factor that affects treatment outcomes for individuals with eating disorders (Werz, Voderholzer and Tuschen-Caffier, 2022; Zaitsoff *et al.*, 2015).

The necessity of a person-centered approach when working with disordered eating has also been strongly emphasised, especially in regard to counsellor's acceptance and non-judgement towards clients. This supports Lakin and Murphy (2023), who found a lack of unconditional positive regard, to play a significant role in developing and maintaining eating distress in women. Additionally, findings confirmed the value of utilising mindfulness in therapy, as reported by Roos *et al.* (2021). The effectiveness of somatic and Gestalt therapies in working with embodied awareness and repressed feelings around food has been previously identified by Pfluger (2015). The usefulness of employing parts work in an IFS informed way has been explored by Lester (2017) and Bardone-Cone, Thompson and Miller (2018). Particularly, aspects such as self-

esteem, self-compassion and self-oriented perfectionism, which can be investigated in relation to disordered eating.

The discussion around exploring ego states from TA theory and their interconnection to the relationship with food, concurs with the research by Seubert (2018). He considers the benefit of exploring relational ruptures between the different ego states or parts that occur as a result of painful experiences, past trauma or shame related to body image. Furthermore, findings also highlighted the efficacy of the practical humanistic techniques; motivational interviewing and narrative therapy. The incorporation of motivational interviewing for food difficulties has been suggested in existing literature by Weiss *et al.* (2013) and Macdonald *et al.* (2012). Efficacy of narrative therapy through the use of creative mediums such as writing, concurs with the research by Ricks *et al.* (2014). For example, creativity can aid in externalising oppressive experiences and allow the re-writing of the narrative without problem-saturated perspective. Other researchers, for instance Georgieva and Georgiev (2022); Rus-Calafell *et al.* (2022) explored the positive impact of employing virtual reality such as the use of avatars in narrative therapy. Their findings are consistent with what was evidenced in this research.

Most participants disclosed they integrate other modalities and approaches when working with disordered eating. This reflects a suggestion by Giannopoulos and Hilsenroth (2024). CBT was mentioned to be the most common modality used, outside of humanistic approaches, especially when working short-term with clients in the public sector. This is consistent with research by Paphiti and Newman (2023); Russell *et al.* (2023); CBT is the preferred modality for working with eating disorders in the NHS. SFT has also been highlighted and the efficacy has been explored by Pietrabissa *et al.* (2014), whereby, brief strategic therapy has shown to be effective for reducing symptoms of BED. ACT is another integrative approach which has been identified to be useful in working with disordered eating. This is consistent with findings from Fogelkvist, *et al.* (2020), who found that ACT offered significant reduction of residual eating disorder symptoms and body image concerns at the two-year follow up compared to the control group. This is further supported by Onnink *et al.* (2022).

Psychoeducation has been highly reported by the participants as being really beneficial when working with disordered eating, offering clients more insight and knowledge about their experiences. This can be related to findings by Balestrieri *et al.* (2013); Liquori *et al.* (2022), whose research underscored the advantage of utilising psychoeducation in the group therapeutic setting for BED.

Traumatic experiences have been identified to be directly linked to disordered eating difficulties. Unsurprisingly, sexual abuse has been particularly mentioned, which is consistent with the current research, for instance by Breland *et al.* (2018). However, other unanticipated types of traumas such as domestic abuse and sexual trafficking were also revealed to be associated with disordered eating. This concurs with research by Holmes *et al.* (2024) who found PTSD from intimate partner violence to be positively correlated with disordered eating in women. Sexual trafficking supports what Hayes and Lease (2024) found; there were much higher rates of disordered eating in sex trafficking survivors compared to non-trafficked individuals.

Therapeutic ways of working were highlighted to differ when working in the public sector compared to privately. MANTRA was revealed to be frequently used within the NHS eating disorder services, which is in line with recommendation from NICE (2020). This is supported by Russell *et al.* (2023) who states that current clinical practice is largely informed by family-based therapies. Bryson, Douglas and Schmidt (2024), further stress that in recent years, family or systemic therapy for adults with eating disorders have been more utilised. This is due to the growing recognition that emerging adults between ages of 18 and 25 still often rely on their families for support. The efficacy of family therapy for eating difficulties is supported by authors such as Fisher *et al.* (2019); Setién Preciados, Díaz Mayoral and Arroyo Sánchez (2024).

Disordered eating has been recognised to be different to eating disorders. However, findings were leaning towards using disordered eating and eating disorders as interchangeable terms. This has been partially explored by Chaves, Jeffrey and Williams (2023). Moreover, Shapiro (2022) highlights the importance of viewing disordered eating as a spectrum which ranges from clinical eating disorders to irregular

eating patterns and may not adhere to the clinical diagnosis based on severity or intensity.

Anxiety and depression have been emphasised to be highly comorbid with disordered eating which supports findings in existing literature (Burt and Klump, 2024; Hambleton *et al.*, 2022; Juli *et al.*, 2023). OCD has also been highlighted as a comorbid factor in disordered eating (Kaczurkin *et al.*, 2021), which Fforeich *et al.* (2016) suggest might be due to underlying fear of losing self-control that occurs both in disordered eating and OCD behaviours.

The negative familial and sociocultural influences have been supported by authors such as Magallares (2013) and Makki *et al.* (2023). Positive correlation between family pressure and disordered eating behaviours concedes with Nebel-Schwalm (2024). The element of parental narcissism and its relation to eating difficulties has been previously explored by Cipriano *et al.* (2024) and Sivanathan *et al.* (2019). Interestingly, the findings of the current study do not concur with Cipriano *et al.* (2024), however it does partially support findings from Sivanathan *et al.* (2019). They note that parental invalidation exhibited through vulnerable narcissism was linked to eating disorders, while grandiose narcissism was not associated.

Expectedly, findings revealed mostly negative effects of social media on disordered eating which has been reflected throughout the literature, for example by Sanzari *et al.* (2023). However, potential effects have also been recognised; social media can be used as a medium for advocacy on anti-diet practices and encourage a different shift towards societal views on weight and health. This aligns with Jovanovski and Jaeger (2022) and partially by Chau, Burgermaster and Mamykina (2018).

5.2 Strengths and Limitations of the Study

A key strength and limitation of this study is the sample size. While a small, purposively selected sample is appropriate for phenomenological and IPA methodologies. This allows for rich, in-depth exploration of therapists' experiences on disordered eating. However, it limits the generalisability of the findings. Equally, the homogeneity of the sample comprising solely female counsellors, practising in the UK, restricts the applicability of the results to male therapists and psychotherapists in other countries.

Furthermore, the idiographic and interpretive nature of this study is both a strength and a limitation. The participants' accounts offer unique insights into their experiences working with disordered eating. However, these perspectives are shaped by individual experiences and might have differed if their clinical encounters had been different. Furthermore, since analysis also involves researcher's interpretive engagement with the data, complete objectivity cannot be assumed. Occasionally, participants elicited vague responses, thus limiting the researcher's ability to interpret certain data at depth and higher conceptual level. The researcher attempted to mitigate this limitation through deeper probing and altered question formulation.

Another key strength of this research is its contribution to an underexplored area in the literature. Existing studies largely focus on clinically diagnosed eating disorders within public sector settings whereas this study examined disordered eating from the perspective of counsellors. It also highlighted the value of humanistic approaches which remain underrepresented in current research.

5.3 Implications for Practice

This phenomenological study explored therapists' lived experiences of working with clients with disordered eating from a humanistic perspective. The findings offer valuable insights not only for the researcher and psychotherapists but also other mental health professionals. Notably, the study contributed to a deeper understanding of disordered eating and the diverse ways in which clients may present with such difficulties. Disordered eating is often misunderstood and the lack of literature also adds to those misconceptions. Hence this research enhanced awareness and knowledge of a spectrum of disordered eating difficulties and clarify how it differs from clinically diagnosed eating disorders.

This study's exploration of how counsellors work with individuals experiencing disordered eating, offers valuable insights for not only trainee and qualified therapists but also mental health services and stakeholders. Since CBT is the primary recommended therapeutic treatment for eating disorders, the findings highlight the possible effectiveness of humanistic and integrative modalities for disordered eating. It also stresses the importance of utilising flexible methods when working with food and body image concerns and emphasises necessary improvements within mental health services. Furthermore, the study also underscores the significance of humanistic approaches even within integrative and pluralistic practices. These insights are valuable in informing future counselling and psychotherapeutic training programmes, and pave the way for the development of a therapeutic model, specifically designed to work with this presenting issue.

This research also identified key factors contributing to disordered eating along with barriers faced by both therapists and clients. Suggestions from the participants can enhance societal understanding of prevention and enhance support for individuals struggling with their relationship with food.

5.4 Recommendations for Future Research

The findings of this study can inform future research on disordered eating and continue to contribute to the development of therapeutic approaches for addressing such concerns. As this research focused solely on therapists' perspectives, it would be valuable to explore clients' experiences of receiving therapy and support for disordered eating.

Future studies can expand on this research by utilising larger and more diverse samples, incorporating both male and female participants from varied ethnic backgrounds. Employing other methods of data collection such as focus groups in addition to individual interviews can also be advantageous. Furthermore, replicating the study in different cultural contexts may yield further intriguing findings.

Additionally, future research could examine the impact of under-explored traumatic experiences such as natural disasters, modern slavery, or domestic abuse and their connection to disordered eating. Equally there is scope to investigate less frequently studied humanistic therapies, such as Gestalt therapy, transactional analysis, and internal family systems, in the context of disordered eating.

5.5 Conclusion

This phenomenological study explored psychotherapists' lived experiences of working with clients experiencing disordered eating, using semi-structured interviews and IPA analysis. The central research question for this study was 'how do psychotherapists work with clients with disordered eating from a humanistic perspective?'. Findings indicate that while some therapists employ integrative or pluralistic modalities when working with disordered eating, a humanistic approach, particularly PCT is seen as essential in building therapeutic relationship and addressing food related issues. Participants also mentioned other humanistic modalities including mindfulness,

gestalt, and internal family systems. Moreover, psychoeducation has been highlighted to be an important supplementary therapeutic component. The study underscores the importance of a flexible, client-directed approach given the complex and intersectional nature of disordered eating. Overall, this study addresses the gap in knowledge and contributes to a deeper knowledge and therapeutic understanding of disordered eating. It also highlights the need for broader systemic and societal changes, providing a foundation for further research.

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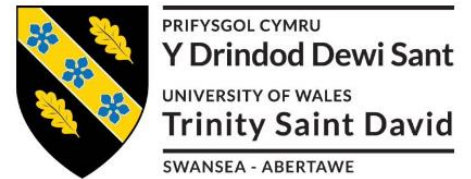
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Appendices

Appendix A: Covering Letter

Covering Letter



Date:

Title of Study: **Psychotherapists' Experience: Working with Disordered Eating from a Humanistic Perspective - A Phenomenological Study.**

You are invited to take part in a research study to explore your experience of working with clients with disordered eating.

Before you decide whether you wish to participate it is important that you understand why the research is being undertaken and what it entails. You should therefore read the attached information carefully and discuss it with others if you wish.

This MA research is supervised by Dr Beverly Cole [University of Wales Trinity Saint David] and has been approved by the university's Research Ethics Committee. The research is bound by the ethical guidelines of the British Psychological Society and the British Association for Psychology and Counselling and it is hoped that this research will enhance understanding of how psychotherapists work with adult clients with disordered eating using a humanistic modality.

Taking part in this study is voluntary and the attached information should clarify any questions you may have. If you still have concerns, please feel free to contact me using the contact details given in the information sheet.

Thank you for taking the time to read this information.

Name and contact details of Student / Researcher:

Agata Junkanc

Email: (provided on original)

Phone Number: (provided on original)

Name and contact details of Supervisor:

Dr Beverly Cole

Email: (provided on original)

Phone Number: (provided on original)

Appendix B: Participant Information Sheet (First Version)

Participant Information Sheet



Project Title: **Psychotherapists' Experience: Working with Disordered Eating from a Humanistic Perspective - A Phenomenological Study**

I am Agata Junkanc, the researcher for this project and a student at the University of Wales Trinity Saint David (UWTSD), completing a degree of Master of Arts Psychotherapeutic Practice (Humanistic). This research project constitutes a partial requirement for this degree in the form of completing a dissertation.

The aim of this research is to discover how psychotherapists work with adult clients who display signs of disordered eating, using a humanistic approach. Therefore, in order to be considered for participation in this research you must be a qualified psychotherapist or counsellor with previous experience of working with adult individuals who suffered from disordered eating. Since the project is focusing on working with such client group from a humanistic perspective, you also need to be using humanistic approaches in your therapeutic practice with clients to be able to take part in this study.

The following information will explain what your participation in this project will involve:

*You will be invited to take part in a semi-structured interview where I will ask you a number of open ended questions to explore your experience of working with clients who have displayed issues with disordered eating. Boundaries will be maintained in a similar format to counselling relationships.

* Interview will be relaxed and open in nature, topics for discussion are provided on the interview schedule which is also attached to give some structure to the interview. However, the interview will be 'participant led' to allow the discussion to flow and go where you lead. You will not have to answer any questions which make you feel uncomfortable.

* Our interview will take form of a one-to-one conversation and last approximately 1 hour. It will take place at a confidential and safe space or room at UWTSD IQ Swansea campus on a day and time most convenient to you. If at any time you wish to draw an interview to a close you will be able to do so without giving a reason. No data supplied by you will then be used.

* The interview will be audio and video recorded using appropriate equipment provided by UWTSD for accurate transcription and analysis purposes. I will also take notes of the most relevant points during the discussion. Only myself the researcher will hear the recordings and have sight of the notes. Recorded and written material will be kept securely and destroyed once research is complete.

*Data stored in the electronic form will be kept on the university OneDrive system which is password protected, has double authentication processes and firewalls. Any documents in the paper form will be stored in the locked filing cabinet ensuring no one has access to them. Data will be safely destroyed after the completion of the project and once the degree is awarded. A dissertation is a public document and if accepted will be available publicly through the UWTSD library.

*After transcription and processing of interview notes, a copy of the interview transcript and derived meanings will be returned to you [unless you indicate that you do not want sight of these]. You will be asked to check the content, censor anything you are not happy to be included and to confirm that your meaning remains intact.

*Involvement in this study is voluntary and you have the right to withdraw your participation at any time without penalty, up to the cut-off point of 1 month after the date of the completed interview. If you withdraw, the data collected from you will not be used in the final draft of the project and will be safely destroyed.

*To ensure your anonymity I will use pseudonyms or generic labelling of a participant (for example participant A, participant B etc.) in the interview transcript, analysis and overall final write up of the project. No comment or circumstance which could be directly connected to you or person named in the research will be identifiable. Any personal details collected for the purpose of contacting you, such as your name, email address and number will be kept confidential, separate from the data and not shared with anyone.

* It is important that when discussing your experience with clients or specific cases, any identifying information about clients is removed from the conversation to protect client anonymity and confidentiality.

*If you agree to participate in this project, you are asked to complete the consent form [attached] and return it to me prior to taking part in the interview. If you have any questions or wish to get in touch prior to signing the consent form, please feel free to do so using the contact details provided in the covering letter.

*You will be reminded at the start of the interview of the consent form you signed and returned, the anonymity of information you share, the fact that the interview is being recorded and your right to withdraw.

*The interview will close with an opportunity to add additional comments to our discussion and for you to ask any questions you may have. You will be thanked for your time and participation and reminded that a copy of the interview transcript and derived meaning will be sent to you along with a copy of the signed consent form for your records [you can decide at this time whether you want to receive these]. You can also indicate on the consent form if you wish to receive the summary of findings.

*Immediately following the interview there will be a short 'cool down' or debriefing period where you will have the opportunity to reflect upon and discuss the interview. Although this study does not directly focus on any issues which would normally involve emotionally sensitive reflection, due to the nature of the research I recognise that some topics or questions may evoke discomfort and /or strong emotions, therefore you will have an opportunity to discuss these feelings during the debriefing period. I will also monitor for any signs of distress during the interview and terminate the interview early if necessary.

*You will be given a debrief form with the information reminding you of the right to withdraw, anonymity procedure, complaints procedure, contact details and list of helpful organisations / support services for additional support so that you can discuss any aspect of the research which has caused you distress.

Thank you for taking the time to read this information sheet.

Agata Junkanc (the researcher)

Appendix C: Participant Information Sheet (Revised Version)

Participant Information Sheet



Project Title: Psychotherapists' Experience: Working with Disordered Eating from a Humanistic Perspective - A Phenomenological Study

I am Agata Junkanc, the researcher for this project and a student at the University of Wales Trinity Saint David (UWTSD), completing a degree of Master of Arts Psychotherapeutic Practice (Humanistic). This research project constitutes a partial requirement for this degree in the form of completing a dissertation.

The aim of this research is to discover how psychotherapists work with adult clients who display signs of disordered eating, using a humanistic approach. Therefore, in order to be considered for participation in this research you must be a qualified psychotherapist or counsellor with previous experience of working with individuals who suffered from disordered eating. Since the project is focusing on working with such client group from a humanistic perspective, you also need to be using humanistic approaches in your therapeutic practice with clients to be able to take part in this study.

The following information will explain what your participation in this project will involve:

*You will be invited to take part in a semi-structured interview where I will ask you a number of open ended questions to explore your experience of working with clients who have displayed issues with disordered eating. Boundaries will be maintained in a similar format to counselling relationships.

* Interview will be relaxed and open in nature, topics for discussion are provided on the interview schedule which is also attached to give some structure to the interview. However, the interview will be 'participant led' to allow the discussion to flow and go where you lead. You will not have to answer any questions which make you feel uncomfortable.

* Our interview will take form of a one-to-one conversation and last approximately 1 hour. It will take place either online via Microsoft Teams (MS Teams) or at a confidential and safe space or room at UWTSD IQ Swansea campus, on a day and time most convenient to you. If at any time you wish to draw an interview to a close you will be able to do so without giving a reason. No data supplied by you will then be used.

*MS Teams is a free international VoIP provider; it provides instant messaging, video calling and voice calls over the internet. It's very popular, works extremely well and is also encrypted. You can download the software from Microsoft Teams <https://www.microsoft.com/en-gb/microsoft-teams/free> on your computer and laptop, or the Microsoft Teams app from an app store for your phone / tablet. Alternatively, you can use the MS Teams web to connect to our arranged meeting on your browser.

* The face-to-face interview will be audio and video recorded using appropriate equipment provided by UWTSD. If the interview is carried out online via MS Teams, it will be audio and video recorded using MS Teams 'record a meeting' option. Audio recorder (provided by UWTSD) will be used as backup. The recordings will be used for accurate transcription and analysis purposes, the MS Teams 'live transcription' option will automatically turn on when recording starts. I might also take notes of the most relevant points shortly after our discussion. Only myself the researcher will hear the recordings and have sight of the notes. Recorded and written material will be kept securely and destroyed once research is complete.

*Data stored in the electronic form will be kept on the university OneDrive system which is password protected, has double authentication processes and firewalls. Any documents in the paper form will be stored in the locked filing cabinet ensuring no one has access to them. Data will be safely destroyed after the completion of the project and once the degree is awarded. A dissertation is a public document and if accepted will be available publicly through the UWTSD library.

*The MS Teams recorded interview and transcript will automatically be saved and stored on the university OneDrive system. MS Teams is secure and adheres to the GDPR regulations. Their policies on confidentiality, privacy and data protection and security and compliance can be found below.

Confidentiality Policy: <https://privacy.microsoft.com/en-gb/privacystatement>

Privacy and Data Protection Policy: <https://learn.microsoft.com/en-us/microsoftteams/rooms/data-and-privacy-info>

Security and Compliance Policy: <https://learn.microsoft.com/en-us/microsoftteams/security-compliance-overview>

*After transcription and processing of interview notes, a copy of the interview transcript and derived meanings will be returned to you [unless you indicate that you do not want sight of these]. You will be asked to check the content, censor anything you are not happy to be included and to confirm that your meaning remains intact.

*Involvement in this study is voluntary and you have the right to withdraw your participation at any time without penalty, up to the cut-off point of 1 month after the date of the completed interview. If you withdraw, the data collected from you will not be used in the final draft of the project and will be safely destroyed.

*To ensure your anonymity I will use pseudonyms or generic labelling of a participant (for example participant A, participant B etc.) in the interview transcript, analysis and overall final write up of the project. No comment or circumstance which could be directly connected to you or person named in the research will be identifiable. Any personal details collected for the purpose of contacting you, such as your name, email address and number will be kept confidential, separate from the data and not shared with anyone.

* It is important that when discussing your experience with clients or specific cases, any identifying information about clients is removed from the conversation to protect client anonymity and confidentiality.

*If you agree to participate in this project, you are asked to complete the consent form and return it to me prior to taking part in the interview. If you have any questions or wish to get in touch prior to signing the consent form, please feel free to do so using the contact details provided in the covering letter.

*The link and codes to our MS Teams meeting will be emailed to you once you return the signed consent form and we agree on the best day and time for our online interview to take place. You have the option to join the meeting anonymously by not signing in and entering an alternative name at the top of the pre-join meeting screen. You can also join the meeting anonymously via a private browsing window.

*You will be reminded at the start of the interview of the consent form you signed and returned, the anonymity of information you share, the fact that the interview is being recorded and your right to withdraw.

*The interview will close with an opportunity to add additional comments to our discussion and for you to ask any questions you may have. You will be thanked for your time and participation and reminded that a copy of the interview transcript and derived meaning will be sent to you along with a copy of the signed consent form for your records [you can decide at this time whether you want to receive these]. You can also indicate on the consent form if you wish to receive the summary of findings.

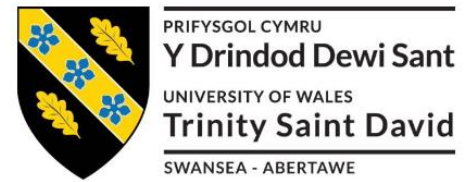
*Immediately following the interview there will be a short 'cool down' or debriefing period where you will have the opportunity to reflect upon and discuss the interview. Although this study does not directly focus on any issues which would normally involve emotionally sensitive reflection, due to the nature of the research I recognise that some topics or questions may evoke discomfort and /or strong emotions, therefore you will have an opportunity to discuss these feelings during the debriefing period. I will also monitor for any signs of distress during the interview and terminate the interview early if necessary.

*You will be given or emailed a debrief form with the information reminding you of the right to withdraw, anonymity procedure, complaints procedure, contact details and list of helpful organisations / support services for additional support so that you can discuss any aspect of the research which has caused you distress.

Thank you for taking the time to read this information sheet.

Agata Junkanc (the researcher)

Appendix D: Interview Schedule



Interview Schedule

Project: **Psychotherapists' Experience: Working with Disordered Eating from a Humanistic Perspective - A Phenomenological Study**

Date: _____ Time of interview: Start: _____ Finish: _____

Venue//Mode of interview: **Face-face or Online via MS Teams**

Interview with participant [insert code] recorded on [insert recording ref. no.]

{Introductions. Briefly describe project and interview protocol [including purpose of study, recording, dissemination and withdrawal], ensure interviewee is comfortable, has copy of the information sheet and has signed consent form}

Topic 1: Please can you tell me what do you understand by the term 'disordered eating'?

Topic 2: What behaviours, signs and symptoms would you look out for to recognise that a client might have issues with disordered eating?

**Topic 3: How do you work with clients who display signs of disordered eating?
Possible prompts: Which approaches? What techniques? What focus?**

How do you work with those clients from a humanistic perspective? (If they haven't mentioned it in the previous question)

Topic 4: What would you say are necessary elements of therapy to get successful therapeutic outcomes with those clients?

Topic 5: What do you feel are the barriers in working with clients with disordered eating?

Topic 6: How do you feel about working with clients who show signs of disordered eating?

Topic 7: What changes do you feel need to be made to improve the way psychotherapists work with clients with disordered eating?

Topic 8: [We have ----- left] Is there anything you would like to add? [Please use this time to continue until you have discussed your thoughts/feelings as completely as possible]

Subsidiary questions for all topics, if necessary: What meaning do you make of this? Further prompts will be derived, e.g. participant's meaning – concreteness – asking for examples, etc. and more specific follow on questions used as necessary.

[Thank interviewee for participating, assure them of anonymity of responses and advise what will happen next. Ask whether participant has any questions, wants sight of notes/meaning, etc. Cool down period, debriefing chat. Remind of the procedures in place [signposting] should participant feel distressed.

Appendix E: Consent Form

Consent Form

Project Title: **Psychotherapists' Experience: Working with Disordered Eating from a Humanistic Perspective - A Phenomenological Study**

Please read this form carefully, initialling each box to indicate agreement as appropriate.

I have read and I understand the information provided about this research, I have a copy of the information sheet for future reference [dated:] and I have no reservations regarding content.

I have had the opportunity to consider the information and ask questions. I have had these answered satisfactorily and I understand that there will be a further opportunity to address any questions at the end of the research period, just prior to the point where I am able to withdraw.

I have a telephone number and an email address for the researcher, and contact details of the main project supervisor should I have any concerns.

I understand that participation in this research is voluntary and I can withdraw at any time without penalty, up to the designated cut-off point without giving any reason. If I do so collected data relating to me will be destroyed and not used in the project.

I understand that any information and actual quotations from my contributions may be used to support the research. My involvement in the study will be confidential and any data collected will be anonymised. Findings may be subject of journal articles / conference presentations and / or other related educational or research work. Data collected will be destroyed once the research project is finalised and degree awarded.

I understand that all electronic data will be stored on the university OneDrive system which is subject to firewalls, passwords and double authentication processes. All data in a paper form will be kept in the locked filing cabinet.

I understand that although this study does not directly focus on any issues which would normally involve emotionally sensitive reflection, due to the nature of the research some topics or questions may evoke discomfort and / or strong emotions and I will have an opportunity to discuss any distress caused during the debriefing period of the interview.

I understand that I will be offered a copy of the interview transcript and derived meanings to check the content before it gets included in the project. I will also have a choice of receiving the summary of findings.

I consent to participate in a face-to-face / online interview and for it to be audio and video recorded.

Signature: _____ **Date:** _____

Tel Number: _____

Print Name: _____

Email: _____

I would like to receive a summary of findings when these are produced

Yes / No

Please return this signed consent form to **Agata Junkanc** by email (provided on original). You may be able to sign it electronically. If this is not the case please note that receipt of this form via your email address will be taken as informed consent.

Debrief Form



Project Title: **Psychotherapists' Experience: Working with Disordered Eating from a Humanistic Perspective - A Phenomenological Study**

Date:

Thank you for participating in this study, I hope you found it interesting. Your time and effort are appreciated.

This research explored how psychotherapists work with disordered eating which is important in that there is a significant increase of individuals who struggle to receive adequate support for such concerns. To date the topic of disordered eating and specifically how psychotherapists work with such difficulties with clients has been under-researched and under-represented within academic literature. By taking part in this study you have contributed to the growing body of knowledge concerning this important topic.

If you would like to learn more about disordered eating, you will find some excellent information within the following material:

* <https://www.verywellmind.com/difference-between-disordered-eating-and-eating-disorders-5184548>

* <https://www.choosingtherapy.com/disordered-eating-vs-eating-disorder/>

You are reminded, however, that you still have the right to withdraw at this point, up to 1 month after today's date. Should you decide to do so you will not have to give any reason and collected data will not be used and will be destroyed.

To protect your anonymity, pseudonyms or generic participant labelling will be used in transcripts, analysis and in the overall project write-up. Your personal details will be kept confidential.

You will be aware that this study has received ethics approval from the UWTSD Research Ethics Committee and if you have any questions, concerns or complaints about your participation in this study, you can contact **Dr Beverly Cole** by telephone at **(provided on original)** or by email at **(provided on original)**.

Although this study did not directly focus on any issues which would normally involve emotionally sensitive reflection, I recognise that sometimes some questions and topics might prove to cause discomfort or evoke strong emotions. You would have had an opportunity to discuss any distress caused during the debriefing period. However, please consider speaking with someone that you trust such as a family member or a friend about any part of this experience that you have found distressing. Alternatively, if you would like to speak to someone else, further support can be found below from a list of helpful charities and organisations that you can get in touch with:

***Beat Eating Disorders**- <https://www.beateatingdisorders.org.uk/get-information-and-support/support-someone-else/nexus-carer-support/>

***Seed Eating Disorder Support Service**- <https://seed.charity/>

* **Anorexia and Bulimia Care**- <https://yippy.health/profile/talk-ed>

* **National Centre for Eating Disorders**- <https://eating-disorders.org.uk/>

If you have any further questions or concerns about the study please contact me by email (provided on original) or by telephone (provided on original).

Appendix G: Sample of Analysis

Participant B Analysis

Exploratory Noting

Original Transcript	Exploratory Comments
<p>Q: <i>Okay, so we'll just get right into it. Um, so can you please, um, tell me what you understand by the term disordered eating?</i></p>	<p>Disordered eating different to eating disorder</p>
<p>PB: <i>So disordered eating isn't quite the same as an eating disorder, that it's used more sporadically. It's used more, as and when, and, hmm, yeah. It's not, the same in--, uh [sighs], I was going to say, it's not intensity, it's just not as continuous, I guess.</i></p>	<p>Disordered eating is more sporadic, not as continuous</p> <p>Wanted to say intense but decided not to, sighed before saying that (frustration with self?)</p>
<p>IN: <i>Hmm. Yeah. So continuous in terms of how long it lasts or how long it's been going on for?</i></p>	<p>Eating disorders is often a continuation gives an example of bulimia, it occurs every day, all the time</p>
<p>PB: <i>Well, [makes speech sounds] work-- working with eating disorders, people, if they are bulimic, a lot of the time it's a continuation. You know, it's an everyday thing. It's an all-day thing. But with disordered eating, it's when stressful periods come, they utilise, the different tools and techniques that have helped them in the past. So when life is good,--</i></p>	<p>Disordered eating occurs when a person has stressful periods where they might utilise different tools and techniques that helped in the past</p> <p>When their life is going well they don't feel the need to use those techniques or tools</p>

<p>--they don't feel the need to use it. And then when, if they feel a bit stressed, or for whatever's going on for the individual, they-- they might, change their behaviour to use a-- the different eating pattern.</p>	<p>If they feel stressed or have a difficult period they might change their behaviour and use a different eating pattern</p>
<p>Q: <i>And speaking of behaviours, what would you say are sort of, signs, symptoms, behaviours you would look out for if you thought that someone might have, disordered eating difficulties?</i></p> <p>PB: [Takes a deep breath in] I suppose [sighs] it can-- it can vary, because depending on what their, the way they control their eating is, whether it is purging, whether it is bulimia, whether it is anorexia or gorging, it all depends. But the obvious things like weight loss or, you know, the-- the physical changes. But outside of that, it could be mood. It could be what you've discussed in the past.</p> <p>If somebody's highlighted that, they have used, eating as a form of control.</p> <p>If they're low, it's a way of checking out, I guess.</p> <p>IN: Yeah. Anything else in terms of any sort of other, signs that you would look out for in someone?</p> <p>PB: [Sighs] Well, everybody's different. And disordered eating isn't, all that common when it comes to, clients revealing themselves in the therapy room. They might say "I have an eating disorder". But disordered eating—</p> <p>-- not so much. It's-- it's not as easy to spot.</p>	<p>Sighs and takes a deep breath in (finds it difficult to answer?)</p> <p>It varies depending on how someone controls their eating</p> <p>It can be purging, bulimia, anorexia, gorging</p> <p>Repeats it all depends</p> <p>Other signs such as weight loss, physical changes, mood</p> <p>If someone says they have used eating as a form of control such as they are low, all those things are a way of checking out</p> <p>Sighs and says again that everybody is different (difficulty giving an answer?)</p> <p>Disordered eating not that common when it comes to clients revealing themselves in the therapy room</p> <p>They might say they have an eating disorder but disordered eating not so much</p> <p>It's not as easy to spot</p>

<p>Or certainly, as a therapist, is it my place to recognise, you know it's, unless they bring food, it's not-- it's not something that you would necessarily question, if that makes sense.</p> <p>IN: Yeah, so it's quite difficult to sort of spot, you know, actually this person might have disordered eating--</p> <p>PB: Yeah.</p> <p>IN: --beyond that spectrum.</p> <p>PB: Yeah, unless-- unless it comes up in conversation, when you're-- you're discussing different behaviours, different thought processes. You know, if somebody says, I've got low self-esteem, then you know what you're looking for, but that's not the same as necessarily spotting--</p> <p>--a behaviour of eating disorder. If that make--, you know?</p>	<p>Questions whether as a therapist it's her place to recognise the signs, unless client brings up topic of food it's not something that you she would necessarily question</p> <p>Unless food comes up in conversation when you're discussing different behaviours with client and different thought process it can be difficult to spot if someone has issues with disordered eating</p> <p>If clients mention low self-esteem then she knows what she's looking for but it's not the same as spotting a behaviour of an eating disorder</p>
---	--

Constructing Experiential Statements

Understands disordered eating being different to an eating disorder

Understands disordered eating as being more sporadic and less continuous compared to eating disorder like bulimia that occurs everyday

Attributes disordered eating to when someone is feeling stressed or has difficult periods in their life

Understands that when people are stressed they will utilise different tools and techniques that will change their eating pattern to become more disordered

Understands that signs and symptoms of disordered eating varies person to person as everyone is different

Mentions that the symptoms and behaviours of disordered eating depends on how someone controls their eating

Gives examples of purging, gorging, bulimia and anorexia

Mentions other symptoms such as physical changes, changes to mood, weight loss

Clients might mention eating as form of control when they are feeling low which can be another symptom

Understands that disordered eating might not be easy to spot in the client as clients don't necessarily reveal that about themselves in the therapy room

Clients are more likely to say they have an eating disorder than disordered eating

Questions if it's therapists role to recognise the signs of disordered eating unless the client brings up behaviours and thoughts associated with food and eating

The client might mention self-esteem relating to food and that might be a sign but it's not the same as spotting a behaviour of an eating disorder

Personal Experiential Themes (PETs) and Sub-themes

PETs and Sub-themes	Page in the Transcript and Time Stamp
PET 1: Key Characteristics of Disordered Eating <i>*Disordered eating vs eating disorder</i> <i>*Frequency of behaviours</i> <i>*Stress</i> <i>*Various signs and symptoms</i> <i>*Form of control</i> <i>*Utilising the behaviours to cope</i>	 P2, 01.38, 02.07, P14, 19.59 P2, 01.38, 02.07 P2, 02.07, 02.27 P2, 02.50, P3, 03.22, 04.09, P4, 04.43, P19, 02.03, 02.10, 02.16, 02.32, 02.39 P3, 03.16, P16, 22.42 P16, 22.14, 22.20, 22.22, 22.30, P19, 02.16, P20, 03.37, 03.51, 03.54

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<p>PET 3: Links to Trauma and Childhood Experiences</p>	<p>P11, 16.05, P12, 16.13, 16.27, 16.40, 16.48, 16.54, 17.01, 17.10, 17.27, 17.33, 17.36, 17.39, 17.47, 18.08, 18.18, 18.20, 18.32, 18.38</p>
<p><i>PET 4: Therapeutic Ways of working / Techniques</i></p> <p><i>*ACT</i></p> <p><i>*Mindfulness</i></p> <p><i>*Person centred</i></p>	<p>P6, 08.43, P8, 12.10, P9, 12.27, 12.34, 12.38, 12.46, 12.51, 13.03, 13.06, 13.22, 13.27, P10, 13.35, 13.45, P24, 08.43, P25, 08.54</p> <p>P6, 09.02, 09.41, P7, 09.45, 09.51, 10.27, 10.41</p> <p>P8, 11.10, 11.23, 11.25, 11.28, 11.39, 11.43, 11.49, 12.02, P14. 20.05, P15, 20.17, 20.46, 20.53, 21.11, 21.17, P20, 03.21, 03.28, 03.34, 03.37, 03.51, 03.54, P22, 05.32, 05.40, 05.46, 05.51, 05.53, 06.02, 06.04, P23, 07.29, P24, 07.32, 07.36, 07.38, P25, 09.49, 09.56, 10.07,</p>

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