**Exploring the processes of change in individual cognitive behavioural therapy**

**for bulimia nervosa from the patients' perspectives: A grounded theory study**

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PROCESSES OF CHANGE IN COGNITIVE BEHAVIOURAL THERAPY FOR
BULIMIA NERVOSA

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**Abbreviations**

ED: Eating disorder

UK: United Kingdom

NICE: National Institute for Health and Care Excellence

GP: General practitioner

AN: Anorexia nervosa

BN: Bulimia nervosa

DSM: Diagnostic and Statistical Manual

BED: Binge eating disorder

ARFID: Avoidant/restrictive food intake disorder

IAPT: Improving Access to Psychological Therapies

NHS: National Health Service

CBT: Cognitive behavioural therapy

RCT: Randomised controlled trial

IPT: Interpersonal therapy

BPS: British Psychological Society

GT: Grounded theory

PHQ-9: Patient Health Questionnaire

GAD-7: Generalised Anxiety Disorder

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**Abstract**

The aim of this study is to explore how individuals with bulimia nervosa (BN)

understand processes of change in individual cognitive behavioural therapy (CBT).

The treatment of individuals with BN remains a major challenge and research

suggests that treatment only helps a modest number of individuals. The rationale for

this investigation is to learn more about the factors that influence change, which

might contribute to or shed further light on the body of research that already exists in

this area.

A qualitative research method is chosen and used from a critical realist framework.

The in-depth interviews of eight participants' experiences of change in CBT for BN

are analysed using a grounded theory methodology. The data analysis includes initial

open coding, categorisation and linking the categories to construct a theory that is

grounded in the data.

The findings indicate that healing from BN is a complex and painful continual

process of personal transition, which involves 'a journey towards de-fusion of the

sense of self and the BN'. Participants described how BN gradually became part of

self and how bodily sensations and attributes affected cognitions and emotions. The

overall finding demonstrates an immediate connection between the participants'

physical and psychological realities. This symbolic communication via the body,

however, was not experienced as metaphors but rather as actual reality, which

affected the change processes in several ways. The processes of de-fusion of the

sense of self and therapeutic change in the BN seemed to have an interactional

relationship that was central to the experiences of change at all stages of CBT for

BN.

The main findings are linked to the wider context and the possible implications are

discussed. A critical evaluation of the study is offered followed by recommendations

for future research and practice in the field of counselling psychology and beyond. In

particular, mentalization-based therapy is explored as a possible framework for

conceptualising BN, which might help grasp some basic limitations and difficulties

in psychotherapy and treatment in general.

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## Chapter one: Introduction

### 1.1 Introduction to the chapter

Eating disorders (EDs) are a large-scale problem in the United Kingdom
(UK). According to the National Institute for Health and Care Excellence (NICE,
2017), more than 725,000 individuals in the UK are affected by an ED. In January
2014, statistics from the Health and Social Care Information Centre showed an 8%
rise in ED hospital admissions in 12 months. However, it should be noted that these
figures only represent rough indications, as most sufferers will not be detected by
their general practitioner (GP) or referred to hospital or mental health care (Smink,
van Hoeken, & Hoek, 2012). Thus, the incidences are likely to be higher.

An ED can impact individuals' quality of life and self-image, physical
wellbeing, relationships and day-to-day living are often adversely affected (Palmer,
2014). Furthermore, EDs are characterised by high levels of comorbidity, such as
depression and anxiety disorders (Kaye, Bulik, Thornton, Barbarich, & Masters,
2004). EDs also have a complex association with trauma (Tasca et al., 2013),
substance abuse (Harrop & Marlatt, 2010) and serious medical complications
(Mitchell & Crow, 2006). Additionally, the adverse physical consequences of
dieting, weight loss and purging behaviours are notable and sometimes prove fatal.
Indeed, EDs carry the highest mortality risk amongst all psychological disorders
(Smink et al., 2012).

According to the NICE (2017), an ED is a psychological illness characterised
by abnormal eating habits that may involve either insufficient or excessive food
intake to the disadvantage of individuals' physical and mental health. For decades,
anorexia nervosa (AN) and bulimia nervosa (BN) were considered the two main

EDs. Recently, however, researchers and therapists[1] realised that some individuals

with ED did not fit into the categories of AN and BN. As a result, the Diagnostic and

Statistical Manual (DSM) of the American Psychiatric Association (5th ed. Revised,

APA, 2013) defined two 'new' ED diagnoses; binge eating disorder (BED) and

avoidant/restrictive food intake disorder (ARFID). Hoek (2002) presents global

figures of the average figure for the point prevalence of AN and estimates it to be

280 per 100,000 females (i.e., .28%). The average point prevalence of BN is slightly

higher and estimated 1,000 per 100,000 females (i.e., 1.0%) (Hoek, 2002). Less is

known about the prevalence of BED and ARFID (Grilo, 2002). The rate ratio of

prevalence of EDs in men vs women is less than 1: 10 (Hoek, 2002), but recent

community-based epidemiological studies indicate an increase in the number of men

diagnosed with EDs (NICE, 2017)

The treatment of individuals with an ED remains a major challenge for

therapists and interventions perceived to be effective fail to help a substantial

number of patients[2] (Wilson, Grilo, & Vitousek, 2007). The findings from a recent

meta-analysis suggest that the average weighted effect size in favour of ED

psychological treatment versus control conditions is statistically significant but small

($d = .33$) (Hubbard, 2013). Those outcomes are below the 40%-60% range of the

average recovery rates for psychotherapy patients in general (Lambert, 2013).

Furthermore, ambivalence to treatment and change is a main issue and the

motivation to change is generally low and/or unstable (Geller, Williams, &

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[1] Throughout this thesis, 'therapist' is referred to as a qualified person who is involved in the
psychotherapy treatment of individuals with an ED.
[2] I have chosen to use the term 'patient' instead of 'client', which refers to the individual with an ED.
My understanding of patient is that it originates from the Latin for 'one who suffers' rather than
having anything to do with passivity or lack of power.

Srikameswaran, 2001) and up to 70% of patients drop out of outpatient treatment (Fassino, Piero, Tomba, & Abbate-Daga, 2009).

In response to the UK Government introduction of the Improving Access to Psychological Therapies (IAPT), there has been an increasing move towards evidence-based and time-limited treatments (Hodgetts & Wright, 2007). Studies investigating psychotherapy outcome have typically evaluated patient change using self-report measures to assess changes in symptoms (e.g., Beck, Steer, & Brown, 1996). However, this mode of assessment has been criticised for lacking important information on the process of change within the psychotherapy session (Rennie, 1994). Therefore, some researchers have highlighted the importance of qualitative approaches whereby an understanding of the in-session process of change situated in the interpersonal situation can be developed (Elliott, 2008). Rennie (1994) proposes that qualitative methods focus on subjectivity, which allows individuals to articulate and contextualise features of change that are important in their own experiences. Traditionally, research in psychotherapy has been conducted from the point of view of the therapists rather than the patients (McLeod, 2011). In this research, however, there is a risk that the experience and the voice of the individual is lost. This is inconsistent to the specified aim of the UK National Health Service (NHS), where the patients are at the centre of their care and the decisions made about them (Department of Health, 2008).

Given the modest outcomes found on average in the treatment trials for EDs (Hubbard, 2013) and the potential burden of the illness on patients and their families, there is a need to consider alternative strategies for researching and developing interventions. Asking the patients about their experiences may be one alternative to

improve the treatment outcomes for EDs and improve knowledge (Tasca &

Machado, 2013). In the context of EDs, the importance of investigating patient

experiences has been highlighted (e.g., Timulak et al., 2013). Bell (2003) presented a

review of qualitative research with individuals who had experienced an ED. The

review identified gaps in the ED literature and stressed a need for further research

into individuals' experiences of treatments. Furthermore, Tasca and Machado (2013)

highlight that most studies have examined the views of individuals with AN. This is

surprising, given that BN is more common than AN (Hoek, 2002; Keel, 2010), but

may be explained by the significant mortality risk associated with AN (Smink et al.,

2012). In view of the scale of the problem, the weak evidence base, the challenges in

treatment and the potential of exploring the experience of individuals with BN, the

aim of this literature review is to examine what literature is available to address

potential gaps in research knowledge.

**1.2 Reflexive statement**

Reflexivity has been conceptualised and defined in many ways (e.g.,

Cutcliffe, 2003; Finlay, 2002a; Hall & Callery, 2001; & Pillow, 2003) and most

authors reviewed refer to reflexivity as the process of examining both oneself as

researcher and the research relationship. Specifically, Etherington (2004) proposes

that reflexivity is "the capacity of the researcher to acknowledge how their own

experiences and contexts…inform the process and outcomes of inquiry" (p. 31).

Numerous theorists (e.g., Moustakas, 1994) have identified a link between a

researcher's personal experiences and the research topic. This is also the case of the

present study in which the experience of therapy by individuals with BN represents

both a personal and professional interest. On a personal level, my interest in this field

is related to my own experience with an ED since I suffered from BN during my teenage years. I remember the time as very difficult; I felt shameful about my body, my behaviours and myself, and I went to great lengths to avoid being caught binging and purging. I avoided disclosing my ED to people around me in fear of stigma, which would lead to more shame and lowered self-esteem. I felt trapped and alone inside my ED and although I did my best to conceal my difficulties, people close to me must have noticed that something was wrong. On a November evening, my dad sat down next to me, took my hands in his and asked me what was going on. After fighting my battle in silence for nearly two years, that evening was the first time I ever told anyone about my ED. The following week, I started individual therapy. The treatment took place in a private setting, included weekly sessions and lasted for about a year. Upon reflection, I am not entirely sure what therapy modality my therapist used. However, I remember that the sessions were flexible and allowed me to explore interpersonal issues in my own time. In particular, I valued the therapeutic relationship and the experience of care within that relationship. More specifically, I valued that therapy allowed a safe space where I could be honest and talk about my feelings and behaviours and explore them in depth without feeling judged. During that year of therapy, I was able to let go of my ED because I had brought myself to an emotional place where I did not need it anymore. Although I recovered many years ago, having suffered from BN is still a part of me and an experience that will accompany me for the rest of my life.

On a professional level, my curiosity in this field is related to my experience as a first-year trainee counselling psychologist in an ED service where I saw patients for individual and group therapy. This clinical placement reminded me of my own experience with BN and highlighted how severely an ED can impact individuals'

quality of life. I have realised that my own personal experience and this area of practice are strongly linked as I identified with my patients' experiences, which sometimes made 'bracketing' hard. I often found myself touched and affected by what patients brought to sessions and felt a strong urge to help them. Although identifying with my patients' experiences, however, I was also reminded that the personal experience of an ED is highly unique and varies widely from one individual to another. Part of my clinical training included offering manualised cognitive behavioural therapy (CBT). I have witnessed signs of impressive processes of change reinforced by CBT, but unfortunately, I have also experienced this approach to be ineffective in some cases. Although I can see the value in a structured manual tailored to individuals with BN, I sometimes struggled as I felt that my clinical flexibility was limited and not always meeting the need of the individual patient. My clinical placement highlighted that the experience of an ED and the journey of change is individual and often involves complex processes.

My choice to focus this study on the experience of therapy by individuals with BN is driven by my own experiences in therapy, in the patient and in the therapist role. Naturally, my subjective involvement has an influence at all stages of the research process, including the review and critique of the literature, research question, sample, design and construction of the interview schedule (Finlay, 2002a). Consequently, I have examined my motivations and assumptions as a precursor to recognise the factors that may affect the research process. I have always struggled to make sense of why I developed BN and upon reflection, a part of me might aspire to understand my own participation in the dark, secret world of BN and my journey of change. By exploring how others make sense of their 'mess', I might be able to make

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sense of my own. Moustakas (1990) refers to this process of internal search for
meaning as 'heuristic research'.

We enter the training as counselling psychologists as human beings
shadowed by our histories, expectations and beliefs, which can be more or less
valuable as a reference point in our interaction with others. I believe it is inevitable
that we all carry with us certain sets of conscious and unconscious assumptions and
that somehow we must 'bracket' these, or at least learn to work with them, if we are
to make any advances in our knowledge. Corbin and Strauss (2015) question
whether full bracketing is achievable or desirable at all and argue that meaning is
constructed by both the researcher and the participants and therefore very much a
project of human participation and negotiation. Finlay (2002a) proposes that
reflexive practice can turn subjectivity into an opportunity rather than a problem. By
writing this reflexive statement, I hope to increase my own awareness and critical
attitude towards my impact as a researcher and my subjectivity in all aspects of this
research.

DeVault (1997) highlights that one of the dangers of reflexive practice is the
researcher's preoccupation with own emotions and experiences, which consequently
may bias the findings and block out the participants' voice. Also, Pillow (2003)
challenges the usefulness of reflexivity and questions whether it really produces
better research. Finlay (2002a) however, argues that reflexivity is the means to
ensure a purposeful rather than a self-centred, personal analysis. Further, Finlay
suggests that good reflexive practice involves learning about ourselves through
listening to others and finding ways to link our subjective involvement to the study's

purpose and contribution. Thus, I recognise that my subjective involvement in this study is an opportunity as well as a limit.

By recognising the connections between myself and the research topic, I will make a conscious effort to bracket my beliefs and ideas that emerge throughout the research journey (Smith & Osborn, 2008). According to McAteer (2010), planning and providing a rationale of how to proceed in light of these influences is imperative to the overall process. Thus, my aim is to examine every procedure in a critical and non-defensive way (Kasket & Gil-Rodriguez, 2011) and only return to myself to increase awareness and insight (Finlay, 2002b). With this in mind, I have implemented a number of reflexive practices to manage my influence on the process; I have made careful use of supervision, peer support groups and personal therapy, which is aimed to help me to reflect on my personal thoughts and feelings towards the general composition of the process. Also, to maintain a relative degree of self-awareness, I have used a reflexive journal to identify and bracket my feelings and assumptions throughout the research journey. I will return to these issues later to explore the potential impact on the research process in Chapter four: Discussion. With respect to the rhetorical structure, I will continue to use the first-person voice throughout the study's main text.

## 1.3 Literature review

In this chapter, first, I will introduce some different theoretical conceptualisations of BN. Second, I will present the treatments currently recommended and offered to patients with BN in the UK and review the research exploring their effectiveness. Third, I will explore the mechanisms of change in CBT

for BN. Fourth, the rationale for asking patients about their experiences of therapy is

discussed and methods of investigation in this area are explored. This is followed by

a review of the qualitative research into experiences of therapy by individuals with

BN. Finally, I will highlight this topic's relevance to counselling psychology.

### 1.3.1 Theoretical conceptualisations of bulimia nervosa

The DSM-5 defines BN as recurrent episodes of binge eating followed by

inappropriate compensatory behaviours to avoid weight gain, such as self-induced

vomiting, misuse of laxatives or diuretics, fasting or excessive exercise (American

Psychiatric Association, 2013). Different theoretical understandings of BN have

been put forward. According to Fairburn and colleagues' (1993, 2008) cognitive

model of BN, dysfunctional beliefs and thoughts about food, weight and shape

complemented by insufficient problem-solving skills, plays a vital role in the

development and maintenance of BN. Individuals with BN suffer from feelings of

insecurity and thus, use food as both a punishment and as a coping strategy to protect

themselves from negative feelings (Fairburn et al., 1993). The illness is perpetuated

by a vicious circle where low self-esteem is associated with an over-evaluation of

shape and weight and efforts to slim. Eating restraints lead to uncontrolled eating and

compensatory behaviour with a renewed urge to eat, which leads to further impaired

self-esteem (Fairburn, 2008).

The cognitive-behavioural formulation of BN is centrally focused on

symptoms and the accompanying emotional experiences, but it does not emphasise a

deeper exploration of the underlying conflict (Hamilton, 2001). In contrast, however,

psychoanalytic conceptualisations focus on the underlying emotional dynamics in

BN. The earliest psychoanalytic understanding of EDs is based on Freud's classical

drive theory (Farrell, 2000; Schwartz, 1988). This theory suggests that unsublimated

aggressive and libidinal drives are displaced and condensed into bulimic symptoms,

which provide an outlet for the unacceptable repressed impulses. More recent

psychoanalytic understandings are proposed. For example, Bruch (1973) proposed

that an ED basically represents a deficit of the self and that these individuals function

with a 'false self', which suggests that they may not discriminate between own and

caregiver's expectations and needs (Winnicott, 1964). Furthermore, object relations

theory describes that an infant gradually internalises the images of the actions of the

caregiver, which then guide patterns of experiencing and relating (Klein, 1975). In

the case of BN, the individual is thought to have experienced a non-contingent form

of affect mirroring and consequently struggles to distinguish between the

psychological and physiological aspects of desire. Thus, hunger may symbolically

remind the patient of a painful psychological reality that must be controlled to avoid

being overwhelmed and eating restraints function to keep such feelings at bay

(Clinton, 2006; Williams, 1997a). As noted above, there are several variations and

nuances of the psychoanalytic conceptualisations of BN. These different theories,

however, can be understood as a set of strategies to regulate affects (Clinton, 2006).

Thus, the over-investment of eating restraint reflects an unconscious need to resolve

past dysfunctional interpersonal relationships and the binging and purging

behaviours serve to displace repressed impulses, release tension and regulate

intolerable affects.

Recently, Schmidt and Treasure (2006) presented the Maudsley Model of

Anorexia Nervosa Treatment for Adults (MANTRA), a cognitive-interpersonal

maintenance model and treatment for EDs, and AN specifically. The researchers

have since refined the model (Treasure & Schmidt, 2013) and they propose that an

ED typically arises in individuals who possess sensitive/anxious and

perfectionistic/obsessional personality traits. The model encompasses four

maintaining factors, including thinking style characterised by rigidity, detail focus

and fear of making mistakes; an in-expressive, avoidant emotional and relational

style; positive beliefs about the utility of the ED for the individual; and a response of

close others characterised by high expressed emotion and enabling of and

accommodation of the illness (Schmidt & Treasure, 2014). In contrast to classical

CBT models for EDs (e.g., Fairburn, 2008) and their focus on weight and shape

concerns as *the* key psychopathology, the MANTRA model highlights that weight

and shape concerns are simply symptoms of more profound and worrying issues.

Indeed, Schmidt and Treasure (2014) note that the most common underlying worry

is interpersonal difficulties, related to fear of rejection, negative perception of self

and experience of negative emotions. The MANTRA model highlights the

importance of relationships and emotions in EDs. In 2017, the NICE recommended

MANTRA as a first-line treatment for adults with AN.

**1.3.2 Treatments offered and their efficacy**

According to the NICE (2017), CBT is a first-line psychotherapeutic

treatment for adults with BN. CBT originates from the cognitive model, which

assumes that non-rational thoughts and beliefs lead to excessive pre-occupation in

certain areas (Beck, 1967). In the case of BN, the focus is on shape, weight and body

image and therefore, the treatment focus is on the modification of these beliefs and

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ultimately behaviour through a combination of cognitive and behavioural procedures
(Palmer, 2014).

CBT for BN (often referred to as CBT-BN) was developed in the early 1980s
by Fairburn, Professor of Psychiatry of the University of Oxford, and has later been
developed and refined (Fairburn, 1981; 2008). CBT-BN is a highly structured
treatment and its originator advises that it should be applied routinely and according
to the manual. Therapists are warned that deviating from the prescription of the
manual, to tailor the therapy to the individual patient, is likely to affect the efficacy
of the treatment (Fairburn, Marcus, & Wilson, 1993). Generally, CBT-BN consists
of 20 sessions of individual therapy delivered over 5-6 months with three different
phases: the first phase focuses on rapid symptomatic improvement; the second phase
concentrates on tackling dietary beliefs and practices besides attitudes toward shape
and weight; and the third and final phase focuses on continued improvement after
ending of treatment and relapse prevention (Fairburn et al., 1993).

Randomised controlled trials (RCT) based on this model support its overall
efficacy in symptom reduction and show it to be superior to other psychological
treatments (Fairburn et al., 1993). However, CBT for BN is believed to lead to
complete remission of symptoms in only about 30%-50% of all cases (Wilson et al.,
2007). Fairburn and colleagues realised the need for increased potency and extended
range, which motivated the development of an 'enhanced' version of manualised
CBT (often referred to as CBT-E) (Fairburn, 2008). The newer 'enhanced' form of
CBT for EDs has much in common with CBT-BN. However, a notable difference is
that there are two versions of CBT-E referred to as 'focused' (core treatment) and
'broad' (with modules addressing mood intolerance, clinical perfectionism, core low
self-esteem and interpersonal difficulties). At this point, CBT-E is beginning to be

used and the clinical experience is starting to grow. One major two-site trial (Oxford and Leicester) compared the two forms of CBT-E on a joint sample of 154 individuals with BN and eating disorder not otherwise specified (Fairburn et al., 2009). The findings revealed both forms of CBT-E to be effective and superior to the comparison group and the benefit was maintained at 60-week follow-up. The results for CBT-E for BN were similar to results obtained in trials with CBT-BN with around half of the cases reporting no binge eating at the 60-week follow-up. Furthermore, the results showed that those patients who had 'complex' illness did better if they received the broad version of CBT-E. In contrast, those individuals who had a more 'straightforward' illness did better if they received the focused version. These results made Fairburn and colleagues conclude that the focused version should be the default treatment and the broad version should be used for 'complex' cases.

As a result of RCTs, the NICE (2017) guidelines have concluded that manualised CBT is the treatment of choice for adults with BN. From the general psychotherapy research literature, treatment manuals have received mixed responses from both therapists and researchers (e.g., Piper & Ogrodniczuk, 1999). On the one hand, manual-based treatments have often proven to be effective in controlled outcome studies, they provide a theoretical framework and they allow standardised techniques (Wilson, 1996a). On the other hand, however, some research proposes that treatment manuals may constrain the clinical practice (Piper & Ogrodniczuk, 1999). For example, Castonguay, Goldfried, Wiser, Raue, and Hayes (1996) investigated the effect of manualised-based cognitive therapy for depression. The researchers found that strict adherence to the treatment manual was associated with

problems in the therapeutic alliance. Consistent with these findings, Henry, Strupp,

Butler, Schacht, and Binder (1993) found that overly conscientious adherence to the

psychodynamic treatment manual led to less favourable outcomes.

Despite the controversies between research and practice, treatment manuals

have been developed and are widely used across different therapy modalities (Piper

& Ogrodniczuk, (1999). Wilson (1996a) highlights that manuals differ greatly in the

degree of structure and standardisation. In line with this notion, Boucher (2010)

suggests that CBT can be perceived on a continuum of application rather than as one

exact modality. At the one end of the scale, CBT greatly relies on theory and

techniques and therapists adopt a prescriptive and manualised attitude with respect to

individuals' presenting issues. At the other end of the scale, CBT is a less

technically-oriented approach and does not offer a guide to the treatment, but rather

an opportunity to explore and interrupt beliefs and interpretations (Boucher, 2010).

As pointed out by Wilson (1996a), manual-based treatment does not exclude

individualised therapy. However, Piper and Ogrodniczuk (1999) warn that treatment

manuals should be applied with care and used as a general guideline rather than as

specific and detailed technical behaviours.

CBT has been found superior to other therapy approaches in treating patients

with BN with one exception of interpersonal therapy (IPT) (Wilson et al., 2007). IPT

was originally developed in the 1970s at Yale University by Klerman and Weissman,

a psychiatrist and a psychologist respectively (Klerman, Weissman, Rounsaville, &

Chevron, 1984). IPT is non-directive and non-interpretive, and the primary focus is

to examine and promote change within the current interpersonal world of the patient

rather than focus directly on the ED symptoms (Fairburn, 1997). Relative to CBT,

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research has identified IPT as an equally successful treatment for BN (e.g., Wilfley et al., 1993).

Fairburn et al. (1993) compared CBT to IPT and found that the former was inferior to the latter at post treatment. However, at one- and six-year follow-ups, the two therapies were found to be equally effective. These results have been replicated and confirmed in other studies, interestingly by the same authors (e.g., Agras, Walsh, Fairburn, Wilson, & Kraemer, 1999). However, Wilson, Fairburn, Agras, Walsh, and Kramer (2002) propose that the difference in time course of response between CBT and IPT is decided by the level of symptoms at the end of treatment, rather than by which treatment they received. Indeed, the equal effectiveness of the two therapies at follow-ups may demonstrate regression to the mean instead of a delayed therapeutic effect (Wilson et al., 2002). Arcelus, Hastam, Farrow, and Meyer (2013) highlight that IPT, with its different focus and course of response relative to CBT, needs to be further explored and investigated. The difference in the time course of response between CBT and IPT suggest that each therapy has particular effects and are likely to work via different mechanisms (Wilson, 1996b).

Psychodynamically based therapies are also used in the treatment of BN (Palmer, 2014). These approaches focus on internal change, understood through patterns of transference and counter-transference, which are thought to lead to symptom remission (Williams, 1997b). Although CBT-E incorporates other things, the focus of CBT seems to be on altering cognition and beliefs in relation to food and weight gain and thus altering unhealthy behaviours. However, studies propose that there needs to be an extended focus beyond the basis CBT focal points (Bell, 2003). Also, the noted efficacy of IPT supports the idea that treatments for BN may

be effective although there is limited attention to symptoms. However, there remain

limited systematic evidence to support this approach (Murphy, Russell, & Waller,

2005). Poulsen and colleagues (2014) compared psychodynamic psychotherapy to

CBT-E in the treatment of BN and found that both treatments resulted in

improvements. However, CBT-E was more effective in relieving binging and

purging even though this approach involved fewer number of treatment sessions.

These findings seem to suggest that psychoanalytic psychotherapy addresses relevant

issues, but that more structured and behavioural interventions are needed in the

treatment of this clinical population (Poulsen et al., 2014).

A number of researchers have proposed that the treatment of BN is likely to

be successful when integrating psychodynamic principles with cognitive and

behavioural interventions (Steiger, 1989; Tobin & Johnson, 1991). This integrative

approach was originally proposed in the 1980s by Lacey, Professor of Psychiatry of

St George's Hospital Medical School in London, and has later been termed

'Conflict-Oriented CBT' (CO-CBT) (Latzer, Peretz, & Kreutzer, 2008). The focus of

this approach is on a deep exploration of the conflict underlying the BN pathology,

combined with treating the symptoms (Latzer et al., 2008). Murphy and colleagues

(2005) developed a treatment protocol for psychodynamic treatment of individuals

with BN, based on an integrative approach with time-limited and behavioural

interventions. The participants showed a significant reduction in bulimic symptoms

after completing the programme. The findings suggest that this integrative approach

may facilitate bulimic symptom reduction through two mediating interventions; one

dealing with interpersonal issues and the other dealing with ED behaviour (Murphy

et al., 2005).

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Taken together, research supports CBT for BN and this approach has been

established as the usual treatment of choice (NICE, 2017). However, CBT is not

universally effective and is thought to eliminate symptoms in only about 30%-50%

of all cases whilst being somewhat helpful in rather more (Wilson et al., 2007). The

evidence base for the conceptualisation and approach to treatment is hopeful, but it

still leaves a quarter to a third of those still suffering from BN (Palmer, 2014).

Manual-based CBT is the most researched evidence-based treatment for BN (Wilson

et al., 2007) and is the most commonly delivered treatment in the UK (Timulak et

al., 2013). However, few studies have investigated how CBT works or determined

the mechanisms of change in CBT for BN (Wilson, 1999). Identifying the

mechanisms whereby psychotherapies produce change has the potential to advance

treatments and improve our understanding of the nature of BN and the processes that

maintain the illness (Wilson et al., 2002; Murphy, Cooper, Hollon, & Fairburn,

2009).

**1.3.3 Mechanisms of change in cognitive behavioural therapy for bulimia
nervosa**

According to the cognitive mediation hypothesis, psychological disturbances

are caused by unhelpful cognitive processes and therefore change in these processes

can produce improvement in the symptoms of psychological distress (Burns &

Spangler, 2001). In the case of BN, dysfunctional attitudes about weight and body

appearance are caused by negative core beliefs (Fairburn et al., 1993). In CBT, those

negative core beliefs are challenged, which lead to a reduction in the frequency of

negative automatic thoughts and thus a reduction of the eating disordered symptoms

(Fairburn, 2008).

According to the theory and research of CBT, several mechanisms of CBT

for BN have been proposed to account for change (Wilson & Fairburn, 1993). For

example, Wilson and colleagues (2002) have identified three possible mechanisms

thought to explain the effects of CBT: One hypothesised mechanism of CBT for BN

is the *reduction in dietary restraint*. Specifically, on a physiological level, adopting a

regular pattern of eating is thought to reduce binge eating and then purging

behaviours. On a cognitive level, reducing the dietary restraint alleviates

dichotomous thinking about eating. A second hypothesis is that CBT enhances *self-

efficacy for coping* with negative affect and interpersonal stress, which is associated

with a reduction in binging and purging. A third hypothesised mechanism of CBT

for BN is *modification in patient cognition*. As dysfunctional beliefs about body

appearance are reduced, the pressure to diet decreases, which is associated with a

reduction in binge eating and purging.

With respect to the CBT mechanisms of change literature, Wilson et al.

(2002) analysed the results of a RCT of the treatment of BN. The results suggested

that rapid change in dietary mediated improvement in both binge eating and

vomiting. The finding supports the notion that dietary restraint is an antecedent of

binge eating at post treatment. Also, self-efficacy over eating behaviour, negative

affect and appearance were found to be mediators of binge eating. Further, two

studies using structural equation modelling found support for the relationship

between over-evaluation of weight and shape, dietary restraint and binge eating in

BN (Lampard, Byrne, McLean, & Fursland, 2011; Lampard, Tasca, Balfour, &

Bissada, 2013).

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Although the above findings are consistent with the theory of how CBT for BN works, Kazdin (2007) proposes that a comparison of symptoms or certain cognitive and behavioural variables post treatment are not adequate to conclude if CBT affects change. To overcome this limitation Spangler, Baldwin, and Agras (2004) investigated the relationship between therapist interventions, patient mechanisms and symptoms at multiple points during treatment in a group of 56 women receiving outpatient CBT for BN. The findings revealed that behavioural interventions (e.g., prescription of regular eating, meal planning, exposure to feared foods) were mainly related with symptom change during treatment while relational interventions (e.g., collaboration, empathy) were mainly related with change in patient mechanisms, for example patient engagement. Also, the findings showed that changes in BN symptoms were mediated by changes in anticipated patient mechanisms while other changes were related with therapist interventions. The findings suggest that the cognitive, behavioural and relational mechanisms of CBT for BN are all related with therapeutic change but mediated by different variables. Spangler and colleagues propose that these findings highlight the importance of flexibility between technical (i.e., behavioural), relational and structural (i.e., agenda-setting, homework assignment, pacing) interventions during treatment. Furthermore, the researchers conclude that applying a mix of interventions is more likely to lead to recovery than reliance on any single intervention.

Additionally, general process outcome research has consistently showed that the therapeutic relationship is related to patient improvement across different clinical issues and theoretical perspectives (e.g., Castonguay, Constantino, & Holtforth, 2006). Indeed, in reviewing integration of psychotherapeutic practices, Beitman,

Goldfried, and Norcross (1989) propose that the therapeutic alliance is a more significant mediator of therapeutic change than specific CBT interventions. With regard to the treatment of EDs, a recent meta-analysis shows that ratings of therapeutic alliance are related to subsequent symptom reduction (Graves et al., 2017). In the case of CBT for BN, research indicates that the therapeutic alliance is related with improvement in symptoms of binge eating and purging behaviour (Treasure, Katzman, Schmidt, Troop, Todd, & de Silva, 1999; Loeb, Lock, Greif, & le Grange, 2012). In contrast, however, Wilson et al. (1999) found that specific CBT techniques were more potent predictors of treatment outcome compared to therapeutic alliance.

According to the theory and research, several mechanisms may influence the therapeutic relationship in CBT for EDs (Waller, Evans, & Stringer, 2012). For example, one hypothesised mechanism is that individual patient characteristics influence the therapeutic alliance, including the patients' expectations of improvement (Constantino, Arnow, Blasey, & Agras, 2005). Another mechanism is that early symptom change is related with a more favourable therapeutic relationship (Graves et al., 2017; Fairburn, Agras, Walsh, Wilson, & Stice, 2004). Furthermore, it has been hypothesised that individuals' motivation to change is associated with the quality of the therapeutic alliance (Treasure et al., 1999).

It can be appreciated from the review above that considerable efforts have been made to evaluate how individuals with BN change in CBT. Although much is known, much remains unclear about how patients change and recover from BN (Lampard & Sharbanee, 2015). Methodological limitations in both CBT and therapeutic alliance research have been highlighted as statistical analyses of

mediators of treatment outcome are correlational and therefore cannot determine causality (Wilson et al., 2002). With respect to research investigating CBT for BN, the relationship observed between certain therapist manipulations, patient mechanisms and symptoms could be due to several causal structures. For example, the positive correlation between therapist interventions and patient engagement could be due to therapist relational interventions facilitating patient engagement, or patient engagement encouraging relational involvement of the therapist (Spangler et al., 2004). Also, with respect to the alliance research, symptom change may have preceded cognitive changes (Waller et al., 2012). In quantitative studies, the deep and rich details of how and why individuals change are not clear (Kazdin, 2007). According to Spangler and colleagues (2004), the mechanisms of change research often assumes that therapist manipulations drive the change in patient symptoms. However, Spangler et al. propose that the meaning that each individual patient ascribes to a certain intervention is likely to affect how they respond to that intervention rather than the intervention by itself. Consequently, a certain treatment intervention may work for multiple reasons. These findings challenge the assumptions of the evidence-based model, which underpins both NICE and IAPT. Qualitative research may be one way of assessing the complex process of cognitive and behavioural change that happens during therapy, which will improve our knowledge about the meaning and interrelationship of different components (Kazdin, 2007).

**1.3.4 Summary of the issues raised**

Several controlled trials in BN have been conducted to evaluate the most

beneficial treatments for this patient group. Although these trials have established

some efficacy, researchers and therapists continue to express reservations about the

effects of treatment on recovery (Tasca & Machado, 2013). Furthermore, the

outcome of treatment in BN continues to be unclear and many patients fail to make

sufficient improvement (Lampard & Sharbanee, 2015). In the past decade,

counselling psychology has, along with related professions, underscored the

importance of qualitative and mixed methodologies in psychotherapy research

(Rennie, 1994). Wilson and colleagues (2007) argue that the development of more

effective treatments rely on an enhanced understanding of the mechanisms whereby

psychological treatments generate therapeutic change. Patients' perceptions of

treatment have the potential to inform the therapeutic process and provide a more

thorough understanding of the processes that influence change (Rennie, 1994).

**1.3.5 Rationale for asking patients about their experiences of therapy**

The research into patient experiences of therapy concerns events perceived

by patients as having been helpful or significant in the therapy process. The rationale

for this research is that such events are likely to be the most fruitful instances of the

therapeutic process and therefore may indicate the elements of therapy that

contributed to or brought about change for that individual (Timulak, 2007). The need

to explore patients' experiences of therapy arose from the observation that the

perspectives on what is significant in therapy differ considerably with the therapist

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and the patient (Timulak, 2010). For example, Llewellyn (1988) compared the

therapist and patient views of the helpful and unhelpful events in therapy. The study

showed that, during therapy, patients found the relief and reassurance provided by

therapy most helpful and, in retrospect, found the problem-solving aspects of therapy

most helpful. In contrast, the therapists, both during therapy and in retrospect,

thought that the insights patients experienced were most helpful. Furthermore,

Llewellyn found that the greater the disparity between the two perspectives, the

poorer the outcome.

The therapeutic alliance is considered to be a vital aspect of successful

treatment and has been found to be a consistent predictor of the therapy outcomes in

psychotherapy research (Horvath, Del Re, Flückiger, & Symonds, 2011). The

findings that there is a positive correlation between the therapeutic alliance and

successful treatment seem to be consistent across different patient populations,

treatments and issues (Martin, Garske, & Davis, 2000). Despite the significance of

the patient-therapist collaboration, Fitzpatrick, Iwakabe, and Stalikas (2005) have

highlighted that the therapist and patient perspectives of the alliance do not always

agree. For example, a meta-analysis of the patient-therapist perspectives of the

working alliance showed that the therapists' ratings were only moderately correlated

with the patient's ratings (Tryon, Blackwell, & Hammell, 2007). Horvath and

colleagues (2011) found that the patient ratings were a superior predictor of a

positive outcome than the ratings of the therapist.

The above findings have led to research investigating the patients'

experiences of therapy to challenge dominant discourses that privilege the therapists'

ideas above those of the patient (Bowman & Fine, 2000). According to Elliott

(2008), research into patient experiences of therapy has the potential to lead to

greater understanding of the patients; how they experience themselves change and

what they found helpful and unhelpful, which in turn can improve effectiveness of

therapy.

**1.3.6 Methods of investigation**

Researchers have used a range of different methods to investigate patients

accounts of their experiences of therapy. Quantitative research has measured

frequency of occurrence of different types of events and differences in patients' and

therapists' perceptions of helpful events (Llewelyn, 1988; Martin & Stelmaczonek,

1988). For example, Gershefski, Arnkoff, and Glass (1996) investigated patients'

perspectives on the helpful aspects across different treatments for depression. The

findings revealed that the helpfulness of the therapist was reported most frequently.

Rennie (1996) reviewed this research and highlighted that the findings were based on

a questionnaire consisting of researcher defined categories. As a result, Rennie

concluded that the results may be biased by what the researchers predicted to be

helpful from the theory.

Additionally, qualitative methods have been used to investigate helpful and

hindering aspects of therapy. Some researchers have used retrospective interviews,

which may have taken the form of structured, semi-structured or unstructured

interviews (e.g., Bowman & Fine, 2000). Also, structured narrative analyses of

psychotherapy transcripts have been used (e.g., Grafanaki & McLeod, 1999).

Different parts of the therapy process have been investigated, ranging from whole

experiences of therapy (e.g., Paulson, Truscott, & Stuart, 1999) to short discrete

events within the therapy session (e.g., Helmeke & Sprenkle, 2000).

The 'significant events' research (Elliott, 1985) represents a particular

approach to investigate the patient-identified important moments in the therapy

process. Significantly helpful or hindering refer to those events which stand out from

the rest of the session. The rationale for this type of research is the idea that such

events are likely to be important in the change process and therefore may indicate the

factors that contributed to or acted against change for that individual (Timulak,

2010). There are several ways of identifying significant therapy events. Typically,

the patient is asked to identify the most helpful or non-helpful event(s) in the session.

These events are then analysed by the means of interpersonal process recall (Kagan,

1980), brief structured recall (Elliott, 1984) and more recently comprehensive

process analysis (Elliott et al., 1994). These methods allow the researcher to explore

the context in which the significant event occurs, the patient's experience of it and its

effect over the course of the therapy.

### 1.3.7 Qualitative research into individuals with bulimia nervosa's experiences of therapy

A number of studies (e.g., Beresin, Gordon, & Herzog, 1989; Hsu, Crisp, &

Callender, 1992; Nilsson & Hägglöf, 2006; Tozzi, Sullivan, Fear, McKenzie, &

Bulik, 2003) have investigated the individuals' perspectives of recovery from AN.

However, only a few accounts of the individuals with BN's experience of therapy,

change and recovery are available. The finding that the bulimic patient's experience

is less clearly explored than the anorexic patient's is also confirmed by a recent

meta-analysis that investigated patients' perceptions of helpful and unhelpful aspects

of treatment (Timulak et al., 2013). Timulak and colleagues (2013) identified 24

studies in total, with nine studies solely patients with AN, three studies only patients

with BN and the reminder included participants with a mixture of AN and BN or

eating disorders not otherwise specified.

Rorty, Yager, and Rossotto (1993) conducted semi-structured interviews with

40 women who considered themselves to have recovered from BN and asked them

about factors that they believed to be related to their recovery process. The semi-

structured interview was part of a larger-scale study of recovery from BN that

involved several self-report questionnaires and interviews. Rorty and colleagues

coded the data according to a categorical system. The study included a wide array of

accounts and experiences of the divergent paths the participants took in the recovery

process (i.e., spiritual guidance, self-help books, contact with other women with BN

and professional/non-professional care). Among other things, the study revealed that

factors such as 'support from therapist or significant others', 'contact with others

with BN' and 'work on underlying issues' were helpful in the recovery process.

Pettersen and Rosenvinge (2002) also investigated patients' perspectives on

recovery and interviewed 48 women with a past or present history of BN or

symptoms within the BN spectrum who had received professional treatment for their

ED. The interviews were analysed using a qualitative approach not further specified.

In accord with Rorty and colleagues (1993), Pettersen and Rosenvinge found that

respect, understanding and empathic relationships (including therapists, other women

with EDs or significant others) are vital to recovery. Furthermore, the study revealed

that positive recovery outcome is related to the timing of therapy and the subjective

feeling of being ready to change. Additionally, the participants stressed the

importance of an improved understanding of interpersonal issues underlying the ED.

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In contrast to the treatment focus in CBT, however, they did not highlight focusing

on symptom control as central for recovery. The findings are also supported by De la

Rie, Noordenbos, Donker, and van Furth (2008) who studied the quality of treatment

of EDs from the perspective of the patient and the therapist and compared their

views. The findings revealed that both patients and therapists stated the therapeutic

alliance, treatment focus and communication skills as central aspects of the quality

of treatment. However, they prized the same areas differently. The patients stressed

the therapeutic relationship and addressing underlying issues as being most

important while the therapists highlighted the focus on the ED symptoms and

behavioural change as most important. De la Rie and colleagues highlight that these

differences have several consequences and may affect the role expectations of both

the therapist and the patient and as a result negatively affect the therapeutic alliance

and therefore hinder the treatment progress.

Poulsen, Lunn, and Sandros (2010) investigated the experience of individual

psychodynamic psychotherapy by 14 individuals with BN through semi-structured

interviews. The interviews were analysed using a combination of qualitative

techniques from grounded theory (Glaser & Strauss, 1967) and Giorgi's (1985)

phenomenological approach. Helpful aspects identified by the participants focused

mainly on the therapists listening to them and accepting them as individuals as well

as their needs and feelings. Another helpful aspect identified was the therapists'

assistance in recognising feelings and expression of emotions. In general, the

participants reported positive experiences of therapy, which were related to the

characteristics of the psychodynamic approach. In particular, regarding affect

regulation and interpersonal issues. However, the findings also revealed pronounced

differences in the participants' experiences. While all participants were confused by

the nondirective technique at the onset of therapy, one subgroup expressed that they

felt therapy was helpful and felt comfortable with the non-directive approach from

the onset of therapy. Another subgroup reported that they struggled to accept the

therapeutic technique, for example, the nondirective position of the therapist and the

relatively unstructured approach. Poulsen and colleagues conclude that the

differences in experience of therapy may be due to the differences in personality

characteristics of the individual participants. This idea is supported by the findings

indicating that individuals with BN differ with regard to individual characteristics

and presenting issues (Cassin & von Ranson, 2005). Similar findings have been

identified in studies investigating patients' experiences of individual psychodynamic

psychotherapy with other clinical populations (Bury, Raval, & Lyon, 2007)

including studies incorporating other therapy approaches (Dale, Allen, & Measor,

1998). These findings suggest complexity in mechanisms for any given treatment

intervention or therapeutic outcome. Taken together, this highlights the importance

of an individualised and flexible approach to treatment and change. This is in line

with a pluralistic epistemology, which acknowledges the truth of multiple views in

answering the question we are faced with in our personal and professional lives

(McAteer, 2010).


In line with the focus of the present study, Laberg, Törnkvist, and Andersson

(2001) investigated how individuals with BN who had received CBT group therapy

with interpersonal emphasis experienced their treatment. Laberg and colleagues

interviewed seven individuals and employed a grounded theory methodology to

analyse the data. The study showed that the therapeutic relationship is important to

the outcome of the treatment. This finding is supported by many studies using

various methodologies that indicate the importance of the therapeutic alliance to
positive outcome of therapy (e.g., Lambert & Barley, 2001). Furthermore, helpful
aspects of therapy included developing new knowledge and insight. In particular, the
participants reported that they had profited from adopting a regular pattern of eating
with the aid of a meal plan. Additionally, the participants highlighted that gaining
new interpersonal skills was helpful in the recovery process, improving coping with
emotions and social relations.

Also in accordance with the focus of the present study, Onslow, Woodward,
Hoefkens, and Waddington (2015) explored the experience of CBT-E. The
researchers conducted semi-structured interviews with eight individuals with BN and
the data was analysed using interpretative phenomenological analysis to identify
which elements of CBT-E participants found most or least helpful. The study
revealed that participants valued aspects that were both specific and non-specific to
CBT-E. For example, the most helpful aspect of CBT-E was gaining insight into the
maintenance cycles through psychoeducation and formulation, which motivated
change and adaptive coping. This finding provides support for the hypothesised
mediators of change in CBT-E offered by Fairburn (2008). However, the participants
also proposed strategies that are deviations from the CBT-E protocol as helpful and
highlighted the therapist's ability to be flexible and apply strategies from other
therapy approaches (e.g., early trauma). The most unhelpful aspects of CBT-E
identified by the participants included focusing mainly on changing behavioural
symptoms rather than changing core beliefs about self.

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**1.3.8 The rationale and aim of the study**

Although much is known, much remains unclear about how patients with BN change in CBT (Tasca & Machado, 2013). Methodological limitations in both CBT and therapeutic alliance research have been highlighted as statistical analyses of mediators of treatment outcome are correlational and therefore cannot determine causality (Wilson et al., 2002). With respect to the research investigating CBT for BN, the relationship observed between certain therapist manipulations, patient mechanisms and symptoms could be due to several causal structures (Spangler et al., 2004). Lampard and Sharbanee (2015) argue that the development of more effective treatments relies on an enhanced understanding of the processes whereby CBT generates therapeutic change in BN.

So far, no study has investigated the processes of change in individual CBT for BN from the patients' perspectives. By learning more about the factors that influence change in CBT, research findings might contribute to or shed further light on the body of research that already exists in this area. Further, in reviewing the current gaps in the literature on BN in terms of the individual experience, I hope that the findings will inform theory, practice and research about how CBT works among this patient group.

**The aim of this study is to explore how individuals with BN understand processes of change in CBT.**

**1.3.9 Counselling psychology relevance**

This study aims to abide by the philosophy underpinning counselling psychology, which is concerned particularly in engaging with and respecting the patients' subjective experiences, feelings and beliefs (British Psychological Society, BPS, 2005). This study, with its qualitative focus, does not aspire to obtain universal laws or arrive at any major generalisations of how individuals with BN recover. Rather, it aims to gain a greater understanding of the processes that contribute to therapeutic change. Counselling psychology encapsulates a holistic approach to practice and research, with roots in phenomenological, existential, psychodynamic and humanistic paradigms, to understand and affirm the meaning of the individual *as it feels to them* (Woolfe, Dryden, & Strawbridge, 2010). Cooper (2009) highlights that counselling psychologists tend to favour humanistic principles in their practice, valuing the individual subjective experience over models and theories, while still striking a balance between the two. In line with this, counselling psychology supports an interactive approach (Boucher, 2010). Thus, rather than expecting patients to submit fully to treatments prescribed by professionals, it stresses the subjective experience of patients. Also, counselling psychology emphasises the need for therapists to engage with patients as collaborators to understand their inner worlds and constructions of reality (Strawbridge & Woolfe, 2010).

This study aims to contribute to the discipline of counselling psychology and beyond by exploring the experience of therapy by individuals with BN. By learning more about the factors that contribute to or act against therapeutic change, the findings can inform counselling psychologists and other allied health professionals in working with this patient group. Further, in reviewing the current gaps in the

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literature on BN in terms of the individual experience, the findings will enhance

clinical expertise in this area and identify potential research possibilities. Thus, the

recommendations from the findings will serve to empower the voice of individuals

with BN to be heard and encourage the implementation of services to meet the needs

of this clinical population.

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**Chapter two: Methodology**

**2.1 Introduction to the chapter**

In this chapter, first, I will introduce the proposed research design for the
study and provide a rationale for choosing a qualitative research methodology.
Second, I will present and discuss the grounded theory methodology, explore the
philosophy underlying the chosen methodology and provide a rationale for semi-
structured interviews. This is followed by a description of the participants, the
recruitment process and the data collection. Finally, I address the ethical
considerations elicited and explore reliability and validity of the study.

**2.2 Research design**

Burck (2005) notes that, although often overlooked, the most important part
of the research process is the research question. This idea matches my own personal
experience of the dilemmas I faced during the initial stages of the research journey
and showed to be vital in directing me towards the chosen methodology. As
highlighted above, a review of the literature shows that a full understanding of how
individuals with BN change in CBT remains elusive. I knew what should happen
according to theory, but I was curious to learn about these individuals' experiences
of therapy, from their perspectives. More specifically, I wanted to explore if they
believed that they had changed in response to CBT and if it was consistent with the
theories.

In their guidelines for publishing qualitative research, Elliott, Fischer, and
Rennie (1999) highlight the importance of "owning one's perspective" (p. 221).

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Thus, researchers must be clear about the guiding paradigm, methodology, personal

beliefs and values at the onset of the research process. This is necessary as a study's

aims and methods require knowledge about the underlying paradigm (Ponterotto,

2005). Furthermore, the philosophical framework is essential in determining the

credibility of the study (Havercamp & Young, 2007).

A researcher is faced with multiple paradigms, including positivism, post

positivism, constructivism-interpretivism and critical theory (Denzin & Lincoln,

2011). According to Ponterotto (2005), paradigms can be characterised through their

*ontology* (the nature of reality), *epistemology* (the study of knowledge), *axiology* (the

role of values and beliefs in the research process) and *methodology* (the procedures

of research). Finlay and Gough (2003) highlight that one must adopt a position to

which one can relate, which requires reflecting on personal beliefs and assumptions

as well as aims and objectives of the study. My personal and philosophical beliefs

fall in line with critical realism. Broadly speaking, critical realism proposes that there

is a world that exists independently of the human mind but it cannot be accessed in

its entirety (Lincoln, Lynham, & Guba, 2011). The goal of critical realism is not to

predict outcomes, but rather to understand a phenomenon in depth (Willig, 2013).

Critical realism seems linked to the concept of pluralism and recognises the validity

of multiple perspectives on the world (McAteer, 2010). My personal and

philosophical beliefs and assumptions come from a non-positivistic stance. I do not

believe in one single, objective reality, but rather that individuals will experience and

interpret events or phenomena in different ways according to their personal world

view, attitudes and beliefs (Willig, 2013). This view of knowledge and reality also

informs my chosen profession – counselling psychology.

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It was essential to adopt a methodology for the present study that was both appropriate in answering the research question and matched the position of a critical realist. The aim of this study is to explore how individuals with BN understand processes of change in CBT. The concept of processes of change in CBT is considered to relate to real structures that patients have experienced. However, how the patients describe and interpret these experiences depend on a more relativistic approach where interpretation and subjectivity is necessary to reach meaning and build a theory. The aim of this study therefore requires incorporating both realism and relativism, which is in accord with a critical realist position (Fassinger, 2005).

The philosophical beliefs and values underpinning this study seem in line with counselling psychology, which is phenomenologically concerned in engaging with and respecting people's inner worlds and uncovering subjective truths (BPS, 2005). Qualitative methods assist the researcher to examine these complex processes by allowing them to investigate the texture of experience, rather than identifying cause-effect relationships (Willig, 2013). The aim of qualitative research is to "investigate the quality – the distinctive, essential characteristics – of experience and action as lived by persons". The researcher attempts to "describe and understand actual instances of human action and experiences from the perspective of the participants who are living through a particular situation" (Fischer, 2006, p. XVI). As these descriptions correspond with my aim to explore therapy from the point of view of the individual who has received it, a qualitative methodology was chosen for this study.

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**2.3 The rationale for a grounded theory methodology**

There are a considerable group of qualitative methodologies to select from
and Fischer (2006) highlights that each of these is linked to a complex literature with
its own history and preferred methods of implementation. According to Cooper and
McLeod (2011), the research question will govern the choice of the methodology.
For example, discourse analysis (Willig, 2013) aims to explore the language
individuals use, which is considered to be a constitutive component of the social
world rather than referential. Interpretive phenomenological analysis (Smith,
Flowers, & Larkin, 2009) aims to understand how individuals make sense of their
experiences to expand our understanding of a phenomenon. Grounded theory (GT,
Glaser & Strauss, 1967) compares individuals' experiences of a phenomenon to
develop a theory where one is not present or current theories are inadequate.

For this study, I have chosen GT methodology for a number of reasons. First,
the aim of the study is to explore how change in therapy is understood. Second, as
highlighted above, a review of the literature shows that a full understanding of how
individuals with BN change in CBT remains elusive. Third, GT is regarded as
particularly suitable for exploring therapeutic processes (Rennie, 2006) and it
involves comparing the experiences of different individuals (Corbin & Strauss,
2015). Furthermore, McCallin (2004) proposes that a main strength of GT is that it
*explains* what is going on rather than *describes* it. GT offers a systematic and
interpretative way of constructing a theory from data that can explain and direct
practice (Fassinger, 2005). With these aims in mind, I have strived to construct a
theory of processes of change in CBT, which is developed from or grounded in
participants' accounts of their experiences.

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## 2.4 Version of grounded theory

GT was originally developed by two American sociologists, Glaser and

Strauss (1967). GT was perceived as partially rooted in the positivistic paradigm due

to its systematic procedures to build conceptual theories of social phenomena that

could be generalised (Fassinger, 2005). Indeed, Glaser (2004) proposes that his

version of GT differentiates itself from other qualitative research methods in its

ability to explain a phenomenon rather than describe it.

Over the years, there have been differences and disagreements between the

researchers of the GT methodology (Lomborg & Kirkevold, 2003). Space does not

permit a detailed discussion of these differences, but the consequence is that there

are several variants of GT. Thus, in conceptualising and implementing the GT

methodology, the ontological, epistemological and axiological considerations will

influence the methodological processes. Indeed, Fassinger (2005) describes the

methodology as a paradigmatic bridge between the post-positivist and constructive

paradigms, and critical approaches. Morse, Stern, Corbin, Bowers, Charmaz, and

Clarke (2009) outline the continuous development of GT since its original

development. My observation from the writings of Morse and colleagues is that the

core components of GT methodology, including inductive and systematic generation

of theory through the analysis of data, have remained mainly the same. However, the

methodology has been modified to adapt to and adopt different paradigms.

McCallin (2004) proposes that GT has become a group of different

methodologies and notes that there are three main types: the Glaserian (Glaser &

Strauss, 1967; Glaser, 1978, 2004) version with a realist epistemology; the Corbin

and Strauss (Strauss & Corbin, 1990, 1998; Corbin & Strauss, 2015) version, rooted

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in pragmatism and interactionism; and the Charmaz's (1995, 2006) constructivist

version. Despite these differences, Morse (2009) highlights that GT is seldom carried

out in identical ways, with researchers adapting the approach to suit individual needs

and demands.

For this study, I have chosen to follow the approach described by Corbin and

Strauss (2015). In the initial stages of planning this study, I also carefully considered

the versions by Glaser (1978, 2004) and Charmaz (1995, 2006). However, I

concluded that they did not seem to adequately capture the specific aims of this study

or my theoretical position as either researcher or therapist. For example, one of my

reservations included Glaser's (2002) request that the researcher should not review

the literature before the data collection and analysis and approach the data 'blind'.

The rationale is to remain open and let the theory arise from the data, rather than

impose the interpretations and preconceived theory from the existing literature onto

the data. This idea has been met with apprehension within the GT literature (e.g.,

Henwood & Pidgeon, 2003). Indeed, Charmaz (2006) criticises this approach,

whereby researchers "assume the role of authoritative experts who bring an objective

view to the research" (p. 132). Also, as a Trainee Counselling Psychologist, this is a

position that conflicts with my critical and interpretative stance. More in line with

my personal beliefs and assumptions, however, is Charmaz's (2006) version with its

recognition of subjectivity and researcher-derived understanding.

My overarching goal of this study was to describe and explain processes of

change in CBT for BN. Glaser (2002) discounts the constructivist-leaning approach

endorsed by Charmaz (2006) and argues that it moves away from the emphasis on

explanatory versus descriptive power. I somehow agree with Glaser's observation

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and feel that the constructivist focus on interpretative understandings of participants'
perspectives might have left me displeased in my aims to raise these perspectives to
a conceptual level.

I feel that the version by Corbin and Strauss (2015), with its paradigmatic
and methodological bridging capacities, takes a middle ground and offers a
systematic set of procedures to develop an inductive derived theory, while at the
same time leaves space for interpretation. This approach seems to offer a valuable
opportunity to explore the processes of change in CBT for BN from patients'
perspectives, and as such, it integrates theory and practice, constituting a
methodological approach of the scientist-practitioner model.

## 2.5 Participants and recruitment

Eight women aged between 19 and 51 years old participated in this study and
they were all individuals who had undergone a course of CBT for BN in the NHS in
the UK. The region of the ED service was located outside of London and although
representative of the clinical population seen within the service, it could be argued
that this study's sample does not fully capture the differences and diversity often
seen in individuals with BN in terms of ethnicity and gender. The demographic
details of all participants are presented in Table 1 at the end of this section. The
inclusion and exclusion criteria for the participants were as follows:

Inclusion criteria

- The participants were required to meet the criteria of the DSM-5 (American
  Psychiatric Association, 2013) for BN prior to treatment

- The participants should have completed a course of individual CBT for BN,

  defined as when ED symptoms had abated, and both the therapist and patient

  agreed about timing of ending therapy

- The willingness to give informed signed consent to participate in the study,

  as required by the BPS (2014)

- A minimum age of 18 years, as individuals above this age with sufficient

  understanding could give their full consent to participate in the study

  independently of their parents/guardians (BPS, 2009)

- The participants must be interviewed within the time frame of 2-18 months

  after completion of therapy, which would allow them to gain some

  perspective on their experience, but still have their experience relatively fresh

  in memory.

Exclusion criteria

- Ongoing psychological treatment

- Current risk of suicide

- History of psychosis

- Ongoing substance abuse

- Individuals that I had previously seen for therapy as a Trainee Counselling

  Psychologist within the service.

The screening process related to the information confirmed by the therapists
within the ED service. Thus, the therapists screened the participants and decided who
met the inclusion and exclusion criteria. At the point of recruitment, I assessed
current risk by the Patient Health Questionnaire (PHQ-9, Kroenke, Spitzer, &

Williams, 2001) and the Generalised Anxiety Disorder (GAD-7, Spitzer, Kroenker, Williams, & Löwe, 2006). Potential participants who scored above 10 and 8 respectively, were excluded from the study as those scores indicate caseness of depression and anxiety (Improving Access to Psychological Therapies, 2014). On a few occasions, I had to exclude individuals from taking part in the study due to high risk scores and in those cases, I encouraged them to contact their GP and ensured that they had contact details for the Samaritans and Crisis Team.

I provided the therapists with an information letter on the study that specified the inclusion and exclusion criteria of the participants (Appendix A). The individuals who meet the inclusion and exclusion criteria received an invitation letter from the service asking them to take part in a study investigating the experience of therapy (Appendix B). As part of the recruitment process, potential participants also received a reply slip (Appendix C), PHQ-9 (Appendix D), and GAD-7 (Appendix E) and a prepaid envelope was provided. To protect myself from giving out own address, replies were sent to the service. Next, I contacted potential participants who had agreed to take part in the study and arranged a suitable time and venue for the interview. The consent to take part in the study (Appendix F) was gained on the day of the interview after briefing the participants (Appendix G) and the demographic details were also obtained (Appendix H). Although I was not in a position to offer any compensation for participating in the study, I reimbursed the participants' travel expenses.

In a GT study, the number of participants is not decided at the onset. The analysis and data collection should continue until the categories are saturated so that new interviews do not produce new information (Corbin & Strauss, 2015). The guidelines for the sample size range from 6-50 (Guest, Bunce, & Johnson, 2006).

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Rennie (2006), however, proposes that saturation may occur in as few as six participants. The issue of saturation will be revisited and evaluated in Chapter Four: Discussion.

Table 1. Demographip details of participants (pseudonyms used throughout)

|  | Participant | Age | Number of sessions | Age of onset of bulimia nervosa | Relationship status | Ethnis origin |
|---|---|---|---|---|---|---|
| A | Anna | 51 | 12 | 16 | Married | White (British) |
| B | Betty | 28 | 5 | 13 | Single | White (British) |
| C | Clare | 27 | 50+ | 12 | Single | White (British) |
| D | Debbie | 37 | Not sure | 12 | Married | White (British) |
| E | Emma | 38 | 20+ | 14 | Single | White (British) |
| F | Fran | 33 | 56+ | 15 | Married | White (British) |
| G | Gina | 19 | 100+ | 14 | Single | White (British) |
| H | Helen | 31 | 50+ | 20 | Single | White (British) |

## 2.6 Data collection

I considered a number of qualitative methods of collecting data. For example, I contemplated diaries (e.g., McLeod & Balamoutsou, 2007), which would allow the participants the opportunity to describe their experiences in their own words and in their own time. However, I reasoned that this method may prove burdensome for the participants and pose a challenge with respect to control of content. The potential consequences might be that some individuals might fail to complete their diaries in full and that the content may not provide the breadth and depth of information that I was hoping for. Instead, I chose semi-structured interviews (e.g., Bowman & Fine, 2000), which would allow a deep understanding of "the lived everyday world from the subjects' own perspectives" (Kvale & Brinkmann, 2009, p. 27). Semi-structured interviews allow the researcher to explore phenomena under investigation, while at

the same time allowing considerable freedom to explore what seems to be important
to the participants' life world in dialogue with the researcher (Robson, 2011).

At some point, I considered telephone interviews as this method would
decrease the burden of the participants and increase efficacy. However, I concluded
that this method was limited by leaving out the non-verbal cues, which have the
potential of enhancing my understanding of the participants' accounts (Robson,
2011). Also, I considered conducting the interviews during a course of therapy. I
reasoned, though, that the study might influence the course of therapy and thus the
possibility of causing harm. Also, the study could intervene with the process of
therapy as participants might struggle to separate therapy and interview. Further, as
the aim of this study is to explore the experience of CBT, it seemed reasonable to
interview individuals who have finished therapy, which may allow some perspective
on the whole experience. As a result, I decided to invite individuals to participate in
the study after completion of therapy.

I conducted one pilot interview with a colleague within the ED service to
refine my interview technique and improve my initial interview schedule (Appendix
I). The interviews lasted between 1 hour and 1 hour and 30 minutes and took place
either in the consulting rooms in the primary care locations convenient to the
participants or in the participants' homes. Mindful of personal safety, a friend was
aware of the location and was contacted before and after the interview.

It was vital to the quality of the study to conduct interviews that could
facilitate the participants to provide meaningful and rich accounts of their
experiences. It is an ethical challenge to tread the line between the role of a
researcher and therapist (Haverkamp, 2005) and it could be argued that there is an
overlap between the skills of the two. However, although using my therapeutic

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sensibility, I was aware of my role as a researcher and took care not to respond therapeutically. Also, I was clear about explicitly stating my role as a researcher at the onset. Although my purpose as a researcher was different from my role as a therapist, I believe that bringing therapeutic skills (e.g., empathy, active listening skills, reflecting and summarising) into the research process enhanced the quality of the data.

I was mindful that the interviews might touch on areas that could be emotionally distressing. In those situations, I would ensure that the welfare of the participants would take precedence over data collection. At the end of the interview, I asked participants to reflect on their experience of the interview and assessed how they felt. I did my outmost to secure them against any distress and a distress protocol was designed should participants be emotionally distressed (Appendix J). To mitigate possible risk if an issue of potential harm arose during the interview, I asked for consent from participants to contact their GP when joining the study. Thus, as part of the recruitment process, potential participants were required to provide the details of their GP and consent to my contacting them if potential risk was identified and a GP risk letter was prepared (Appendix K). Although some participants were emotional during the interviews, none were distressed, and thus no further action was required. Lastly, I gave the participants a debriefing form to take along including my contact details in case they wanted to withdraw from the study or had any further questions (Appendix L).

In line with GT methodology (Corbin & Strauss, 2015), each interview was informed by the analysis of previous interviews. Thus, whilst core questions remained, I would investigate particular elements of the participants' responses in more depth depending on the relevance of that material in terms of ongoing theory

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development. I therefore reflected on and refined the interview questions and a second interview schedule was devised (Appendix M). In keeping with explorative interview, Socratic dialogue was aimed at following the participants' idiosyncratic experiences and to limit researcher's agenda. Each interview was recorded using a digital dictaphone. I transcribed the recorded interviews myself and even though this was time consuming, I believe this process allowed me to become intensely familiar with the data. Further, each transcript was read several times to gain a deep understanding of the participants' account (see Appendix N for an example transcript).

## 2.7 Data analysis

The data analysis followed the procedures outlined by Corbin and Strauss (2015) and began immediately after the initial interview was conducted. The steps included initial open coding, categorising and linking the categories with the help of memos to construct a theory that was grounded in the data. Although this process is presented in a linear way, the data collection and analysis were an integrated and circular process that continuously informed the interview schedule and sampling.

## 2.7.1 Open coding

According to Corbin and Strauss (2015), the GT analysis begins with the process of open coding where data are split into discrete parts also referred to as meaning units. These are sections of text where the participant appears to make a point. The meaning units varied in length from one sentence to a paragraph and were

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given a conceptual (descriptive) label that aimed to represent the essence of each

unit. These coded units of meaning were compared to other coded units of meaning

and concepts were progressively grouped together into categories that encompassed

those concepts. The meaning units were assigned to as many categories as possible.

An example of initial open coding is shown in Figure 1:

**Transcript excerpt:**

Line: *"It sounds like some kind of fusion happened between you and the eating disorder – is that how you experienced it?"*

**Open coding:**

Participant: *"Yeah, yeah, definitely and I think the lower the weight you become, the stronger the illness gets. It's like the stronger the illness gets, the weaker you are. Like, there's less of you and more of it – like, it takes over your brain..."*

BN definitely takes over self

The lower one's weight is, the stronger BN gets

The stronger BN gets, the weaker one gets

BN takes over your brain

**Memo:** BN takes over self

Figure 1. Example of initial open coding of a transcript excerpt.

## 2.7.2 Memos and diagrams

Memos and diagrams are considered essential to GT analysis and played a

key role throughout the research process. Corbin and Strauss (2015) describe that

memos and diagrams begin "…as rudimentary representations of thoughts and grow

in complexity, density, clarity and accuracy as the research progresses" (p. 117).

Corbin and Strauss encourage researchers to develop their own set of strategies to

structure memos. During open coding of the first interview, I started recording

thoughts, questions and theoretical reflections, which developed into an ongoing

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record of the research process and the theory development. An example of a

transcript memo is shown in Figure 2:
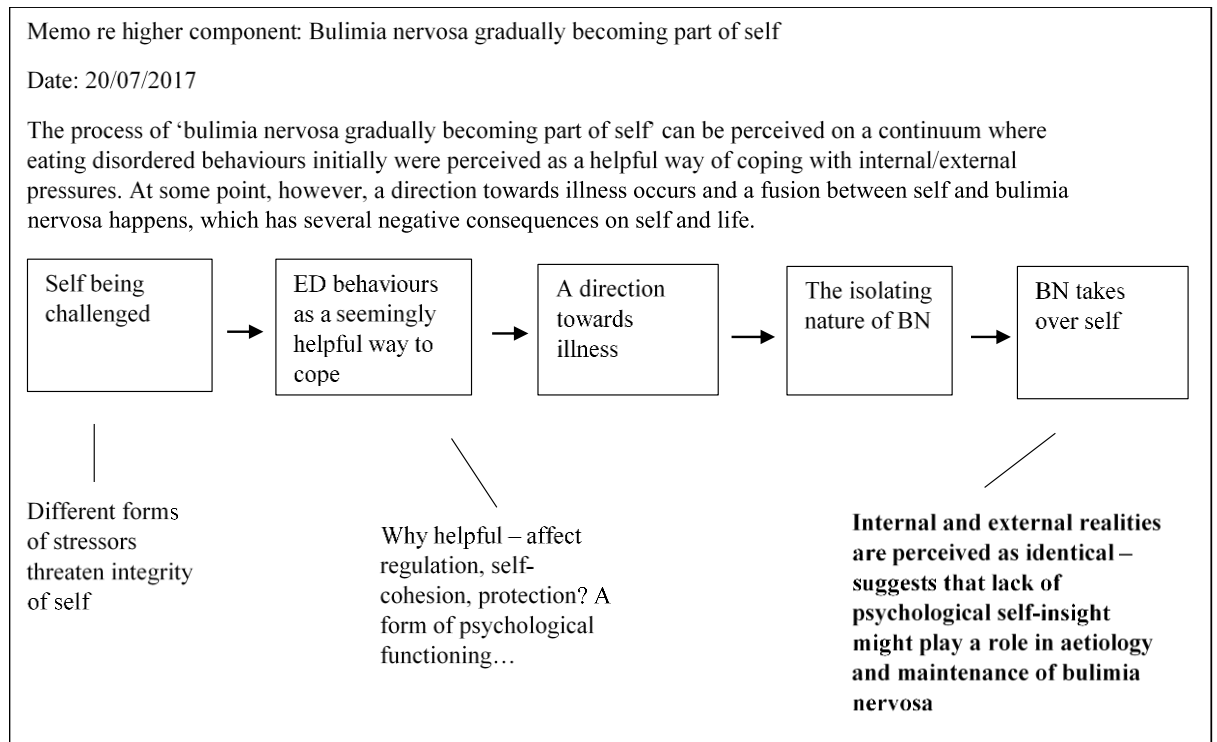


Figure 2. Example of a transcript memo: 'Bulimia nervosa gradually becoming part

of self.'

### 2.7.3 Constant comparison and theoretical comparison

During the analysis, I used the technique of constant comparison (Corbin &

Strauss, 2015). In doing so, each meaning unit was compared against each other for

similarities and differences. If the meanings were considered similar, they were

grouped together under the same conceptual label and if the meanings were

considered different, a new category was created. Corbin and Strauss describe this

process of constant comparison as essential in differentiating and identifying the

properties and dimensions of the categories. The memo for the lower category 'BN

takes over self' shown in Figure 2 holds my reflection:


*"Internal and external realities are perceived as identical – suggests that*

*lack of psychological self-insight might play a role in aetiology and maintenance of*

*bulimia nervosa"*


I arrived at this reflection as the meaning units assigned to the category 'BN

takes over self' was compared to other pieces of meaning units with the same

conceptual label. In this example, the process of constant comparison revealed that

participants seemed to become fused with BN over time. Such within-data

comparison ensured that the complexity and diversity of the data were captured

(Willig, 2013).

Throughout the analysis I also made use of what Corbin and Strauss (2015)

have termed 'theoretical comparison', which helped me to examine the data in

relation to formal theories and situations from everyday life.


**2.7.4 Focused coding and axial coding**

Following initial coding, the next stage of the analysis involved focused

coding where the relationships among the categories were organised and further

explicated, aimed to produce a hierarchical conceptual system where the lower

categories became the properties and dimensions of the higher categories. These

higher-level components were then synthesised at increasing levels of abstraction to

produce a broader core category. The categories remained hypothetical until they

were considered to fit into a hierarchical matrix of the categories that presented the

proposed model.

According to Strauss and Corbin's (1990) version of GT, axial coding is

essential in the model construction. Corbin and Strauss (2015) however, propose that

axial coding and open/focused coding are essentially the same procedures as they

involve hierarchal synthesis of data at increasing levels of abstraction.

## 2.7.5 Selective coding, theory construction and saturation

Following the focused coding, the next stage of the analysis involved

selective coding, where a core category was chosen that integrated the other

categories into an explanatory whole. Corbin and Strauss (2015) note that the

process of searching for a core category can pose a challenge for novice GT

researchers and describe how the concepts exist in complex relationships. In

constructing the theory, I reviewed and sorted through the memos searching for

recurring themes, I wrote the story line of the analysis and constructed diagrams to

explore the relationships between the categories. Finally, I spent a lot of time

thinking and reflecting. Corbin and Strauss describe an 'aha' experience where the

analytic story emerges from the data. This description is in line with my own

experience of constructing a hierarchal synthesis of the data. I will present the theory

and narrative in Chapter three: Findings.

Theoretical sampling is perceived vital to the GT methodology, where the

data collection is based on concepts derived from data. Corbin and Strauss (2015)

propose that the researcher continues to gather data until reaching a point of

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'saturation', "when no new categories or relevant themes are emerging" (p. 139).

The issue of saturation will be revisited and evaluated in Chapter Four: Discussion.

## 2.8 Ethics and quality

This study was carried out in line with the BPS's Code of Ethics and Conduct (2009). I obtained ethical approval from the London Metropolitan University Ethics Committee (Appendix O) and subsequently I was granted ethical clearance from the NHS Health Research Authority (Appendix P). In accordance with the London Metropolitan University's (2014) Code of Good Research Practice, I aimed to ensure the highest possible ethical standards. I was mindful that the individuals participating in this study were potentially vulnerable and I therefore carefully considered the possibility of causing further psychological distress. A procedural account of ethical working can be found in the following.

## 2.8.1 Consent

According to the BPS (2014), a researcher should ensure that individuals consent freely to the process based on adequate information. Thus, I made sure potential participants received sufficient information about the study in the invitation letter. Also, I obtained written informed consent from the participants. However, as the interviews were semi-structured and flexible, I reasoned that it might not be possible for the participants to be certain of the effect of taking part in the study might have on them. Thus, I regarded this consent to be ongoing and I made it clear

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to the participants that they had the right to withdraw from the study at any point

until I began the process of data analysis (three weeks after the data collection).

## 2.8.2 Anonymity and confidentiality

The interviews were audio recorded and the recordings were saved on an

encrypted USB stick. All electronic audio and written data and documents were

stored on a password-protected laptop, in a password-protected folder. Further, any

documents with the participants' names were stored in a locked file cabinet within

the service. All identifying details (e.g., names, locations) in all other

documentations (audio/written documents/transcripts) were anonymised. The file

names of audio/written documents were also anonymised and pseudonyms were used

in all transcriptions and write ups of data. Only I, the researcher, had access to the

data and the data shared with my research supervisor were anonymised. The

participants were informed that in accordance with the BPS's Good Practice

Guidelines for the Conduct of Psychological Research within the NHS (2004), all the

collected data would be kept for a minimum of 5 years.

Also, in line with the Data Protection Act (as cited in BPS, 2009),

information obtained from and about the participants is confidential. However, the

participants were told that the duty of confidentiality may in exceptional

circumstances be overridden by more compelling duties such as protecting

individuals from harm. Any identifying details were changed so neither the

participants nor the therapists would be identified. However, although removing the

personal information, I am mindful that the contextual identifiers in individuals' life

stories might remain. Also, the participants' statements from the interview would

appear and may be recognisable. This possibility is highlighted in the participant

consent form and therefore, on this basis, has been sanctioned by the participants.

Kvale and Brinkmann (2009) highlight that precaution must be taken to protect

participants' privacy. The principle of the participants' right to privacy can pose

ethical and scientific dilemmas. On the one hand anonymity can protect the

participants and on the other hand it can deny them their voice to be heard. I am

mindful that individuals agreeing to take part in this study may have a personal

message that they wish to communicate. Conducting qualitative research involve

various ethical issues along the entire research process. Throughout this journey, I

have aimed to engage in reflexive practice and adhere to the ethical principle of

beneficence and non-maleficence. Thus, the benefits to participants and the

importance of knowledge gained should outweigh the risk of harm to the participants

(BPS, 2014).


### 2.8.3 Relationship between researcher and service

In the period between September 2014 and July 2015 I worked as a trainee

counselling psychologist within the ED service where I recruited the participants

from. Although I excluded individuals that I have previously seen for therapy, I

reasoned that some participants may question my relationship with the service.

Therefore, I decided to be honest about my historical relationship but stated that the

study was part of my doctorate degree. Also, I highlighted that participation in the

study would not be shared with anyone from the service, that the interview was

confidential, and that participation would have no effect on past, present or future

care/relationship with the service. Furthermore, I reasoned that participants might

feel reluctant to disclose information on their therapists because of my past

relationship with them. Thus, I decided that one way to overcome this issue was

politely to suggest that the identity of the therapists was referred to as 'therapists'

rather than by name. Also, I highlighted to the participants that this study was not

about the therapists but about their experiences of therapy and specifically, how they

changed through therapy. I wonder if my previous relationship with the service from

which I recruited from impacted potential participants' willingness to take part in the

study. Although I attempted to be as transparent as possible, some individuals might

have perceived me as 'part of the clinical team' and therefore feel reluctant to take

part in the study or even feel pressured to participate. Upon reflection, it would have

been appropriate to reflect on this with participants and ask them about their

experiences at the end of the interview.

**2.8.4 Credibility checks**

Elliott, Fischer, and Rennie (1999) propose guidelines for checking the

credibility of the findings in qualitative research. These include asking the

participants themselves to comment on the interpretations made by the researcher,

jointly analysing the data with a team of analysts or an auditor or comparing the

findings with those derived from other methods or sources. Other researchers (e.g.,

Morrow, 2007), however, challenge the usefulness of such checks given the

acceptance of multiple realities in qualitative research.

In line with a GT methodology (Corbin & Strauss, 2015), on completion of

the analysis and theoretical integration, a summary of the initial findings was sent to

the participants (Appendix Q). I did, however, not receive any feedback from the

participants and can only hypothesise on the reasons for this. I was mindful that this

procedure involved ethical issues. For example, I did not know if the participants

would perceive the findings distressing and therefore had no chance of responding

accordingly. Also, the unavoidable delay between the interview, transcription,

analysis and receiving the initial finding might have affected the participants'

memory recall and changed their understanding of their experiences, which could

affect the validity of this credibility check. Also, although being the experts of their

experiences, the participants might be defensive about aspects of themselves and

dislike my interpretations, which raised the issue of what to do in case of

disagreement. Despite these dilemmas, I decided to offer the participants the

opportunity to comment on the initial findings from this study, which was aimed to

allow them their voice to be heard and feedback any issues they might want to raise.

Additionally, I made careful use of an auditor in the form of my supervisors,

whom provided theoretical advice, recommendations and support at every stage, as

well as reviewing the final thesis at different degrees of completion (see Appendix R

for independent audit of one of the higher-level components).

## 2.9 Summary of the issues raised

In this chapter, I have aimed to be transparent about my epistemological

position as a researcher and the GT methodology I have used to answer the research

question. I have attempted to offer information about the context and the procedures

I employed to evaluate the quality of the study. In the next chapter, I will present the

main findings. Throughout the process, I have aimed to engage in a critical analysis

of the data. Also, I have attempted to provide a coherent account of the analysis and

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the process by which the categories were generated and provide evidence from the

interview transcript to illustrate this. My aim has not been to uncover one single,

objective truth, but rather to contribute to the discipline of counselling psychology

and beyond by exploring the experience of therapy by individuals with BN.

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## Chapter three: Findings

### 3.1 Introduction to the chapter

In this chapter, first, I will provide an overview of the findings and the proposed model of processes of change in CBT for BN will be presented. Next, I will in turn describe each of the higher-level components and their lower categories, which is lastly followed by a review of the chapter. The findings are illustrated by participant quotes from the transcripts. All transcript data has been anonymised and I have chosen to give pseudonyms to the participants, which is in line with the personal experience being investigated. The interview quotes are presented in italics and a sequence of dots signifies that superfluous text is missing.

### 3.2 Overview of the findings

Six higher-level components emerged from the analysis and they were identified as representing the key processes of change in CBT for BN. A core connecting category of 'a journey towards de-fusion of the sense of self and BN', explaining the overall processes of change, was also identified. The model of the proposed processes of change is shown in Figure 3.

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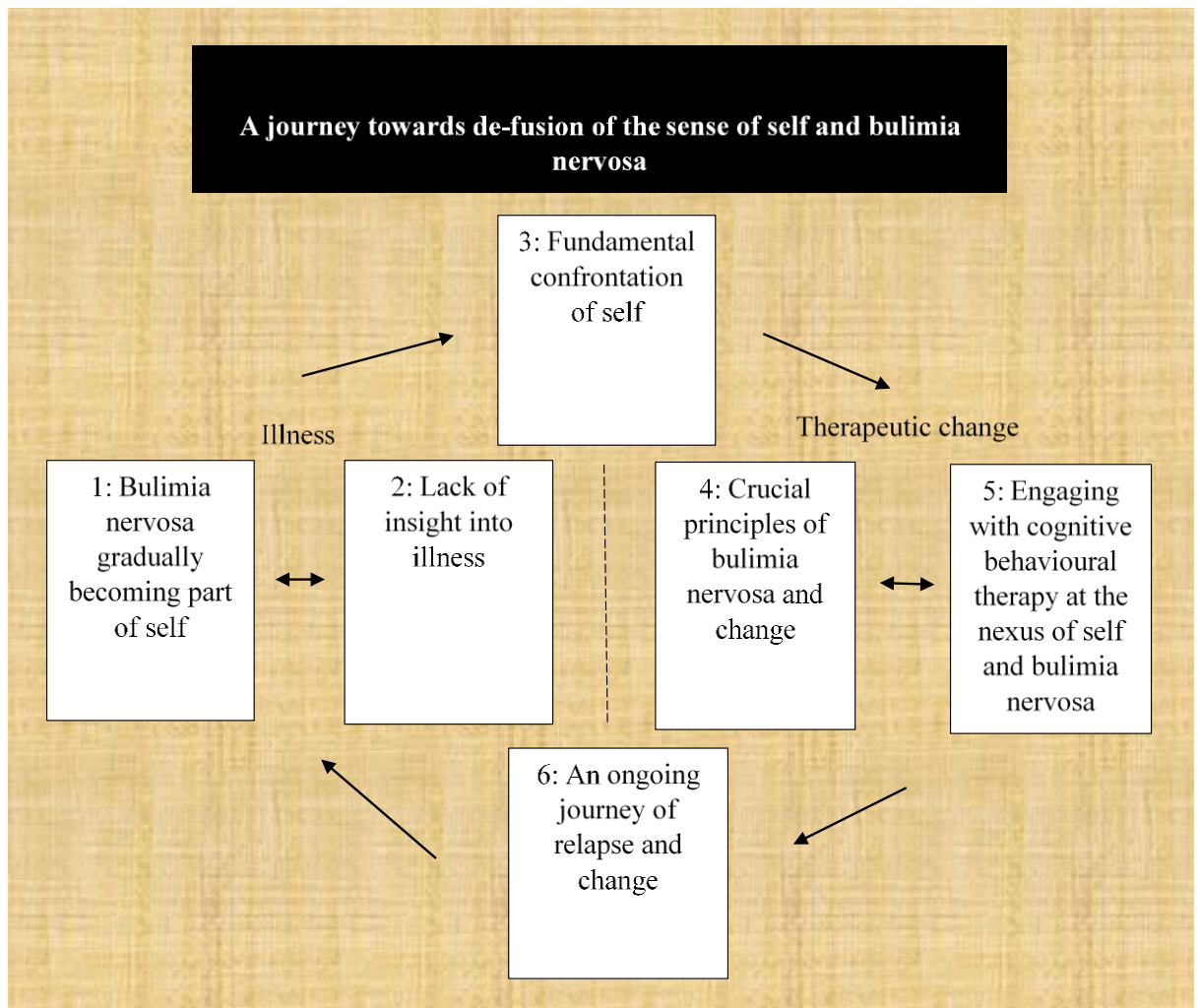


Figure 3. A journey towards de-fusion of the sense of self and bulimia nervosa: The

core category and higher-level components.


The development of the model was a gradual process and was continuously

shaped by coding and analysis of the interviews. I also changed and amended my

interview schedule as the initial interview schedule did not seem to feature the

meaning of BN and change, but rather focused on the experience of CBT. After the

third interview of Clare, however, it became clear that there was more to BN and

change than CBT and after coding and analysing the data, the interview schedule

was adjusted so that deep dynamics of the processes could be surfaced. Upon

reflection, the initial limited data on the meaning of BN and change might also have

had something to do with the fact that the first two participants (Anna and Betty) had

effective and short-term CBT introduced, whereas the remaining six participants

represented a more chronic clinical population with multi-treatment episodes (see

Appendix S for stage 1 of the model development).

The high-level components of the model are deceptively simple in describing

a highly complex psychological process of what BN can mean for an individual and

what therapeutic change represents and involves. The findings indicated that healing

from BN can be experienced as a complex and painful continual process of personal

transition that involves a journey of de-fusion from the ED. All participants in this

study described how BN was experienced as gradually becoming part of self and

how bodily sensations and attributes affected cognitions and emotions. The overall

finding demonstrated an immediate connection between the participants' physical

and psychological realities. In other words, symptoms fundamentally served to

maintain the cohesion and stability of a fragile sense of self. This symbolic

communication via the body, however, was not experienced as metaphors, but rather

as actual reality, which affected the change processes in several ways. For example,

at the beginning of the treatment process, participants had limited insight into the

illness. Also, although symptoms were destructive, they functioned as self cohesion

and affect regulation, and were therefore subjectively experienced as helpful.

Consequently, participants were ambivalent about treatment and change. The

processes of de-fusion of the sense of self and therapeutic change in the BN seemed

to have an interactional relationship that was central to the experiences of change at

all stages of CBT for BN.

### 3.3 The model in details

Six higher-level components were identified and represent the main dimensions of processes of change in CBT for BN. In the following, each of the higher components with their lower categories will be presented in turn. For each higher component, I have indicated the participants that are represented in each category.

**Component 1: Bulimia nervosa gradually becoming part of self**

The first component of the model represents the participants' initial meeting with BN and how the ED gradually became part of self. This process can be perceived on a continuum where eating disordered behaviours initially were a seemingly helpful way of coping with internal and external pressures. At some point, however, a direction towards illness occurred and a fusion between the participants and BN happened, which had several negative consequences on self and life. The main factors identified within this component are described in turn as presented in Figure 4.

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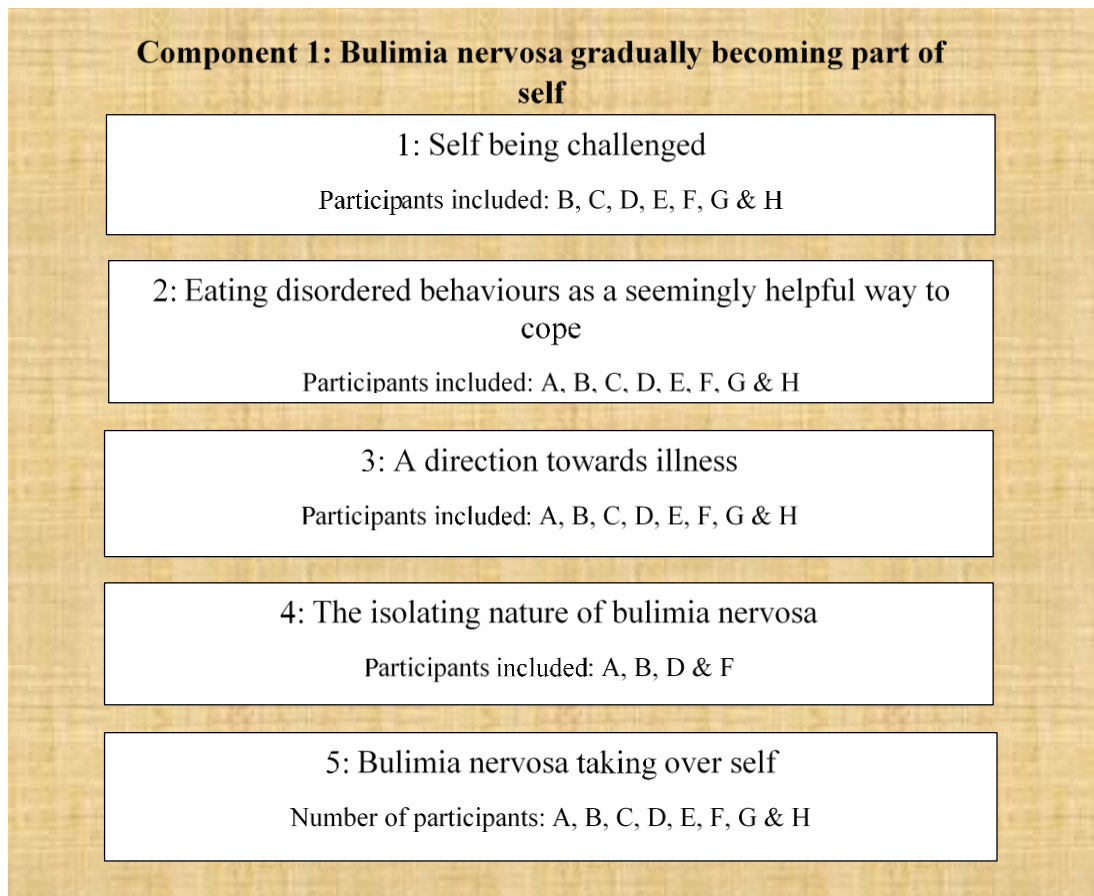


Figure 4. Bulimia nervosa gradually becoming part of self: The higher component

and lower categories.


 **1.1 Self being challenged**

During the interviews, participants were asked to reflect on how BN began.

All participants reported significant life stressors, including abuse, bullying, financial

problems, illness and bereavement in the close family.

Fran: *"It was a very difficult time. Just lost my mother-in-law and that's*

*when things started to go wrong, so to speak. I ended up feeling that I*

*wasn't in control of anything, so I started to control something and that's*

*when everything started out."* [4-6]

Other participants, however, did not associate the onset of BN with a
specific triggering event and described the process as a reaction to stressors that
threatened integrity of the self.

Gina: *"A lot of people with an eating disorder have had something traumatic*

*happening in their life but it wasn't like that for me. I think the main reason was that*

*I was always, I wouldn't say I was badly bullied, but I was always the odd one out in*

*the group of friends. Like, I was always a bit weird and I wasn't the best-looking kid,*

*you know, I had frizzy hair, freckles and I was pale."* [29-33]

**1.2 Eating disordered behaviours as a seemingly helpful way to cope**

Analysis showed that although there was variation in how participants made
sense of factors affecting the onset of BN, there was a consensus that, initially,
eating disordered behaviours were a helpful way to cope with internal and external
pressures. BN became central to participants' wellbeing as their source of comfort,
pride and identity. They came to define themselves by the ED, equating self-worth
with weight loss. Accounts illustrated that the participants felt they did not control
life and instead used food and weight as tools for an increased sense of control.

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Debbie: *"I realised that the eating disorder was just something I was using*

*to cope with everything. It was the only thing I could depend on."* [232-233]

The findings suggested that that the drive for thinness in BN represented
more than purely reducing weight. Bodily experiences and sensations, like weight,
shape and hunger, also referred to non-physical experiences of handling difficult
emotions and cognitions.

**1.3 A direction towards illness**

The participants described that gradually eating disordered behaviours had
several negative consequences on self and life. For example, they noted becoming
obsessed with food and losing weight, which impacted physical health, social
relationships, finances and school/work. At some point, the participants realised that
eating disordered behaviours were not a choice anymore but served as immediate
solutions for problems and had become a way of dealing with difficult emotions and
stress. The findings demonstrated a direct connection between physical and
psychological realities (i.e., restrictive control of food signified psychological control
of self). This corporeality was experienced as an obsessional and cruel reality, which
increasingly was difficult to escape from.

Debbie: *"At home, I had my routine with my eating disorder ... it was my*

*comfort thing where I would go the whole day without eating and then in the*

*evening I would have just a normal meal, so no one would know. And I*

*would time it, have a coffee, and then go up and be sick as quietly as I could,*

*and no one knew. And I was losing a lot of weight… I was doing it cos I*

*didn't know how else to cope. I didn't realise that is wasn't a choice*

*anymore, I was doing it because I had to do it, that's how I coped with life."*

[13-19]

## 1.4 The isolating nature of bulimia nervosa

The participants described how they suffered in silence, not telling people
around them of BN. They noted being shameful and worried of what others might
think, while at the same time feeling that nobody would be able to understand the
suffering they were going through.

Anna: *"I was disgusted with myself. It just seemed like nobody would*

*understand … I didn't feel anybody would possibly understand."* [43-45]

## 1.5 Bulimia nervosa takes over self

The participants described a process of fusion of self and BN where one
could not recognise self because the illness impacted personality in several ways. For
example, the participants expressed how they completely lost their personality
because BN dominated them and described losing friends because they could not
recognise them anymore.

Helen: *"You lose your personality. You know, you don't enjoy things, you*

*don't laugh, you don't smile, you can't concentrate, you can't really engage*

*in social situations at all, you can't … yeah, it's almost as if it wipes your*

*personality … like, you completely lose it really because bulimia just*

*dominates you."* [93-95]

Gina: *"It was almost like my life has been split between different people. So,*

*I have who I was before my ED and I have who I was during my ED. Two*

*completely different people you wouldn't even understand. Like, I lost*

*friends because people didn't recognise me anymore, I wasn't the girl I used*

*to be."* [102-105]

BN also affected cognitions and the participants described that they were not
able to think straight, and that the ED made every decision for them. Furthermore,
judgement, memory and concentration were distorted. During this process, BN
became so destructive and all-consuming that the participants lost sight of what they
loved and cherished before the ED.

Gina: *"It's like a relationship between… like the symbolic relationship*

*between the hippo and the bird where your body becomes the host for this*

*thing."* [128-129]

**Component 2: Lack of insight into illness**

The concepts included in the second higher-level component illustrate the
participants' experiences at the time of entering therapy and highlight a difficult
transition involved in seeing symptoms as evidence of BN and recognising the need

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for therapy. The three lower categories highlighted within this component will be

presented in turn as illustrated in Figure 5.
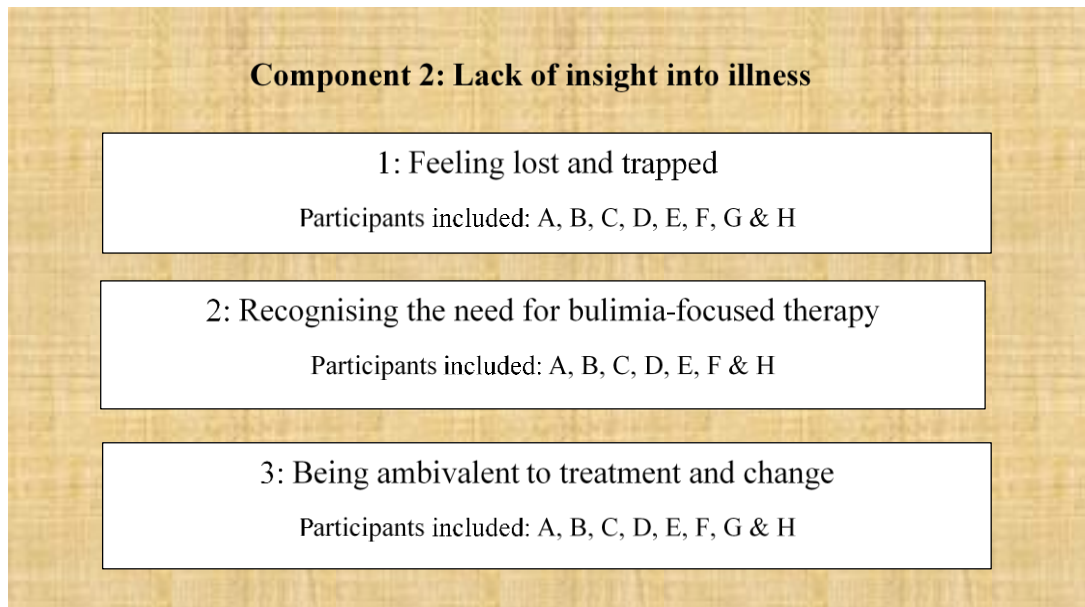


Figure 5. Lack of insight into illness: The higher component and lower categories.

## 2.1 Feeling lost and trapped

The participants described a process where they initially felt trapped and lost

in a vicious cycle of restricting, binging, purging and compulsive exercising, which

led to further impaired self-image.

Debbie: *"I would go for so many weeks with binging and purging. At days, it*

*could be up to 8 times per day. Then guilt would kick in about what I was*

*doing and then I would go back to restricting up to the point where I could*

*not restrict any more. So, it was going around in a circle and there was just*

*no way to get out cos it was just a continuous circle. Binging, restricting,*

*binging, restricting, feeling bad, and then restricting again. It was just an*

*endless cycle."* [254-258]

The accounts suggested that although the participants knew that something

was wrong, they were not aware one was bulimic as the illness seemed to have

creeped up on one.

## 2.2 Recognising the need for bulimia-focused therapy

The accounts suggested a difficult transition involved in starting therapy.

Initially, the participants were resistant to treatment and change and did not feel they

needed bulimia-focused therapy. At some point, however, the participants accepted

that they needed professional support to get better and break the vicious cycle of

eating disordered behaviours. The findings showed that at the time of accepting the

need for bulimia-focused therapy, participants were desperate for help because the

ED was all-consuming and caused significant pain.

Helen: *"I guess you get to a point where, like sometimes you have to get to*

*your really lowest point until you sort of say… almost like you have hit the*

*rock bottom where you surrender and say, "I need help, help me". I think*

*you get to the point where you're so desperate you either start allowing*

*people to help you or doing it yourself or you die basically. Like, you can't*

*get any lower and it's almost as if you think, "nothing can be as bad as*

*this."* [108-112]

**2.3 Being ambivalent to treatment and change**

The findings suggested that the participants continued to feel ambivalent about treatment and change. On the one hand, they wanted to keep BN because it had become a part of self and was a seemingly helpful way to cope with internal and external pressures. On the other hand, however, they were keen to overcome BN as symptoms caused significant pain. Consequently, therapy was challenged by this ambivalence to engage with the processes of change drawing participants in conflicting directions. The accounts demonstrated an immediate connection between physical and psychological realities and implied a kind of psychological functioning, which contributed to an unstable motivation to change.

Gina: *"I didn't want to get better, I was so far in, I didn't want to get better because getting better would mean weight gain, getting better would mean the loss of all this hard work, it would mean ugliness, it would mean fatness, it would mean just everything I hated in life would come back again. So, I was resisting therapy all I could, I was resisting against it for a long time, a really long time."* [95-99]

The participants perceived BN as akin to an addiction and accounts suggested that the ED was not simply something 'negative' to overcome. Rather, the illness also seemed to have a vital function, serving as a kind of release channel for intolerable emotions and as a vehicle for self-soothing.

Anna: *"Even before going into therapy, I recognised that my bulimia could*

*equally be alcohol or drugs. So, I think I already recognised it as a go-to,*

*obviously in myself, like I could see that immense numbing effect … what it*

*facilitated was for me to switch off. I can't remember when the last episode*

*was, it's quite a long time ago, but I still remember the numb feeling*

*afterwards. It's almost like complete exhaustion. What happens in that space*

*is that all of the other stuff goes away."* [390-394]

The participants described feeling scared to lose BN and not knowing how to
cope without it. The ambivalence to treatment and change seemed rooted in a deep
and complex fusion with BN and they reported emotions as grief and anger during
those initial processes.

Emma: *"I felt angry and sad … and grief, I felt grief about losing something*

*I've always had in my life. Like, it might sound crazy, but my eating disorder*

*was my only friend. Throughout my whole life it's the only consistent thing,*

*it has always been there. So, I think I was grieving for it at times."* [142-

144]

**Component 3: Fundamental confrontation of self**

The third higher-level component represents a turning point in which
participants begin to distance themselves from BN to identify that it is no longer
helping them attain life goals and aspirations. The analysis highlights a complex
matrix of psychological, physiological and social factors, which were involved in the

processes of change in BN. At this stage, BN was a chronic illness and a terrifying battle between self and the ED was involved in the change process. The participants seemed to be trapped in a punitive corporeality, which was difficult to escape from. The process was further complicated by the dilemma that change was experienced just as painful as BN and involved intense emotions and physical reactions. The analysis showed concurrent shifts in the participants' *self-awareness* from seeing BN as a solution to recognising it as a problem, in *self-regulation* from passivity to active participation in the healing process, and in *self-differentiation* from disengagement to (re)connection with self and others. During this process, participants were struggling to recover, and accounts suggest that to overcome the illness, one had to engage with and accept the pain. The main factors identified within this component are highlighted in turn as presented in Figure 6.

**Component 3: Fundamental confrontation of self**

1: The terrifying battle between self and bulimia nervosa
Participants included: A, B, C, D, E, F, G & H

2: Terror as part of change
Participants included: A, B, C, D, E, F, G & H

3: Engaging with the pain as part of change
Participants included: A, B, C, D, E, F & G
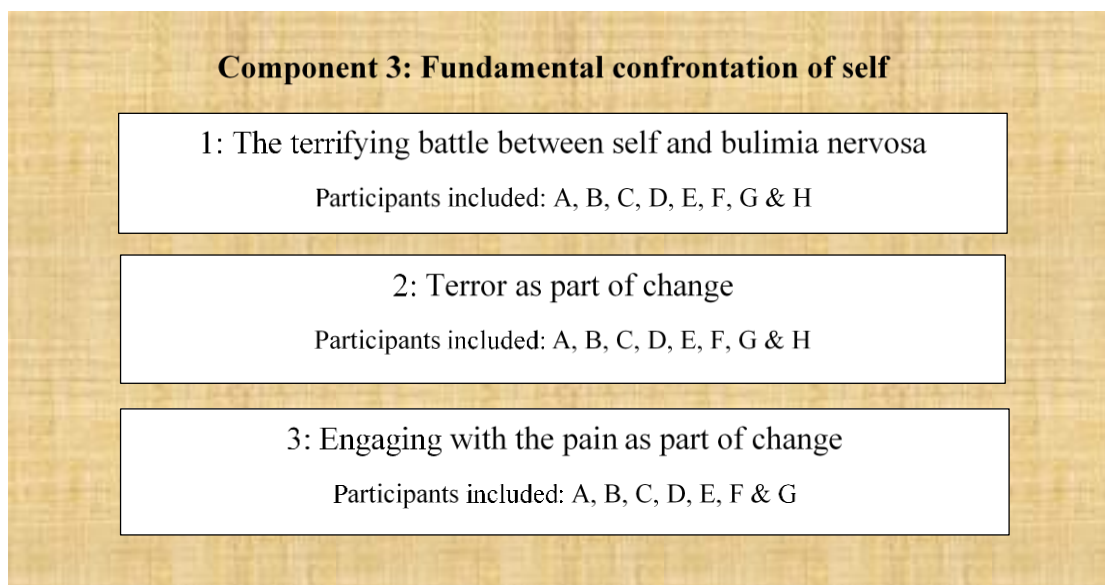
Figure 6. Fundamental confrontation of self: The higher component and lower categories.

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**3.1 The terrifying battle between self and bulimia nervosa**

The findings suggested that following a period of ambivalence to treatment,

participants accepted that change was necessary and entered a process characterised

by terror and perceived sense of loss of control. The accounts illustrated that the

participants struggled to fight BN and felt hopeless to ever overcome the illness.

Fran: *"It was so uncomfortable to challenge the voice of the eating disorder.
It felt like it was the wrong thing to do, like, listening to someone else rather
than what my head was saying was wrong. It was like betraying my head in
a way."* [71-74]

Helen: *"It was very hard to challenge BN. You get a lot of mental backlash
from it. Like mentally, it's very very difficult all the time. The more you
challenge it the harder mentally it is. It's mentally exhausting."* [189-190]

**3.2 Terror as part of change**

The accounts illustrated that significant pain was associated with change and

participants described painful emotional and physical reactions during those

processes. Also, the findings showed that emotional experiences were organised and

felt, based on different domains of physical life.

Helen: *"Especially in terms of the emotions, you do go through a lot during
recovery, like every single day. Every time you eat, well not only when you
eat, because you feel anxious all the time. You get very irritable and angry.*

*As the weight goes up, the anxiety can increase and then you can panic and
be like "I need to lose weight". There're so many thoughts and emotions
that go with it every single day and they change almost minute to minute. ...
And also in terms of the physical things, there are a lot of things that you go
through as you gain weight. Like, you get really bad diarrhoea,
constipation, you get bloated, sometimes you feel full all the time, sometimes
you feel hungry all the times. You think about food all the time."* [148-155]

The accounts illustrated that self-harm served to escape, avoid or
otherwise regulate aversive emotional states during processes of change.
Furthermore, some of the participants described that they had attempted to
engage with therapy and change on several occasions but had either dropped out
of therapy and/or relapsed as they could not cope with the pain that accompanied
the change process.

Clare: *"It has been a cycle where I would see someone for a while and then I
would stop because I couldn't really handle the emotions that go with it. And
then I would get worse and I would ask to see someone, and I would be on
this long waiting list. It has been a continuous cycle until now."* [50-53]

## 3.3 Engaging with the pain as part of change

As noted in the above, the participants spoke of experiencing deep and
lasting emotional pain for giving up BN. They described therapy as an intrusive
process, which required them to put down guards and allow themselves to be

vulnerable. There was a consensus amongst participants that change in BN required

one to take responsibility, challenge self and accept that pain was part of getting

better.

Anna: *"Accepting pain that's a part of the whole thing in recovery. ... Yeah,*

*therapy was never comfortable, it very often involved me going through a*

*box of tissues ... But very necessary… I think that I by that point in time I*

*wasn't shying away from the discomfort. I would have gone through*

*anything, or that's how it felt like, in order to help me get better."* [183-189]

**Component 4: Crucial principles of bulimia nervosa and change**

The fourth higher-level component illustrates that the participants have

entered the healing stage in the processes of change. The categories included in the

fourth higher component highlight the three main principles highlighted by

participants in overcoming BN. The accounts indicated that each principle is equally

important and likely to either promote or hinder change. The main factors identified

within this component are presented in turn as presented in Figure 7.
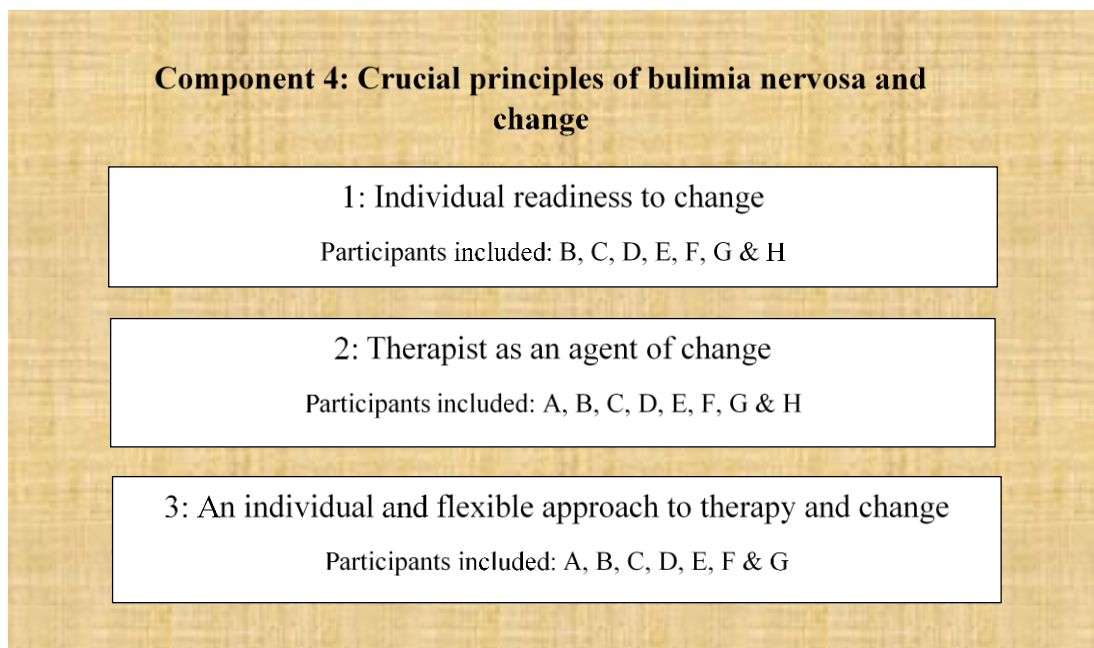
Figure 7. Crucial principles of bulimia nervosa and change: The higher component
and lower categories.

## 4.1 Individual readiness to change

The participant accounts indicated that readiness to engage and comply with
treatment recommendations as well as motivational readiness to change were critical
factors in the processes of healing.

Debbie: *"Change is very very slow. But it's very individual rather than the
therapists. Like, it depends where you are and how you feel, cos if you're not
willing to let it in and you're just doing it to please others, it's never going
to work. You have to get there yourself."* [97-99]

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The findings suggested that motivation to change partly came from acting,
which suggested that when the participants were ready and able to challenge BN and
face their fears, changing behaviours could be powerful and effective.

Emma: *"... one thing I think that did actually really help in cognitive*
*behavioural therapy was learning that motivation follows action. So, if you*
*actually do something to start changing it, even though you might not be*
*ready for it, but when you start trying to change something then the*
*motivation comes in."* [205-207]

## 4.2 The therapist as an agent of change

The findings showed that certain qualities of the therapist were critically
important to motivate and promote processes of change in BN. For example, the
participants highlighted that it was vital that the therapist completely understood
EDs, showed empathy, listened, and provided safety and consistency in therapy.

Helen: *"Like, it was really important that the therapist had compassion and*
*an understanding of how difficult things are and why things are difficult. I*
*think it does come down to having compassion and empathy but also an*
*actual understanding of the illness."* [63-65]

The significance of these factors seemed related to the fundamental
confrontation of self that participants faced in therapy, which helped them to cope
with the painful processes of change.

Anna: *"So, if I'm going to see somebody to help me, in some way, they need to convince me that they completely understand and they are actually people that can give me the help and the advice that I need and that they are experts in that area."* [133-136]

Some of the participants described that they did not feel understood by their therapist, which had a negative impact on the overall therapeutic process.

Helen: *"The first therapist I started seeing, I really didn't get on with her at all. I found that very hard, I didn't get on with her. She didn't seem to get me, it just didn't work. But I carried on seeing her although I did request to see a different one, but they wouldn't let me change so I carried on seeing the same one but then I didn't want to go as often. So, I would go for a period for a time and not get anywhere. So, I'd stop going and then I'd be referred back to see her again. It just didn't work, it didn't help at that point."* [46-51]

The participants also described that the therapist needed to be strong and assured because those characteristics gave them the confidence to fight BN. In line with this, the accounts also showed that the participants needed the therapist to be firm and offer clear structure and guidance in therapy.

Clare: *"I think I just needed my therapist to be really firm with me and say, "so this is what we're going to do, you need to this and this" and then I would do it. I just needed a regimental plan really."* [93-94]

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**4.3 An individual and flexible approach to therapy and change**

The findings indicated that the journey of change is individual, which highlighted the importance of flexibility in therapy.

Gina: *"So, it's really important that the therapist is someone who has an in-depth knowledge, who knows that it's different for everybody, because it is different for everybody. And they need to be able to understand that. So, they need to listen to how you deal with it and they need to be flexible with how they start their sessions, so they understand that you are different from everybody else, but they can sort of work with that. Because if they're just solid on "this is how eating disorders are cured and we're going to this and that," then it's not going to work because it's so different for everybody. Like, I've never met anybody that has had the same experience."* [294-300]

Some of the participants described that they felt their therapist was resistant to alternative ways of dealing with BN.

Anna: *"I think flexibility may be needed in the traditional way of dealing with eating disorders. I think we need to look at it slightly differently. It might not be for everybody and everybody might not be ready to look at it in a different way and I think my therapist was a bit resistant to an alternative avenue in the treatment."* [261-264]

**Component 5: Engaging with cognitive behavioural therapy at the nexus of self and bulimia nervosa**

The fifth higher-level component focuses on how the participants engaged with CBT within the context of BN and aspects of therapy perceived as significant to change. Although there was a consensus amongst the participants that therapy was helpful, findings suggested that CBT may more accurately be perceived as a part of change rather than as the primary cause of change. The main factors identified within this component are presented in turn as illustrated in Figure 8.
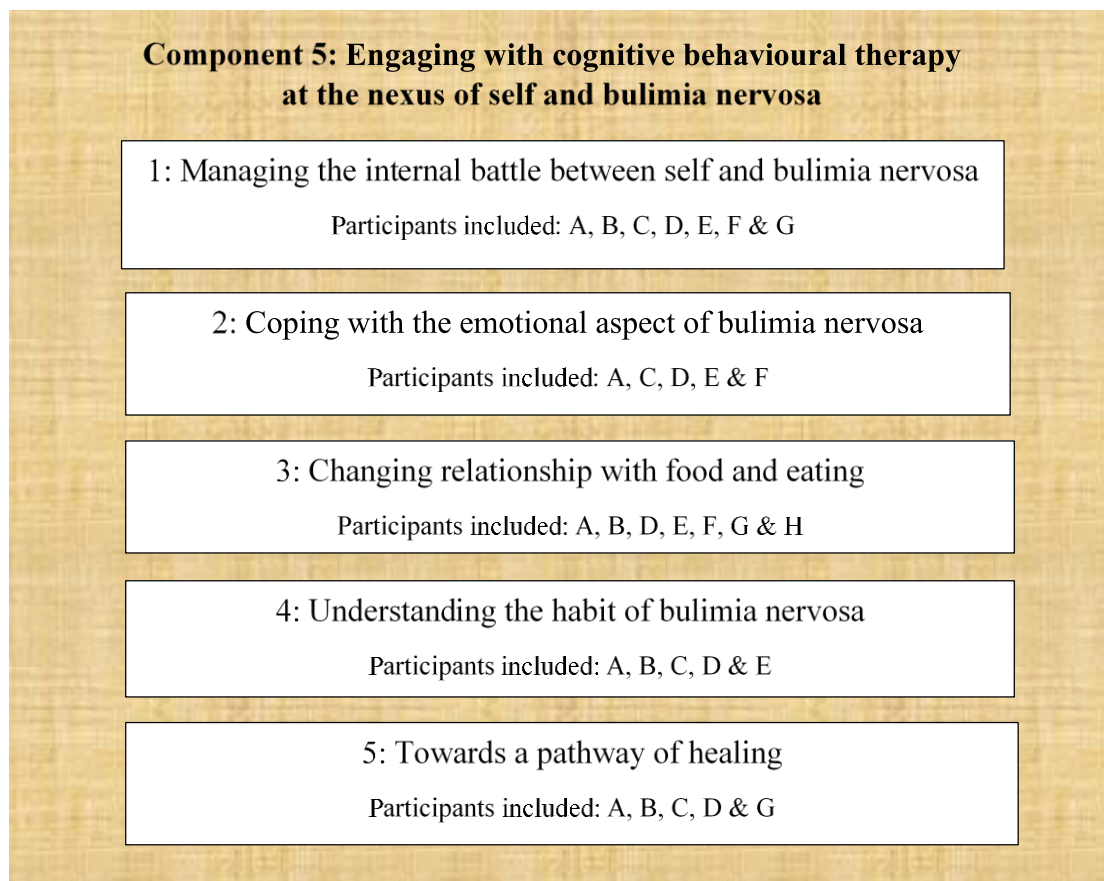


Figure 8. Engaging with cognitive behavioural therapy at the nexus of self and bulimia nervosa: The higher component and lower categories.

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**5.1 Managing the internal battle between self and bulimia nervosa**

The findings indicated that therapy provided a safe space to challenge the voice of BN. For example, the participants highlighted that therapy helped reframe life by challenging eating disordered thinking. Furthermore, the participants described that it was helpful to be told facts about BN and knowing that they could trust those rather than reinforced beliefs.

Betty: *"Therapy helped me change the way I think, to challenge what I had considered to be facts… so, eat this, you get fat and life's crap [laughs] to make it a very simple model. And then also to challenge the things that feed that, so not only the way that I think about things about me but also how I would interpret signals coming in I suppose."* [211-214]

The accounts also indicated that the participants found it helpful to carry out tasks between therapy sessions to uncover eating disordered behaviours and challenge beliefs. Some of the participants, however, noted that it provoked anxiety to carry out tasks independently between sessions.

**5.2 Coping with the emotional aspect of bulimia nervosa**

The participants described that therapy helped to comprehend the emotional aspects of BN and findings suggested that therapy helped them to both recognise and regulate difficult emotions directly through use of assertive communication, effective problem solving and conflict resolution skills.

Emma: *"I think I still have like parts of the eating disorder and it still affects me, but I think the place that I'm in at the moment is much better though. I don't have to show my distress through my eating disorder because I have someone that I can explain my distress to in words rather than food."* [47-50]

## 5.3 Changing relationship with food and eating

The findings indicated that therapy helped most of the participants build a healthier relationship with food. For example, the accounts revealed that food diaries were helpful tools in highlighting eating disordered behaviours, and that it was possible to hold back the urge to binge and purge with a structured meal plan and regular eating.

Debbie: *"There have been a few times where I have not been able to cope and I have been sick, but with the regular eating I can hold back that urge of having to binge and purge."* [321-323]

One of the participant, however, described that a negative consequence of the meal plan was that it created dependency.

Gina: *"I was put on a meal plan in November 2012 and I didn't come out of it until August 2015. Like, I changed a few things, but it was the exactly same things every single day. … it meant that I didn't have a wide variety of food, like I was really rigid with the structure and I couldn't go out with*

*friends and I couldn't eat with other people because I had to eat that."* [262-

265]

Although there seemed to be a consensus amongst the participants that

therapy helped to build a healthier relationship with food, findings indicated that

therapy interventions should focus wider than purely on eating behaviours.

Debbie: *"I felt that the only thing the therapists cared about was just that I*

*put on weight. That's how it felt like at the time, like, that's what they cared*

*about and everything was just about eating... and that was hard. I felt that*

*there was minimal therapy compared to just eating."* [182-185]

## 5.4 Understanding the habit of bulimia nervosa

The findings suggested that it was not only important to address eating

disordered behaviours in therapy but also to understand the habit of BN and

comprehend how it is physiological set in place in order to change.

Anna: *"But actually, what did it for me was seeing my eating disorder as a*

*hard biological habit that formed itself and knowing that I could step away*

*from it and actually that I had a choice."* [341-343]

## 5.5 Towards a pathway of healing

The findings suggested that change happened at different speeds and some

participants described that certain CBT interventions created a sudden change while

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others expressed that change was slow and ongoing. The accounts generally

indicated that CBT was effective in reducing symptoms although most of the

participants described that CBT only provided part of the answers to healing.

Anna: *"I think individual therapy helped to frame… I think it helped to*

*frame recovery! I can't say no or yes… it's not as simple as that! … So, it*

*was hugely beneficial, but did it provide the answer or not? It was a part of*

*the answer I would say. My gut feeling is that it was part of the answer but*

*not the whole answer for me."* [246-253]

In contrast, one of the participant expressed that she did not find

CBT helpful.

Clare: *"I don't really think therapy has done anything for me to be honest,*

*but I don't know if that's me or the therapy… I think I just haven't really*

*been able to deal with the emotions that were associated with the recovery*

*period and it just stopped me from engaging with the therapy completely.*

*From my experience, it hasn't done anything for me at all."* [190-193]

The range of different experiences included in this category suggest that each

of the participant came to new realisations of themselves and BN, which were related

directly to themselves and their individual situations.

**Component 6: An ongoing journey of relapse and change**

The categories included in the sixth and final higher-level component relate
to the participants' experiences after ending therapy. Most of the participants
reported an ongoing painful and challenging journey of change, which is
complicated by the fact that BN has become a way of engaging and coping with the
world and therefore continues to be part of self. The participants described that BN
can sneak up anytime and that is vital to have continuous support from others to
continue their journey of change. The main factors identified within this component
are presented in turn as shown in Figure 9.
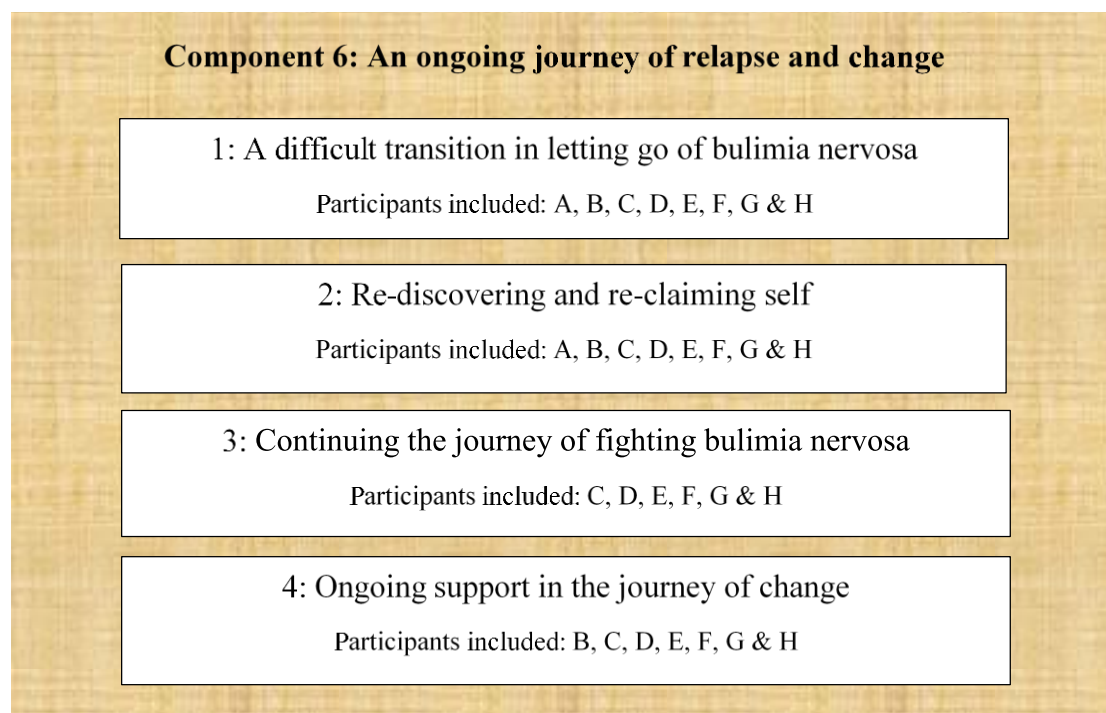


Figure 9. An ongoing journey of relapse and change: The higher component and
lower categories.

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## 6.1 A difficult transition in letting go of bulimia nervosa

As noted above, the findings showed a process of fusion between the participants and BN where one experienced an immediate connection between physical and psychological realities (i.e., restrictive control of food signified psychological control of self). This corporeality, however, was experienced as a cruel reality, which was difficult to escape from. The participants described that therapeutic change was/is a challenging and ongoing process. The accounts suggested that BN continuous to offer a sense of safety and control and therefore the participants struggle to give it up completely.

Gina: *"It was extremely difficult to challenge the voice of my eating disorder, extremely difficult. And it's still something I struggle with today really. It has still not gone 100%, it's still there like 50% of the time, but now I've got to the point where it's not all or nothing. But it's such a struggle because you're arguing with someone in your head and they're winning. It's hard to comprehend, hmmm, it's something that makes you feel so safe, like it makes you think that you're safe. Like, going without it feels scary because it feels like you're going somewhere you didn't know. So, challenging it is extremely difficult, 100%!"* [239-244]

The accounts suggested that the current and ongoing healing process is characterised by relapses and the participants described that BN continuous to be part of self.

Emma: *"I don't feel that I have given BN up in a lot of ways… I think I still have like parts of the ED and it still affects me."* [47-48]

Fran: *"I don't think the eating disorder ever sort of leaves you at all. You just learn to deal with it, to live with it and to control it."* [235-236]

The participants reflected that although the change process was/is painful and ongoing, the process had also been hopeful and brought them to a place of healing.

Betty: *"You can't live a life when you have bulimia, like you can't do anything. So, whatever it was that was on track to help you, no matter how hard it is to change that deep habit, is good, even if it's hard."* [228-230]

## 6.2 Re-discovering and re-claiming self

The participants described that although BN continues to be a part of self, the change process has had a positive impact on self and life. For example, they reported that emotions are less intense, relationships with family and friends have improved, they can enjoy and maintain school/work and they have a positive outlook in life.

Clare: *"I'm a lot happier and I've got a relationship with my daughter now. I'm getting on better with my family and they've noticed a huge change in me, like I'm not so serious anymore, I'm laughing and joking with them whereas before when I was quite ill with the eating disorder, I didn't have any relationship with my family at all, I didn't see them or speak to them for*

*months. I'm doing really well at work. I look much healthier. Yeah,*

*everything has just changed for me, I'm a completely different person."*

[219-223]


### 6.3 Continuing the journey of fighting bulimia nervosa

Despite the positive changes noted, the participants described that healing

from BN is an ongoing process where they need to challenge the voice of BN every

day.


Helen: *"...to an extent it's almost like there's a gene that you have that*

*predispositions you to the danger of relapsing. So, I think wherever you are*

*in your life, something can trigger you to relapse whether purposely or un-*

*purposely. But I don't think it has to affect your everyday life. I think you*

*can get beyond it, but I think the eating disorder will always be in you*

*somewhere."* [238-241]


During this process, accounts highlighted that it is vital for participants to

continuously remind self not to be trapped in eating disordered thinking and

behaviours.


Debbie: *"I'm slowly getting back to normality, but when things go wrong ...*

*I sometimes go back to the eating disorder. Then I have to just go 'I can't do*

*that anymore'. I have a notebook where I keep my notes from therapy and it*

*helps me to remember, like to stay out of the bubble."* [240-244]

**6.4 Ongoing support in the journey of change**

The accounts indicated that it is challenging to sustain recovery and that relapse is an inevitable part of the healing process. The participants reported that continued support from ED services are vital in overcoming BN. Other important factors included a supportive social network, including family and friends, and other individuals with a personal experience of an ED.

Emma: *"Last time I was discharged from therapy was June last year, and I have a much better support system in place, so I feel I had much more continuous support. Like, I was still seeing a dietician every two week and I was still seeing Dr [name; psychiatrist]. So, I feel that there has been a much more consistent level of support since I left, and I think that has helped me to continue to fight."* [108-112]

This concludes the higher-level components, which emerged from the analysis.

**3.4 Chapter review**

In this chapter, I have presented the main findings of the study, which suggested both individual similarities and differences in participants' experiences of processes of change in CBT for BN. Exploring the subjective experiences of change from the perspectives of individuals with BN yielded rich and powerful explanations of the meaning of BN and change. The findings indicated that change in BN is experienced as a complex and painful recurrent process of personal transition.

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During the analysis, I was particularly intrigued by the pain participants experienced in overcoming BN and I kept asking myself how the ED had become part of self to such an extent and what made the change process so challenging and continuous? The analysis indicated that participants were trapped in a harsh corporeality, with an immediate relation between physical and psychological realities. I decided on the core category 'a journey towards de-fusion of the sense of self and BN' as those processes proved to answer my questions and seemed to have an interactional relationship that was central to the experiences of change at all stages of CBT for BN.

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**Chapter four: Discussion**

**4.1 Introduction to the chapter**

In this chapter, first, I will review the core category and discuss the main

findings in relation to the literature reviewed in Chapter one, while also considering

new literature in view of the findings. Next, I will consider the strengths and

limitations of the study, followed by a discussion of the implications of the findings

in the field of counselling psychology and beyond. Lastly, I will offer some final

personal reflections and comment on some of the rewards and challenges I have

faced during this research journey.

**4.2 Theoretical integration and development**

The aim of this study was to explore how individuals with BN experience

processes of change in CBT. A review of the literature showed that a full

understanding of the mechanisms that influence change remains elusive. For

example, Rennie (1994) criticises general psychotherapy outcome studies for lacking

vital information on the processes of change within the therapy session. With its

qualitative focus, however, this study had the potential to generate new knowledge of

in-session processes of change situated in the interpersonal situation. GT was chosen

as the most appropriate methodology to describe and explain processes of change.

Qualitative semi-structured interviews were conducted with eight participants and

through comprehensive analysis, six higher-level components emerged, and they

were identified as representing the key processes of change in CBT for BN. A core

connecting category of 'a journey towards de-fusion of the sense of self and BN'

explaining the overall processes of change and potential relapse, was also identified.

The findings frame a multi-treatment episode model of BN and change or a 'chronic'

BN model of change. These findings are supported by the well-known observation

that a significant number of patients with BN continue to display eating disordered

symptoms for a prolonged period after CBT, with some ultimately recovering, but

others experiencing chronic, lifelong ED that does not resolve (Lampard &

Sharbanee, 2015). Indeed, CBT for BN is believed to lead to complete remission of

symptoms in only about 30%-50% of all cases (Wilson et al., 2007). Perhaps CBT

for BN needs to be rethought and developed further to suit the needs of a group of

patients with a chronic presentation? In the following, I will explore and discuss how

findings from this study might inform theory, practice and research about how CBT

works among patients with BN.


### 4.2.1 A journey towards de-fusion of the sense of self and bulimia nervosa

Exploring the subjective experiences of change from the perspectives of

individuals with BN yielded rich descriptions and comprehensive explanations of the

meaning of BN and change for them. The study suggested that change in BN was

experienced as a complex and painful continual process of personal transition that

involved a journey of de-fusion from the ED. All the participants in this study

described how BN was experienced as gradually becoming part of self and how

bodily sensations and attributes affected cognitions and emotions. The overall

finding demonstrated an immediate connection between the participants' physical

and psychological realities. In other words, symptoms fundamentally served to

maintain the cohesion and stability of a fragile sense of self. This symbolic

communication via the body, however, was not experienced as metaphors, but rather as actual reality, which affected the change processes in several ways. The subjective experience of fusion with BN is best illustrated through quoting one of the participants in this study. In the following quote, Gina describes how painful it was for her to differentiate and regulate emotions associated with change. The quote illustrates how mental states are felt and acted on as if they were presentations of reality and not *re*presentations of reality.

*"I used to feel that my throat was cut off. I used to feel that someone was physically grapping my throat and that's what it used to feel to eat food that I wasn't happy with. I remember getting panic attacks as well, where I felt like I couldn't breathe. And I don't think a lot of people understand the actual physical pain of having an ED. It becomes such a fear, it's absolutely… it stops you so badly, it's terrifying. Like the run up to having food would just be… I would be shaking, I would be so scared. So, that was a big part of it. That was one of the big reasons why is was so hard to recover because getting across that feeling was one of the biggest challenges that I have ever faced. Like that feeling is so hard to get rid of and overcome."* [150-157]

The overall findings from this study seem to share commonalities with other models of disorder and change. One example, and one that has received increasing attention in recent years, is the relationship between EDs and conventional drug addiction. Research has highlighted comparable clinical and behavioural parallels among food and drug abuse and similarities in their biological underpinnings (Davis

& Carter, 2009). Amongst these parallels is the progressively compulsive nature of the addicted behaviour, despite damaging consequences to physical health, social relationships, school/work and finances (Robinson & Berridge, 1993). Indeed, the DSM-5 defines addiction as a "problematic pattern" of behaviour "leading to clinically significant impairment or distress" (American Psychiatric Association, 2013). Furthermore, with continual exposure, individuals develop tolerance of their behaviour to produce the same reinforcing effect (Davis & Carter, 2009). These individuals also tend to experience a pronounced sense of craving for the behaviour. Following its removal, they often experience pronounced withdrawal symptoms and repeated failures at giving up the habit and recurrent cycles of cessation and relapse are involved in the change process (Robinson & Berridge, 1993). These characteristics of conventional addictions show parallels in the core clinical and behavioural features of BN. For example, eating disordered behaviours, such as dieting, binge eating, compensatory behaviours and excessive exercise, most often become increasingly extreme with time. Also, individuals with BN describe a strong compulsion to continue to engage in eating disordered behaviours despite persistent physical and psychological consequences, which is reflected in the repeated failures at giving up the habit and the high levels of relapse (Palmer, 2014). With respect to treatment, there is strong empirical support for CBT in both drug addiction (Carroll & Onken, 2005) and BN (Wilson et al., 2007) although a substantial number of patients fail to recover, and the rate of relapse is significant (Davis & Carter, 2009). Indeed, relapse rate is reported to be as high as 95%-99% in conventional drug addiction (Cui, Wu, & Luo, 2008) and estimated to range from 25%-40% in BN (Wilson et al., 2007).

At the biological level, parallels between BN and conventional addictions are also evident. Some theories argue that the two illnesses represent different displays of a basic predisposition to addictive behaviour patterns either due to genetic vulnerability or because of a common addictive personality style (Holderness, Brooks-Gunn, & Warren, 1994). Support for this idea comes from the evidence that mood-related comorbidities, such as depression and anxiety, are premorbid features in both addictions (Jaffe & Clouet, 1982) and EDs (Kaye et al., 2004). Other theories, however, maintain that self-starvation and excessive exercise activate the dopaminergic reward pathway of the brain (Casper, 1998). The resulting biological processes are highlighted in the auto-addiction opioid theory, which suggests that a chronic ED is an addiction to the body's production of endogenous opioids and therefore parallels the psychology and physiology of conventional drug addictions (Heubner, 1993; Marrazzi & Luby, 1986). In other words, dieting, binge eating and compensatory behaviours serve as drug supplies as they increase levels of endorphins, which are chemically homogeneous to exogenous opioids (Davis & Claridge, 1998). Davis and Carter (2009) further propose that these endorphins are addictive as they activate the dopaminergic reward pathway in the brain.

In sum, this study's proposed model of processes of change in BN clearly shares compelling similarities with the model of conventional drug addiction and change, including clinical and behavioural features, comorbidity, treatment approaches and evidence of a shared diathesis. Interestingly, and much in line with the core finding of this study proposing a fusion between BN and self, earlier work defined 'addicted' as "to give over…to someone or some practice (cited in Davis & Carter, 2009, p. 2). Based on the common themes, this current model, however, has the potential to unpack these complicated processes by helping to *describe* and

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*explain* some of the underlying processes that may contribute to such psychological

symptomatology in adults with BN (and perhaps any related addictions).

## 4.2.2 An alternative conceptualisation of bulimia nervosa

The findings from this study helped to illustrate how the participants

experienced the early stages of BN. All the participants described that they

developed BN in response to adverse internal and/or external stressors. The study

showed that initially eating disordered behaviours were a seemingly helpful way to

cope with difficulties. The participants described an experience of receiving

something positive from the ED, including a sense of control and predictability,

feeling beautiful and that the illness represented comfort and protection. In other

words, bodily sensations and qualities were perceived as actual solutions for

emotional, cognitive and relational problems. In line with this finding, Pedersen,

Poulsen and Lunn (2014) conducted qualitative interviews with five women with BN

and found that all used the ED in different ways to regulate affect. This finding is

further supported by Fairburn and colleagues' (1993, 2008) cognitive model, which

highlights that individuals with BN suffer from feelings of insecurity and thus, use

food as a coping strategy to protect themselves from negative feelings.

From the results it is evident that difficulties in affect regulation and

recognition present key features in BN, which have also been highlighted in the

literature (e.g., de Groot, Rodin, & Olmsted, 1995). In line with this, recent

psychoanalytic conceptualisations have characterised individuals with BN with an

inability to recognise emotions and an impaired capacity for symbolisation (e.g.,

Freedman & Levander, 2002) and bulimic symptoms have been perceived as a

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bodily centred strategy to regulate emotions (Clinton, 2006). Similarly, within CBT,

there is increasingly a focus on emotional dysregulation in BN in the 'enhanced'

version for EDs (Fairburn, 2008).

The findings from this study helped to illuminate the participants'

experiences at the time of entering therapy and highlighted a difficult transition in

seeing symptoms as evidence of BN and recognising the need for therapy. As

highlighted in the literature review, ambivalence to treatment and change is a main

issue in individuals with BN and the motivation to change is generally low and/or

unstable (Geller et al., 2001) and up to 70% of patients drop out of outpatient

treatment (Fassino et al., 2009). Furthermore, Wilson and colleagues (2007) propose

that treatment outcome is generally poor.

The therapeutic process seems to be challenged by two factors: Firstly, and as

highlighted in the above section, the participants' subjective experience of receiving

something positive from BN and secondly, their fusion with the illness. The

participants' accounts suggested a basic and close relationship between the physical

body and emotions. Thus, the over-investment of eating restraints may reflect an

unconscious need to resolve psychological difficulties (e.g., dysfunctional

interpersonal relationships) and binging and purging behaviours serve to displace

repressed impulses, release tension and help to regulate intolerable affects. In line

with this, Skårderud (2007a; 2007b; & 2007c) argues that reduced symbolic capacity

is a key psychopathological trait in AN. Skårderud proposes that individuals with

AN are trapped in a concrete reality of mind-body representation, which is difficult

to escape from for the patient. Taken together, these findings might contribute to a

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better understanding of BN and explain why it is so challenging to engage these

individuals in the therapeutic process.

The present research suggests a turning point in the change process in which

participants started to distance themselves from BN. This process was marked by a

perceived sense of loss of control and significant pain, including intense emotions

and physical reactions. It was found that fear of eating and gaining weight were main

features, but my analysis also highlighted a symbolic connection between reducing

body weight and removing negative emotions and cognitions. From the results it is

evident that BN is associated with difficulty regulating emotions and that the ED is

used to compensate for those difficulties, which might explain why processes of

change were related to significant pain and distress. The participants seemed to feel

trapped in a punitive corporeality, which was difficult to escape from; what was

thought and felt was also experienced as physical reality. These findings are

supported by empirical studies that have found impairments in social cognition in

AN (e.g., Ward et al., 2001) and EDs in general (e.g., Rothschild-Yakar, Eviatar,

Shamia, & Gur, 2011). Also, it was found that self-harm served to escape, avoid and

otherwise regulate aversive emotional states during processes of change, which

further suggests that individuals with BN lack the ability to regulate affects.

The accounts suggested a challenging transition involved in letting go of such

BN processes and most of the participants described that therapeutic change was

slow and ongoing. The findings extend research into psychotherapy for AN

(Skårderud, 2007a; 2007b; & 2007c) by indicating that individuals with BN may

struggle to change because they feel trapped in the concreteness of body symbolism.

During those early change processes, my findings showed that it was vital to have

continuous support from ED services, strength of commitment from therapist and/or other sources of social support such as family, friends or supportive individuals with EDs.

### 4.2.3 Processes of change in bulimia nervosa

The findings from this study helped to illuminate the main principles that facilitated and/or hindered change in CBT for BN. It was found that treatment effects were associated with subjectively 'feeling ready' and 'being motivated' to change. Participants described negative treatment experiences related to early stages of treatment where they were unable to comply with therapy. At later stages, however, the evaluation of treatment was more positive and they indicated readiness to give up eating disordered symptoms. Thus, a positive treatment experience seems correlated with timing and being in a mode of action to change. This interpretation is supported by Pettersen and Rosenvinge (2002) who found that positive recovery outcome in treatment for BN was related to the patients' feeling of being ready to change. These interpretations point to a paradox within the current research literature. Although there is substantial agreement around the propositions that patients with BN should start therapy as soon as possible (e.g., le Grange & Loeb, 2007), this highlights that patients' subjective feeling of readiness should be considered, which might increase satisfaction and engagement with treatment and thus outcome.

A general framework for conceptualising readiness for change in treatment-resistant individuals is provided in the transtheoretical model of change (Prochaska, 1979; Prochaska, DiClemente, & Norcross, 1992). In line with the work by Prochaska and colleagues, Geller and Drab (1999) introduced the 'Readiness and

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Motivation Interview', which is a symptom-specific measure of readiness and motivation for change in EDs. For four categories of symptoms (cognitive, restrictive, binging and compensatory strategies), the measure provides scores on the extent to which individuals are in precontemplation, contemplation and action/maintenance, and the extent to which change is made for internal versus external reasons. Geller, Cockell, and Drab (2001) examined the measure and found that readiness to change varied across the symptom categories; lower levels of distress were associated with actively working on symptom reduction and making changes for internal as opposed to external reasons. From the results it is evident that levels of distress need to come down for active change to happen also supports the findings from this study where participants reported that individual readiness was a critical factor in the processes of change.

Taken together, two points are proposed: obtaining a 'readiness profile' might help to inform treatment decisions for individuals with BN; and reducing distress might be a helpful step in preparing these individuals for symptom-reduction treatment. An approach to therapy, where therapists are responsive to patients' readiness and motivation to change across symptoms might help to increase patients' satisfaction and engagement with treatment and thus the outcome.


This study also revealed that therapeutic factors played an important role in facilitating readiness and overall motivation to change. As noted in the above sections, analysis showed that processes of change were complicated by a complex fusion between self and BN, which triggered intense emotional and physical reactions. The participants expressed that certain therapist qualities were critically important to motivate engagement in this painful process and highlighted

understanding, empathy, safety and consistency as key therapeutic conditions. These

findings are consistent with Roger's (1957) 'core conditions', more specifically,

empathy, congruence and unconditional positive regard, which are provided by the

therapist and thought to lead to therapeutic movement. At the same time, however,

findings showed that the participants needed clear structure and guidance in therapy,

which provides support for the more structured CBT approach for BN (Fairburn,

2008). The current interpretations extend previous research (e.g., Murphy et al.,

2005; Onslow et al, 2015) and show that the treatment of BN is likely to be

successful when integrating different approaches.

While findings from this study revealed that certain therapist qualities are

vital in the change process, participants' accounts also highlighted the importance of

an individualised and flexible approach to therapy. This interpretation is in line with

general process outcome research that shows that one of the most consistent

predictors of therapeutic outcomes is the degree of consensus between the therapist

and patient on the goals and tasks of therapy (e.g., Llewellyn, 1988). Furthermore,

research suggests that a therapeutic approach that takes patients' understandings of

problems and expectations into account and works collaboratively is likely to

improve therapeutic alliance, reduce drop-out rates and improve overall effectiveness

of treatment (Lambert & Barley, 2001). The finding that there is a positive

correlation between therapeutic alliance and successful treatment seem to be

consistent across different patient populations, treatments and issues (Martin et al.,

2000). In the case of CBT for BN, research suggests that the therapeutic alliance is

related with improvements in eating disordered symptoms (Loeb et al., 2012). In

contrast, however, Wilson and colleagues (1999) found that specific CBT

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interventions were more potent predictors of treatment outcome compared to therapeutic alliance.

Taken together, according to the findings from this study and the general outcome of theory and research, several mechanisms seem to influence processes of change in CBT for BN. While some research indicates that the congruence of patients' treatment preference and the treatment they receive is positively correlated with therapeutic alliance (Iacovielle, McCarthy, Barrett, Rynn, Gallop, & Barber, 2007), other findings, however, suggest that individual preference for a given treatment is not related with effect in psychological treatment (Bakker, Spinhoven, van Balkom, Vleugel, & van Dyck, 2000). These interpretations seem in line with a pluralist framework (Cooper & McLeod, 2007), which holds that the patient's perspective on what is helpful/not helpful in therapy is as valid as the therapist's. In other words, for therapy to be successful, both participants (patient and therapist) must draw on individual knowledge and skills and through a collaborative relationship change and healing emerge.

This study showed how the participants engaged with CBT within the context of BN and aspects of therapy that they perceived as helpful and/or hindering in the change process. As reported in the literature review, the cognitive mediation hypothesis proposes that psychological disturbances are caused by unhelpful cognitive processes and therefore change in these processes can produce improvement in the symptoms of psychological distress (Burns & Spangler, 2001). In the case of BN, dysfunctional attitudes about weight and body appearance are caused by negative core beliefs (Fairburn et al., 1993). In CBT, those negative core beliefs are challenged, which lead to a reduction in the frequency of negative

automatic thoughts and thus a reduction of the eating disordered symptoms (Fairburn, 2008).

In line with the theory and research of mechanisms of change in CBT for BN (e.g., Wilson et al., 2002), this study suggested that modification in the participants' eating disordered thinking decreased the pressure to diet, which was associated with a reduction in binge eating and purging. Also, the findings revealed that reduction is dietary restraint accounted for change on different levels: Physiologically, adopting a regular eating pattern reduced the urge to binge and then purge; and cognitively, reducing dietary restraints improved dichotomous thinking about eating. Finally, this study indicated that CBT enhanced self-efficacy for coping with negative affect and interpersonal stress, which was associated with a reduction in binging and purging. In line with the literature (e.g., Timulak, 2007), findings also showed that a helpful aspect of therapy included increased self-knowledge, also referred to as 'insight'. For example, one of the participants, Anna, explained that she needed to understand the habit of BN and comprehend how it was physiologically set in place in order to change.

The range of different experiences of therapy revealed that participants generally found CBT effective in reducing eating disordered symptoms. One negative case, however, highlighted that she did not find therapy helpful. Although the above interpretations are consistent with the theory of how CBT for BN works, findings also revealed individual differences among participants. Some described how new understandings lead to change in their perspective of reality, which then lead to a change in behaviour. Others described how changing behaviours lead to a new understanding, which again lead to a change in perspectives. Taken together, these findings suggest that a range of different elements of CBT brought about

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change and that there are several processes by which the participants changed. This interpretation is in line with the pluralistic framework described by Cooper and McLeod (2007), which assumes that psychological distress has multiple causes and that different individuals are helped by different processes at different times. A pluralistic approach therefore proposes a framework to psychotherapeutic theory and practice, which is open to a wide range of ways of engaging with the individual patients (Cooper & McLeod, 2011). With respect to CBT for BN, this view is also supported in research findings. For example, Spangler and colleagues (2004) investigated the relationship between therapist interventions, patient mechanisms and symptoms in a group of women who received CBT for BN. The researchers concluded that cognitive (e.g., cognitive restructuring), behavioural (e.g., prescription of regular eating, meal planning, exposure to feared food) and relational (e.g., collaboration, empathy, involvement) mechanisms are all related with therapeutic change but mediated by different variables, which highlights individual differences and the importance of flexibility in therapy interventions. Furthermore, according to the theory and research investigating psychotherapy for BN, it has been highlighted that individuals with BN differ with regard to individual characteristics and presenting issues (e.g., Cassin & von Ranson, 2005).

This study also indicated that change happened at different speeds and some participants reported a sudden change while others described the change process as slow and ongoing. This interpretation also supports the proposal that there are several change processes. Indeed, research supports this finding and proposes that change can happen at different speeds, both without therapy (e.g., Schreiber, 1998) or across different therapies (e.g., Carey, Carey, Stalker, Mullan, Murray, & Spratt,

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2007). Taken together, the research suggests complexity in processes of change for

any given treatment intervention or therapeutic outcome.

As highlighted in the introduction, a review of the literature shows that a full

understanding of how individuals with BN change in CBT remains elusive. In this

study, however, eight individuals agreed to share their experiences of living with and

recovering from BN. The story of each individual was unique but through the

systematic procedures of GT, a model was developed that describes and explains

processes of change in CBT for BN. This study frames a multi-treatment episode

model of BN and change, or a 'chronic' BN model of change. These findings extend

the well-known observation that a significant number of patients with BN continue

to display eating disordered symptoms for a prolonged period after CBT, with some

ultimately recovering, but others experiencing chronic, lifelong ED that does not

resolve (Lampard & Sharbanee, 2015). Indeed, CBT for BN is believed to lead to

complete remission of symptoms in only about 30%-50% of all cases (Wilson et al.,

2007). Furthermore, and in line with research findings, the participants' accounts

indicated that the ED was associated with high levels of comorbidity (Kaye et al.,

2004), trauma (Tasca et al., 2013) and serious medical complications (Mitchell &

Crow, 2006). The main finding of this study demonstrated an immediate connection

between the participants' physical and psychological realities where eating

disordered symptoms fundamentally served to maintain stability of a fragile sense of

self. This symbolic communication via the body, however, was not experienced as

metaphors, but rather as actual reality, which affected the change process in several

ways. The study indicated complex processes of learning about self, recognising the

problematic nature of BN and preparing for behavioural change.

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Taken together, research supports CBT for BN and this approach has been

established as the usual treatment of choice (NICE, 2017). However, CBT is not

universally effective and many patients fail to make sufficient improvement

(Lampard & Sharbanee, 2015). Fairburn and colleagues (2008; 2009) conclude that

the focused version of CBT-E should be the default treatment and the broad version

should be used for 'complex' cases. Based on the findings from this study, I propose

that there is a need to consider the development of a *broader* version than the broad

version of CBT-E in the treatment of patients with 'chronic' BN. Indeed, the present

model illustrates the relapsing journey that represents the chronicity of the illness

and shows how multiple presentations may happen and work. I will explore the

practical suggestions of the findings in section 4.4.1. Practical implications.

## 4.3 The strengths and limitations of the study

In the following section, I will discuss some of the strengths and limitations

of this study. The aim was to explore how individuals with BN experience processes

of change in CBT. GT was chosen as the most appropriate methodology to describe

and explain these complex processes.

One of the strengths of choosing the GT methodology, including answering

the research question, was the quantity and quality of data, which helped to

illuminate how processes of change is experienced. Although I consider the large

amount of data to be one of the main strengths of this study, it may also be

considered a principle limitation. A qualitative study like this one has the potential to

produce rich, complex and multifaceted data that can be overwhelming and

challenging to make sense of. Although the GT methodology offered structure and

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guidelines, the large amount of data also carried the risk of missing some of the fine

interpretative details. Overall, my aim has been to offer my interpretation of the

participants' interpretations of their experiences of CBT, although recognising that

this is one of many possible interpretations. Morrow (2007) highlights that

participants' account unavoidably involves interpretation, which unintentionally will

always be influenced by the researcher's values, beliefs, experiences, cultural

backgrounds etc. I will return to issue of personal involvement and explore the

potential impact on the research process in section 4.5. Final words of reflexivity.

In terms of the participants, further limitations arise. Although a sample size

of eight is considered adequate for a GT study (Guest et al., 2006) and participants

varied regarding age and socioeconomic status, they were all females and of the

same ethnic group, which might have affected the generalisability of the findings.

For example, the experience of therapy and change by male participants might have

yielded differences between genders. Although the sample is representative of the

general clinical population with BN in terms of age, gender and ethnicity, a larger

and more varied sample might have produced greater differences between

participants. It should be noted, however, that it was not a conscious choice only to

include white British, female participants but rather a matter of convenience

sampling. During the recruitment process, more than 120 individuals were invited to

take part in this study and only eight females who met the inclusion/exclusion

criteria agreed to take part. A further limitation concerns the exclusion of individuals

whose risk scores indicated caseness of depression or anxiety. I decided on this

exclusion criteria to protect potential vulnerable individuals against the risk of harm

as I was mindful that the interview might touch on sensitive areas. Although I

believe this was an ethically right decision, I had to turn down several participants

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who wanted to take part in the study but who did not meet this criterion. One individual subsequently emailed me and shared her concern that a sample excluding depressed or anxious individuals might not be representative of bulimic individuals. I think this is a very valid point and acknowledge that this study's sample might not be representative of this clinical population, which precludes any firm conclusions. Nevertheless, the generalisation of the findings was not an aim of this study. Instead, I sought to generate hypotheses for research and to deepen our understanding of the experience of therapy.

As described in Chapter 2: Methodology, I decided to interview individuals who had finished a course of CBT, which was aimed to both avoid the risk of interfering with the process of therapy and allow participants some perspectives on the whole experience. One of the downsides, however, is the retrospective nature of this procedure, which may not capture the experiences in real time. Therefore, I make no claim that I have accessed the true meaning of participants' experiences. This method of data collection, however, is in line with the critical realist epistemological stance of this study, where the aim was to explore the experience of therapy from the perspective of the patients. Furthermore, although I highlighted my role as a researcher at the onset of the study, participants might have associated me with their therapist, which could affect their need to be seen in a favourable light, as opposed to the treatment per se. However, the fact that the participants commented on perceived shortcomings of their treatment, reassured me that that these comments might have been free from constraints.

In evaluating the proposed model, I acknowledge that the interpretations of the data are subjective and could be viewed differently by another researcher. However, I feel satisfied that the theoretical construct is sound although recognising

that some lower categories could be further developed in terms of dimensions and

properties. Therefore, I do not claim that I reached a stage where no new categories

emerged from the data, also referred to as 'saturation' (Corbin & Strauss, 2015).

Breckenridge (2009) highlights that saturation is an abstract concept and that there

are no measurable guidelines about when categories become saturated. Thus, rather

than presenting the findings from this study as 'true' facts, I propose, however, that

the findings present plausible hypotheses that are grounded in the data, which

subsequently might be used in or further developed in future research. In line with

this, Morrow (2005) encourages counselling psychologists to produce accounts that

are educative and invites further exploration and highlights the importance of

bridging theory and practice. Throughout this research process, it has been my hope

that the findings will inform theory, practice and research on how change in CBT for

BN might happen and the implications for practice and research are discussed in the

next section.

## 4.4 Implications of the findings

In the following, first, I will explore the practical implications of the study

followed by a discussion of the implications for further research.

## 4.4.1 The practical implications

The findings from this study raise several practical implications for

counselling psychologists and other allied health professionals engaged in the

therapeutic practice with individuals with BN. Participants described a range of

different experiences, connected to cognitive, behavioural and relational factors, that

both facilitated and hindered healing, which suggest complexity in processes of

change in CBT for BN. These findings highlight individual differences and the

importance of flexibility in therapy interventions. Also, participants' accounts

revealed a highly complex process of what the illness can mean for an individual and

what therapeutic change represents and involves. The present model illustrates the

relapsing journey that represents the chronicity of the presentation and highlights the

potential value of therapists being able to share this with patients as a 'construction'

or 'map' of what treatment can look like, especially with patients who may feel that

they have 'failed' in therapy and so cannot be helped. The normalising of such

failure may be one usefulness of the model for patients re-referred for CBT again.

Thus, through the process of normalising, failure and relapse can be accepted and

understood to be inevitable characteristics of the illness and the processes of change.

Furthermore, the overall finding shows an immediate connection between the

participants' physical and psychological realities where they were trapped in a

punitive corporeality, which was difficult to escape from. The proposed model of 'a

journey towards de-fusion of the sense of self and BN' suggests that the

psychological treatment of individuals with BN should address eating disordered

symptoms as highlighted in CBT for BN (Fairburn, 2008), as well as deficiencies in

social cognitions. This should include rehabilitation of this compromised capacity,

with an emphasis on how the body is representing mental states. In line with

empirical findings in the general field of EDs (Rothschild-Yakar et al., 2011;

Skårderud, 2007a; 2007b; & 2007c), the conclusions from this study indicate that

difficulties in affect regulation and recognition present key factors in the

development and maintenance of symptoms in bulimic individuals.

The ability to identify and regulate affects is a central feature of

mentalization theory, which makes it of particularly interest in the field of BN.

Mentalization theory is developed by Fonagy, Clinical Psychologist and Professor of

Contemporary Psychoanalysis of University College London, and Bateman,

Psychiatrist and Psychotherapist and visiting Professor at University College London

(Bateman & Fonagy, 2004). Mentalization-based therapy is an integrative approach,

which draws on theoretical principles from developmental psychology, current

psychoanalysis, neuroscience and revised versions of attachment theory (Bateman

and Fonagy, 2012). Different terms are used interchangeably to convey the same

ideas and 'mentalization' covers several concepts, including social cognition, mind-

blindness, emotional intelligence, and theory of mind (Allen, Fonagy, & Bateman,

2008). The theory of mentalization originally evolved as a model of the development

and treatment of borderline personality disorders (Bateman & Fonagy, 2004). Over

the past decade, however, the theory has been developed and applied within other

areas, such as families with parental substance use disorder (Söderström &

Skårderud, 2009), high-risk parent-child relationships (Schechter & Willheim, 2009)

and professionals in crisis (Bleiberg, 2003). With respect to the theory and research

of EDs, Fonagy, Bateman, and Bateman (2011) propose that impaired mentalization

and reduced symbolic capacity represent a core deficit in all chronic EDs and

Robinson et al. (2014) are currently working on developing mentalization-base

therapy adapted for EDs.

Bateman and Fonagy (2012) suggest that mentalization provides an

individual with the ability to distinguish internal from external reality and to

understand the representational nature of the mind. For example, 'psychic

equivalence' is a construct used in mentalization theory and refers to equating the

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internal with the external world (Fonagy, Gergely, Jurist, & Target, 2002). With respect to a mentalization-based treatment approach to patients who present with chronic BN, the aim of the psychological treatment would be to assist the patient in developing the ability to distinguish between bodily sensations and mental representations and identify thoughts, feelings and compulsions to assist the ability of symbolising. A detailed account of mentalization-based treatment goes beyond the scope of this study. Taken together, however, the findings from this study propose that to best understand and support individuals who present with chronic BN, treatment should include aspects of mentalization-based therapy. At the minimum, conceptualising BN from an alternative angle might guide us to grasp some basic limitations and difficulties in psychotherapy and treatment in general.

**4.4.2 The research implications**

The findings from this study raise a number of implications for further research. One main consideration is a more varied sample that includes males with BN and 'high-risk' individuals, which would be more representative of this clinical population. Also, therapist adherence to the treatment manual was not monitored in this study, which might pose a limitation. For example, one could argue that the aim to investigate the experience of CBT for BN relies on therapists adhering to the model. I propose, however, that this design offers a useful insight into a 'real life' ED service rather than a controlled environment. Nevertheless, as the sample only constituted individuals from one single trust, findings could be tainted by the specific approach of the service. Thus, further research could replicate this study in larger cohorts of patients from different trusts and locations. Another direction for future

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research could be extension of research indicating that patients who imply

satisfaction with therapy generally value what their therapist practices, no matter

their theoretical approach (Goldman & Greenberg, 1992). Therefore, it could be

interesting to conduct a similar study including different theoretical approaches to

explore similarities and differences in processes of change further. Additionally,

future research could compare patients' and therapists' accounts of change, include

outcome measures used in treatment and other information that could help broaden

our understanding by integrating patients' accounts with information from other

sources. For example, mixed method studies provide the strengths of a more

complete and comprehensive understanding of the research problem than either

qualitative or quantitative approaches alone. This kind of studies should be continued

to provide useful information on processes of change in BN.

## 4.5 Final words of reflexivity

Coming to an end of this study, I feel that the journey has been

transformative, leading to growth both personally and professionally. During this

process, with its highs and lows, I feel that I have learned a lot – about BN, about

CBT, about processes of change and about myself. Corbin (2009) describes that a

researcher inevitably influences the research process, and in turn the research process

influences the researcher. This description resonates with me as it highlights not only

what I have brought to the process but also what I take away.

Finlay (2002a) highlights that qualitative research has the potential to

transform the phenomenon under investigation. Indeed, Beer (1997) describes that

"interviews augment experience, rather than simply reflecting it. They alter meaning,

instead of delineating it. They change people." (p. 127). In line with this, through

listening to my participants' stories, my own story of BN and change in therapy has

also deepened and taken new shapes. I have felt moved by my participants' powerful

accounts and in awe of their bravery and honesty. Although I connect with my

participants' experiences, this study has also highlighted that the experience of BN

and therapy is highly unique and vary widely from one individual to another.

Corbin and Strauss (2015) propose that the theory development in GT is "a

representation of both the participant and researcher (p. 29). Throughout this study, I

have aimed to be transparent about my personal involvement in this topic and my

epistemological position as a researcher. I acknowledge that my own experience of

BN and therapy, in the patient and in the therapist role, might have influenced this

study in several ways. For example, I may have tended to focus on aspects of BN,

CBT and change that supported my own views. According to my experiences and

beliefs, change in BN is complex and requires psychological treatments that go

beyond focusing on modification of eating disordered beliefs and ultimately

behaviours as proposed in the cognitive-behavioural model of BN (Fairburn, 2008). I

propose that there is a need to consider the development of a *broader* version than

the broad version of CBT-E in the treatment of patients with 'chronic' BN. I believe

that psychological distress has multiple causes and maintaining factors and that it is

impossible for one single model to account for these processes. Ashley (2010)

highlights that effective psychological therapy goes beyond reducing or managing

symptoms and that an awareness of different models (and their strengths and

limitations) encourages a stance of curiosity and respect for differences. This

pluralistic epistemology is at the core of counselling psychology and highlights the

validity of different perspectives in answering the questions we are faced with in our

professional and personal lives (McAteer, 2010). While I acknowledge that my

personal involvement might have impacted this study in various ways, I do believe

that my experience and knowledge also at times enabled me to dig beneath the

surface (Corbin & Strauss, 2015). Furthermore, I hope that by grounding the

categories with several examples will show how I attempted to bracket my own

involvement in this study.

I acknowledge that there were other avenues that would also have been

appropriate to explore in this study, but they will wait for another time. At this point,

I feel content that I have managed to capture a glimpse of the experience of change

in CBT by individuals with BN. It is my hope that this study is taking an active and

meaningful step in empowering the voice of individuals with BN to be heard and

that the findings will inform theory, practice and research about how CBT works

among this patient group.

## 4.6 Summary and conclusion

The aim of this study was to explore how individuals with BN understand

processes of change in individual CBT. The treatment of individuals with BN

remains a major challenge and research suggests that treatment only helps a modest

number of individuals. The rationale for this investigation was to learn more about

factors that influence change, which might contribute to or shed further light on the

body of research that already exists in this area. A qualitative GT methodology from

a critical realist stance was chosen to answer the research question. The findings

suggested that healing from BN can be experienced as a complex and painful

continual process of personal transition, which involves 'a journey towards de-fusion

of the sense of self and BN'. The participants described how BN gradually became part of self and how bodily sensations and attributes affected cognitions and emotions. The model captures an immediate connection between the participants' physical and psychological realities. This symbolic communication via the body, however, was not experienced as metaphors but rather as actual reality, which affected the change processes in several ways. The processes of de-fusion of the sense of self and therapeutic change in the BN appeared to have an interactional relationship that was central to the experiences of change at all stages of CBT for BN. The present model illustrated the relapsing journey that represents the chronicity of the illness and showed how the cycle completes itself (and may repeat) for such a chronic presentation. These findings might be useful as psychoeducation for patients who present with 'chronic' BN as a way of normalising and accounting for the experience of 'failure' or relapse. The main findings were linked to the wider context and possible implications were discussed. A critical evaluation of the study was offered followed by recommendations for future research and practice of counselling psychology. In particular, mentalization-based therapy was explored as a possible framework for conceptualising BN, which might help us grasp some basic limitations and difficulties in psychotherapy and treatment in general.

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PROCESSES OF CHANGE IN COGNITIVE BEHAVIOURAL THERAPY FOR
BULIMIA NERVOSA

**Appendix A: Information letter**



Dear Colleagues,

I recently worked within [name of eating disorder service] as a trainee counselling
psychologist. I really enjoyed my time with the service; in particular, the therapeutic
work with individuals with eating disorders. As a result, I have developed a special
interest in this area. I am currently undertaking a research project involving this
particular clinical population with the London Metropolitan University and I am
looking for participants to take part in the study.

I would be very grateful if you would help me recruit participants for my study. By
assisting me in the recruitment process you are helping me complete my Professional
Doctorate in Counselling Psychology.

**What is the research about?**

I aim to conduct semi-structured interviews to explore the processes of change in
individual CBT for bulimia nervosa from patients' perspectives.

**What are the inclusion and exclusion criteria of participants?**

Inclusion criteria include:

- Participants should meet the criteria of the Diagnostic and Statistical
  Manual of the American Psychiatric Association (5th ed.; 2013) for
  bulimia nervosa prior to treatment
- Participants have undergone a course of individual CBT with you or one
  of your colleagues, duration defined as when eating disorder symptoms
  have abated and both you and the patient were in agreement about timing
  of ending therapy
- Participants must be interviewed within the time frame of 2-18 months
  after completion of therapy

Exclusion criteria include:

- Ongoing psychological treatment
- Current risk of suicide
- History of psychosis
- Ongoing substance abuse
- Individuals that I have previously seen for therapy

**Recruitment process**

Any previous patients that you identify meeting the inclusion and exclusion criteria
will receive an invitation letter asking them to take part in a study investigating the

experience of therapy. This letter will be send out from [name of eating disorder service] to patients who have completed a course of therapy.

## Safety and confidentiality of participants

I aim to ensure the highest possible ethical standards as possible. I am mindful that the participants have gone through a course of therapy and so are a potentially vulnerable group and I will do my outmost to secure them against any harm. Also, any information obtained from and about the participants is confidential and no names or personal details will be used, so neither you nor the patients will be identified. However, participants will be informed that the duty of confidentiality may in exceptional circumstances be overridden by more compelling duties such as protecting individuals from harm.

At the point of recruitment, I will assess current risk by PHQ-9 and GAD-7.

## What are the benefits of this research?

This study aims to explore the experience of CBT among individuals with bulimia nervosa. By learning more about the factors that influence change in CBT, research findings might contribute to or shed further light on the body of research that already exists in this area. It is my hope that findings will inform theory, practice, and research about how CBT works among this patient group.

After completion of this research project, I will present the findings to [name of eating disorder service].

My aim of this study is not to evaluate your practice but rather to explore the experience of CBT from the patients' perspective. Also, neither your nor the participant's identity will be revealed at any time.

Thank you very much for taking the time to read this letter. If you feel that you would be able to help me in recruiting participants for my study, I would be very grateful to hear back from you. Also, if you have any further questions, please do not hesitate to contact me by either calling 07816242921 or emailing lid0162@my.londonmet.ac.uk for an informal discussion.

Many thanks in advance.

Sincerely yours,

Line Devantier

Trainee Counselling Psychologist

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## Appendix B: Invitation letter

To whom it may concern,

My name is Line Devantier and I am a Trainee Counselling Psychologist at London
Metropolitan University. As part of my training I will be conducting a research project. This
study is being undertaken for educational purposes as part of my Doctorate in Counselling
Psychology.
You have recently undergone a course of therapy within [name of eating disorder service]
and I am inviting you to take part in a research project.

### What is the research about?

I am interested in looking at the experience of therapy from the point of view of the
individual who receives it to learn more about how change might occur.

### What participation involves?

You will attend an interview in one of [name of eating disorder service] primary care
locations convenient to you or alternatively the interview can take place in your home. The
interview will take approximately 1.5 hours in total. You will be asked to reflect on the
therapy that you have received and to talk about your experiences. You are not required to
answer any questions if you do not wish to.

Please find two forms attached to this letter. These forms measure your current mood and
anxiety and will help the researcher to establish whether you are eligible to take part in this
study. If the forms indicate that you are feeling very low or anxious, the researcher will
encourage you to contact your GP for further support to manage low mood and anxiety.

The interview will be audio recorded.

### Confidentiality

The interview is confidential and all identifying details (e.g., names, locations) will be
anonymised. Thus, any identifying details will be changed so neither you nor your therapist
will be identified. Also, the information you give at the interview will not be shared with
your therapist. The results of the study may be published or presented at professional
meetings, but your identity will not be revealed. All electronic information will be kept in
password protected files and paper documents will be stored in a locked file cabinet within
[name of eating disorder service]. Only the researcher will have access to the data and the
data shared with the research supervisor will be anonymised. All collected data will be kept
for a minimum of 5 years and thereafter destroyed safely.

### Restrictions of confidentiality

Only in exceptional circumstances may confidentiality be broken. This will only happen if
you are perceived to be at risk of harm to yourself or to others. Therefore, one of the criteria
to participate in this study is that you consent to providing details of your GP, and consent to
my contacting your GP if during the interview, you let me know that you are at risk of harm
to yourself or to others. It is only under these circumstances that I will contact your GP and I
would discuss this matter with you first.

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**Compensation for taking part in the study**

Although I am not able to offer any compensation for participating in the study, I will
reimburse your travel expenses.

**Do I have to take part in this interview?**

No! Whether or not you decide to take part will have no effect on your past, present, or
future care/relationship with the service. If you decide to take part, you have the right to
withdraw from the study at any point until data analysis without giving a reason. We will
agree on the exact date that I will begin analysing the data at the day of the interview.

**What are the benefits of taking part in the interview?**

It is my hope that you will find the interview interesting as it allows you the opportunity to
reflect on the therapy that you have received. Also, the findings of the study may be
published at a later date and shared with other health professionals. Therefore, I hope that
this study has the potential to improve future services for yourself and other individuals.

At a later date, you will have the opportunity to provide feedback on the initial findings if
you would like to.

**What if there is a problem?**

If you have concerns about any aspects of this study, I will do my utmost to answer your
questions. In case I am unable to resolve your concern, please contact BEAT (beating eating
disorders) on 08456341414 or by email to help@b-eat.co.uk.

Thank you very much for taking the time to read this letter. If you are willing to take part in
the interview, please complete the enclosed reply slip and forms and return them in the pre-
paid envelope provided. I will then contact you to arrange the interview.

If you have any further questions, please do not hesitate to contact me by emailing
lid0162@my.londonmet.ac.uk.

Sincerely yours,

Line Devantier

Trainee Counselling Psychologist

IRAS ID number: 197507

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## Appendix C: Reply slip

Name  …………………………………………

Address  ………………………………………

…………………………………………………

…………………………………………………

Contact telephone number………………………..

**I would like to take part in the study** ☐

**I do not want to take part in the study** ☐

**I would like more information before deciding to take part in the study** ☐

(please tick)

**If you are willing to take part or would like more information before deciding,
please indicate if it is acceptable to contact you on the above telephone number**

**YES/NO**

(please circle)

**What is the best time of the day to call you?** …………

(please indicate)

**Is it okay to leave a message** **YES/NO**

(please circle)

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Please indicate which location it is most convenient for you to attend the interview

**[Name of location 1]** ☐

**[Name of location 2]** ☐

**In your home** ☐

(please tick)


Please provide details of you GP

Name   ……………………………………….

Address   ………………………………………

…………………………………………………..

…………………………………………………...

PROCESSES OF CHANGE IN COGNITIVE BEHAVIOURAL THERAPY FOR BULIMIA NERVOSA

## Appendix D: PHQ-9

**Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?**

*(Use "✔" to indicate your answer"*

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things.......……………… | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless………..…………….. | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much..................................……..……………………. | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy.......………..……………. | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating...............….………………. | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down………………………………. | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television.………………………………………. | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual...............……………………………………………... | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way......……………………………………….. | 0 | 1 | 2 | 3 |

**Column totals** ___ + ___ + ____ +

___

= *Total Score _____*

## Appendix E: GAD-7

| Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer"* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | 2 | 3 |
| 5. Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |

**Column totals:**       ___  +  ___  +  ___  +  ___

=  *Total Score* _____

**Appendix F: Consent**

**London Metropolitan University**

**Faculty of Life Sciences and Computing**

**School of Psychology**

LONDON
metropolitan
university

**PARTICIPANT CONSENT FORM**

**Title of study: Exploring the processes of change in cognitive behavioural therapy for bulimia nervosa: A grounded theory study from the patients' perspectives**

**Name of researcher: Line Devantier; IRAS ID number: 197507**

Please tick:

1. I have read and understood the information sheet for the above study ☐

2. I have had the opportunity to consider the information, ask questions, and have had these answered satisfactorily ☐

3. I understand that my participation in the study is voluntary and that I am free to withdraw at any point until the data is analysed, without giving a reason. Data analysis will begin three weeks after today's date ☐

4. I understand that the interview will take approximately 1.5 hours and will be audio recorded ☐

5. I understand that the interview is confidential and <u>all</u> identifying details (e.g., names, locations) will be anonymised so neither I nor my therapist will be identified at any point ☐

6. I agree to the use of direct quotes in the study, which may be published ☐

7. I understand that the audio-recoded, electronic, and paper-based data will be collected and stored anonymously and safely according to the British Psychological Society's Data Protection Act (2009) ☐

8. I understand that only the researcher will have access to the data and the data shared with the research supervisor will be anonymised ☐

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9. I understand that the results of the study may be published and presented at ☐
professional meetings

10. I agree to the researcher contacting my GP if potential risk is identified ☐

I agree to take part in the above study

**Print name ………………………………………………………….**

**Signature ……………………………………………………………**

**Date ……………………………………………………………**

**INVESTIGATOR'S STATEMENT**

I have informed the above named participant of the nature and purpose of this study
and have sought to answer his/hers questions to the best of my ability. I have read,
understood, and agree to abide by the British Psychological Society's Code of
Conduct, Ethical Principles and Guidelines (2009) for conducting research with
human participants.

**Print name ………………………………………………….**

**Signed ………………………………………………….**

**Date ………………………………………………….**

An original copy of the participant information sheet and completed informed
consent form is to be given to the participant, in addition to the original copy that is
filed in the investigator file.

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**Appendix G: Briefing form**



1. Thank you for taking part in this study

2. Highlight background of the study:

My name is Line Devantier and I am a Trainee Counselling Psychologist at London
Metropolitan University. This study is being undertaken for educational purposes as
part of my Doctorate in Counselling Psychology.

3. Explain rationale for the study:

I am interested in looking at the experience of therapy from the point of view of the
one who receives it to learn more about your journey in therapy and how you have
experienced it. I am not looking for anything particularly and there are no right or
wrong answers.

4. What happens during and post the interview:

The interview will be recorded, transcribed, and the data will be analysed. The
interview is confidential and all identifying details (e.g., names, locations) will be
anonymised. Thus, any identifying details will be changed so neither you nor your
therapist will be identified. Also, the information you give at the interview will not
be shared with your therapist. The results of the study may be published or presented
at professional meetings, but your identity will not be revealed. All electronic
information will be kept in password protected files and paper documents will be
stored in a locked file cabinet within [name of eating disorder service]. Only the
researcher will have access to the data and the data shared with the research
supervisor will be anonymised.

5. Distress procedure:

PROCESSES OF CHANGE IN COGNITIVE BEHAVIOURAL THERAPY FOR BULIMIA NERVOSA

The interview may touch on areas that can be emotionally distressing. In that case, the welfare will take precedence over data collection. Further, a distress protocol has been developed.

6. Do you have any questions?
7. If you are happy to take part in this study, please sign the consent form

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**Appendix H: Demographic sheath**

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**Age**: _____                    **Sex**: Female / Male (please
circle)

**Occupational/educational status:**

_____

**The number of individual therapy sessions attended**:

_____

**Age of onset of bulimia nervosa (years):**

_____

**Please tick the box from the following list that best describes your marital status**

| | |
|---|---|
| Married | ☐ |
| Single | ☐ |
| Divorced | ☐ |
| Life partner | ☐ |
| Separated | ☐ |
| Widowed | ☐ |
| Other | ☐ |

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**Please tick one box from the following list which best describes your ethnic
origin**

| | | | |
|---|---|---|---|
| White (British) | ☐ | White (other) | ☐ |
| Asian or Asian British (Chinese) | ☐ | Mixed (White and Black Caribbean) | ☐ |
| White (Irish) | ☐ | Black or Black British (Caribbean) | ☐ |
| Other Asian background | ☐ | Black or Black British (African) | ☐ |
| Mixed (White and Black African) | ☐ | Other Black background | ☐ |
| Mixed (White and Asian) | ☐ | Other Mixed background | ☐ |
| Other ethnic background | ☐ | Asian or Asian British (Indian) | ☐ |
| Asian or Asian British (Pakistani) | ☐ | Asian or Asian British (Bangladeshi) | ☐ |
| Not known | ☐ | Information refused | ☐ |

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**Appendix I: Interview schedule 1**

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**Before therapy** (approximately 10 minutes)

Can you tell me a bit about what led you to seek therapy?

- Prompt: What was going on for you at that time?
- Prompt: How did your difficulties affect your life?

How did you feel about starting therapy at that time?

- Prompt: What hopes did you have for therapy, if any?

**Experience of therapy** (approximately 40 minutes)

Overall, can you tell me how therapy was for you?

What was particularly important for you, if anything?

- Prompt: What was important about it?
- Prompt: What were you thinking/feeling?
- Prompt: What did you do?

How has therapy influenced you, if it has?

- Prompt: In the sessions, what kinds of aspects helped you to change, if any?
- Prompt: Can you give examples of situations in your everyday life where you notice the change?
- Prompt: How do these changes affect your life?
- Prompt: What do you think was the key to change?

How did your therapist work?

- Prompt: What did he/she do during the sessions?
- Prompt: How did the two of you work together?
- Prompt: What were you thinking/feeling?

What parts of treatment did you experience as particularly helpful/unhelpful, if any?

- Prompt: What was helpful/unhelpful about it?
- Prompt: What were you thinking/feeling?
- Prompt: What did you do?

Post interview (approximately 10 minutes)

- How did you find talking about this today?
- How was it for you to reflect on your therapy?
- Is there anything important to you that I should have asked?

When I have finished my preliminary analysis, you will have the opportunity to comment on the findings of your interview. If you agree, I will send you a feedback form.

**Thank you very much**

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**Appendix J: Distress protocol**



This protocol has been developed for managing distress and/or agitation that individuals may experience in the context of their participation in a research interview about their experiences of therapy (developed by London Metropolitan University for using qualitative research interviews).

What follows is a two-step protocol specifying signs of distress/agitation that the researcher will look out for along with a number of responses at each stage.

**Distress:**

- Participants indicate that they are experiencing high levels of stress or emotional distress

Or

- Participants exhibit behaviours that suggest that the interview is too stressful, for example, crying, shaking, voice becomes choked with emotion, inability to talk coherently, or signs of restlessness/distraction

**Stage 1 - Response:**

- Stop the interview
- Assess the mental state of the participants, for example, ask what thoughts they are having, how they are feeling
- The researcher will offer participants to pause and compose themselves

**Stage 1 - Review:**

- The researcher will ask participants if they feel able to continue
- Remind participants that they can stop at any time if they wish

If participants feel able to carry on, the interview is resumed

If participants are unable to carry on, go to stage 2

**Stage 2 - Response:**

- The researcher will intervene to terminate the interview
- The researcher will debrief the participants
- The researcher will accept and validate the participants' emotions and distress
- The researcher will encourage participants to contact their GP or mental health provider or offer contact details of therapeutic services available, e.g., Samaritans

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**Follow up:**

- The researcher will follow the interview up with a courtesy call (if
  participants consent)

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**Appendix K: GP risk letter**



[Date]


PRIVATE & CONFIDENTIAL

[Address of GP]


Dear Doctor,


**PLEASE NOTE: THIS LETTER CONTAINS RISK INFORMATION**


Re: [Name of participant], DOB: , Address: , Telephone number:


My name is Line Devantier and I am a Trainee Counselling Psychologist. I am
currently undertaking a research project as part of my Doctorate in Counselling
Psychology at London Metropolitan University. This research has had ethical
approval from both London Metropolitan University and NHS Health Research
Authority. As part of my research I am conducting semi-structured interviews with
individuals who have completed a course of Cognitive Behavioural Therapy for
bulimia nervosa and ask them about their experiences of therapy.

I am writing to let you know that the above person participated in an interview on
[date]. During that interview, [Name] indicated that [state details and risk issue].

The above person has given consent for me to contact you with this information. I
have provided him/her with emergency out-of-hours contact details, including the
Samaritans, BEAT (beating eating disorders), and the Crisis Team.

Although I do not feel that [Name] is in immediate risk, I wanted to make you aware
of …

Or, if applicable:

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Due to their presenting risk, I recommend that [Name] makes an appointment with you for an assessment.

If you have any questions, please do not hesitate to contact me by phone or email: 07816942921 (please leave a message if necessary) or lid162@my.londonmet.ac.uk.

Sincerely yours,

Line Devantier

Trainee Counselling Psychologist

[Name of eating disorder service]

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**Appendix L: Debriefing form**



**Thank you very much for participating!**

All audio-recorded, electronic, and paper-based data will be treated and stored
confidentially. You have the right to withdraw at any time before data analysis. After
this date, data will already have been analysed and submitted as part of the research
project. As agreed, data analysis will begin three weeks after your interview.
The data will be confidential, kept anonymously and will only be used as research
material in publications and /or conferences. Only the researcher will have access to
the data and the data shared with the research supervisor will be will be anonymised.

This study investigates the experience of therapy from the point of view of the
individual who receives it to learn more about the journey in therapy and how it is
experienced. Research into the individual experience of therapy has the potential to
enhance understanding of how change might occur, which in turn can improve
effectiveness of treatment.

It is my hope that the interview has not been emotionally distressing to you.
However, should you experience any distress as a result of the questions asked, I
encourage you to contact:

- Your GP
- Samaritans

Telephone number: 116123

Email: jo@samaritans.org

Website: www.samaritans.org

Offers a 24 hours, 365 days a year, support helpline service

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- BEAT (beating eating disorders)

Telephone number: 08456341414

Email: help@b-eat.co.uk

Website: www.b-eat.co.uk

BEAT is a charity supporting individuals affected by an eating disorder or
difficulties with food, weight, and shape.

- Crisis team

Telephone number: 03003659999


If you would be interested in the initial analysis of your interview or have concerns
about any aspect of this study, please do not hesitate to contact me on the email
below and I will do my outmost to answer your questions. Additionally, if you wish
to contact the research supervisor of this project please contact Dr. Philip Hayton,
London Metropolitan University, by emailing p.hayton@londonmet.ac.uk.


Sincerely yours,

Line Devantier

Contact details: lid0162@my.londonmet.ac.uk

**Appendix M: Interview schedule 2**

LONDON
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**Before therapy** (approximately 10 minutes)

Can you tell me what led you to seek therapy?

- Prompt: What was going on for you at that time?
- Prompt: How did your difficulties affect your life?
- Prompt: Did you experience a relationship between life stressors and BN, if so can you describe?

How did you feel about starting therapy at that time?

- Prompt: What were you thinking/feeling?
- Prompt: Did you ever experience mixed feelings of starting therapy, if so can you explain?
- Prompt: How did you feel about 'giving up BN"?
- Prompt: How did BN affect your thinking, if it did?
- Prompt: What hopes did you have for therapy, if any?

**Experience of therapy** (approximately 40 minutes)

Overall, can you tell me how therapy was for you?

- Prompt: What were you thinking/feeling?

How would you describe the process of therapy?

- Prompt: How was it for you to challenge the BN?
- Prompt: What emotions did you notice, if any?
- Prompt: What were you thinking/feeling?

In therapy, what was particularly important for you, if anything?

- Prompt: How was CBT helpful/unhelpful?
- Prompt: What do you think it is about CBT that made a difference for you?
- Prompt: What did you do?
- Prompt: What were you thinking/feeling?

Working with your therapist, what was particularly important for you about that relationship, if anything?

- Prompt: What was important about it?
- Prompt: What qualities of your therapist did you find helpful/unhelp, if any?

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What knowledge/understanding of BN has been important for you to change, if
anything?

- Prompt: What was important about it?
- Prompt: What do you think was the key to change?

### After therapy (approximately 10 minutes)

How has therapy influenced you, if it has?

- Prompt: Can you give me examples of situations in your everyday life where
  you notice the change?
- Prompt: How do these changes affect your life?
- Prompt: Reflecting on your experience of BN and therapy, how would you
  describe the journey that you have been through?
- Prompt: What helps you to stay well and continue your journey, if anything?

Post interview (approximately 10 minutes)

- How did you find talking about this today?
- How was it for you to reflect on your therapy?
- Is there anything important to you that I should have asked?

**Thank you very much**

PROCESSES OF CHANGE IN COGNITIVE BEHAVIOURAL THERAPY FOR
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**Appendix N: Example transcript**

Line: Can you tell me a bit about what initially led you to seek therapy?

Gina: Well, I didn't seek therapy at all, it was something that I was made to do by
parents and doctors because it had got to a point where they believed that I needed it.
And … one of the reason why I started therapy was that they wouldn't allow me to
take any anti-depressants until I had therapy and my mum was really set on me
having anti-depressants, so she was like "you have to go to therapy" so that was the
big reason why I was sent to therapy really.

Line: How did you feel about starting therapy?

Gina: I was furious, I was really angry cos I didn't think that there was anything
wrong with me at all and I didn't want to talk to any strangers about anything.
Obviously, at that age to be told that you need a therapist you just think there's
something completely wrong with you. It's kind of embarrassing to say that you
have a therapist as well so yeah, I wasn't happy. I was only 14 at the time as well
and it was just something that I didn't expect to have so young. So yeah, I wasn't
happy at all.

Line: Do you remember how you made sense of your difficulties at that time?

Gina: Hmm … The problem is … I don't know what happened but while I was
really bad, like at the depths of the ED, I kind of blocked every memory out of my
head so trying to bring back the feelings I had can be really tricky. I think the only
time I came to the point where I was like "okay, I need therapy" was when I was
actually diagnosed with the ED, that I had anorexia, OCD, depression, anxiety, all in
one day and that was the only time where I was like "yeah, this is maybe a problem".
I remember that I texted my best friend and I was like "yeah, this is maybe a
problem".

Line: Was that when you were diagnosed? (Gina: Yeah). Was it a relief?

Gina: I wouldn't say it was a relief, it was more of a shock because suddenly I had
something that I had only ever seen on the news or in the magazines. Like, I didn't
even know anybody who had an ED. To suddenly be told that "you have BN was *so*
scary. I didn't realise that I'd got to that point obviously and then to be diagnosed
with this. Especially with the depression, that really shocked me because I was quite
happy as a kid and then to be told that you have an ED, depression and OCD was …
it was something that really shocked me. It just creeped up on me really.

Line: How do you make sense of what led to these difficulties, what was going on in
your life at that time?

PROCESSES OF CHANGE IN COGNITIVE BEHAVIOURAL THERAPY FOR
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Gina: It's another thing … it's hard… A lot of people with an ED have had
something traumatic happening in their life bu it wasn't like that for me. I think the
main reason was that I was always… I wouldn't say that I was badly bullied but I
was always the odd one out in the group of friends. Like, I was always a bit weird
and I wasn't the best-looking kid, you know I had frizzy hair, I had freckles and I
was pale. I was always reading books and I didn't care about clothes and all this sort
of stuff. And as I was getting older I kind of got rid of quite a few toxic people in my
life who didn't make me feel good, but the friends I did have were all quite insecure
like I was. So, when we were around 13 or 14 we were like "yeah, we're going on
diet" and all this sort of stuff and we would say that every day and then the next
morning on our way to school we would have a massive bar of chocolate or
something like that and laugh that we were not able to keep up with eating. And then
one day I was just like "I'm going to do it, I'll show them that I *can* lose weight".
Because I was starting to look at pictures and think that actually I don't like what I
see, I'm not happy with the way I look, and I started to compare myself to others.
That's really how it started, it was just I trying to prove to people that I could lose
weight. Yeah, that's really how it started, it was just a thing that we would talk about
in our friendship group and it would have stuck with me, like completely.

Line: How do you make sense of the relationship of the stressors that you
experienced and the ED?

Gina: Hmmm … I think especially now I can see that the difficulties I experienced
and my ED go hand in hand. It's like, when your life is going at 100 miles per hour
and you've got exams and you've got this and this, but the one thing *you* can control
and you can have *complete control* over is your food and your weight and I think that
was a big thing for me. Because you know, I had friendship problems and although I
did well at school but sometimes I did struggle and to be able to be like "but I can do
this and I don't have to have a talent to do this, I can be that person that can lose all
that weight". It's something that I still feel now so much, like when everything is
going mad, this is the one thing that I have control over, it makes you feel powerful
because you're like "I can do this". You know, when everything else goes like shit.

Line: It sounds like the ED almost became a way of coping with life?

Gina: Yeah, 100%! There just became a point where this was comfortable. It sounds
weird, but it was a comfort to have control over my food. The routine I had and the
food I ate was such a comfort. I have only just started eating normally in the past 1.5
years and up to the end of my GCSE's I had the same meals every single day, the
same breakfast, lunch, and dinner at the same time. It was like a safe place for me. I
still do some of these weird behaviours, like when I feel stressed, I still do that same
weird routine and it just … it kind of just held me on the spot when everything else
was moving too quickly, it kind of kept me in a position where I felt comfortable and
where I didn't have to deal with everything else.

PROCESSES OF CHANGE IN COGNITIVE BEHAVIOURAL THERAPY FOR BULIMIA NERVOSA

**Appendix O: London Metropolitan University ethics certificate**

LONDON
metropolitan
university

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

I can confirm that the following project has received ethical approval by one anonymous Reviewer, the Head of School of Psychology and the Dean of the FLSC to proceed with the following research study (Professional doctorate):

*Title:*    Exploring the processes of change in individual cognitive behavioural therapy for bulimia nervosa: A grounded theory study from patients' perspectives

*Student:*    **Ms Line Devantier**

*Supervisor:*    Dr. Isabel Henton

Ethical clearance to proceed has been granted providing that the study follows the most recent Ethical guidelines to dated used by the School of Psychology and British Psychological Society, and follows the above proposal in detail.

The researcher and her supervisor are responsible for conducting the research and should inform the Ethics panel if there are any substantive changes to the project that could affect its ethical dimensions, and re-submit the proposal if it is deemed necessary.

Signed:      *Lange-Küttner*          Date: 11 April 2016

Prof Dr Chris Lange-Küttner
(Chair - School of Psychology Research Ethics Review Panel)

Email c.langekuettner@londonmet.ac.uk

**Appendix P: NHS Health Research Authority ethics approval**

**NHS**
**Health Research Authority**

Miss Line Devantier
Trainee Counselling Psychologist
School of Psychology, London Metropilitan University
166-220 Holloway Road
London
N7 8DB

Email: hra.approval@nhs.net

22 September 2016 reissued

Dear Miss Devantier

### Letter of HRA Approval

| | |
|---|---|
| Study title: | Exploring the processes of change in individual cognitive behavioural therapy for bulimia nervosa: A grounded theory study from the patients' perspectives |
| IRAS project ID: | 197507 |
| Protocol number: | N/A |
| REC reference: | 16/LO/0991 |
| Sponsor | School of Psychology, London Metropolitan University |

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

**Participation of NHS Organisations in England**

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

*Appendix B* provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

PROCESSES OF CHANGE IN COGNITIVE BEHAVIOURAL THERAPY FOR
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## Appendix Q: Participant feedback

Dear …,


Again, thank you very much for participating in my study. Your participation is greatly appreciated and I feel privileged to have met you and heard about your journey.

I have completed an initial analysis and identified some core themes that seem important to the people I have interviewed. The model below attempts to show the changes that take place in the recovery from bulimia. The findings indicate that the recovery is experienced as a complex, painful and continuous process of personal transition that involves de-fusion from the eating disorder.
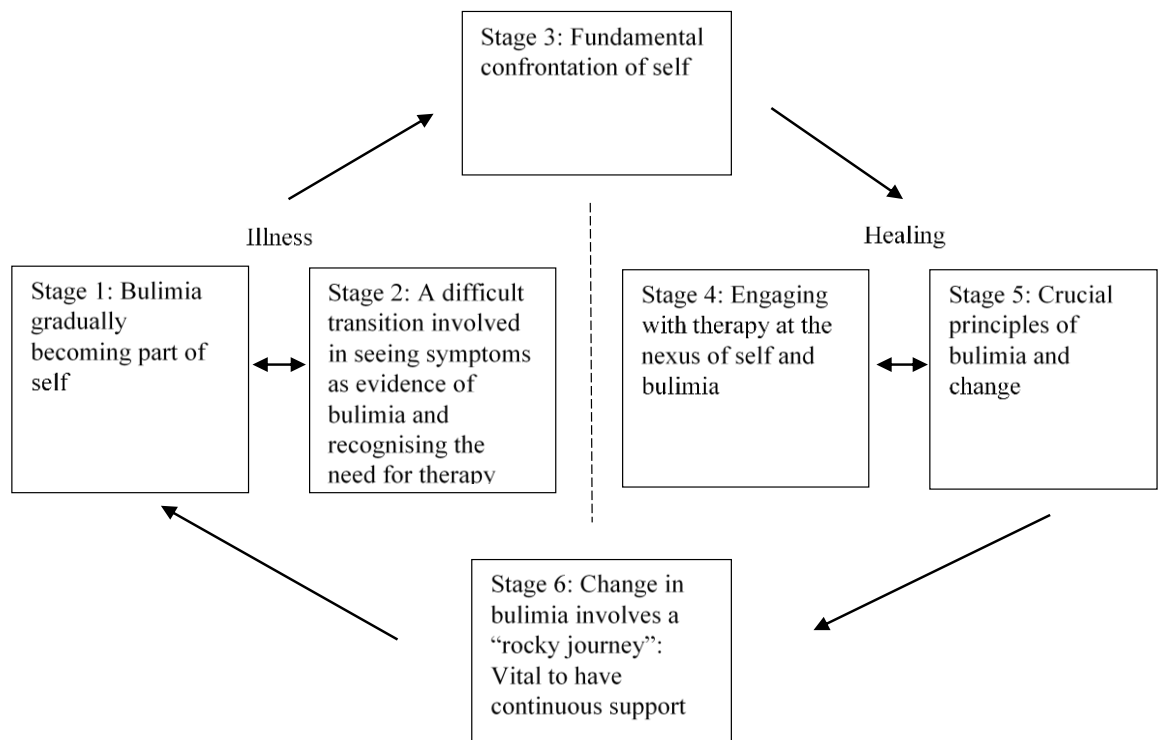


### Stage 1: Bulimia gradually becoming part of self

This stage illustrates the first meeting with bulimia and how the eating disorder gradually became a part of self. Initially, strict dieting and other weight control behaviours were perceived as a helpful way of coping with difficulties in life. At some point, however, a direction towards illness occurred, which had several negative consequences for self and life. For example, the eating disorder became destructive, all-consuming, and one suffered in silence.

**Stage 2: A difficult transition involved in seeing symptoms as evidence of bulimia and
recognising the need for therapy**

This stage tells the story of how one felt lost and trapped in the endless cycle of restricting,
binging, purging, excessive exercising and feeling bad, and therefore seeking psychological
support. This process was complicated, however, by the fact that one initially did not
identify with the label 'bulimic' and therefore did not recognise the need for bulimia-focused
therapy.

**Stage 3: Fundamental confrontation of self**

This stage illustrates the painful processes of change. At this point, bulimia had a tight grip
in one and a terrifying battle between the self and the eating disorder was involved in the
recovery. This process was difficult because change involved intense emotions and physical
reactions, but to overcome bulimia one needed to engage with the pain.

**Stage 4: Engaging with therapy at the nexus of self and bulimia**

This stage tells the story of engaging with cognitive behavioural therapy and aspects of
therapy that one perceived as particularly significant. For example, it was helpful to
challenge the voice of the eating disorder, understand the habit, change relationship with
food, and cope with the emotional aspect of the eating disorder. Although therapy was
helpful, it only provided part of the answer to change.

**Stage 5: Crucial principles of bulimia and change**

This stage illustrates the three main things, which were likely to either promote and/or
hinder recovery. These include: 1) The importance of feeling understood and respected by
the therapist, the therapist being confident and strong as those characteristics provided
confidence to fight bulimia, and structure and guidance offered by the therapist. 2) The
importance of realising that one had a problem and accepting that change was necessary. 3)
The importance of flexibility in therapy in terms of therapist being open to alternative ways
of dealing with bulimia as an eating disorder is an individual and complex experience.

**Stage 6: Change in bulimia involves a "rocky journey": Vital to have continuous
support**

This stage illustrates the painful and challenging journey of recovering from bulimia. This
can be perceived as an ongoing process, which is complicated by the fact that the eating
disorder has become a way of coping with life and therefore continues to be part of self.
Consequently, bulimia can sneak up anytime and it is vital to have continuous support (e.g.,
from eating disorder service, family, & friends) after ending therapy.

I would greatly appreciate your feedback on my understanding so far. If you would like to
take part in this phase of the research, please reply via email to the following three
questions:

PROCESSES OF CHANGE IN COGNITIVE BEHAVIOURAL THERAPY FOR
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**1: Do you feel that the model makes sense?**

**2: Does the model appear to fit with your experiences?**

**3: Is there anything that you feel is missing?**

I wish you all the best for the future.

Sincerely yours,

Line Devantier

Trainee Counselling Psychologist

Email: lid0162@my.londonmet.ac.uk

PROCESSES OF CHANGE IN COGNITIVE BEHAVIOURAL THERAPY FOR
BULIMIA NERVOSA

## Appendix R: Independent audit

**Independent Audit**

'A', 'B', and 'C' refer to the three participants (Anna, Betty, and Clare) and the number after
the letter denotes the line number of the transcript

**Higher level category: Experiencing the ambivalence of giving up bulimia nervosa (BN)**

**Sub-category 1: Feeling lost and realising the need for help to change**

- **Code 1: Feeling lost**

**Quotes & open coding:**

A30-31: I'm a yoga teacher but who do I think I am when I can't even (cope with life)

B18-22: When in the zone of binging, you realise how bad it is but you quickly recover from
that pain – I've just seen that cycle so often

B49-51: (the time leading up to seeking therapy) I found myself in stressful situations
because I (the symptoms of BN) had worsened and because I was less confident because of
my big secret (BN)

C99-101: I sort of saw therapy as my last straw of hope – If I don't have any help then I'm
lost

- **Code 2: Realising self as bulimic**

**Quotes & open coding:**

B4-5: (before starting therapy) I didn't know that I was bulimic

B7-9: (before starting therapy) I didn't know it (my difficulties) was bulimia, but obviously,
it was

B24-26: (when initially seeking help) I didn't even consider going to the GP because I didn't
think I was ill, I just knew I was struggling

B94-96: (when initially being diagnosed with BN) I needed to be told that this is what is
wrong with you and this is how you can help (yourself)

> **Comment [pp1]:** This title doesn't adequately
> express the complexity contained within the
> codes. I suggest re-working this, and probably
> breaking this category up into a number of
> parts. Such as Not being aware one was
> bulimic, not considering the symptoms to be
> an illness, not identifying with the label, and
> not recognising the need for Bulimia-focused
> therapy.
>
> You need to stay with some specificity at this
> level, because that will allow meaning to arise
> more gradually, and give more space for
> different participants' comments to overlap.
>
> The over-arching issue – assuming these sub-
> codes are still clumped together under this
> same heading, needs to be reworded. Perhaps
> something closer to 'a difficult transition is
> involved in moving to a position of seeing the
> symptoms as evidence of bulimia, identifying
> as bulimic, seeing bulimia therapy as relevant,
> and recognising the need for it' Later on, you
> might tighten that down to a shorter title, but
> at this stage, the detail helps you to not lose
> too much meaning (specificity) too soon..

1

B101-102: (at the beginning of therapy) I was thinking that I was a bit of a fraud because
when I was told that I was bulimic, I stopped purging (questioning self as bulimic)

B104-106: The forms (that are administered at the ED service) ask you when was the last
time you purged and it would be two years (questioning self as bulimic)

B107-108: I never saw myself as bulimic, so I thought the therapist might think that I wasn't
meant to be in the service

B179: I don't really understand exactly what an eating disorder is

B301-304: The form (that is administered when referred to the ED service) asks you 'are you
going to kill yourself' and none of that was me but for some it must be 'yes' (questioning self
as bulimic)

B306-309: During therapy, I was always thinking maybe I'm not meant to be here
(questioning self as bulimic)

- **Code 3: Realising th**at it would be impossible to 'climb out of the hole' of
  **bulimia' without professional**e need for **help** and a different perspective

**Quotes & open coding:**

A69-70: I felt that I wasn't going to climb out of this hole (overcoming BN) myself

B28-29: I'm so grateful that this system (ED service) exists because I needed the guidance (in
overcoming BN) because I got myself worse and worse

B29-30: All the strategies that I thought would be helpful just reinforced and strengthened
this horrible cycle (of BN)

B:195: I needed help (from therapy) to restructure my (ED) thinking

B195-196: I didn't have the tools to change without therapy – I was exhausted of trying to fix
myself and it not working

B198-200: (when initially seeking help) I needed someone who understands this thinking (of
the ED) that I didn't even understand

- **Code 4: Being desperate to**, and going to extreme and varied lengths to, **change**

**Quotes & open coding:**

2

A189-190: I would have gone through anything to get better

B14-15: (before therapy) I tried lots of things to stop this habit (of BN)

B227-228: I would have done anything (in therapy) because I was so desperate, life was so
ridiculous

C207-210: (at some point) my eating disorder just got the better of me and my uncle flew me
over to South Africa where I stayed in a hospital for three weeks

**Sub-category 2: Ambivalence to treatment and change**

- **Code 1: The process of seeking help**

**Quotes & open coding:**

A5-6: Talking therapy decided that they couldn't deal with the eating disorder and referred
me to eating disorder therapy

A10: Talking therapy referred me (to the ED service)

B16-17: (when initially seeking help) I found BEAT online and sent them an email

B22-24: (when initially seeking help) I wrote an email to BEAT and they recommended me
to go to my GP

B26-28: After contacting my GP (and telling them about difficulties), I then step by step
followed the amazing system (of the ED service)

B30-32: My GP recommended the eating disorder service, they diagnosed me with bulimia,
and then it just went on (started therapy)

B88-94: I ended into one-to-one therapy long time after I initially was diagnosed because of
referral process and waiting list (of the ED service)

B96: (the waiting time for therapy) I just did what I could and be patient until I could get
further help

B197-198: (when initially seeking help) I didn't know what to do with this (the BN) and
that's when I emailed BEAT

Comment [pp2]: See above comment. It
applies here too.

3

**Code 2:** Resistance to start therapy and give up BN                    Comment [pp3]: As above.

**Quotes & open coding:**

C4-5: My parents forced me to go to therapy when I was 12 so it really wasn't my decision

C10-11: When I developed a full-blown eating disorder, my parents became worried and said that I had to go and get help for it

C20: (when ED started) it became a big issue in my family, but I was enjoying it

C20-21: I wanted to keep my eating disorder because I was getting results

C21: I wanted to keep my eating disorder because I felt like a better person

C22: I wanted to keep my eating disorder because I didn't feel ugly anymore

C20-22: I wanted to keep my eating disorder, because I felt that people were recognising me more because I was losing weight

C24: I experienced my eating disorder as amazing

C27-28: When I did start losing weight, it was this miracle, like the best thing that had ever happened to me – there was no way I was going to give it up (BN)

C30: (when ED started) I didn't see it as an issue

C32-33: It didn't really mean anything to me to be taken into therapy because I didn't want to give my eating disorder up

C33-34: (when I was taken into therapy) I was rebellious because I didn't want to talk to people from the eating disorder service

C34-36: (when I was taken into therapy) I was too far involved with self-destruction that I had no reason to want to get better – it was completely unhelpful

C36: (when I was taken into therapy) I had no reason to want to be there

C36-38: (when I was initially taken into therapy) my parents saw that it was not helping me and I was being even more rebellious the more they tried to make me go, so it was a huge clash the whole time

C38-39: (when I was initially taken into therapy) I didn't really do anything for myself (my recovery) at all because in my mind I had no reason to get better

4

C40: I just hated therapy, I didn't see the point of it

**Code 3: Being keen to start therapy and sort out BN**

**Quotes & open coding:**

A71-72: wasn't coerced into therapy, it was my decision to look for help

A72-74: When I was in my early 20s, I knew that the best way of dealing with the eating disorder was to go and get help

A77: I was keen to try and sort it out (the ED)

B4: I seeked psychological help in 2012 (my decision)

**Code 4: Being ambivalent about engaging with therapy**

**Quotes & open coding:**

C98-99: I think I just tended to go with it (the therapy) because at the time I was so lost in my head, I was so depressed

C183-185: (during therapy sessions) sometimes I was able to talk to her (the therapist) absolutely fine and then at other times, I sort of didn't really want to be there but I was because I had dragged myself there and I just didn't really engage as much as I probably should have

C189: (during sessions) sometimes I was able to talk fluently and other times I would just listened to them (the therapists)

**Sub-category 3: Hopes for change** ............................................................ Comment [pp4]: As above

**Code 1: To knock the BN**

**Quotes & open coding:**

A79: I hoped that therapy was going to rid me completely of my eating disorder

A93: (before starting therapy) I was hoping to knock the eating disorder and rebuild a healthy relationship with food

A96: I went into therapy to stop the eating disorder

A100-101: I went into therapy to stop binging and purging

C58-59: In therapy, I actually just wanted to tackle the bulimia itself

**Code 2: To stop the habit**

**Quotes & open coding:**

A96-99: I thought that I might end up understanding the development of the eating disorder but I didn't necessarily see it as important to stop the habit – it was just the case of how do I stop this habit (of BN)

**Code 3: Looking for the solution to life's problems**

**Quotes & open coding:**

A87-89: (before starting therapy) I was still looking for the solution to some of my problems that might help me fix the eating disorder

**Code 4: To stop "the addiction"**

**Quotes & open coding:**

A89-91: (before starting therapy) I was hoping to stop the addiction (the habit of BN) because nothing is ever going to take away the life's problems, it's part of life

**Code 5: Just looking for something that could help me to change**

**Quotes & open coding:**
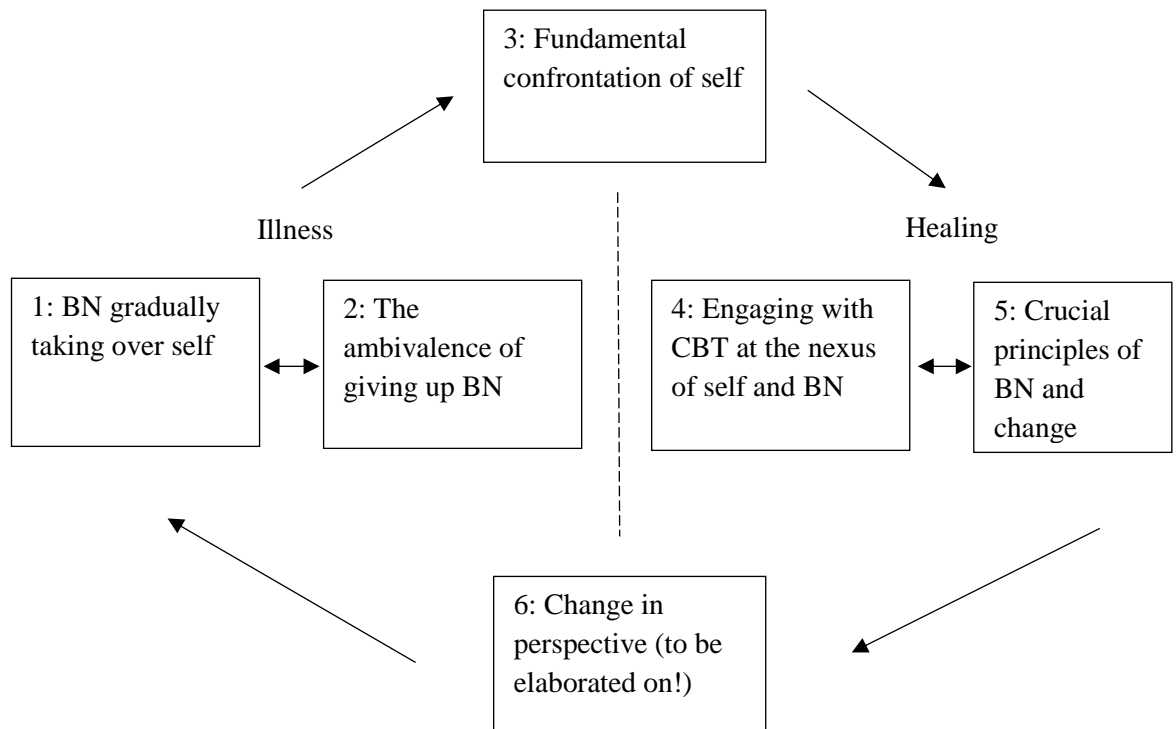
A70-71: I wanted the support to find my footing again

A87: I just hoped that something in therapy could help me (to change)

B13-14: Before therapy, I was just looking for something that would help (me to change)

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**Appendix S: Stage 1 of the model development**

**<u>Core category: The painful journey of change (?)</u>**

```
                    ┌─────────────────┐
                    │ 3: Fundamental  │
                    │ confrontation   │
                    │ of self         │
                    └─────────────────┘
        Illness            ╎            Healing

┌──────────────┐ ┌──────────────┐  ┌──────────────┐ ┌──────────────┐
│ 1: BN        │ │ 2: The       │  │ 4: Engaging  │ │ 5: Crucial   │
│ gradually    │↔│ ambivalence  │  │ with CBT at  │↔│ principles of│
│ taking over  │ │ of giving up │  │ the nexus of │ │ BN and       │
│ self         │ │ BN           │  │ self and BN  │ │ change       │
└──────────────┘ └──────────────┘  └──────────────┘ └──────────────┘

                    ┌─────────────────┐
                    │ 6: Change in    │
                    │ perspective (to │
                    │ be elaborated   │
                    │ on!)            │
                    └─────────────────┘
```

**<u>Higher level category 1: BN gradually taking over self</u>**

**Sub-category: Self being challenged**

**Codes:**

- Growing up with a low self-esteem (C)
- Family focus on weight and shape (B, C)
- Experiencing life stressors (B)
- Experiencing a breakdown: BN as exacerbator of depression (A, C)

**Sub-category: BN's impact on self and life**

**Codes:**

BN taking over life (B, C)

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BN and general impact on life (A, B, C)

BN and self-loathing (A, C)

BN impacting personality (B, C)

BN impacting thinking (B)

ED as a "continuous Achilles heel" (A)

**Sub-category: The isolating nature of BN**

**Codes:**

- The silent suffering: Secrecy, stigma, and shame (A, B)
- The isolating nature of BN (A, B)
- Impossible to understand BN unless you have been there (A, B)
- Disclosing the secrecy to others (B)

**Sub-category: Previous attempts of change**

**Codes:**

- Previous attempts of change: Therapy, groups, and dietician (A)

**Higher level category 2: The ambivalence of giving up BN**

**Sub-category: Feeling lost and realising the need for help to change**

**Codes:**

- Feeling lost (A, B, C)
- Realising self as bulimic (B)
- Realising the need for help (A, B)
- Being desperate to change (A, B, C)

**Sub-category: Ambivalence to treatment and change**

**Codes:**

- The process of seeking help (A, B)

- Resistance to start therapy and give up BN (C)
- Being keen to start therapy and sort out BN (A, B)
- Being ambivalent about engaging with therapy (C)
- Hated therapy (C)

**Sub-category: Hopes for change**

**Codes:**

- To knock the BN (A, C)
- To stop the habit (A)
- Looking for the solution to life's problems (A)
- To stop "the addiction" (A)
- Just looking for something that could help (A, B)

## **Higher level category 3: Fundamental confrontation of self**

**Sub-category: Exposing self as part of change**

**Codes:**

- Therapy as an intrusive process (B)
- Letting down guards as part of change (B)

**Sub-category: The terrifying battle btw self and BN**

**Codes:**

- Letting go of BN is scary (B)
- It requires bravery to challenge ED thinking (B)
- The "sneaky voice of BN" (B)

**Sub-category: Terror as part of change**

**Codes:**

- Change is scary: Involves intense emotions and physical reactions (C)
- The therapy process was hard: Involved more pain (A, B, C)
- Pain as part of change: "I wish someone had prepared me for it" (C)
- Accepting pain as getting better (A, C)

- Failure to engage with previous therapy: "Difficult to cope with emotions that go with change" (C)

## **Higher level category 4: Engaging with CBT at the nexus of self and BN**

**Subcategory: Focus of CBT**

**Codes:**

- The BN (A)
- Not helpful to talk about the past (C)
- Did not feel able to voice to therapist "that I needed something else" (C)

**Sub-category: Challenging the voice of BN and managing the internal battle btw self and BN**

**Codes:**

- Therapy as a safe space to "unpack complicated issues" (B)
- Therapy helped reframe life by challenging ED thinking (A, B, C)
- Helpful to be told facts about BN: "Knowing that I can trust them rather than my reinforced beliefs" (C)
- Therapy helped to identify and understand triggers (A)
- "Binges triggered by certain food did not relate to me" (A)
- Part of therapy not being relevant: "I was very structured" (A)
- Therapy helped identify and learn coping strategies (A)

**Sub-category: Challenging BN in own time**

**Codes:**

- Helpful to carry out tasks btw sessions: Uncover unhelpful behavioural patterns and challenge thoughts (A, B)
- Petrifying to carry out tasks btw sessions (B)
- Reading ad researching btw sessions (A)

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**Sub-category: CBT as a route to change**

**Codes:**

- Therapy as a route of healing (A, B)
- Some improvements of last course of therapy (C)
- "Therapy has done nothing for me" (C)

**Sub-category: Therapist as an agent of change**

**Codes:**

- Important therapist "completely understands EDs" (A)
- Ability to understand other's suffering comes from own experience (A)
- Helpful to have a therapist who is confident and strong (B)
- In therapy, "I needed advice and structure" (B, C)
- Expectations of therapist before starting therapy (B)

## Higher level category 5: Crucial principles of BN and change

**Sub-category: Understanding the habit of BN**

**Codes:**

- "The crux of therapy is dealing with the habit and understand the link to the brain" (A)
- Sense making of how the habit forms (A)
- EDs develop in the formative years: Habit become deeply ingrained (A)
- EDs similar to addiction (A)

**Sub-category: Understanding the emotional aspect of BN**

**Codes:**

- BN as a way of coping with emotions (A, C)
- The emotion and habit as two separates (A)
- Accepting emotions and difficulties as part of life (A)

**Sub-category: Changing relationship with food**

**Codes:**

- "Allowing myself to eat whatever I want was an important message to me" (B)
- "I don't want food or weight to be a thing anymore" (B)

**Sub-category: The journey of change is individual: The importance of flexibility in therapy**

**Codes:**

- Therapist open and adaptive (A, B)
- Therapist resistance to alternative ways of dealing with BN (A)
- Change is individual (A, C)
- Flexibility is needed in dealing with BN (A)

**Sub-category: Love of self and faith in overcoming BN**

**Code:**

- The need to love self and the link to God (C)

**Higher level category 6: Change in perspective (OBS to be elaborated on!)**

**Sub category: Change in BN involves "a rocky journey"**

**Codes:**

- "A rocky journey" (A, B, C)
- Worth going through the change process (B)

**Sub-category: Processes of change impacting self**

**Codes:**

- Positive change impacting self (C)
- Finding back to self (B, C)
- Emotions not as intense anymore (A, C)
- Positive change impaction body (C)