'We need to remind them they are people too': The benefits and limitations of group therapy for Anorexia Nervosa and the impact of labelling: A qualitative study from Psychologists' perspectives.

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Abstract

In seeking to gain a greater understanding around group therapy for Anorexia Nervosa (anorexia), this study explored what psychologists perceive to be useful and not so useful about working in this complex setting. Qualitative research studies, with a focus on process, are limited in this field. Existing literature predominates its exploration of clients' experiences, and neglects to consider the perspective of the therapist. This research study aimed to address this gap in the literature. Interviews with eight participants were conducted and transcribed verbatim. They were then subject to analysis, using Interpretative Phenomenological Analysis (IPA) approaches. Researcher reflexivity was carried out throughout the various phases of the research, and are highlighted in the text.

Three superordinate themes were created from the findings produced in the analysis. These were titled; Connecting with others, Them against us, and Addressing the elephant in the room. These themes aimed to encapsulate findings of participants' perceptions of what is useful and not so useful about running therapeutic groups for those experiencing anorexia. Likewise, the themes shared participants' observations of how psychologists' experience facilitating group therapy for those suffering from anorexia. The participants offered recommendations as to how to manage the perceived challenges in the group setting.

From the perspective of the participants', the group was seen as a unique and powerful tool in encouraging a plethora of positive therapeutic factors, and had many positive implications for clients meeting others who shared similar difficulties. The participants considered the group process to be capable of alleviating individuals' social isolation, commonly attributed to those suffering from anorexia, and aid in establishing a support network and building interpersonal relationships. Limitations of group therapy in this

context were highlighted, and the role of the group in the development of ambivalence and the exacerbation of symptoms, was discussed.

The findings and their relationship to Labelling Theory were explored, alongside their implications for future clinical practice. Such implications included a focus on the use of stigmatising language, the overall structure of the group, specific interventions, and the use of the relational approach to therapeutic work. The relevance of the findings to Counselling Psychology practice were highlighted, and evaluation of the strengths and limitations of the study were addressed, alongside recommendations for future research.

Chapter 1: Introduction

1.1 Overview of the Chapter

This chapter aims to provide the reader an insight into existing literature belonging to this particular field of enquiry. The review of the literature reflects the journey taken by the researcher, in order to construct the established research questions for the current study. It begins with a description and overview of the literature pertaining to the prognostic features of anorexia. Various treatment modalities for anorexia are outlined, including pharmacological, dietetic, and psychological interventions, along with relevant outcome research. A brief synopsis of the advantages and limitations of outcome research is documented, prior to the presentation of more qualitative findings. The literature review presents research from service users' perspectives, exploring relevant research addressing clients' experiences of treatment for anorexia. A focus on group therapy for anorexia introduces Yalom's (1995) therapeutic factors intrinsic to group therapy norms, and Bion's (1961) theory on group process is referenced. Research with a focus on clinicians' experiences is addressed, outlining findings concerning eating disorder populations and others. The aims and intention of the study, and its relevance to counselling psychology, are identified, and subsequent research questions are detailed.

1.2 Eating Disorder Pathology

To introduce the literature on eating disorders it seemed best fit to begin with lead researcher Christopher Fairburn's definition of eating disorders. He believes that eating disorders are commonly understood as a disturbance in eating habits, and are most often characterised by the over-evaluation of the importance of one's shape and weight (Fairburn, 2008). Whilst the literature on eating disorders exceeds a century in

scope, the last 25 years have found anorexia and bulimia at the forefront of interest to both the research community and the general public. There is a considerable amount of quantitative resources which outline prevalence data for anorexia and bulimia, of which many are in conflict. It has been inferred that the possible tendency of individuals to under-report their eating difficulties and defer from seeking professional help, due to shameful or ambivalent feelings, could explain the lack of continuity and reliability of said statistics (Walsh & Devlin, 1998). Nevertheless, it is suggested that anorexia and bulimia is found to affect approximately 3% of women over their lifetime, with bulimia increasing in incidence (Walsh & Devlin, 1998; Hudson, Hiripi, Pop, & Kessler., 2007; Hoek, 2006).

Amongst the literature is the discussion surrounding who is and isn't affected by anorexia. A common misconception, made prominent by Hilde Bruch's (1979) book on anorexia 'The Golden Cage', defined anorexia as 'a disease that selectively befalls the young, rich, and beautiful.' This still remains to be a source of debate and discussion in academic literature. Research, both explicitly and implicitly; through purposive sampling methods; continues to associate anorexia with a very specific demographic, typically upper-middle class, white, heterosexual women (Hall & Ostroff, 2013; Gibson, 2014; Abraham, 2015).

For Treasure (2013) however, she perceives anorexia to be indiscriminate and unselective, and believes the risk factors for developing anorexia can apply to anyone, as such, an individual approach to assessment and formulation is considered paramount. Research carried out by Brautigam & Herberhold (2006), indicates that in fact the number of males affected by all eating disorder presentations is increasing in incidence, with one in ten sufferers being male. They argue that the likelihood of underdiagnoses is relevant to this particular client group.

Significant strides have been made in the field of research to develop an understanding of the aetiology and pathology of eating disorders, with particular focus in recent years on effective treatment options. Through clinical trials and research findings, the treatment for bulimia, commonly cognitive behavioural therapy (CBT) specific to the treatment of eating disorders (CBT-E; Fairburn, 2008), was found to be an effective treatment method, however treatment for anorexia remains enigmatic. Various theorists and researchers have explored the difficulties in treating anorexia and what makes this illness distinct from others of its kind.

Anorexia, according to the DSM-5 (American Psychiatric Association; APA, 2013), is defined by several key features, these include: "Persistent restriction of energy intake leading to significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory, and physical health), either an intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain (even though significantly low weight), disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight."

The recent integration of the new DSM saw significant changes to the diagnostic criteria for anorexia. The most significant adaptation was the removal of amenorrhea (loss of menstrual cycle) from the criteria. It has been argued that by removing this criterion, men and boys presenting with anorexia will be able to receive an appropriate diagnosis (Keel, Brown, Holm-Denoma, & Bodell, 2011). Further changes to the criteria included the mention of a patient presenting with '85% of less than their recommended body weight'. This was considered too specific and did not capture those who meet the other criteria for anorexia but were not presenting with such low body

mass (Keel et al, 2011). The improvements put forward by the DSM-5 proposes to further support those suffering from anorexia to receive the most appropriate treatment.

Several theorists have attempted to explore anorexia further than that of its clinical status, producing findings that can begin to shed light on the challenges faced when treating such a disorder. According to Costin (2007, p.9), anorexia "serves to cope with feelings of meaninglessness, low self-esteem, failure, dissatisfaction, the need to be unique, and the desire to be special, successful, and in control". This explanation identifies anorexia as a coping strategy for an individual, which serves to manage other difficulties they are experiencing. The perception that anorexia acts as a coping strategy for individuals'' is widespread, and can be further understood as a way to support those suffering with difficult emotions (Hall & Ostroff, 2013). It is considered that a focus on losing weight offers a fixed goal which provides energy, effort and planning. This therefore serves as a suitable distraction from the difficult emotions they may be experiencing (Hall & Ostroff, 2013).

Tozzi, Sullivan, Fear, McKenzie, & Bulik (2003) supports this assertion and describes anorexia as a need, akin to a compulsion, compelled by the benefits anorexia is perceived to be giving its sufferers. Therefore, the idea that anorexia is an 'adaptive illness'; meaning that it is doing something useful for its sufferers, can make a successful recovery process lengthy, and the progress of recovery fraught amongst many sufferers.

As acknowledged above, treatment for anorexia continues to be in a state of review. Extensive research, both qualitative and quantitative, have explored the rationale and effectiveness of out-patient, day treatment and in-patient treatment options

in supporting adults, adolescents and children with anorexia. These include evaluation of the effectiveness of psychological, pharmaceutical, and dietetic interventions.

1.3 Treatment for Anorexia, An Exploration of Outcome Research

What became clear following review of the literature was the detailed and coherent nature of the research pertaining to the diagnostic and clinical features of anorexia. There was however an absence of 'good evidence' (Treasure, Schmidt, & Furth, 2003) concerning the efficacy of treatment for anorexia, and eating disorders more generally. In the most part, research states that treatment for eating disorders should take an interdisciplinary approach, incorporating support from psychiatry, psychology, pharmacology and dietetic. The reader will now be provided a brief overview of various treatment interventions, alongside relevant RCT findings.

1.3.1 Pharmacological interventions. An overview of the current literature does not see effective use of medication alone in the treatment of anorexia (National Collaborating Centre for Mental Health, 2004). According to the APA guidelines, and new NICE guidelines (2017) psychotropic medications are not advised as the sole treatment for anorexia, but can compliment alternative treatment approaches, and are considered advantageous in the treatment of comorbid presentations, such as OCD and depressive symptoms, and for the prevention of relapse in recovered clients (APA, 1993).

Specific medications associated with the manipulation of appetite and satiety have been examined for the effective treatment of anorexia, and for the impact on weight restoration. Controlled studies are limited in this field, and therefore the overall effectiveness of anti-depressant, anti-psychotic, and antihistamine medications, in stimulating weight gain, is undetermined (Gorla & Mathews, 2005; Treasure & Kordy,

1998). However, recommendations for the use of antipsychotic medication, including pimozide and sulipride (National Collaborating Centre for Mental Health, 2004), have been proposed for the treatment of related symptoms of anorexia; the psychotic-like, and obsessional thinking traits, high anxiety and impaired insight (APA, 2006; NICE, 2017).

When reviewing the literature, there was an absence of evidence in the use of pharmaceuticals in current clinical practice. The various studies which substantiated the use of medication in the treatment of anorexia were critcised, in light of their poor generalisability and their low statistical power (Goldberg, Casper, & Eckert, 1980; Biederman et al, 1985; Fassino et al, 2002). More recent research studies have reviewed the effectiveness of drug treatments for anorexia and have drawn a similar conclusion. Findings indicate that pharmacotherapy offers little value to treatment for anorexia currently (Crow, Mitchell, & Roerig, 2009).

Treasure & Kordy (1998) argued that psychotherapeutic approaches are considered of higher regard with this particular client group, and they believe that studies produced to validate the effective use of psychotherapy in treating anorexia are more credible, and reflect more long-term positive effects than the use of medication alone.

1.3.2 Dietetic interventions. According to the American Psychiatric Association, (APA, 1993) guidelines for treatment of eating disorders, and anorexia specifically, recommend dietetic interventions as an essential aspect for the recovery of its sufferers. The most recent NICE guidelines (2017) support such a claim, and stipulate the valued role of dietetic support within the wider multidisciplinary approach to treatment. Within the literature, this type of treatment is referred as 'nutrition

counselling' or 'nutritional management' (Herrin & Larkin, 2013). Research evidence informs the effective implementation of nutritional counselling to improve clinical outcomes (APA, 1993; Laessle et al, 1991). Aspects integral to dietetic interventions include a focus on challenging and adapting dysfunctional behaviours associated with anorexia. For instance, Laessle et al (1991) saw significant improvement in eating disorder related symptoms, including a reduction in restrictive eating behaviours, a more established eating routine, a reduction in binge/purge and other compensatory behaviours. There has been little evidence to certify the effective use of dietetic interventions in the treatment of anorexia alone (Herrin & Larkin, 2013), however extensive reports reaffirm the significance of it in the interdisciplinary approach, integral to the treatment of eating disorders (Lask, 2000; NICE, 2017).

1.3.3 Psychological interventions. Various therapeutic models have been researched as to the most effective treatment protocol for anorexia, the most prominent in the literature will be referenced in this review.

The recent recommendations put forward by NICE (2017) stipulate that psychological treatment for adults with anorexia should involve either individual CBT specifically tailored for eating disorders (CBT-E), Maudsley's treatment for adults with anorexia (MANTRA); this includes a focus on motivation, nutrition, symptom management and behavioural change, or specialist supportive clinical management (SSCM); this includes a person-centred approach to treatment with a focus on weight and health monitoring, psychoeducation, and dietetic advice.

Psychodynamic approaches originated as the most suitable model of therapy, however few systematic reviews were conducted to validate such an assertion (Treasure, Schmidt & Furth, 2003). Zerbe (2001) perceive the psychodynamic approach

to offer a unique understanding towards the development and treatment of anorexia. The model places greater emphasis on an individuals' personal history than other contemporary models, and it is the purpose of this particular approach to process this history within the safety of the therapeutic relationship (Zerbe, 2001). Interventions are likely to be informed by drive theory, object relations and attachment theories in this context.

Historical findings such as Hamburg (1996), observed through clinical practice, evidence for the implementation of long-term psychoanalytic psychotherapy for those suffering from anorexia, however randomised controlled trials (RCTs) saw no differences in outcome between the use of psychoanalytic approaches and other educational and behavioural models of therapy (Treasure et al, 1995). In contrary however, more recent developments in academic literature found psychodynamic therapy to be an advantageous treatment approach, when compared to the CBT model, in the findings produced from a RCT and the recovery rates produced at 12-month follow up (Schauenburg, Friederich, Zipfel, & Herzog, 2009).

From the 1960s, the introduction of the CBT approach became progressively more prevalent, and was considered an advantageous treatment model for anorexia (Fairburn & Brownell, 2005). Through the support of RCT's and other outcome research, attempts have been made to determine the effectiveness of CBT approaches in treating anorexia. The findings suggest that the CBT model elicits higher rates of engagement, due to the empathic, collaborative nature of the CBT approach, which maintains a focus on developing motivation and challenging distorted cognitive beliefs, compared to that of counselling modalities (Garner & Bemis, 1982). Further, more recent outcomes have seen CBT to be marginally more accepted by clients than psychoanalytic approaches (Fairburn & Brownell, 2005), due to the more directive style

that CBT traditionally promotes, however with considerable limitations at a design level, for instance a particularly small sample size, it is difficult to draw clear conclusions.

The outcome of the findings suggested that the uniqueness of the individual and his or her circumstances will impact the efficacy of treatment. As a consequence, outcome research has seen inconsistencies in the effectiveness of a specific psychotherapeutic model when treating those suffering from anorexia. Whilst the research evaluating specific individual therapeutic approaches is perceived to only yield equivocal findings, continuing attempts are made to establish more reliable and substantive results.

The use of family interventions in therapeutic work with anorexia is expansive in the literature, and evokes considerable debate. Initial research produced by Minuchin, Rosman & Baker (1978) proposed that family therapy was a key resource in treatment for anorexia, based on the assumption that families play a crucial role in the development of the illness, commonly termed 'the anorexogenic family'. Conversely, more recent findings suggest, through the lack of empirical evidence for the use of family therapy in addressing family dysfunction, that work with the family should aid in building resources and support for the anorexic family member (Eisler, Le Grange, & Asen, 2003).

Further systemic contributions to eating disorder literature explores the role of family semantics around power, and the impact this has on possible eating disorder development. Theorists identify the common 'battle' in defining relationships in a family, particularly surrounding who is 'the winner', 'the loser', and who is 'more' and 'less' (Ugazio, Fellin, Negri, & Di Pasquale, 2009; Winter & Button, 2011; Faccio,

Belloni, & Castelnuovo, 2012; Castiglioni, Faccio, & Bell, 2010). This type of competitive comparison making in family relationships, from a systemic perspective, can have considerable consequences on an individuals' identity, which can feel uncertain and unstable. According to Faccio et al (2012), anorexic sufferers specifically are likely to place themselves in the role of the 'winner'. It is suggested that eating disorders are likely to develop when power semantics become prominent and pervasive within the family's communication and interactions, and more so when the individuals' are unable to resume their position of power (Faccio et al, 2012; Castiglioni et al, 2010). Despite this being a significant area of interest for systemic researchers, literature is yet to progress to understand how this theoretical perspective can support eating disorder treatment.

Attempts have been made, through controlled trials, to evaluate the efficacy of other specific individual therapeutic approaches, including cognitive analytic therapy (CAT; Tanner & Carolan, 2009; Dare et al, 2001). Dare et al (2001) compared the CAT model with other forms of psychological interventions, such as family therapy and psychodynamic therapy, and found it to have similar therapeutic values. In addition, the ACT model aims to provide a focus on dietary restriction and low weight akin to the recommendations put forward by NICE (2017), along with other presenting difficulties that may contribute to the maintenance of an eating disorder. Further efforts in ascertaining the effective use of motivational interventions have been made (Treasure & Ward, 1997), yet, RCTs in this field are absent.

Group therapy is distinct from other areas of psychotherapy, as it attempts to treat and positively change behaviours of individuals in the presence of a group. Whilst no comparative, outcome research studies have conclusively established that group therapy is superior to individual psychotherapy in the treatment of anorexia, a

significant amount of clinical research claims group therapy to be a successful and efficient treatment alternative (Moreno, Fuhriman, & Hileman, 1995). Downey (2014) proposed that the interest in group therapy for eating disorders is growing, and is perceived to be a cost-effective treatment method, and is seen to be advantageous in developing interpersonal growth and insight into oneself. The composition of what is involved in group therapy treatment for anorexia is unknown; research has been carried out on the implementation of CRT, IPT, DBT, and transition groups independently, which have evoked positive outcomes (Agras et al, 1995; Touyz, Thornton, Rieger, George, & Beumont, 2003). Additional research endeavours aimed to explore the benefits of group therapy for anorexia from the perception of the client, and used more qualitative approaches to learn more about individual experiences of group treatment. These findings will be illustrated at a later stage within the review of the literature.

1.3.4 Outcome research- the strengths and limitations. Throughout quantitative outcome research, RCTs take precedence in their ability to provide outcomes which illustrate cause and effect results, and are therefore seen in numerous efficiency studies (Lowenthal & Winter, 2006). Seen as common place for evidence-based practice, RCTs, as illustrated above, assess the abilities of different therapies, and aim to certify delivery of effective approaches to clients (Rowland & Goss, 2000). In so doing, control studies can support and safeguard clinicians if the approach to client's care is challenged. Likewise, the outcomes of RCTs can offer support for continuing treatment in financially compromised services and guide the development of clinical practice (Rowland & Goss, 2000).

There is controversy however in the use of RCT's in validating treatments, particularly when researchers hold specific epistemological positions, which see individuals' 'lived experience' at the centre of their understanding of the development

of knowledge, as noted by Spragg & Cahill (2015). With this in mind, experimental methods underpinning typical RCT approaches have been critcised as unethical, and are considered unsuitable in the study of human beings. Instead, Landridge (2007), for example, encouraged a phenomenological research design when conducting explorative studies of this kind. It is the intention for the remainder of the literature review, to examine qualitative findings, focusing specifically on experience studies to illuminate the research in this field.

1.4 Treatment from Clients' Perspectives

Clients' experiences studies fall suitably in line with the underpinning of IPA, which aim to explore how participants make sense of their experiences, and to appreciate the meaning they attribute to such experiences (Smith, Smith, Flowers, & Larkin, 2009). As recognised by a variety of theorists, by listening to a client's account and perception of their illness and treatment experiences, this can illuminate a rich understanding of the illness, which can subsequently be used to guide theory and clinical practice (Colton & Pistrang, 2004, Bell, 2003; Le Grange & Gelman, 1998).

Following a review of existing qualitative research, Bell's (2003) findings were of particular interest. He examined the views of individuals' suffering from an eating disorder, and their perception of the usefulness of different treatment approaches. The findings saw treatment that focused on the psychological underpinnings of their illness, from a variety of different modalities, as valuable, particular emphasis was placed on a positive relationship with the therapist, and with this the ability to address underlying difficulties attributed to the illness, in comparison to various medical interventions that focus primarily on weight restoration (Bell, 2003).

Consistent with Bell's (2003) earlier findings, Smith et al (2014), in their study on the experiences of women in a specialist inpatient programme for anorexia, found that participant's accounts focussed on the positive impact of the therapeutic relationship much more than the content of treatment. Further findings produced by Smith et al (2014) highlighted the need for autonomy in treatment, and the different levels of control based on the progression of treatment.

To support such an assertion, a plethora of qualitative studies have sought to identify the experiences of treatment from clients' perspectives, for anorexia specifically. Le Grange and Gelman (1998) found that treatment for anorexia, which places greater focus on psychological issues, over food and weight, is preferable. These findings however challenge those of Olmsted et al. (2009), who's discoveries placed importance on treatment goals surrounding weight restoration and the normalisation of the relationship with food, as well as that of the exploration of psychological difficulties.

Qualitative research studies have identified differing perspectives when addressing related psychological issues in treatment for anorexia. Lamoureux & Bottorff (2005) for example, recognised the importance of treatment supporting clients in developing their self identity, and an increased level of self awareness and understanding. Evaluation of such findings derived from nine participants, and their sense of the role their anorexia played in their identity. It was with this in mind, that the participants endorsed treatments which focused on their 'identity crisis'. Alternatively, findings produced by Cockell, Zaitsoff, & Geller (2004), emphasised a treatment that focuses solely on challenging the dysfunctional or distorted beliefs around food. The participants' experiences indicated the usefulness of the knowledge gathered in

treatment, to support them in modifying their negative food myths, which promoted a more positive recovery journey.

The review of clients' experience studies saw considerable contradictions and conflictions over what is thought to be more or less valuable in the treatment of anorexia. This conflict could be explained through the understood implications of qualitative research methods; these will be addressed more extensively in the methodology section of the research. Alternatively, and in the case of the findings produced by Le Grange and Gelman (1998), it is questioned that clients' perspectives are not always in the best interests of their health and long term recovery. Such an observation provides speculation as to how informative client perspective findings are in developing knowledge and clinical practice. By appreciating the position of the client struggling with anorexia, and their primary fear being centered around weight gain and particular food groups (Tozzi et al. 2003), it is comprehensible that one would find a treatment focused on weight gain and food less preferable. Therefore, it may be helpful that researchers consider the nature of anorexia and the effect this may have on a participant's perception of treatment, when research is carried out in this way.

Alternatively, and an argument put forward by Fleming, Doris, & Tchanturia (2014) as to the conflictions in client experiences studies of group treatment for anorexia, is the discrepancy in treatment content and the therapeutic model underpinning the therapy, the differing sample sizes, and the varying use of outcome measures. These variances make it challenging to form any assumptions from the studies that are available.

Alternative qualitative research studies that have pursued a similar methodological approach, exploring clients' perspectives of various group treatment

approaches are presented, in brief, for the reader. This was considered essential when the validity of client experience studies was questioned. The works of Spragg & Cahill (2015) produced contributions to the research exploring group CBT approaches for treatment of obsessive compulsive disorder. This study explored the accounts of service users, the findings saw the group setting to stimulate a variety of therapeutic factors which encouraged engagement and instilled hope, and made significant recommendations for the development of the ongoing group and its role in future clinical practice. Likewise, Noble, Hall, Lucock, Crowley, & Ashton (2006) uncovered illuminating findings, pertaining to the role of the group in establishing the appropriateness of group therapy for individuals, and its ability to pre-empt and manage drop outs, in their study on clients' experiences of an assessment group for group psychotherapy.

In order to fully encapsulate this research, the remainder of this literature review will define the intentions of group therapy and aim to provide the reader an account of the theoretical and clinical understandings of the use of group treatment for those suffering with anorexia.

1.5 Group Therapy for Anorexia

As previously noted, group therapy is considered a recognised treatment approach (Wanlass, Moreno, & Thomson, 2005), and is frequently prescribed for those suffering from an eating disorder (Tchanturia, 2015). Its popularity in this domain is founded on the assumption that group therapeutic settings benefit from the sharing of experiences and from the learning from others, in a safe and contained environment; factors that are considered less evident in alternative treatment modalities (Tchanturia, 2015). Yalom (1995) and Yalom & Leszcz (2005) proposed that effective therapy groups share common therapeutic features. The findings illustrate the importance of

cohesion, universality and peer interactions, where significance is placed on being able to feel connected with others who share similar experiences.

Research studies exploring group treatment for anorexia have significantly increased in precedence over the last 50 years. Various theorists, commenting on the effectiveness of group therapy for those experiencing anorexia, saw Yalom's (1995) therapeutic factors to be of particular importance (Wanlass et al, 2005; Corey & Corey, 2006; Rich, 2006; Tchanturia, 2015).

In addition to Yalom's therapeutic factors (1995), research investigations provided supplementary information towards the value of the group in eating disorder contexts, from the perspective of the client. The development of a strong support network, both during and outside of treatment, was emphasised throughout various research studies, with particular attention on clients' ability to talk honestly and openly about felt issues (Bell, 2003; Cockell et al, 2004; Le Grange & Gelman, 1998; Tozzi et al., 2003). Likewise, Wanlass et al (2005) recounted participants' perceptions of the group providing them the opportunity to develop communication skills and problem solving strategies.

Contrary to this, the findings of Colton & Pistrang (2004) suggest that, whilst participants in their study supported the notion that the patient community on an inpatient ward is supportive, they also expressed that it can be a source of many triggering unhelpful behaviours, for instance patients competing with one another as to who is the 'sickest'. Whilst these findings are difficult to generalise, as they were taken from an adolescent sample that were based on an inpatient ward, it nonetheless sheds light on possible drawbacks of individuals being treated closely alongside others with similar difficulties. Comparably, Wanlass et al (2005) described clients' experiences of

the challenges they faced in being treated in a group context. These included an unwillingness to disclose and be active in the group when the group membership changed regularly, i.e. when individuals came and went or absenteeism was high. Additional findings saw participants' frustration towards ambivalent group members predominating the group and minimising the needs of others (Wanlass et al, 2005).

These findings were further supported by Tchanturia (2015) who believed the group dynamic exasperated certain characteristics ascribed to the presentation of anorexia, these included ambivalence to change and low motivation. She argued that by spending time with others in a group, this can evoke discomfort which presents itself in a reluctance to engage in treatment (Tchanturia, 2015).

1.5.1 A theory on group process. An exploration of theory on group process began following preliminary findings, which identified the tensions and unhelpful manifestations of being treated as a member of a group, as detailed above. The researcher was curious about the 'negative' aspects of group treatment, as these observations also fit with her own clinical experiences. The understanding of group process rooted in this research begins with the work of Bion (1961).

Wilfred Bion extended the work of Klein (1975), and her understanding of the splitting off and fragmented nature of an individuals' unconscious processes, and was instrumental in developing these concepts into theories of group dynamics. For Bion, groups foster a set of regressive drives that aid in resolving noticeable pressures and anxieties for its members, pushing them away from the explicit goal or task of the group (Charles, 2013). These observed pressures, noted by Bion, can generate an implicit pull for cohesiveness in the group, and as a consequence, difference or uniqueness in a

group is considered dangerous and subversive (Bion, 1977). This prevailing need for conformity, and the subsequent fear of 'standing alone', for Bion, can be silencing.

Additional theorists supported Bion's view, and offered further insight into group process. Oberholzer & Roberts (1994) for example, generated work which explored the differences between the explicit purpose and goal of the group, versus the reality of the work that is being conducted. Psychoanalytic theorists who have explored group dynamics recognise the ability of the particular purpose of a group to be adapted coercively by unconscious internal processes (Charles, 2013).

Literature in support of this particular theoretical perspective have considered extensively the role of the therapist, and the impact these tensions can have on their professional practice. 'Us versus them' predicaments have been present in much of the findings, identifying the conflicts present for practitioners when they feel as though they are attempting to maintain the specific task of the group, and are instead 'fighting against' something (Charles, 2013). Understanding of these particular group processes, and possible tensions that evolve as a consequence, is essential for clinicians, from both a theoretical and experiential perspective. Research encourages the therapist to engage in these observed 'tensions' actively and reflexively, with anticipation that this will increase their awareness of the dynamics they may be being pulled into, similar to the group members (Charles, 2013).

The remainder of the literature review endeavours to document specific research that demonstrates the use of the reflective practitioner in a group context, as posited by Bion.

1.6 Treatment from Clinicians' Perspectives

Research studies in the field of eating disorders, and anorexia specifically, that place a focus on the experience of clinicians, is limited. It is therefore prudent that the literature review encompasses research from practitioners' perspectives, pertaining to a non-eating disordered population. Ayes, Bratiotis, Saxena, & Loebach (2012), for example, conducted a qualitative research study exploring the experiences of a CBT approach to treating hoarding disorder in an older adult patient group, from the perspective of the clients and therapists. The research produced cohesive findings from both the clients and the therapist, and conclusively saw agreeable advantages and disadvantages of this specific treatment approach.

Conversely, Aaron (2012), who investigated therapists' experiences of therapeutic mistakes, saw a disparity between his findings and existing empirical research that focused on the perspectives of the clients and supervisors. This noticeable discrepancy in findings urged a focus on therapists' perspectives, particularly when the field of enquiry is largely made up of clients' perspectives alone.

Clinicians are able to offer additional understanding that supports and extends original discoveries produced by clients themselves, as shown in the study by Wanlass et al (2005). In their exploratory investigation of therapist and client perspectives' of group treatment for anorexia, Wanlass et al (2005) found several key features distinct from the findings produced by clients' perspective studies alone.

The therapist noted a number of issues that made group therapy valuable to the participants. They acknowledged that group therapy appeared to be a safe place to discuss the difficulties clients face in making necessary behavioural change (Wanlass et al, 2005). They also recognised that a group setting provides clients the opportunity to

explore and develop fundamental communication skills, such as reflective listening, assertive confrontation and conflict resolution (Wanlass et al, 2005). Furthermore, the therapist mirrored the comments of the study participants, in acknowledging that the therapeutic group was cohesive, which met the clients' need for belonging and connection, in a bid to decrease their feelings of alienation.

One of the biggest areas identified by the therapist as problematic was the formulation of subgrouping (Wanlass et al, 2005). They found that the strong intergroup relationships that were being built inside of the group, and informal contact that was extended away from the formal meetings, that was in part perceived to be positive and valuable, led to the creation of subgroups within the greater group network. The findings, supported by the experiences and observations of the therapist, saw small subgroups periodically dominating the group's attention, having subsequent negative effects on the other group members. Furthermore, it was felt that members colluded to avoid confrontation, fearing the impact this could have on their newly developed friendships, and subgrouping led to possible exclusion of certain group members and occasional joint defensiveness (Wanlass et al, 2005).

This study produced findings that suggest that clinicians and clients identify issues in group therapy that are collaborative and distinct from one another. Whilst this is the case, it is important to consider the methodological approach to the study, and how this impacts on the current findings. Firstly, the incongruity between the therapist and participants' perspectives could exist as a result of the therapist's use of Yalom's (1995) therapeutic factors, as descriptors when commenting on the group process, whereas the participants were not given such clear direction on the factors they should consider. Furthermore, factors such as the therapist's training, theoretical orientation, and depth of knowledge and experience in group therapy, could have influenced their

observations and interpretations of the group process. While Wanlass et al. (2005) took an IPA approach to their study; they neglected to consider the role of the researcher and the importance of researcher reflexivity when exploring findings from the therapist's perspective.

In as much as these are noted considerations, this study supports others observations', and sees a group intervention for clients suffering with anorexia as a valued therapeutic setting (Yalom, 1995; Colton & Pistrang, 2004), and provides relevant ideas for further research.

1.7 Aims of the Study and its Relevance to Counselling Psychology

This research could have numerous implications for therapists, clients and the field of counselling psychology. The synthesis of literature on group treatment for those experiencing anorexia allows mental health professionals the opportunity to enhance their learning and knowledge of the successfulness of working in this context. It provides insight into clients' perspectives of the positives and challenges of working in a group therapy setting. This knowledge could be used to guide professionals and therapists specifically, in their work with clients experiencing anorexia in this context, and provide them with supplementary information which could be used to consider the inclusion criteria of clients in this setting.

The research aimed to explore therapists' perception and experiences of the useful and not so useful aspects of running therapeutic groups for those experiencing anorexia. It endeavoured to add to existing qualitative literature, and to provide additional material to improve treatment efficacy, thereby supporting counselling psychologists, and other practitioners alike, to work more effectively in this context. The theoretical underpinnings of this research and subsequent methodology, invested in

the works of IPA. This process focuses on the individual subjective experiences of the participants, which relies on participants' ability to engage in a process of reflective thinking about their experiences (Smith et al, 2009). The selected methodological approach will be addressed more extensively in the proceeding chapter. The therapists used in this study were therefore drawn into a process of reflexivity, which provided the researcher significant insight into their experiences. Reflexivity is a core value in the field of counselling psychology that supports its professionals in not only looking at things scientifically and critically, but reflectively too (BPS, 2005). The outcome of the research that addresses the possible challenges faced when working in a group therapy setting, and provides strategies and techniques as to how to manage such challenges, could be used to inform practitioners, support their understanding, and develop their awareness of the demands this setting could have on their professional practice.

1.8 Research Questions

Initially the overarching aim of the research study was to explore how psychologists' experience facilitating group therapy for those suffering from anorexia. Embedded within this were 4 sub questions which aimed to explore what psychologists perceive to be useful and not so useful when running therapeutic groups for those experiencing anorexia specifically. Consideration of the differences between their experience in this context and when facilitating group therapy for other presenting difficulties was hoped to be explored.

From conducting the analysis and discussing the findings it became apparent to the researcher that the participants had not engaged in the interview questions in the way she had anticipated. As noted in the limitations (pg113), the participants accounts lacked personal reflections as to their own experience, and instead focused on the perceived experience of their clients. The construction of the interview questions could

be considered as to why the participants did not appear to engage in the research in the way in which it was intended. In addition, upon further reflection, the participants' want to answer the questions largely from clients' perspectives could be considered as a result of their reluctance to disclose personal feelings. Highlighting personal feelings may have been experienced as exposing for the participants and a perceived questioning of their professional competency.

As a result, reprioritisation of the research aims was carried out to better reflect the analysis. The revised research aim and sub questions are:

1.What do psychologists perceive to be useful and not so useful about running therapeutic groups for those experiencing anorexia?

-How do psychologists' experience facilitating group therapy for those suffering from anorexia?

-How do these experiences compare to other experiences of facilitating groups with other presenting difficulties?

-How do psychologists manage the possible challenges they experience when facilitating a group treatment for those suffering from anorexia?

Chapter 2: Methodology

2.1 Overview of the Chapter

This chapter aims to offer the reader an understanding of the epistemological position underpinning the research; critical realism; and its philosophical assumptions. In addition, it aims to provide rationale for the preferred methodological approach, IPA, and the implications this had for the research at a design level. This chapter incorporates an understanding of the ethical considerations integral to this piece of work, and introduces the researcher's reflexive process as the research evolved; a theme that will be prominent throughout the study.

2.2 Research Design

2.2.1 Epistemological positioning of the research. Psychological research has traditionally been governed by positivist and post-positivist paradigms (Ponterotto, 2005). Dependent on the adopted paradigm by the researcher, this will guide the research methods and practices. Researchers adopting a positivist or post-positivist paradigm use scientific methods in a bid to gain knowledge and produce objective findings (Landridge, 2007); it is here that psychology's engagement in the medical model is fostered. However, with the development of postmodern perceptions, qualitative research methods were given rise to, and counselling psychology, alongside other psychological spheres, adopted these methods with significant emphasis (Ponterotto, 2005).

Qualitative methods complement the underlying ethos of counselling psychology, where the focus lies on individuals' subjective experiences (BPS, 2005). According to Wertz (2005), qualitative research aims to provide a deeper and richer understanding of current knowledge, by exploring participants 'lived reality'. Immersed

within every research paradigm, there are underlying epistemological and methodological assumptions. Amongst the qualitative paradigms lies the critical realist epistemological perspective; its values support interpretative qualitative research (Clark, 2008), and suitably represents the philosophy of this study. Central to the objectives underpinning the current research, is the aim to explore participants' experiences, drawing on their unique perceptions. It is with this in mind that the research aligns itself with the critical realist position. Critical realism acknowledges the existence of reality, but asserts that this reality can only be partially understood if individuals' perceptions and meaning making isn't taken into account (Willig, 2001).

Critical realism adopts three domains of reality; the real, the empirical and the actual, where mechanisms, events and experiences cannot be thought about or interpreted in isolation (Bhasker, 1975). This epistemology asserts that phenomenon can only partially be interpreted through language (Larkin,Watts, & Clifton, 2006), and places significant emphasis on the collaborative relationship between the researcher and participant, where both engage in an inter-subjective process of meaning-making (Smith et al, 2009). Researchers who hold a critical realistic position assume their findings to be 'accounts of reality', where accuracy is questionable, but most significantly; negligible; from this perspective (Willig, 2001).

The critical realist paradigm can influence research at a methodological level, and has significant impact on recognised approaches, for example, phenomenological methods. Landridge (2007) states that the phenomenological approach considers experience as having many different meanings, due to perceptual and contextual implications, and it is these differences that phenomenological enquiry offers an alternative way of constructing knowledge about the world. The current research endeavours to engage in participants' unique experiences, taking into consideration their

personal perceptions and contextual differences, in a bid to interpret their meaning making.

2.2.2 Rationale for choice of method. This research study aimed to explore what psychologists perceive to be useful and not so useful about running therapeutic groups for those experiencing anorexia, and the meaning these individuals attribute to their experiences. The research endeavoured to add to existing qualitative literature, and to provide supplementary information surrounding experiences of group therapy in this context. With a focus on experience and the attention sought for meaning-making, the adopted qualitative approach for the research study was IPA (Smith, 2008).

The open-ended, explorative nature of the research question is suitable for an IPA study, as it does not attempt to 'explain something' (Landridge, 2007; Spragg & Cahill, 2015). This style of questioning is traditionally considered too specific for an IPA investigation. Alternative approaches, such as grounded theory and thematic analysis, are typically more appropriate methods when exploring helpful and hindering effects of therapy (Rennie, 1990; Sherwood, 2001; Spragg & Cahill, 2015). With this being said, due to the explorative nature of the study in obtaining accounts of participants' experiences, as stipulated in the research sub questions, the chosen methodology was IPA. The informed choice for using the IPA approach is further substantiated in the detailed explanation of IPA below, and its 'best fit' for this particular research study.

IPA is a qualitative method that has generated substantial interest amongst psychological researchers. It has roots in phenomenology, which originated with Husserl's efforts to build a philosophical science of consciousness which aims to understand human experience and behaviour (Giorgi, 1995). Phenomenological enquiry

is concerned with an individual's experiences, narratives and their 'lived experience' of the world (Landridge, 2007). It argues that the meaning of an experience is negotiated by perception, and therefore time and context must be considered when interpreting this meaning (Landridge, 2007). IPA places emphasis on the role of the researcher, where; according to Husserl; reflexivity and a focus on one's own conceptions and interpretations are of paramount importance when making sense of a participant's text (Smith et al, 2009). The researcher's interpretation of participants' accounts must bear the wider social and cultural contexts in mind, while remaining committed to the individual's subjective experience. It is considered imperative that researcher reflexivity is engaged in throughout the duration of the current study, given the researcher's clinical experience and held preconceptions.

Hermeneutics; the theory of interpretation (Ricoeur, 1970), which instills the importance of an inquisitive yet compassionate position to interpretation, and symbolic interactionism, which suggests that the meaning individuals attribute to events are only accessible through an interpretative process (Biggerstaff & Thompson, 2008), both play key roles in the development of IPA. Together; hermeneutics, phenomenology and symbolic interactionism stress that findings deduced from research investigations should be considered as interpretations only (Ashworth, 2003). In contrast to the assumptions put forward by post-positivist quantitative research; which has a strong focus on empirical measurement and the verification of theory, phenomenology is grounded in constructivism, which is considered a conducive method when exploring a phenomenon as it is experienced in the natural world (Creswell, 2003). IPA has developed in the last decade as a distinctive approach to conducting empirical research in the field of psychology, and is particularly suitable in research where it is

fundamental to explore several individuals' accounts of an experience (Creswell, 2003), which is particularly relevant for the present study.

IPA is made distinct from other qualitative methods by key characteristic features. One key feature is that of idiography, which asserts the need to regard the individuality of participants and how they understand and perceive experiential occurrences (Larkin et al, 2006). Analysis must therefore reflect depth and detail into participants' experiences. This aspect of IPA was particularly relevant in this research; it ensured that the individuality of each psychologist, their unique theoretical orientation, knowledge and experience was considered throughout the analysis phase.

IPA adopts an epistemological position whereby, through a clear and precise interpretative methodology, it enables access to an individual's cognitive inner world (Biggerstaff & Thompson, 2008). This process relies on participants' ability to engage in a process of reflective thinking about their experiences. In order to fully encapsulate and explore a participant's world view, IPA asserts the need and importance of researcher self-reflection, which requires the researcher to bracket, and explicitly identify their own perspective of what is being examined, in the knowledge that it is not possible for the researcher to remove themselves and their thoughts about the world in order to fully reveal how things are from the participant's worldview (Larkin et al, 2006).

2.3 Reflexivity

Reflexivity can be understood as the process which explores 'the ways in which a researcher's involvement with a particular study influences, acts upon and informs such research' (Nightingale & Cromby, 1999, p.228). This approach encourages the researcher to attend analytically to the context in which knowledge is constructed, and

to generate awareness of the impact their background, beliefs and assumptions, has on the research process, throughout the duration of the investigation. According to Malterud (2001), the individual views the researcher holds will effect their decision making around what to investigate, the particular methods in how to do so, the findings which are considered most valuable, and the way in which conclusions are constructed.

There are many approaches to reflexivity; several were carefully considered when embarking on this research project. Ahern (1999) introduced the concept of 'reflexive bracketing', which aims to illuminate potential areas of bias, without having to remove them from the investigation. The process of bracketing requires the researcher to; with intent; put aside their own views and beliefs about the subject of the investigation (Carpenter, 2007). In so doing, researchers can attend to, and enter into, participants accounts, while also developing the 'ecological validity' of the investigation (Banister, Burman, Parker, Taylor, & Tindall, 1994).

Research conducted by hermeneutic phenomenological theorists however suggests that the bracketing process is problematic and unreliable, and asserts that a researcher's position cannot be excluded or bracketed for the benefit of challenging researcher bias (Koch, 1995; LeVasseur, 2003). In addition, Giorgi (2009) criticised IPA for not providing a set procedure for implementing bracketing, which left the process ominous and open to interpretation by the researcher. In both quantitative and qualitative paradigms, the concept of researcher bias generates considerable controversy. To quote Malterud (2001, p484); 'preconceptions are not the same as bias, unless the researcher fails to mention them.' His writings stress the importance of reflexivity and an understanding of the perspective and values held by the researcher.

Researchers will differ over their approach to reflexivity; these decisions are often driven by the epistemological position that underpins their study. This investigation, which assumes a critical realist position, placed emphasis on personal reflexivity which attended to the researcher's role in the study, making the researcher a distinct and visible part of the process. In addition, personal reflexivity aims to generate an understanding of the emotional involvement the researcher has in the project (Clarke & Braun, 2013).

2.3.1 Personal reflexivity. I was mindful of my own personal interest in this research project prior to investigation, and therefore addressed my beliefs and assumptions toward the subject. My curiosity toward the present investigation was generated by my work experiences within the Eating Disorder Service. I had facilitated group therapy sessions for the out-patient and day-patient community for several years as both an Assistant Psychologist and Trainee Counselling Psychologist. I found these experiences challenging and would often use supervision and my own reflective time to consider why.

I often felt as if the clients suffering from anorexia were working against me, instead of in a collaborative piece of work, moving towards recovery. They would often present as obstructive and difficult; sharing very little, and being silent or passive in the dynamic, causing me as a facilitator to feel responsible for generating conversation in the group. On these occasions I would often end my sessions feeling frustrated; my supervision time enabled me to explore these emotions. In addition, I noted that I had no other experience in running group therapy, which led me to question whether the challenges I experienced were generalisable across all group dynamics, or whether they were specific to this context. These observations fuelled my want to explore others' experiences of group therapy when working with anorexic sufferers.

However, my involvements meant that I assumed unavoidable predictions and assumptions of facilitators experiences of working in this setting. It is possible therefore, that my views could have influenced the choices and wording or questions I asked, and questions I didn't, during the interview phase. I recognised the potential impact that my prior experiences in this field could have had on the data collection, analysis and overall integrity of my findings. As a consequence, I engaged in the bracketing process (Ahern, 1999) throughout the entirety of my research, maintaining awareness of the thoughts, feelings, assumptions and beliefs I held towards the topic of investigation. To note, researchers are not able to bracket completely (Ahern, 1999), I will illustrate my efforts in the bracketing process in later chapters.

Further considerations including the fact that the current research was to be partially carried out within the organisation in which I worked must be addressed. Glesne and Peshkin (1992) described this conflict as 'backyard research', which is a term used to define those research projects which are undertaken in the same setting where the researcher holds a preexisting role. The present research recruited psychologists, my colleagues, as some of the participants of the study. My dual role as colleague/researcher, and the close relationship I share with some of my participants, must be considered as a conceivable issue which could impact the validity of my findings. It is possible that, given the nature of my dual relationship with the participants, this could compromise their self-disclosure in the interviews. My personal and professional relationship with some of the participants could jeopardise my ability to obtain a rich account of their experiences, as they may feel uncomfortable disclosing specific, intimate details in this context. In addition, it is possible that my interpretations of their accounts could be compromised due to possible assumption making of their experiences based on my personal knowledge of these participants. I endeavoured to

recruit participants both inside and outside of my organisation, so I could remain mindful of the possible impact my personal relationships could have on the disclosure of some of my sample throughout the interview phase.

2.4 Procedure

2.4.1 Participant sample. Like all qualitative approaches, IPA has specific underlying assumptions at a methodological level, essential when conducting a study. Purposive sampling methods were implemented to recruit participants, in order to ensure their relevance to the research study (Robson, 2002). Typically, IPA researchers will recruit a homogenous sample on the basis that it would be counterproductive to use random or representative sampling methods. It was essential that the researcher remained mindful of the intention of the study, and its aim to provide a detailed, rich account of the experiences of the psychologists recruited as a part of the particular subject group, but it did not claim to say something about all psychologists alike. To restate, it was not the intention of this research study to produce transferable, generalisable findings or causal results, but aimed to provide insight into the experiences of psychologists in this context. With this in mind, recruitment of the participants was sought with a strict inclusion and exclusion criteria in mind, ensuring the sample was appropriate and relevant (Jupp, 2006).

2.4.2 Inclusion and exclusion criteria. Initially contact was sought for chartered Counselling Psychologists specifically, who had experience in facilitating group therapy for clients experiencing anorexia. It was hoped that this would suggest that the participants had received a similar training experience and academic input. However, with limited availability to meet these conditions, this inclusion criterion was widened to include all psychologists; both clinical and counselling trained. In addition, the criteria were established to recruit those who had worked specifically with the

'anorexic population' in a group setting, excluding those who had facilitated groups within a wider eating disorder context; where bulimic and binge eating disorder clients may have been present. This aimed to ensure that the participants experiences were relevant to the specific research questions.

Furthermore, it was stipulated that those recruited must have had experience of running this particular group therapy for a minimum of 3 months, excluding those with experience less that this minimum set. This criterion was supported by Garvin, Reid, & Epstein (1976), and their work on time-limited group therapy. Commonly group therapy will run for a minimum of 10-12 weeks, with a definitive beginning, middle and end phase of treatment (Garvin et al, 1976). Therefore, it was considered integral that the participants in the study had sufficient experience in working with a group throughout the entirety of the treatment, in order to provide a comprehensive account of their experiences of the group, through all of the stages.

2.4.3 Recruitment. In the initial recruitment phase contact was made, via email, to various private Eating Disorder Clinics in the UK that had been sourced from different search engines. An example of an email to the first point of contact in the service, typically the administrator, can be found in the appendix (Appendix A). Enclosed within this email was the participant information sheet (Appendix B) and the participant consent form (Appendix C). This initial phase of recruitment saw 4 participants show their interest in taking part in the study.

Secondary attempts at recruitment involved discussions with the project supervisor, regarding the impact of using existing colleagues as possible participants for the research. Holding an Assistant Psychologist position within a specialist eating disorder service meant the researcher had access to several willing participants readily.

The unavoidable implications that the dual role as colleague/researcher could have on the findings were recognised, such as influencing their narratives and the emotional and descriptive content of their experiences. However, it was nonetheless decided to recruit within the service in which the researcher worked. Possible implications of this decision will be addressed in later chapters.

In total, this study recruited 8 psychologists, who have engaged in facilitating group therapy for those experiencing anorexia.

Table 1.

Participant demographics

Participant	Age	Gender	Qualification	Theoretical Orientation
Matt	51	Male	Clinical Psychologist	Psychoanalytic Therapy, CB
Sarah	36	Female	Counselling Psychologist	CBT
Lisa	48	Female	Clinical Psychologist	Systemic Strategic CBT
Megan	48	Female	Clinical Psychologist	Retrospective Eclecticism
Nicole	32	Female	Clinical Psychologist	CBT and Systemic
Anna	52	Female	Clinical Psychologist	Person-Centred Approach
Louise	33	Female	CLinical Psychologist	CBT
Donna	48	Female	Clinical Psychologist	Trans-Personal

The rationale for using fewer participants in an IPA study supports the assertion from idiography (Larkin et al, 2006), and stresses the importance of conducting a thorough and comprehensive exploration of the experiences of the participants. Demographic information including, age, gender, qualifications and theoretical orientations were documented. The age range of participants was 32-52, with a mean age of 44. Participants were either Counselling Psychology or Clinical Psychology trained, with varying theoretical orientations.

2.5 Ethical Considerations

2.5.1 Gaining ethical consent. This research gained ethical approval from the University of East London's Research Ethics Committee (UREC; Appendix D). It was not necessary to gain ethical approval from the Integrated Research Application System (IRAS); the affiliated ethics committee in the NHS Trust from which the research was carried out. Instead, the researcher requested and gained approval from the Research and Development Department from the elected NHS Trust (Appendix E). All applications were sought and approved prior to commencing the research.

2.5.2 Protecting the participants. Researchers have a duty to protect the participants in their study and abide by, and adhere to, the ethical code of conduct put forward by the various governing bodies they follow. According to The British Psychological Society's code of ethics and conduct (BPS, 2016), researchers must respect the privacy and rights of their participants, and be mindful of the boundaries and conduct set by the institution in which the research is taking place.

Irrespective of what orientation the researcher comes from, and what code of conduct they follow, their responsibilities to the participants of their study are unanimous; they must obtain consent, protect their integrity and ensure their privacy (BPS, 2016). In the current research, the nature of the study was made explicit to each participant in the information sheet (Appendix B). This form provided them with the necessary information about the purpose of the study, their role in it and how the results will be used. In addition, emphasis was placed on a participant's ability to withdraw from the study at any given time. Once it was deemed that participants had a clear understanding of the nature of the study, and their involvement in it, consent forms were signed in order for participation to commence (Appendix C).

Furthermore, the level of risk towards participants experiencing adverse implications due to participating in the current study was assessed as low. However, given the detailed, comprehensive style IPA takes in the interview process, the researcher endeavoured to investigate the experiences of the participants sensitively, and ensured that all of the participants were engaging in regular supervision to certify that they were receiving sufficient support if any issues were to arise, adhering to the BPS code of professional conduct (2005). In addition, the participants were also provided with relevant contact details of both the researcher and the research supervisor, should they have further questions about the research, and/or require additional support.

2.5.3 Anonymity and confidentiality. Anonymity and confidentiality are ethical concerns that are essential to consider when research is being conducted on professionals, whose anonymity and professional code of conduct is paramount. Participants were informed of the efforts made to protect their confidentiality, which included; anonymity from the outset with a unique study number, this helped identify them and the relevant consent forms, tape recordings and paper transcripts associated with them. Furthermore, all material containing participant information was stored in a locked cabinet and on password-protected electronic data sheets; which falls suitably in line with the BPS (2016) guidelines regarding research at doctoral level, and will be destroyed 5 years post data collection.

2.6 The Interview

2.6.1 The interview schedule. In order for the researcher to gain a rich understanding of participants' experiences and attributed meanings, a flexible data collection method was required. Whilst other methods were considered, the best possible way of collecting data in an IPA study is through semi-structured interviewing (Biggerstaff & Thompson, 2008). This approach allowed the researcher to engage in a

dialogue with the participants, where original questions were adapted in accordance with the participants' responses (Lindlof & Taylor, 2002), allowing the researcher to diverge and explore interesting areas that arose. With this in mind, a semi- structured interview schedule was constructed (Appendix F). It was essential that the interview schedule was to act only as a guide to data collection, and opportunity should be given to participants to direct the interview in order to provide accounts obtained from their internal worlds (Smith & Osborn, 2003).

Peer discussions and support from the research supervisor were essential when initially forming the interview schedule. Following these preliminary stages, a pilot interview was conducted, which provided insight into the impact of the questions delivered, and how they were received by the participant. Initial findings saw the participants accounts to lack depth, leading the interview to be very short and succinct. As a consequence, the delivery of the questions was modified, and Smith and Osborn's (2003) recommendations on constructing an interview schedule were reviewed. They proposed that researchers interview schedule should reflect the process of examination into different areas of interest in a logical order (Smith & Osborn, 2003). Therefore, revisions included re-ordering of the questions and adding additional probes, in order to obtain more meaningful qualitative data.

Each interview began with any additional explanation the participant required with regards to the nature of the study. Following this, consent was obtained and voice recording commenced. The interview schedule was weaved flexibly within the participants' accounts of their experiences of facilitating group therapy. It was comprised of open-ended questions about their experiences, exploring their perceptions of the usefulness of group therapy, and their considerations of the challenges and pitfalls of treatment in this context. Probes for further clarification were required in

order to gain a deeper understanding and sufficient detail of their responses. These included; 'how do you find it?', 'can you provide an example of…?', and 'why do you think that's particularly important?'. Participants were given the opportunity at the end of the interview to provide any additional information they felt would be important to mention.

2.6.2 The interview conditions. The interviews were conducted in mutually convenient locations; these included participants' places of work, homes, and skype calls where necessary. Thorough risk assessments were carried out prior to conducting the interviews to ensure the safety of the location and the ability to carry out the interviews confidentially. The duration of the interviews lasted for an average of 28.98 minutes (varying from 13.18- 41.20 minutes). The interviews were voice recorded and transcribed verbatim, applying pseudonyms to ensure anonymity of the participants.

2.6.3 Reflections of the interview process. Throughout the duration of the study, but in particular, prior to and throughout the interview process, I exercised reflexivity by note keeping in order to observe my own process. I also engaged in a bracketing process (Ahern, 1999), where I documented my own responses to the questions. Both strategies were integral to supporting my awareness of how my perception may influence the research findings (Malterud, 2001). Below is an extract from my reflexive journal, commenting on my observations throughout an interview with 'Sarah', logging and reflecting on how I felt during and after the interview, and noting my observations from listening to the recording.

2.6.4 Reflexive journal extract. Waiting to meet Sarah, I began to feel anxious about how the interview would go. She was the first interviewee I was due to see after reflecting on my pilot interview. I think this contributed towards my increased anxiety

as I was concerned that I would not be able to implement the changes I had deemed necessary from the preliminary interview. In particular, I observed that I was often very passive and withdrawn throughout the pilot interview process, as I was wary of the preconceptions I held of the subject matter under investigation, and the impact these could have on my findings. Smith et al (2009) argued that the phenomenological researcher needed to disengage from their 'taken for granted' assumptions, and keep their focus on the participant's experiences, using exploratory skills to help deepen their understanding. On this basis, I had written a list of prompts to help me elicit depth from participants' accounts, although I still remained cautious as to when to use these, in an effort not to lead or direct the interview.

I held this in mind when beginning the interview with Sarah, and used my list of prompts to guide me when I found myself withdrawing from the process. Half way through the interview, Sarah began to discuss her experiences of a negative group dynamic, and her thoughts on the impact of an unwell or ambivalent client on the rest of the group. These were similar observations to my own, which had led to my initial interest in this area of research. I realised quickly that I was not exploring her narrative in as much detail, and attempted to go back to it later on in the interview to readdress her point, and ask for a more extensive explanation. Once the interview had terminated I was relieved that I had gone back and probed for a deeper understanding of Sarah's experiences, and not assumed these experiences to be the same as my own. From listening to the recording back, the interview still contained structure despite my returning back to earlier questions.

2.7 Analytic Technique

The interviews were transcribed verbatim and subjected to a case by case systematic qualitative analysis. Working with transcripts that have been cited verbatim

ensured that the data maintained the participants' personal meanings and experiences and retained an authentic feel of the interview, as informed by Smith et al (2009). In the first instance, transcripts were read alongside the listening of the audio recording, to incorporate aspects such as tone of voice and silences into the analytic process.

The analysis endeavoured to follow inductive approaches and to transform annotations of the text into themes that captured the essential features of the readings. Initial steps involved exploring each transcript individually, highlighting anything of interest in the text. At this stage, reading the transcripts repeatedly and making tentative notes was fundamentally helpful in identifying commonalities in the text, and an opportunity to begin to summarise and interpret the content and meaning of the transcripts. The notes were then expanded as the analysis progressed interpretatively; key descriptive, linguistic and conceptual concepts were extracted from the transcript and highlighted in the margins (Appendix G); it was here that emergent themes within the text evolved. The developing themes were formed directly from the information gathered via the transcripts, supporting the overall aim of the research which was to generate knowledge and understanding (Smith et al, 2009). As opposed to analysing the text with a set of themes in mind, to confirm or deny a set of predictions held by the researcher.

After themes had been established within an individual transcript, they were then placed in chronological order and several were discarded and/or amalgamated, particularly if they were deemed to overlap each other. Following this, the findings from each transcript were analysed alongside each other; integrating the central themes from each; in order to establish the recurrent themes running throughout. Initial aims of this investigation were used to support this process. To recall, the research aim and subsequent questions underpinning the present study include; what do psychologists

perceive to be useful and not so useful about running therapeutic groups for those experiencing anorexia? How do psychologists' experience facilitating group therapy for those suffering from anorexia? How do these experiences compare to other experiences of facilitating groups with other presenting difficulties? How do psychologists manage the possible challenges they experience when facilitating a group treatment for those suffering from anorexia? Three superordinate themes then emerged when connections were made across the different cases (Biggerstaff & Thompson, 2008). The ability to produce recurrent, superordinate themes within the data set suggested a mutual or shared understanding between the participants of their experiences.

Within the process of finding shared themes, consideration was given to the differences in responses and participants' meaning; this is further highlighted in the analysis section. In the following chapter, the analysis has been outlined, and the themes have been discussed. Extracts from each interview were categorised within themes that they were deemed relevant to. These quotes were chosen with explicit intent to support the reader in understanding how and why the researcher produced the themes in which she did. Narrative accounts which surround the extracts reflect an understanding of the participant's meaning and emotional responses, and further aid in transparency around the analysis process.

2.8 Reflexivity of the Analysis Process

My lack of experience in conducting qualitative research caused significant anxiety through the interview phase of the research. As highlighted in the previous chapter, I was concerned that my findings lacked depth through my insufficient use of prompt questions, and therefore when embarking on the analysis I was uncertain of the quality of my findings. I assumed that my interviews lacked the depth and richness that

an IPA study requires (Landridge, 2007), which could have led to a struggle in identifying prominent themes.

In order to combat these anxieties, and to approach the transcripts with an open mind, I followed the steps outlined by Smith et al (2009), who encouraged an initial phase of 'pre-reflexive reflexivity'. This supported me in focusing on the descriptive and linguistic components to the narratives, and discouraged me from exploring meaning or deducing what is and isn't 'important' at this stage. In doing so I began to feel more at ease that my interview skills had enabled my participants to share meaningful experiences and engage in reflexive thinking around their experiences.

Through the guidance of my supervisor, I listened to my interviews whilst reviewing the initial comments of my transcripts, to capture a greater sense of the emotional content of my findings. This assisted me in being able to connect with the meaning my participants' attributed to their narratives. I was shocked to realise, at this stage, that I actually felt I had so much valuable information and became overwhelmed with the idea that I then had to consolidate these findings into themes and dismiss the rest. I was ruminating over the notion that I would have to decide what was and wasn't valuable, and the level of responsibility I felt towards my research at this stage in getting it 'right' left me with a sense of unease. I had to remind myself of the philosophies underpinning my research, and the role I play as a researcher. To recall Ashworth (2003), who noted that the philosophies that underlie IPA stress that findings deduced from research investigations of this kind, should be considered as interpretations only.

My supervisor encouraged me to take a break from my analysis, and to pursue other areas such as the literature, in order to get some distance from my initial findings.

When I returned to my analysis, I began to consolidate by grouping similar findings using post-it notes. I used the research questions to support the creatation of the sub-groups, which later went on to represent my three superordinate themes. This process was time-consuming, however did support me in recognising significant themes within my transcripts, and left me with a huge sense of relief and reward that I had been able to produce quality findings.

2.9 Reflexivity and the Introduction of Second Order Analysis

The second order analysis identified a recurrent theme that ran throughout all of my superordinate themes. As prompted by my supervisor, I closely examined the citations I had extracted from the participants' transcripts to support my subthemes, I began to notice a similar theme generating between all of them. This theme related to participants use of labels when describing their experiences of this specific client group. I endeavoured to explore this concept more thoroughly, taking into account my own personal experiences of working in this context, as well as my reflections and feelings evoked from the narratives of my participants. It was important at this stage to remind myself of the positioning of the research, and the methodology underpinning the study; phenomenological approaches encourage a deeper level of reflection, which involve a richer examination and stretching of the data (Smith et al, 2009).

This overriding theme throughout the research first became apparent to me when reflecting on the conceptual detail of Anna's accounts. In her narrative she addressed her experiences of 'calling people anorexic' (Transcript 6, pg5., l 226-229) [1] * and the impact of defining clients as their 'whole disorder' has on their ability to separate themselves away from their illness. I was struck by Anna's narrative and how unique an experience it was compared to that of my other participants. I believed that what she

[1] **(Transcript No., Page No., Line No.)*

had begun to explore was the impact of diagnosis, and reflected on my own perception of this concept. It is considered imperative in qualitative research to 'own one's perspective' and accept the unavoidable influence this will have on the research (Elliott, Fisher, & Rennie, 1999). Akin to the ethos of my counselling psychology training, I felt passionately towards a more holistic way of working, considering an individual's subjective experience at the forefront of treatment, and a transition away from the medical model where I perceived diagnosis to introduce a 'one size fits all' approach to care. I considered a diagnosis a label, and pondered over the negative implications a label of this kind could have on individuals. I felt aligned to the experiences put forward by Anna and reviewed the findings produced by the rest of my participants with this in mind.

When reflecting on the linguistic detail of the accounts put forward by my remaining participants I noticed the reoccurring theme that transcended throughout their narratives. They were frequently using the diagnosis 'anorexia' to label clients and describe their experiences. Referring to Megan's experiences for example, she used the term 'anorexia' to generalise her observations of clients. For instance, she made claims such as 'anorexic thinking is very powerful' *(Transcript 4, pg.4, l 195)* and 'in groups with anorexics there is more than one goal operating' *(Transcript 4., pg.5, l 233)* These statements felt bold and presumptuous, and seemed to consider all clients suffering from anorexia alike.

Second order analysis encourages the integration of theory to support reflections, it is with this in mind that I began to explore literature which addressed the concept of labelling (Becker, 1963). Further considerations on how the research findings have implications on the theory of labeling, and how the use of labels may be

impacting on the participants' view of clients, will be addressed in the following chapter; discussion (4.0).

Chapter 3: Analysis

3.1 Introduction to the Analysis

This research study aimed to explore psychologists' experiences of facilitating group therapy for those suffering from anorexia. It endeavoured to gain an understanding of what the participants experiences were when working with this particular client group, together with the challenges they may encounter. A secondary consideration were the perceived benefits and pitfalls of working in this context. The analysis examines participants' responses to the questions asked, and their overall narratives, to determine similarities and differences between them. A reflexive account of the process through the analysis was integral at this stage of the research, and will be illustrated throughout the following chapter.

3.2 An Overview of the Three Superordinate Themes

From the comprehensive analysis of the interviews, three superordinate themes were produced. The first theme; 'Connecting with others', related to participants' perception of the growing sense of connection and identification that clients gain when in group treatment, and drew on participants' experiences of the role the group dynamic plays in fostering and managing relationships between clients. The second superordinate theme 'Them Against Us', generated themes that related to the participants' descriptions of the difficulties they face when working in this context, and addressed participants' experiences of the interactions between themselves and their clients, and between clients and each other. Lastly, 'Addressing the Elephant in the Room' the third theme, incorporated themes which drew on the strategies the participants' use to manage specific challenges they experience when working in this setting. The theme included participants' descriptions of making the unspoken, spoken; in order to support

a more positive treatment outcome. Table 2. illustrates the superordinate themes and their subthemes. Each superordinate theme and corresponding subthemes are described and explained with verbatim citations from the original transcripts. The quotations have been selected specifically to support and represent the related subthemes, and are discussed in relation to existing literature. This was considered advantageous in supporting the suggested findings and profited the narrative flow of the study.

Table 2.

Superordinate themes and their subthemes

Connecting with others	**Them against us**	**Addressing the ro**
Decreasing isolation	Resistance	Create a safe spac
Developing interpersonal skills	Self doubt	Make the unspoke
Sharing experiences	'They have to fit in'	Model feelings
A supportive environment	'The perfect anorexic'	'Expose the anore
The group- a symbol of family	The power of the group	

3.2.1 Reflexivity of the effect my own clinical observations may have on my findings. The following is an extract from my reflexive journal throughout the analysis period: My confidence in my findings had grown significantly as my themes began to come together, and I quickly established that my findings were validating my own clinical observations. Although I had committed to extensive reflexivity practice throughout the duration of the interview phase, the main themes which highlighted the benefits and pitfalls of group therapy from a clinicians' perspective, were similar to views I held due to my experience in this field.

In particular, the challenges my participants described in facilitating group therapy in this context, and the concept of self doubt that appeared throughout many of

my participants accounts, echoed that of my own experiences. Furthermore, supporting my view of the role connecting with others plays in the usefulness of group therapy, my participants shared their experiences of the impact of the group in decreasing social isolation and the benefit of sharing with others. When reflecting on this, I questioned whether my own experiences and the emotional investment I have in this research investigation, were influencing me to recognise and extrapolate findings that confirmed my observations.

With this in mind, I sought to review my findings, and to take a more in depth look at the findings. In so doing, the subtheme 'Create a safe space' was generated, which incorporated participants' views of the importance of containing clients, and facilitating a safe space where they feel able to talk. I had initially overlooked the narratives where these values were made prominent, perhaps due to my own bias influencing the analysis of the transcripts. Through further exploration, I learnt of the impact participants' saw in 'Creating a safe space', a theme which will be explored in more depth throughout this chapter.

Prior to presenting the analysis, the superordinate themes and their corresponding subthemes are presented in the table below (Table 3.). Along with the number of participants who made references to these themes in their accounts.

Table 3.

Number of Participant responses to associated themes

Superordinate themes	Subordinate themes	No. of participants' Responses
Connecting with others	Decreasing isolation	8
	Developing interpersonal skills	5
	Sharing experiences	6
	A supportive environment	6
	The group- a symbol of family	4

Them against us	Resistance	6
	Self doubt	6
	'They have to fit in'	6
	'The perfect anorexic'	7
	The power of the group	5
Addressing the elephant in the room	Create a safe space	5
	Make the unspoken, spoken	7
	Model feelings	5
	'Expose the anorexia'	5

3.3 Theme 1: Connecting with Others

When commenting on their experiences of the usefulness of group treatment for individuals experiencing anorexia, all of the participants highlighted the perceived benefit of connecting with others, and the impact this has on decreasing isolation. The notion of 'coming together', and the perceived advantages of the nature of sharing reported by the participants, can be likened to Yalom & Leszczs' (2005) therapeutic factors intrinsic in group therapy norms, and their concept of 'universality'.

Five subordinate themes were created to group together the findings produced from the transcripts. Each of these subthemes were considered to reflect different aspects of the positive implications of connecting with others in group therapy, described by the participants. The first subtheme 'Decreasing isolation', referred to participants' perceptions of the impact group treatment has on clients' social exclusion and their perceived sense of isolation. 'Developing interpersonal skills' captured findings for the second subtheme, which addressed participants' experiences of the group context aiding in the development of communication and social skills, of which clients may be lacking.

The observed benefits of sharing encapsulate the third subtheme 'Sharing experiences'. Participants offered different explanations of the advantages of clients

being able to share their experiences with others, accounts drew on; sharing elicits hope in others, and sharing reduces clients sense of shame. The fourth subtheme 'A supportive environment', related to the perceived advantages of group therapy providing clients with a support network inside and outside of treatment. The group becoming an enactment of a clients' family dynamics is discussed in the fifth subtheme 'The group- a symbol of family'. Here, participants discussed their perception of clients' 'roles' in the group, and how these roles replicate those in one's family network.

3.3.1 Subordinate theme 1: Decreasing isolation. All eight of the participants commented on the observed benefits of group treatment in decreasing isolation. Broadly, these accounts drew on the therapeutic value of group treatment in reducing social isolation, however some participants shared their experiences of its relevancy to this particular client group. It is these accounts that were shared and explored within this subtheme.

Extract 1- Megan. Megan, Counselling Psychologist, predominant theoretical orientation; retrospective eclecticism, drawing on psychodynamic thinking. In the following extract, Megan shares her experiences of the impact groups can have on an individuals' sense of loneliness. She makes reference to her knowledge of anorexia to make sense of her experiences.

Groups will make people feel not alone, they're social, they're companionable. But also, most people with anorexia have not only poor relationships with themselves but very often, and this isn't always the case, but with a lot of our patients, they also have difficulties in relationships with others. Their social world will become smaller the

more ill they get, therefore group environments can really help with that (Transcript 4., pg3., l 119-124.)

Megan details her experiences of the advantages of groups for clients generally, drawing on her perception of the groups ability to decrease one's sense of loneliness. She places significant emphasis on the groups capacity to 'make people' not feel alone (Wanlass et al, 2005). The use of the word 'make' could imply that it is an unconscious process of inclusion.

Megan offers further insight into her perception of the role the group space plays for those struggling with anorexia specifically. She presents an understanding that often clients experiencing anorexia may have poor relationships with themselves and others. Megan's experiences of clients' social world becoming smaller and their poor relationships with others could be interpreted as either an absence of relationships or a poor quality of relationships, or both. Megan asserts that the more pervasive the illness, the smaller a clients' social world will be. Previous literature supports such claims, inferring that the worse the symptomology, the increase in social isolation (Hall & Ostroff, 2013).

Megan asserts that the group environment can 'really help' in decreasing these concerns. The impact of relationships formed within the group will be discussed further in later themes. Support from existing literature assumes group therapy to provide stability relationally, and is seen as advantageous in reducing isolation (Kleinberg, 2015).

Extract 2- Louise. Louise, Clinical Psychologist, predominant theoretical orientation; CBT. Louise offers her reflections of the usefulness of group treatment for

those suffering with anorexia. She draws on her understanding of the limited social skills and poor interaction those struggling with anorexia present with.

So, I guess it can be quite helpful in that often people with anorexia isolate themselves and, you know, don't have many social skills or don't interact much with other people (Transcript 7., pg2., l 72-74.)

Both Megan and Louise share knowledge of the 'anorexic' pathology to support their experiences of group treatment benefiting social inclusion. They both offer explanations which suggest a limited social network in clients with anorexia, and a loss of relationships with others. Louise suggests that individuals experiencing anorexia often isolate themselves and lack social skills.

By entering into group treatment, Megan, Louise and various theoretical advisors, suggest that isolation is broken down. In building trusting relationships, and interacting and reconnecting with others, the loneliness of anorexia is compromised (Hall & Ostroff, 2013).

3.3.2 Subordinate theme 2: Developing interpersonal skills. Five out of eight participants discussed their experiences of the group therapeutic relationship supporting clients in building interpersonal skills and developing their interpersonal learning.

Extract 1- Nicole. Nicole, Clinical Psychologist, predominant theoretical orientation; CBT and Systemic. In the following extract Nicole describes her experiences of the group as a social hub, and how it can aid in the building and developing of social skills.

I think what the group offers is a place to practice those social skills and to actually just tolerate being with others and allowing others in. If that's an outcome that

you can achieve at the end of a group, then that's quite a positive one. So, I think the social setting of the group is really important. (Transcript 5., pg3., l 116-120.)

Qualities and skills such as being with and trusting others are alluded to in Nicole's narrative as she acknowledges the importance of clients practicing skills of 'tolerating being with others and allowing others in'. Nicole details that for clients who are able to enhance and practice these particular social skills in a group space, the outcome is 'quite a positive one'. It is possible that she considers these traits to be lacking in this particular client group, or considers these to be fundamental in instilling change, thereby achieving a 'positive' outcome. Yalom & Leszcz (2005) share similar experiences of the groups ability to encourage the development of social skills, and consider this to be one of the core therapeutic factors in group treatment. They claim that a clients' ability to approach people, provide feedback for others and manage difficulties with others are particular social skills developed from being treated in a group context.

Extract 2- Lisa. Lisa, Clinical Psychologist, predominant theoretical orientation; Systemic Strategic CBT. In the following citation Lisa shares her experiences of the relationships in the therapy room, and how they aid in the development of interpersonal learning, a concept understood by Yalom & Leszcz (2005) as an opportunity to gain personal insight through the feedback and appraisal from others.

I think the experience of being... having to take some risks in having to put themselves out there in an environment where they can't control everything. What other people think, what other people are going to say, how the group is going to respond... (Transcript 3., pg2., l 70-73.)

Here, Lisa's narrative surrounding clients relationships in group treatment, suggests a feeling of discomfort attributed to their experiences. This can be understood by the particular language she uses when describing these experiences, such as taking 'risks', and an inability to 'control everything'. She exaggerated her descriptives when recounting her observations.

Lisa suggests that by interacting with other group members one cannot control their judgement or perception. It is implied that this may be of significance to this particular client group. The idea that control is integral in those struggling with anorexia is emphasised by Hamburg & Herzog (1990). By not controlling their environment and taking some 'risks', as Lisa would explain, this enables clients in the group to be subject to appraisal from other group members. This is understood as an integral part of interpersonal growth, where individuals can learn more about themselves, through the interaction and observation from others (Barker, 2009).

3.3.3 Subordinate theme 3: Sharing experiences. Six out of a total of eight participants described the perceived benefits of clients sharing their experiences in group treatment contexts. They proposed that clients profit from sharing, as it has the capability of normalising experiences and subsequent feelings, and provides them the opportunity to relate to one another. The following extracts illustrated participants' explanations of the advantages of sharing with others, the impact this has on shame reduction, and the influence it has on eliciting hope in others.

Extract 1- Matt. Matt, Clinical Psychologist, predominant theoretical orientation; Psychoanalytic Therapy, CBT. Prior to the extract below, Matt had begun to share his feelings towards his enjoyment in running group therapy, and his perception of

the rewards for those who receive treatment in this context, and their ability to 'connect with others'.

……where the unspeakable becomes spoken about and becomes normalised in that process, I think is very, very important, and impacts in many ways. I think that one of the underestimated dynamics of human beings is shame, and I think shame incapacitates us psychologically and also physiologically, and I think we react to shame in a very unhelpful way. I think it has a great impact on us. And there is the potential, in a group situation, where some of this shame can be altered to be... They can allow themselves to expose that shameful part and have a reaction which then changes how they're positioned within their mind, this terrible thing which I need to keep hidden because if anybody was to see it, they'd think, oh, it's... you know, I'm a monster or whatever. They suddenly become, oh god, it's actually not that bad, you know (Transcript 1., pg3., l 105-117.)

Matt begins by emphasising, interpreted by the use of the repetitious wording of 'very', the importance of the 'unspeakable becoming spoken about', and the impact this has on normalising one's feelings and experiences. The idea of something being 'unspoken', as put forward by Matt, could be understood as something that remains hidden, with a connotation of shame or embarrassment associated with it. This is perhaps why Matt understands shame to have a 'very unhelpful' and 'great impact' on us.

Matt introduces the concept of shame and understands it to be a debilitating emotion which compromises human beings significantly. He suggests that by sharing and 'exposing' something that has remained private or unspoken, particularly in a group context, can result in altering shameful feelings for clients. The use of the word

'expose' when referring to disclosure could infer feelings of threat, anxiety or vulnerability, particularly when sharing something deemed shameful. He continued to provide an example of how shame may be personified; 'if anybody was to see it, they'd think I'm a monster'. Perhaps Matt holds these feelings towards sharing shame inducing experiences, hence his particular use of more 'negative' language.

Theoretical understanding supports Matt's perception of the importance of shame reduction, and offers explanation of the significance of this in clients struggling with anorexia. Various studies have found the likelihood of experiencing shame to be positively linked to those with a dysfunctional relationship with food (Gee & Troop, 2003; Murray, Waller, & Legg, 2000; Sanftner, Barlow, Marschall, & Tangney, 1995).

Extract 2- Nicole. *I think it's about patients being able to identify with one another and realise that, yes, we are going through similar things. The illness might have the same label but the way that it manifests can be really different, however there always seems to be some qualities that will be similar in everyone, and it's these qualities that make people come together, and help people see they have stuff in common, and their illness is not unique to them. Even when things are different between them, they can still learn off of each other, as if you hear other people's stories and how they have coped, then there might be some tips and ideas for you (Transcript 5., pg5., l 219-226).*

Here, Nicole addresses the notion of commonality and the impact this can have on clients' feelings of togetherness. She emphasises the groups' ability to recognise their similarities and the experiences they share in common. She acknowledges that a group of people, whom share a diagnosis, are not going to share exactly the same symptomology, however what Nicole does experience, is that they will share 'some

qualities' alike. Existing literature supports such a notion that establishing a 'universal theme' (Spitz & Spitz, 1999), which brings everyone into a discussion, can generate feelings of a shared experience. It can be inferred from Nicole's experiences that by sharing common feelings, a bond of understanding can form feelings of togetherness for the group members, and combat potential feelings of isolation developed from the idea that their illness is 'unique to them'. Yalom & Leszcz (2005) supported the assertion that being a part of a group and gaining an understanding of not being alone with their illness, reduces one's feelings of uniqueness and isolation.

Extract 3- Megan. In the following extract, Megan provided a specific example of her encounters in group treatment. This particular example relates to a client's share and the impact it had on the group as a whole.

I had it in a group today where one patient spoke about having been able to go away on a family holiday over half term that would not have been at all possible when she was more in the throes of anorexia. This was something that she just didn't think was ever going to be possible at all. We then led the discussion to how other people could relate to that. Quite a few people then said that really gave them hope because it made them question some of their fixed beliefs about things that they thought weren't possible because if it could be true for her then why couldn't it be true for them? (Transcript 4., pg3., l 143-150.)

The particular example portrayed in Megan's extract may have been been used to illustrate how, by a client sharing their experiences of being able to achieve something they did not previously deem possible, can elicit hope in other group members. She described her experience of a client share supporting others in challenging their limitations and fixed beliefs about themselves. Megan stated twice, when recalling this

experience, that going on a family holiday would 'not have been possible' for her client previously. I felt Megan's sense of pride and hopefulness for her client in this instance, understood through the warmth in her tone of voice when describing this experience.

The progression in one client, as described by Megan, encouraged other group members to consider their capabilities and stimulated hope. Much like Yalom & Leszcz (2005) proposed, the instillation of hope for change is crucial in group therapy, and can be induced when observing others who are on a continuum of severity.

3.3.4 Subordinate theme 4: A supportive environment. Six out of a total eight participants described the benefits of clients support to and from others and the impact this has on fostering relationships, creating a support network and the nurturing of cohesion and altruistic traits.

Extract 1- Anna. Anna, Clinical Psychologist, predominant theoretical orientation; person-centred approach. Here, Anna describes her observations of the usefulness of group treatment in nurturing cohesion, and introduces altruism when highlighting clients' feelings of being 'needed' within the group.

Having group work certainly enables another level of support, especially if someone is struggling, the group can be really good in helping them move forward, I think people like to feel needed and that they've helped someone. Supporting each other definitely helps in fostering a more cohesive group, and by doing so makes them feel a greater sense of belonging. I just think that the relationships that they create here are great, and I think really develop a person's support network. (Transcript 6., pg1., l 48-53.)

Anna's sense of clients' mutual support in aiding in group cohesion is apparent in the above extract. She details that by creating a cohesive group, an increased sense of

belonging is stimulated. Similar to the observations of Yalom & Leszcz (2005), cohesion is an integral therapeutic factor in group treatment. She harnesses the idea that creating a supportive environment and building relationships with others, assists in clients' potential growth when she states 'helping them move forward'. It could be interpreted that group cohesiveness is much like a therapeutic group relationship, in the role it plays in stimulating change through the strength of relationships between group members (Wanlass et al, 2005). Anna shares additional thoughts of the role supporting others plays, when drawing on her perception of the impact helping others has on one's feelings of being 'needed'. Anna implies that positive feelings are induced in those who help others and are needed by others, qualities attributed to altruism. The role altruism plays in group therapeutic factors is shared by various theorists (Yalom & Leszcz, 2005).

In the following two extracts, the participants discuss the impact of a supportive environment when fostering active support networks, which are made up of others who share similar difficulties. They draw on the differences between the client-therapist relationship and the relationships shared between clients, and the impact these relationships have in providing support for clients inside and outside of treatment.

Extract 2- Donna. Donna, Clinical Psychologist, predominant theoretical orientation; Trans-personal.

I think that support within the group is really important because I think it's a very different relationship, a clinician to a patient. You know, they can get courage with you in what they want to talk about individually but in a group there's a very different support which comes from your peers who are also struggling and that makes a very different relationship, and creates a positive support network (Transcript 8., pg3., l

113-117.)

In the above extract, Donna addresses the different relationships shared between clinician and client, and client and other members in a group context. Her attitude towards the distinction between these relationships, and the value of the 'different support' provided by peer interactions is shared by multiple theorists, and is discussed extensively in group psychotherapy research (Fuhriman & Burlingame, 1990). Yalom (1995) described this relationship dynamic as 'tripartite', which encapsulates the relationships of the member to the group, member to member, and member to the leader. In her experiences cited here, Donna appears to place significant value on the member to member relationship, as she emphasises the differences this relationship brings through the use of the word 'very'. Finally, Donna describes her perception of the groups relationships on the development of a positive support network, a concept which will be illustrated further in relation to findings produced from Louise.

Extract 3- Louise. *Obviously they can have things in common and they can support each other, especially if they are having to eat together in treatment. They also support each other outside of treatment which I think is important, as obviously their difficulties continue on away from the therapeutic setting, and having each other's support outside can be really helpful I think (Transcript 7., pg2., l 74-78.)*

Louise's experiences here draw on a significant dilemma within academic research and practice (Kleinberg, 2015; Wanlass et al, 2005), where skepticism is at its height when looking at the benefits of relationships between members in group treatment modalities, and the overall impact of friendship relationships between group members. From Louise's perspective, a support network made up of group members, who can provide support outside of the treatment setting is 'important'. Her experiences

detailed here highlight the commonality between group members, and how this can benefit in creating a supportive environment inside and outside of the therapeutic setting. Whilst some theorists argue that relationships should remain in the group for therapeutic use as opposed to socially, there are alternative perceptions which support Louise's claims, and assert the importance of socialisation outside of the therapeutic setting, in a bid to challenge individuals' isolation (Lubin & Johnson, 2008).

3.3.5 Subordinate theme 5: The group- a symbol of family. The following subtheme aimed to encapsulate findings from the accounts of four participants, who detailed their experiences of the therapeutic group replicating family dynamics. Extracts from the analysis were provided to support this theme, and existing literature was referred to, in order to expand on the findings and address the implications of such a notion.

Extract 1- Nicole. *I think, also, often the group becomes a symbol of people's family and social networks. It's the idea that people take on different roles in a group. So, sometimes you get one person who is happy to help with resources or plan things out, sometimes you get people who want to take the lead. It's quite interesting in a structural, systemic sense, how the group pans out. That can really change over the weeks, depending on mood, depending on the illness itself, really (Transcript 5., pg7., l 314-319).*

In the presenting citation, Nicole details her experiences and observations of group dynamics representing similar dynamics found in one's family and social networks. It could be interpreted that individuals' family dynamics will impact the type of role clients embody in the therapeutic group, and may influence their behaviour. Nicole uses examples such as one's inclination to 'take the lead' in the group, and infers

that these decisions are to some degree based on the roles they play within their individual family systems. Existing literature has argued that this type of 'mirroring' of one's family dynamics within the group context is advantageous in promoting learning and plays a powerful factor in therapeutic change (Yalom & Leszcz, 2005; Kleinberg, 2015). In the extract highlighted above, Nicole seems to present this idea from a quizzical standpoint, when she states 'It's quite interesting in a structural, systemic sense, how the group pans out.'

Extract 2- Matt. Prior to the following extract Matt had begun to describe a specific client who he perceived to reenact particular family dynamics in the group setting. He addresses the perceived benefits for this client in using the group to question observed relational patterns.

And then she started to talk about her mother, and I started to wonder and it felt that that was mirroring what she was experiencing in the group. In that her mother is very, very unwell, and her mother has really, really bad difficulties. And she, what she went on to explain, was that she can't be okay, because her mother is not well. So the idea of her not being able to be okay when her mother's unwell is felt to be similar to her experiences of my peers are unwell so I can't be ok if they're not. Is it okay for me to be okay for me? This is where the group is brilliant in helping answering that question you know, and just generally trying to support in changing this type of thinking (Transcript 1., pg4., l 186-193).

This client described by Matt was observed to be mirroring family dynamics with her mother with other ill group members, which conflicted with her ability to be 'well' and get better. According to Bender (2000, pg.303), "each member brings into the group the whole sociocultural context in which he or she lives." Matt's client's

relational difficulties were playing out in the here and now and conflicted with her ability to recover. From his perspective, the group context can support clients', such as this particular lady, in understanding the relational patterns that are existing, and can aid in making changes. It can be inferred that he considers this to be a positive attribute of group working, when he states 'this is where the group is brilliant'.

Interaction with other group members can provide clients like the lady in Matt's example, the opportunity to understand their relational conflicts and make alterations, particularly when receiving positive appraisal and affirmation from peers in the group (Yalom & Leszcz, 2005).

3.4 Theme 2: Them Against Us

Theme 2 'them against us', evolved to incorporate the complex findings produced from the current study, which highlighted participants' experiences of the challenges of group therapy, and the drawbacks of working in this context. Broadly, this theme encapsulated findings which referred to narratives surrounding participants' interactions between themselves and the client group, and those between clients and each other. The notion of 'them against us' is played out in many of the participants' narratives, and was felt to predominate their more negative experiences of group treatment for those experiencing anorexia.

To best review the findings, five subordinate themes were generated. The first subtheme; 'Resistance' compiled multiple findings from participants who shared their experiences of ambivalence and obstruction from clients, and how this could be understood. Participants discussed their perception of the impact these attitudes have on the group and clients' ability to recover. Participants' questioning of their practice encapsulated findings to support the second subtheme 'Self Doubt'. The linguistic and

emotional content of participants experiences were explored, in order to provide understanding of their feelings of not doing enough or needing to do more when working in a group context. The 'In group-out group mentality' addressed by theorists such as Hogg & Abrams (1988) was prominent in the current findings. The experiences of participants who observed clients to 'split-off' and create subgroups within the wider group setting was explored within subtheme three, and considered alongside Hogg & Abrams (1988) ideas. The competitive nature of anorexia was discussed in subtheme four, when participants' experiences of 'The perfect anorexic' were addressed, and the challenges that this evokes were explored. The final subtheme; 'Anorexics in numbers', addressed participants' experiences of clients working together against recovery, colluding with each other and encouraging disengagement.

3.4.1 Subordinate theme 1: Resistance. The following extracts have been chosen to demonstrate six out of a total of eight participants who shared their experiences of resistance within the therapeutic setting. The excerpts indicate participants' perceptions of the impact ambivalence has on the group, due to competition and the effect of the 'saboteur'. Participants' findings explore ambivalence through the perceived 'value nature' of the illness, and the impact this has on recovery.

Extract 1- Megan. *I think because of the ambivalence about getting better, there's a part of them that's wanting to sabotage the group a lot of the time. In a nutshell, I would say that it's probably that. There's a saboteur in the room, a lot of the time when you're working with anorexics. So, it's almost like competing. I get drawn into the competition because I have to compete with the anorexic confessional, the saboteur and I have to make sure that I'm the one who wins. So, it's interesting, to get pulled into the same dynamics that they live with. I find that experiencing that competition can help me to understand what it feels like to be an anorexic, in a way.*

So, I'm trying to use those experiences usefully to inform what I do rather than to react against it (Transcript 4., pg2., l. 85-94).

In the extract detailed above, Megan shares her experiences of ambivalence, and the impact this has on the group and the therapeutic relationship. For instance, she explains that the ambivalent client will sabotage the group, placing emphasis on the idea that the 'saboteur is in the room', which could imply that the ambivalence is apparent in the group space, not just in individual group members.

Megan discusses her experiences of how her clients' ambivalence impacts the therapeutic relationship, when she details being 'drawn into the competition'. She illustrates an interesting role that is carried out between client and therapist in this context, where she acknowledges her feelings of competing against the 'saboteur', or as it could be understood, the part of a client that is resisting treatment. According to Engle & Arkowitz (2006) Megan's experience is not an isolated one; they suggest that every therapist will have experiences of clients who seek out their help, and yet also act in a sabotaging manner towards the help which they were seeking. Megan demonstrates good reflective practice in this citation, as she considers her experiences of being in competition with her clients, in order to better understand their lived experiences, and to, as a result, inform her practice.

Extract 2- Nicole. Here, Nicole discusses her clients' ambivalence towards recovery based on their value of their illness. She refers to clients' fears of moving away from their illness, based on its value to them individually, as concepts to support her claim that clients are ambivalent towards change and recovery.

People are valuing their illness and they may not wish to recover……. I don't really want this illness any more. I think that's quite difficult for people to use a group

space to say, because of the value nature, the competition, and the fear that people feel about moving away from the behaviours (Transcript 5., pg2., l 89-94).

In this extract, Nicole describes her experiences of ambivalence from the position that clients are afraid to let go of their anorexia. She describes the illness as 'valuable', which leaves a sense of 'fear' in clients at the prospect of moving away from it, and as Nicole suggests, valuing their illness may lead to ambivalence towards recovery. Her experiences illustrated here, support the most common understanding of ambivalence, where an individual can identify the positive impact change will have, but also have several negative beliefs associated with the impact of change, thus causing what is known as 'approach-avoidance conflict' (Engle & Arkowitz, 2006).

Nicole does not provide further rationale or examples as to why her clients would place value on the illness, or why they would experience feelings of fear when moving away from their behaviours. However, she does allude to the 'difficulty' clients may face in saying 'I don't really want this illness anymore', in a group context. She implies that it is something about being a member of the group that makes moving away from the illness, and subsequently creating more ambivalence, harder. She references 'competition' when drawing on her experiences of ambivalence to change, a concept that will be further discussed in later themes.

3.4.2 Subordinate theme 2: Self doubt. Six out of a total of eight participants described feelings which could be understood as self doubt, insecurity and a lacking in confidence. For several participants their narratives were concerned with the idea of not doing enough or needing to do more when working in this context.

Extract 1- Lisa. In the following extract Lisa describes feelings of confusion and disappointment as she details her experiences of facilitating group therapy in this setting.

.... that feeling every time I come into the room, they look at us, they don't say anything, and they wait for something to happen, as if it was... I don't understand why they're never looking... they never look as if they were looking forward to having the group. That's something that I'm disappointed about, because I'm thinking, if I was a patient, and I was dreading every time a session, I'd be thinking, well, I'm going to stop this. This is... you know, why would I want to continue doing something that is, not something that I look forward to? But maybe it's wrong for me to want them to look forward to the group, but I don't understand why they don't, because I come in feeling, I want to help you. (Transcript 3., pg7., l 342-350.).

Lisa reflects a questioning stance to her clinical practice in this extract. This could be understood from the back and forth, reflective nature of her narrative, where she is posing questions to herself as to why clients rarely present as 'looking forward' to the therapeutic group. She expresses reoccurring feelings of an inability to understand when she repeats 'I don't understand' twice in the above extract. It is possible that these experiences could be eliciting feelings of insecurity and self doubt in Lisa, which may explain the back and fourth nature of her questioning in the narrative. The prospect of possible self-doubt within Lisa is further portrayed in the extract, when she states 'maybe it is wrong for me to want them to look forward to the group'. Lisa's voice when recounting these experiences was that of a concerned-questioning tone.

She emphasises the idea of how clients 'look' three times in this extract, which could infer that she attempts to understand how the clients are feeling based on how she

perceives them physically, and her interpretation of their body language. Further to this interpretation, language such as 'they never look as if they're looking forward to having the group' and 'why would I want to continue doing something that is, not something that I look forward to?' could reflect feelings of anger or frustration in Lisa, as she presents a blaming attitude towards the clients for not feeling or acting in the way she hopes. Existing literature claims that clinicians who are treating those who are struggling with anorexia may experience feelings of helplessness, frustration, impotency and anger when trying to support them in reaching their goals and engaging in change (Hamburg & Herzog, 1990; Brotman, Stem, & Herzog, 1984).

Extract 2- Matt. In the following extract, Matt reflects feelings of 'worry' and other emotional reactions that he experiences when considering that he did not work hard enough in a group session.

I've come out of a group and thought, that's been really hard work, and I'll often think about it for ages afterwards. Sometimes I worry and think maybe I should of worked harder to generate discussion. On the other hand, I've come out of a group and thought, I feel really frustrated, and I've come out of groups feeling angry, and as if I'm wasting my time (Transcript 1., pg4., l 200-204.).

Much like Lisa's experiences described above, Matt expresses similar feelings of worry and self doubt that he should have 'worked harder' to elicit discussion. More generally, this extract illustrates significant emotional expression from Matt, when he shares feeling of 'worry', 'frustration', and anger. Alongside this, Matt explains that he will 'often think about it (the group) for ages afterwards'. The idea that Matt ruminates over the group, and the emotional experiences he describes, could imply feelings of under-confidence and self-doubt. The various feelings Matt describes in this extract

could be likened to Hamburg & Herzogs' (1990) account of clinicians experiences of frustration and anger when working with anorexic clients.

Extract 3- Sarah. Sarah, Counselling Psychologist, predominant theoretical orientation; CBT. She reflected on her experiences of facilitating group therapy in a weight-restoration programme, drawing specifically on meal times, and her feelings of not doing enough.

....and I think it's hard for clinicians to feel that they're doing enough, as the clients feel so wretched. They feel so anxious and, actually, they don't want to eat, and they don't feel they need to eat, and there's always food around and I just don't know how to make this bit easier for them really. There's an enormous amount of food, and it's so distressing, and how could we do this to them? (Transcript 2., pg2., l 82-86.)

It could be viewed that Sarah's feeling of not doing enough in relation to her experiences of working in this setting, are a depiction of self doubt. Likewise, Sarah continues in the above extract to express insecurity in her ability to 'make this bit easier', and in her questioning of 'how could we do this to them?'.

Prior to, and during the above extract, Sarah expresses an empathic stance towards her clients in her reflections, through the use of words such as 'wretched' and her distressed tone of voice. Sarah reflects on her experiences through describing how difficult treatment is for her clients. It is felt that she is very astute to her clients' experiences, and takes these on as her own.

3.4.3 Subordinate theme 3: 'They have to fit in'. Six of the participants in the study commented on their experiences of the group dynamic and the impact this has on clients' abilities to focus on their recovery. The notion of 'fitting in' and being 'a part of' is addressed in the following extracts, and how this can predominate the treatment

and subsequently neglect the true goal of the therapy. The impact of a new group member on the group and its existing members is also explored within this theme. Findings gleaned from the transcripts present a picture whereby individuals are either in or out of the group, depending on how much they are willing to maintain similar attitudes held by the group as a whole.

Extract 1- Lisa. In the following extract, Lisa shares her experiences and observations of the negative impact the group dynamic can have on an individuals' ability to pursue recovery. She perceives that 'fitting in' in the group can, in some instances, maintain clients' ambivalence towards getting better.

The group can then hinder the recovery of the patient…….They have to fit in. That's sort of, you know, human nature. They have to be part of the group, but at some point, it's about them, and they're own recovery……..I can think of other patients who are going to have to somehow say, well, sorry, guys, but I have to move on, and I'm going to be different to you, because there is that pressure that we're in this together (Transcript 3., pg4., l 175-190).

Lisa suggests in the use of her word 'hinder', that she perceives the group to obstruct the recovery of individual group members. The pauses in her dialogue could suggest periods of reflection, as she offers further insight and meaning to her experiences following a break in her speech. It is possible that Lisa's perception of 'they have to fit in', can offer explanation as to how or why the group hinders the recovery of its members. She places emphasis on this idea by her repetitious use of the words 'have to' in her narrative. This notion carries with it a feeling of pressure or coercion.

As Lisa asserts, fitting in or belonging within a group is seen as 'human nature'. This could be interpreted as something which lies innately within human beings. She

explains that, in order for one to pursue recovery, clients would have to move away from the group, and place themselves as 'different' to the group members. In her narrative, Lisa states 'sorry guys but I have to move on' implying a possible sense of guilt from the client to the group, or the idea that somehow they are letting the group down.

Lisa's perspectives can be likened to the phenomenon of in-group versus out-group, which is understood within social psychology literature, and supports the work of Bion (1961). Theorists argue that when the representation of the self is made up of in-group identification, separation from such grouping is challenging (Hogg & Abrams, 1988). Likening this to Lisa's experiences, she recounts particular individuals who need to move away from the group in order to pursue their own recovery, however acknowledges the pressures of being able to do so.

Extract 2- Anna. Anna described similar experiences to Lisa in her observations of the impact of the group dynamic on recovery.

There have been times when I've felt the group have been really quite sabotaging of those that wanted to or were thinking about making change. It feels quite uncomfortable when the group seem to turn on these guys, who really just want to get better, and some how they shun them from their gang because they no longer belong, type of thing…you know. (transcript 6., pg3., l 108-112).

In this extract, Anna describes similar experiences of the affect the group can have on those who want to deviate away from the group, and 'make change'. Her use of the word 'sabotaging' implies a negative, destructive impact the group can have, and refers to her own feelings of discomfort when observing such behaviour. From Anna's perspective, the group is described as a 'gang', who will 'turn on' or 'shun' those who

want to get better. The idea that those who deviate from the group, and want to pursue their recovery, and no longer belong, is supported by Wanlass et al (2005), and their observations of group members colluding to avoid confrontation, fearing the impact this could have on their newly developed friendships.

Extract 3- Matt. Matt shares his experiences of the impact weight, shape, and size can have on the evaluation of new group members by the existing group.

Because they are preoccupied with weight and shape as defining features, and because they've got the distortion in their own view, then a new person entering their group will just be measured in terms of their... what's valued by the group, which is their shape and their size, and the distortion will see that that person is better than them because they're slimmer than them, therefore I don't want that person to be in front of me because that's going to remind me that... of what a loser I am (Transcript 1., pg9., l 420-426).

His narrative offers an understanding of how group members will evaluate a new member based on their shape and size. In his explanation, he states that due to the preoccupation and distortion of their own weight and shape, appraisal of a new individual will be founded on a similar value system. According to Matt, the likelihood of the group assessing newcomers as 'slimmer' is high, given the distortion of how they perceive shape and size.

Following the introduction of a new member to the group, Matt shares his observations of the impact this has on existing clients in his narrative, 'I don't want that person to be in front of me because that's going to remind me that of what a loser I am'. This could be interpreted as a challenging experience for the existing clients following the introduction of a 'slimmer' and 'better' new member.

3.4.4 Subordinate theme 4: 'The perfect anorexic'. The following subtheme was generated to incorporate findings from seven of the participants, who addressed the implications of perfectionistic traits on the group treatment process. Freeman et al (2013) saw perfectionism in anorexic clients as the 'setting of, and striving to meet, very demanding standards that are self-imposed and relentlessly pursued despite this causing problems'. The extracts indicate that this perceived trait can conflict with treatment goals particularly when in a group context and the participants described a focus on being the 'perfect anorexic'.

Extract 1- Megan. *It's important to keep an eye on the perfectionism, the competition, the things that can derail and scupper the recovery of the group. In another therapy group, there's a consensus that everybody wants the same goal. I think that sometimes, in groups with anorexics, there's more than one goal operating because there's this perfectionism in the illness which can create ambivalence to getting better, and instead of focusing on recovery, they seem more hell-bent on being the perfect anorexic, and they compete with each other for this title (Transcript 4., pg5., l 229-236.)*

In Megan's extract she acknowledges the presence of perfectionism and competition in the therapeutic group, and suggests that these aspects have the potential to 'derail and scupper' recovery. She makes it clear that awareness of these dynamics is important from her perspective. In her narrative comparisons are made to other therapy groups, and the distinction is made, that unlike other therapy groups those that function to support individuals struggling with anorexia have 'more than one goal operating'. It can be inferred, that perhaps being the 'perfect anorexic' maintains itself as a goal within the treatment.

She explains that in her experiences, clients focus more attention towards being

the 'perfect anorexic', and will strive to maintain this title within the group, instead of moving away from their illness and towards recovery. This could therefore explain Megan's perception of perfectionism creating ambivalence towards recovery. Much like this experience, existing literature supports the notion that perfectionism is present in those with anorexia, and has been identified as one of the main underlying traits in those struggling with the illness (Fairburn, 2008).

Extract 2- Lisa. Lisa shares her experiences of clients glorifying or 'putting a positive spot' on their eating disorder in order for them not to be perceived as flawed or problematic.

They don't want to be perceived as people with sort of flaws, problems, difficulties. So either they put a sort of... a positive spot on their eating disorder, or they try to put a positive spot on what they can do when having an eating disorder (Transcript 3., pg3., l 111-113).

Similar to Megan's account, Lisa's narrative suggests this particular client group may struggle with feelings of imperfection, understood from her experiences; 'they don't want to be perceived as people who have 'flaws, problems, difficulties'. Lisa's experiences support research findings which address the implications of perfectionism, stating that perfectionism leaves no capacity to cope with feelings of being flawed (Freeman et al, 2013). From Lisa's narrative, and the emphasis she places on the phrase 'a positive spot', it could be interpreted that she recognises the importance placed by clients in considering their eating disorder from a positive viewpoint, in order to maintain perfectionism.

3.4.5 Subordinate theme 5: The power of the group. Five out of a total of eight participants described their experiences of the negative implications of group

treatment. In the following extracts, participants explored the impact of treating more than one individual struggling with anorexia at the same time has on the effectiveness of the group treatment process. The idea that the collective thinking of clients in group treatment can create a 'powerful' resistance against facilitators and treatment generally, was discussed.

Extract 1- Megan. *Anorexic thinking is very powerful. So, when two or three people get their anorexic thinking together, it becomes even more powerful because then they're almost mobilised together. It can feel like you're fighting against or coming up against something even bigger because there would often be a case of caucusing or getting together, putting heads together and thinking about things and shoring up their own pathology. So, sometimes somebody might have one thought and somebody will come and convince them that thought was absolutely right. Anorexia together can be quite harmful because it can make itself even more powerful. The collective can sometimes work against recovery (Transcript 4, pg4., l 195-203).*

Here, Megan discusses her experiences of the negative impact group anorexic thinking can have on treatment and recovery. Her experiences could be deemed negative by the use of the words 'harmful', when addressing the powerful nature of treating those who are experiencing anorexia together.

In previous themes, the participants described many positive outcomes when considering the idea of treating those in a group context. The groups ability to aid in decreasing isolation, the ability to share with and support others, and motivating factors such as the instillation of hope (Yalom & Leszcz, 2005), are findings that see the group dynamic as a positive and rewarding contribution to treatment. On the contrary however, Megan describes the negative impact sharing and 'coming together' has on

recovery. She describes her experiences as a facilitator as feeling like she is 'fighting against or coming up against' something. This description allows for interpretation that the notion of the group coming together could be considered intimidating and a force which is challenging to work with. These suggestions are likened to Charles (2013), and his identification of the conflicts present for practitioners when they feel as though they are attempting to maintain the specific task of the group, and are instead 'fighting against' something.

Megan observes the impact the group can have on supporting and substantiating individuals' thoughts. She explained that this can contribute to the 'shoring up' of their own pathology. Theorists have identified group members teaching each other techniques and encouraging symptoms as a principle concern when working within group treatment for eating disorders, due to the implications it has on increasing pathology (Bieling, McCabe, & Antony, 2006).

In the following two extracts, the notion of pro-anorexia ideology is discussed in relation to the group dynamic, and the impact the group can have on cultivating and maintaining such ideological views.

Extract 2- Lisa. *I've seen groups where I've actually thought that was... I didn't feel comfortable, because I could see that it was more feeding into their identity of... who they are was an eating disorder, and making them feel almost good about it rather than making them feel good about not being like that…… the dynamic can sort of turn into them maintaining that status quo of being ill and not doing anything about it but sort of listening to their own voice and just feeding from each other's eating disorders rather than feeding... being vitalised into changing (Transcript 3., pg2., l 86-96).*

Lisa highlights her experiences of the group dynamic supporting clients in

maintaining their illness, and feeding into each others eating disorders when she states 'I could see that it was more feeding into their identity of who they are was an eating disorder'. Lisa suggests that clients in the group would 'feel good' about their eating disorder, instead of being 'vitalised into changing'. Similar to Anna's experiences addressed below, Lisa describes the negative impact of the group in maintaining or reinforcing individuals presentations, or what she terms as the 'status quo' of the illness. Anna shares similar views, but labels this concept 'pro-anorexia ideology'.

Extract 3- Anna. *..... They're so varied but one in particular may be pro-anorexia ideology rules, if a number of people in a group start to collaborate together and collude with that and re-enforce that ideology in that sort of scheme and those beliefs, then actually they're just re-enforcing the idea of anorexia, this can be really, I think, unhelpful in a treatment group (Transcript 6., pg2., l 99-103).*

Anna describes her experiences of 'pro-anorexia ideology' and how this can have a negative impact on group treatment. It can be understood that Anna sees 'pro-anorexia ideology' to be the collaboration and collusion of unhelpful beliefs. Extensive literature discusses the notion of pro-anorexia from a philosophical and ideological perspective. They both endeavour to address the negative implications pro-anorexia (commonly shortened to pro-ana) is having on eating disordered sufferers, and society more generally. Broadly, pro-anorexia is a viewpoint which argues approval of eating disorders, and perceives them to be reasonable lifestyle choices (Brady, 2015). Anna explains that with the culmination of such thinking, and the reinforcement of particular ideologies, that the 'idea of anorexia' is maintained.

Participants in this study, including, but not exclusively, Megan, Lisa and Anna, saw the impact of 'anorexic' thinking coming together in a group treatment dynamic as

problematic. Their different perceptions have one main theme; the power of the group creates resistance and ambivalence towards treatment and recovery.

3.5 Theme 3: Addressing the Elephant in the Room

The final theme of the research, 'addressing the elephant in the room' aimed to integrate findings produced from participants' accounts who addressed their experiences of managing the challenges and difficulties faced in group therapy for those suffering from anorexia. The various strategies put forward by the participants all emphasised the importance of being transparent, open and honest with clients, generating discussion and open communication about the particular challenges that have arisen. This theme was termed 'addressing the elephant in the room' with intent to illustrate the unspoken dynamics that the participants discussed, and the importance of acknowledging these within the group space.

Four subordinate themes were created to group together the findings produced from the transcripts. Each of these subthemes were considered to reflect different strategies or approaches the participants used in managing the challenges observed in this context. The first subtheme 'Create a safe space', related to the importance of creating and sustaining a safe and containing environment for clients to talk and share. 'Making the unspoken, spoken' evolved to incorporate findings for subtheme two, which aimed to address participants' descriptions of the benefits of sharing, exposing or making transparent the dynamic undertones of the group. The concept of 'modeling' was addressed in subtheme three 'Model feelings', where participants' narratives addressed the benefits of sharing their own thoughts and feelings in a bid to 'raise awareness', and encourage clients to share and disclose theirs. Finally, subtheme four, 'Expose the anorexia', aimed to incorporate findings which described participants'

experiences of externalising the eating disorder and acknowledging the impact it has on the group and its individuals.

3.5.1 Subordinate theme 1: Create a safe space. The following subtheme brings together examples obtained from participants' accounts who addressed the importance and the implications of creating and maintaining a 'safe space' for their clients in group treatment. Five out of a total of eight participants cited in their narratives their role as the 'leader', and their responsibility in generating safety and/or containment for the group. The following examples are discussed in relation to the extensive theoretical knowledge put forward to address safety and containment in a therapeutic setting.

Extract 1- Anna. Anna reflects upon her role in creating a space that permits clients to explore and express how they think and feel. She describes the importance of making clients feel comfortable and ensuring an appropriate use of the group space.

The main things for me are about how to get people to feel comfortable, to talk in a group setting. I think you need to allow the space for people to express what they feel and what they think, and do so in a safe and contained way. So, I think you can contain that and I think you can redirect people if they are using the space inappropriately, it can be difficult at times (Transcript 6., pg4., l 186- 190.)

Anna describes the responsibility she experiences in creating and maintaining a safe space within the group. She determines her role in this extract as 'getting people to feel comfortable', as a way to enhance engagement in the therapeutic process. Creating safety, as a way to engage clients in therapy is understood by Rogers (1951), as reflecting a non-judgmental, empathic stance to your therapeutic work. Person-centred therapists, akin to Anna's predominant theoretical position, are likely to follow Rogers

(1951) determinants for therapy, and will place significance on an authentic, empathic and congruent approach to engagement. She details her perception of her responsibility in managing the atmosphere of safety, and the appropriateness of clients' shares within the group space.

Anna uses the word 'contain' twice in this extract to describe her role in managing the group dynamic. The importance she places on containment could be understood from the repeated use of this word. The concept containing and/or holding is central to a relational psychotherapeutic way of thinking, and is used to describe a clients' feelings of safety through the relationship with the therapist (Greenberg & Mitchell, 1983). How practitioners will understand the notion of safety in a therapeutic environment will vary according to their theoretical approach to client work.

Extract 2- Matt. In the following extract, Matt describes his experiences of eliciting safety in group therapy, and introduces the notion of the 'secure frame'.

Some people share and some people have experienced something similar and whatever, but to get from that to that takes work, and it's creating that safe environment and building the secure frame, and also the therapist's ability to be able to lead the group to say, it's going to be all right (Transcript 1., pg4., 166-169.)

Matt describes experiences of the therapy group and providing members the opportunity to share their encounters and compare their experiences. It is his experience that the creating of a safe environment and the secure frame is essential to allow sharing to occur. Hardy, Bass, & Booth (2007) support this assertion and promote safety as a tool to elicit difficult thoughts and feelings from clients. Along with the importance of safety, Matt acknowledges the role he plays as the leader and his ability to reassure the group, particularly when he suggests 'it's going to be all right'.

Matt introduced in this extract, the building of the 'secure frame', inference can be made as to what he meant when referring to this notion. The concept a 'secure frame' is understood as the physical and psychological space in which therapy will take place (Howard, 2009). The secure frame, referred to by Matt, is understood by relevant theorists as an environment that maintains structure, safety, support and containment (Howard, 2009).

Extract 3- Lisa. *I think structure and rules are important to make the group feel held, and it's for the facilitator to create this, and the space around that person so that person is safe and they can then disclose the relational and interpersonal difficulties they are struggling with…. (Transcript 3., pg4., l 176-179.)*

Lisa emphasises the need for structure and rules in a group, in order to create the holding, safe environment that will encourage a client to share their interpersonal difficulties (Wanlass et al, 2005). Lisa describes her role in creating and maintaining rules which 'hold' a client group and elicit safety. Specific rules that Lisa refers to can be inferred by the support of existing literature; Kleinberg (2015) argues that fixed rules of confidentiality, and individuals' roles within the group are of key importance when stimulating group members experience of safety.

3.5.2 Subordinate theme 2: Make the unspoken, spoken. The following subtheme draws the experiences of seven participants who address the notion of 'making the unspoken spoken', which has been referred similarly to making the unconscious conscious (Gans & Alonso, 1998). Participants share their observations of the benefits of working in such a way, and the overall impact this has on the group and their treatment.

Extract 1- Matt. Within Matt's narrative of the challenges he faces in working in a group context with those suffering from anorexia, he shared his experiences of addressing the unspeakable thoughts and feelings of the group and its members, and somehow breaking the implicit 'rules' of the group.

I think my aim is to create a safe space where the unspeakable becomes spoken about and becomes normalised in that process. I think it's very, very important, and impacts in many ways……. I also think that one of the biggest rules in the group is all around the unspeakable, what they're unable to speak about, what they can't speak about, and whatever. And so I really like working in a way to say something that breaks these rules, and allows for the unspeakable part or I guess the unconscious part of someone's psyche to become spoken about and made conscious. All the time trying to make it transparent and known to the group (Transcript 1., pg3., l 105-130).

Matt described his role in 'creating a space' for the unspeakable to become spoken about in the group. He did not proceed to explain how he creates this space, however he did share the importance of doing so, when he detailed how it contributes to 'normalising'. He shared his observations of the rules that maintain the unspeakable within the group dynamic. It is possible that these rules have an implicit undertone, and is not something that is overtly discussed between group members, given the nature of something being 'unspoken'. Matt detailed his role in challenging or breaking these rules, and introducing the unspeakable or unconscious constructs into the groups' awareness, by making it 'transparent' and 'known'.

Multiple theorists have explored and hypothesised the advantages of making the unconscious conscious, a broad understanding would be that by initiating greater

intensities of affect into the group, members can learn more about the self, others, and their interpersonal relationships (Gans & Alonso, 1998).

Extract 2- Donna. Similarly to Matt's observations, Donna detailed her experiences of the importance of using the dynamics of the group to understand and interpret 'what's going on for the group'.

I use the group dynamics as a tool to understand where the group is and what's going on for them relationally. I don't think I could run a group without actually understanding the feelings and context of what's happening and putting it in the context of the people that are in the group and what I know about them. Once I understand it, I think its really important to feed that back to the group, and by doing so creating, you know like a space where we can talk about it all together as a community of people working together. So for me the dynamic undertones of the group are vitally important to understand what's happening, and can help in deciding what will happen next in the therapeutic work and what needs to be addressed (Transcript 8., pg5., l 240- 248).

In the extract illustrated above, Donna explains that in her experiences, it is essential to explore the group dynamics present in the therapeutic group, in order to better understand the clients' presentation and what is happening in the group. She states that this understanding can support decision making and what needs to be addressed in the therapeutic work. Integration of interpretations by therapists is seen as an important therapeutic intervention (Barth, 2014), and as Donna claims, can help in guiding the remainder of the therapeutic process.

Theorists state that turning thoughts into words can provide opportunities to consider one's ideas from a different perspective, and increase one's self awareness (Barth, 2014). As per Donna's experiences, once the unconscious dynamics of the group

have been interpreted, she emphasises the importance of feeding-back to the group what she has understood, in order to explore them therapeutically within the community.

Extract 3- Louise. Within Louise's narrative, she described making the unspoken spoken as 'naming the elephant in the room'. She explained that in her experience addressing the dynamics present supports individuals in being better able to understand the internal and external conflicts that arise within the therapeutic group.

We have a community meeting where we might name, you know, actually talk about there seemed to be a lot of competitiveness so, kind of, name the elephant in the room. Well, it's often explained that, you know, it's part of the illness, you know, it's not that they're horrible people but, you know, the illness can make us very competitive really. So, I guess, talking about the dynamics and being open with the patients about it can be really helpful in making them understand themselves better (Transcript 7., pg5., l 235-241).

Louise's experiences described here emphasise the value of acknowledging the 'elephant in the room'- such as competitiveness, in helping clients make sense of their presentation and separating themselves away from their illness. Similar approaches have been discussed within the person-centred framework, where reflection of unspoken and spoken constructs is considered paramount in generating empathy and acceptance of oneself (Rogers, 1951). Louise shared in her experiences, that by generating an open dialogue, addressing the unconscious dynamics, and by being compassionate towards themselves and their illness, specifically when she states 'it's not that they're horrible people', individuals are able to understand themselves better.

3.5.3 Subordinate theme 3: Model feelings. Five out of eight participants described the perceived benefits of modelling feelings to clients, and the impact this has

on their ability to be open and share, and aids in fundamental learning that feeling certain emotions is acceptable and tolerable. The following extracts aim to support this theme, and reference existing literature in a bid to support participants' claims.

Extract 1- Megan. Megan shared her experiences of making herself vulnerable to group members and the impact this has on making her more relatable and consequently encourages openness amongst the group.

I model trying to be very open with my own experience. I try and make myself vulnerable sometimes. I will model admitting how I'm feeling, you know like nervous, anxious, stressed, angry etc. I then rely on the fact that the ones who are experiencing similar, difficult emotions will also really know what I'm feeling and relate to me. I think that by sharing my feelings they think its okay to do the same, and people are generally more open if you are too (Transcript 4., pg7., l 329- 334).

The above extract followed Megan's narrative of her experiences of silent groups, and clients' reluctance to share. It can be understood that Megan provides this example to illustrate how she manages such challenges in the group, and how she aims to overcome clients' unwillingness to engage in the therapeutic process. The extract seems to be based on an underlying understanding that clients' reluctance to share or engage is based on their anxieties of whether it is deemed 'ok' to do so. She described her experiences of modelling her own feelings to the group and the expression of her own vulnerabilities, in order to encourage clients to feel safe enough to do the same. Teyber & Teyber (2010), supported Megan's observations of the benefits of modelling, in their work on the interpersonal processes in therapy. They argue that therapists can support clients in identifying and expressing their feelings more extensively if they demonstrate openness, transparency and vulnerability.

Extract 2- Matt. *What I will do is I will share how I'm feeling like there's anger, or I'm feeling like people might be angry with me, or I'm feeling there's a lot of sadness in the room. So I will share. I will share my experience as a way of owning something for myself, but also giving a really clear message, it's okay to have feelings, and it's okay to feel these things and you will get through it, you know (Transcript 1., pg6., l 252-256).*

Matt highlighted the importance of sharing his experiences and 'owning something' for himself. He explained that this reassures clients that is ok to feel, and that they will get through it. His experiences may be based on an understanding that this particular client group struggle to tolerate emotion, as understood from his narrative 'it's okay to have feelings' and 'it's okay to feel these things'. Therefore, it could be interpreted that modelling his own feelings will be a particularly rewarding and novel experience for them. The concept of sharing one's own experiences in this context is similar to the notion of modeling. Matt's ability to share his feelings of anger or sadness for example, are for Beck (1976) an opportunity for clients to gain awareness of alternative ways to express their feelings. He states that a therapists' ability to model their feelings enables a client to imitate and practice similar skills, and ultimately aid in the integration of personal growth and development (Ballou, 1995).

Extract 3- Anna. Anna shared an alternative experience of modeling, where she expressed the importance of representing a non-judgmental, empathic stance to clients' feelings, in order to encourage similar behaviour in them.

I think certainly being able to model feelings of empathy and understanding is so important for these clients as they are just so hard on themselves. Often as a facilitator, I think our biggest job is to show them that we accept them, we do not judge

them, and hopefully by us doing that they learn to be kinder to themselves. (Transcript 6., pg4., l 197-200).

Anna perceived this particular client group to lack empathy and compassion for themselves, specifically when she described 'they are just so hard on themselves'. In her experiences illustrated above, she believes that by modelling an empathic, accepting and non-judgmental stance, clients will learn to be kinder to themselves. Experiences like Anna's draw on theories which explore the use of the self in therapy. In amongst the literature, the notion that the therapist acts as a model is supported. Baldwin (2013) for example, argues that when the therapist listens acceptingly to clients' experiences, they model non-judgmental, compassionate behaviour and clients learn new alternative ways to approach themselves and their difficulties.

3.5.4 Subordinate theme 4: 'Expose the anorexia'. The following extracts have been chosen to demonstrate five out of a total of eight participants who shared their observations of the benefits of separating individuals away from their anorexia and focusing on their other, healthier side. The extracts deem anorexia a 'sham friend', and discuss the negative connotations of labelling clients by their disorder.

Extract 1- Megan. Megan provided her experiences of focusing on a clients' values in order to expose the anorexia as a 'sham friend', which the clients believe helps solve problems, but instead compounds them and hinders their ability to act in accordance with their true values.

Exposing the anorexia for what it is, which is just a sham friend that pretends it's solving problems when it actually solves nothing. So, it's about constantly exposing that and constantly looking at, what are your real values? What are your real personal values about yourself as a person that your 'friend' the anorexia sabotages? So,

getting away from all of the anorexia and trying to understand, why did you develop this? Who were you before all of this? What other path could you have taken? Doing all of this takes time, but hopefully then a client will be more confident in letting go of their illness, and not aligning themselves with it so much (Transcript 4., pg6., l 263-271).

In the above extract Megan shared her experiences of facilitating clients' movement away from their anorexia and towards a focus of understanding and a focus on values. She explained that by placing emphasis on the negative attributes of the disorder, and focusing on individuals 'real values', clients are better able to explore alternative paths, and see their illness for 'what it is'.

Similar to Megan's experiences, it is common that anorexic sufferers will perceive their illness as a friend (Noordenbos, 2013). Clinical research into the treatment of eating disorders and anorexia specifically, emphasise the importance of confronting clients with the negative implications and consequences of their illness, on a physiological and psychological level, to support them in perceiving the anorexia as more an enemy than a friend (Tierney & Fox, 2009).

Megan explained that encouraging clients to move away from their disorder and see it for 'what it is', takes time. She articulated that clients need to build 'confidence' in aligning themselves away from their illness, Sarah shared similar observations.

Extract 2- Sarah. *I sometimes say to their eating disorders; it's valid, you're here, I'm not going to kick you out of the room. I think this helps as sometimes clients can feel threatened that you're ganging up on their eating disorder, so I make sure I acknowledge it. I talk very openly though about the fact that there are two parts of them, and I want to talk to the other healthier part of them. I say to them; I don't*

believe the anorexic you is the real you but I understand that it came along as some kind of help but actually, it's got a non-helpful side as well. Definitely recognising why they hold onto to it so much is very important, and then you can think of ways to replace it with more helpful strategies (Transcript 2., pg5., l 229-237).

Sarah recounted her experiences of the importance of acknowledging the eating disorder in amongst treatment, and accepting the helpful role it is perceived to play in clients' lives. She emphasised that if she did not acknowledge the presence and value of the disorder, clients are likely to feel threatened and protective of it. Sarah explained that from her perspective, clients remain focused on the helpful role the illness plays, and feel concerned at their ability to cope without it. Warin (2010) suggested that clients are unlikely to experience their anorexia as unwelcome, and instead may perceive it as an integral part of themselves, and something of which they share a relationship. From this perspective, Sarah detailed that from her experiences, by acknowledging the helpful nature of the disorder, clients may be more willing to think collaboratively of alternative ways to cope, and begin adopting more helpful strategies. It is with this in mind that Sarah's experiences seem to emulate those of Boughtwood, Halse, & Honey (2007), who stipulate that the best course of action towards change in eating disorder treatment is to see the anorexia as both a friend and an enemy.

Extract 3- Anna. In the following extract, Anna shares alternative experiences of the importance of exposing or 'separating' the anorexia in clients, in order to encourage them to move away from their illness and towards change.

It's a pet peeve of mine, but we often call people anorexic and actually being able to separate that and lead it away from the client is really important because we're

already defining them as the whole disorder, when they're not, we need to remind them they are people too (Transcript 6., pg5., l 226-229).

It can be understood from Anna's narrative that, from her perspective the diagnosis of anorexia has negative implications for treatment, as she describes this as a 'pet peeve'. She explained that labelling someone as 'anorexic', as per their diagnosis, discourages clients from being able to consider themselves separate from their illness, and instead is considered to be a defining aspect of them. Her experiences are shared in Duchan & Kovarskys' (2005) accounts of the implications of diagnosis in practice. They argue that diagnosis can represent an integral part of one's identity, how they see themselves and their likeness to others. Whilst it is suggested that on occasion the impact of a diagnosis can be a positive one, in the experiences described by Anna, the implications arising from a label of this kind can be seen to be greater than the perceived benefits of categorising someone in this way.

Chapter 4: Discussion

4.1 Introduction to the Discussion

The following chapter presents an overview of the findings from the analysis, and implications for theory are discussed. The relevancy of the findings to Counselling Psychology are outlined, and the implications on clinical practice are addressed. This chapter aims to provide recommendations, following the findings produced by the analysis, towards the development of group treatment for those experiencing anorexia. Considerations for future research are presented, following a critical evaluation of the current study, addressing its strengths and limitations.

4.2 An overview of the Findings

To recall, the aim of this study was to explore psychologists' experiences of facilitating group therapy for those suffering from anorexia. It endeavoured to gain an understanding of what the participants' experiences were whilst working with this particular client group, together with the challenges they may encounter. A secondary consideration was the perceived benefits and pitfalls of working in this context.

Initial findings of the research saw participants 'labelling' clients as 'anorexic' in their narratives, it is possible that they did so in order to support their claims and somehow provide further insight into their experiences. It became apparent through all eight of the participants' accounts, that there was an 'understood' underlying assumption of the 'typical' anorexic presentation, it is possible that they used this to guide their narrative and descriptions of their experiences. This became the precursor, overarching theme which encapsulated the three superordinate themes generated from the participants' narratives. Subsumed within each master theme were a range of emotional experiences presented by the participants, and whilst these were observed to

be varied, it was interpreted by the researcher that they all had one similar theme, that their understanding of 'anorexia' was at the centre of their experiences.

The analysis provided a multifaceted view of the impact being treated within a group has on the individual. Phenomenological accounts proposed that the experience of being in a group can aid in decreasing one's isolation; a value shared by all eight of the participants. The findings suggested many positive outcomes for clients meeting others who share similar difficulties, and seemed to be particularly beneficial in motivating change and instilling hope. Contrariwise, the analysis suggested that individuals' want to 'fit in' and be a 'part of' the group, and the competition that is perceived to take place between group members, can be seen to have possible negative implications within a group setting. These findings were closely linked to the group therapeutic factors put forward by Yalom (1995) and Yalom & Leszcz (2005), and Wanlass et al (2005) observations.

The findings highlighted in the first superordinate theme 'Connecting with others' emerged with the aim to answer the following established research question, 'what do psychologists perceive to be useful and not so useful about running therapeutic groups for those experiencing anorexia?' It was within this theme that the idea of 'connecting with others' or 'coming together', was explored. A strong sense of unity and 'togetherness' was illustrated across the participants' accounts. They drew on their observations of clients benefiting from the interaction of others and the impact it has on decreasing isolation. The participants placed particular emphasis on the group's ability to provide social relationships, which clients may be lacking in their personal lives. It could be considered, that the profound sense of loneliness that the participants observe for their clients, may also be stimulated as a result of stigma or shame surrounding their presenting difficulties. It is with this in mind, that meeting those who share similar

difficulties may help individuals overcome this proposed sense of shame, and in turn decrease their isolation. The idea that the group can support in disconfirming individuals' beliefs around being alone with their illness was supported by Laberg, Tornkvist, & Anderson (2001) in their study on eating disordered sufferers' experiences of group CBT, and Spragg & Cahills' (2015) findings on the impact of group treatment in reducing shame in OCD clients.

The idea of 'coming together' and the general sense of unity was emphasised in participants' narratives, particularly surrounding their perceived sense of group cohesion. According to Bieling et al (2006), a sense of cohesion in a group will often develop when individuals feel mutually supported. Participants' described their observations of the impact sharing with others has on individuals' sense of commonality, and how this can evolve to introduce a unique level of support. Philips (2009) supports such an assertion, and argues that isolation from self and others is the most pervasive experience in those struggling with mental health difficulties. Instilling connection between those struggling, and encouraging interaction in a group setting, is fundamental for recovery (Wanlass et al, 2005).

Whilst it was not one of the stronger themes, with only four participants making inferences to it, the theme 'the group- a symbol of family' was addressed. This theme drew on participants' experiences of the group dynamic representing similar dynamics found in one's family and social networks. Yalom and Leszcz (2005) term this concept 'the corrective recapitulation of the primary family group', a therapeutic factor in which details the reenactment of precarious family dynamics with peers in group treatment. This reenactment gives the opportunity for family conflicts to be relived in an alternative way, or as Yalom and Leszcz would deem it 'relived correctly' (2005, pg.16). The group is understood to provide clients the opportunity to be exposed to

emotional situations in the here and now which replicate past experiences of which they were unable to deal with. In order to profit from the interactions and representations in the here and now, and engage in corrective experiences, Yalom & Leszcz (2005) argue that awareness, insight and interpretation, typical to the work that takes place in an individual setting, are insufficient, and the relational aspect, unique to group therapy, is paramount in challenging clients' beliefs and dysfunctional relational patterns.

Throughout the remainder of the analysis, the participants voiced their concerns of the group dynamic, which served to answer the research question; 'what do psychologists perceive not be to useful about running therapeutic groups for anorexics?' These concerns were understood to provide insight into the implications for clinical practice.

Being fearful of moving away from behaviours which are causing signifcant impairment due to them being deemed 'valuable' by an individual, as cited by Nicole in her narrative incorporated within the theme 'Resistance', is similar to Freud's perspective where lies the question; 'why don't people change symptoms which create such distress?' (Engle & Arkowitz, 2006). Within this body of work, this type of ambivalence is understood as a form of resistance which is said to occur to reduce anxiety produced from the awareness of unconscious conflicts (Engle & Arkowitz, 2006). When considering Nicole's experience from this perspective, clients' value of their illness could be a form of resistance against the internal, underlying conflicts and distress.

Another pivotal concern put forward by six of the participants was the idea of clients having to 'fit in' in the group. It can be considered that Lisa's experiences echo the challenges faced within subgrouping. Subgrouping is considered the 'splitting off'

into smaller units away from the entire group, and is most commonly observed within inpatient settings (Vinogradov & Yalom, 1989; Wanlass et al, 2005). In the case illustrated by Lisa, the whole group appears to include a subgroup which consists of those who perceive their recovery to exist only when in accordance with others. She described the tension for individuals to move away from the group where belonging is at its height, and instead focusing on their own recovery independently of the other group members.

As Lisa asserted, fitting in or belonging within a group is seen as 'human nature', something which lies innately within all of us. With this is mind, existing in the predominant subgroup will undoubtedly be of paramount importance, and moving away from this group may cause anxiety for individuals (Rose, 1998). This phenomenon of in-group versus out-group is understood within social psychology literature. Theorists state that group behaviours such as subgrouping derive from the 'depersonalisation of the self', where there is seemingly no separation between the group and the self, meaning that the self representation becomes a 'collective self' (Hogg & Abrams, 1988). When the representation of the self is made up of in-group identification, separation from such grouping is challenging. Likewise, interpretations were considered alongside Bion's theory on group process. The observed pressures of the group, noted by Bion, can generate an implicit pull for cohesiveness, and as a consequence, difference or uniqueness in a group is considered dangerous and subversive (Bion, 1977). Likening this to Lisa's experiences, she observed particular individuals who need to move away from the group in order to pursue their own recovery, however acknowledges the pressures of not being able to do so.

Pro-ana ideologies are most often seen on internet websites, blogs and other virtual tools, which generate forums for individuals with anorexia, and encourage the

glamorisation, glorification and competition of the illness (Brady, 2015). Much like the experiences of Anna and Lisa proposed in the sub-theme 'The power of the group', pro-ana forums see collusion and collaboration of distorted beliefs and viewpoints when individuals come together, which is argued to lead to the maintenance and reinforcement of the disorder (Hall & Ostroff, 2013; Bieling et al., 2006).

Various theorists have commented on such a notion, and argue that the presence of pro-anorexic ideologies is not always a conscious resistance and defiance of professionals, thereby it cannot be implied that the creators of such web-forums for example intend to engage in resistance, even if the outcome cultivates such feeling within the online community (Bobel & Kwan, 2011). There is limited research on the impact of pro-anorexia ideologies on group treatment, but remains to be a compelling and complex predicament in the eyes of the participants.

4.3 Implications for Theory - Labelling Theory and its Relationship to Mental Health Disorders and Counselling Psychology

Since the 1960s, the concept of labelling, originated from a sociological constructivist perspective, has advised medical practice and has been used to consider the 'symbolic meaning of health and illness' (Crinson, 2007). From this viewpoint, the theory of labelling sought to understand the experience of those who are, or deem themselves to be, 'sick', considering both physical and social implications.

Labelling theory, as initially posited by Becker (1963), places emphasis on deviance, and more significantly, the 'rules of deviance'. He argues that individuals will hold specific connotations, and enforce particular labels towards groups, or individual group members, who 'deviate' from the norm. Becker (1963) states 'deviance is not a quality that lies in the behaviour itself, but in the interaction between the person who

commits an act and those that respond to it'. Thereby, it can be understood that labelling theory places focus on the collective reaction towards specific deviant behaviour.

The work of Lemert (1967) proceeded Becker, and shared insights as to the significance of individuals' reactions to deviant behaviour. He asserts that individuals' evaluation, judgments or labelling can have considerable consequences for the deviant individual, particularly in altering their self-esteem and social status. When considering these perspectives in the context of medical practice, professionals embark on a process of categorisation, and in so doing individuals are labelled as either 'sick' (classifying those who deviate from the 'norm'), or healthy (Crinson, 2007). It is within this process that the act of deviance is represented by a diagnosis, through which stereotypes are carried.

Existing literature asserts that the implications of labelling and the negative stigmatisation of individuals who qualify as mentally ill, irrespective of their specific diagnosis or level of severity, is more acute than the experience of those presenting with alternative health conditions (Corrigan, 2004). Taking this into consideration, the role of the psychiatrist in diagnosing mental illness is a significant one. Labelling theory stresses that, being given a mentally ill diagnosis, an individuals' identity is consequently altered and will have considerable implications on how they are treated; both interpersonally and by professionals involved in their care (Crinson, 2007). This seemed to be the case for many of the participants in the study. Louise for example made reference to her experience of 'people with anorexia' as not having 'many social skills', this generalising, labelling statement infers something about the identity of those suffering with anorexia, which may inform the way Louise works with these particular clients. Likewise, various participants commented on the perceived 'perfectionism' in anorexia, and how this can stimulate ambivalence towards getting better. This

assumption, put forward by Megan for instance, has the potential to cause her to alter the way that she works with these clients.

It is with this in mind that clinicians and academics have criticised the role of diagnosis in mental health, and its implications on treatment specifically. Extensive debate has been carried out as to the role the medical model plays in treating those with mental illness. Crinson (2007) for example, argues that specific diagnoses for mental disorders are given to 'label' individuals, however Goldberg & Huxley (1992) emphasise the importance of such 'labels' in supporting the development of knowledge, providing clinicians a greater understanding of the aetiology of disorders and the most appropriate treatment methods. In support of such a claim, all of the participants commented on the observed benefits of group treatment in decreasing clients' isolation. It could be suggested that, without an understanding of the isolation that anorexia is commonly associated with, group therapy may not be considered the most effective treatment approach (Wanlass et al, 2005), and therefore clients would not benefit from the interaction with others.

Much of the debate surrounding diagnosis and classification descends from the ever growing role and function of the diagnostic and statistical manual of mental disorders (DSM; APA, 2013). Significant exploration has gravitated towards the distinct boundaries that exist between different disorders. Both nosologists and clinicians more generally have shown substantial interest in establishing clear and correct classifications for mental health presentations, in a bid to make clinical practice 'easier' (Main-Banzato, 2008). With this in mind, the DSM-V was constructed to address the 'gap' in the DSM-IV, incorporating up-to-date scientific and clinical evidence. The development of a new DSM was to certify the best possible approach to care for clinical populations, and advance the usability for clinicians (Regier, Kuhl, & Kupfer, 2013).

Critique of the DSM saw the 'overemphasis on classification' being of detriment to the process of assessment, where the comprehensive clinical picture of the patient is not being captured (Mezzich et al, 2003). The International Guidelines for Diagnostic Assessment (IGDA) aimed to build on traditional diagnostic tools such as the DSM, to incorporate an assessment of quality of life and an idiographic formulation (Mezzich et al, 2003). Furthermore, the use of the DSM in approaching mental health problems is considered to be incongruent with the identity and common practices of counselling psychology (Eriksen & Kress, 2006; Connolly et al, 2014).

Prior to the 1950s, psychologists perceived effective treatment methods for mental distress to be largely scientific in their nature (Strawbridge & Woolfe, 2010). Following which behavioural, humanistic, and relational thinkers led the discipline away from the medical model. They sought to develop alternative ways of working with mental disturbance, in an attempt to move away from preliminary diagnosis and its held preconceptions, and towards a new psychosocial approach to understanding mental health. Rogers (1951) was one of the lead theorists to establish the 'humanistic movement', which emphasised the conceptualisation of the 'self' as individual, as opposed to a pathologised 'self' (McLeod, 2003). Strawbridge and Woolfe (2010) claimed that the counselling psychology discipline emerged from this particular school of thought, and was motivated by those who considered individuals' subjective experiences to be fundamental in psychology. The underpinning position of counselling psychology was based largely on the notion that 'we must not assume one way of knowing', whilst also being grounded in the scientific practitioner model (Lane & Corrie, 2006), and recruiting its knowledge base from psychology (Barkham, 1990).

Discussions around the role 'disorder' and diagnoses play in the counselling psychology discipline takes place in the handbook of counselling psychology, and its

chapter on disorder and discontent (Woolfe, Strawbridge, Douglas, & Dryden, 2009). Here, the notion that disorder can evolve into descriptors of 'personhood' is presented. Authors posit that with such an acceptable and generalisable framework, seen common place in clinical and societal spheres, terminology such as 'anorexic', or 'psychotic' for instance, is used readily, and its impact on the development of a stigmatised personhood, is paid less attention (Woolfe et al, 2009). They addressed the implications of identification via diagnoses on one's ability to move away from their distress. In the context of those suffering from anorexia for example, Woolfe et al (2009) suggested that individuals may struggle to widen their identity and extend it beyond their anorexia, when clinicians perceive them as 'anorexic'.

Whilst significant strides have been made in counselling psychology to position itself away from the use of diagnosis in assessment and formulation, it has nonetheless been argued that directly opposing the DSM would be ineffective due to its political position, and would risk counselling psychology being marginalised professionally (Connolly et al, 2014; Sequeira & Van Scoyoc, 2002). As such, this can present as problematic for manly counselling psychology practitioners.

Likening this to the findings produced in the current study, Anna shared her frustrations of labelling clients' and defining them as the 'whole disorder'. She emphasised the importance of reminding clients that they are 'people too'. This account stresses the significance for clinicians to not only consider clients as individuals as opposed to a group of people who fit within a diagnostic criterion, but also, in turn, to remind the client that they are more than just their illness. This experience illustrates how applying a broad diagnostic label to understand an individual's mental distress can be detrimental to the way clients' identify with their diagnosis.

4.4 Implications for Theory- Labelling Eating Disorders

The use of labels within eating disorders is thriving, with the diagnoses anorexia nervosa and bulimia nervosa being common place in clinical discussion, in the media and society more generally. The use of such labels within this domain is perceived to have both positive and negative implications, according to existing literature.

The literature determines the positive use of a diagnosis as a label to support those in facilitating communication surrounding this particular set of difficulties, and is considered to be advantageous in encouraging further investigation and research into the development of the disorders and effective treatment options (Ross, 1980; Hobbs, 1975). Hobbs argued that "classifications is essential to human communication and problem solving; without categories and concept designators, all complex communicating and thinking stops" (1975, pg5). With the support of the DSM-V (APA, 2013), the complex and diverse behaviours and beliefs that underpin anorexia nervosa including; persistent restriction of daily intake of food, significant weight loss, an intense fear of weight gain and a disturbance in body image, have been organised into clinically meaningful patterns which form the current diagnosis (Smead, 1985). In the findings produced from the analysis, the subtheme 'self doubt' was created to encapsulate the experiences of the participants' in describing feelings of self doubt elicited from facilitating group therapy. In the case illustrated by Sarah, she articulated her feelings of self doubt and concerns of 'not doing enough' in relation to her understanding of the 'anorexic' client group, and their suffering. In this instance, it is possible that the categorisation and shared understanding of the 'anorexic pathology' supported Sarah in making sense of her own experiences when working with this population.

Conversely, alternative research addressing the impact of labelling in adults and children with disabilities and other related difficulties, is presented (Ross, 1980; Asch, 1984; Szasz, 1960). These findings considered the possible 'pitfalls' of labelling from the perspective of Hobbs (1975), who argued that labels and equivalent categorisation either 'say too little or say too much' about individuals. The idea that labels may imply 'too little' is consistent with findings that suggest that diagnoses, specifically anorexia and bulimia, have been considered to conceal the individual and unique attributes that make up those who have been given such a 'label', which can have various implications on 'de-humanising' the individual (Smead, 1985). In this case for example, a label of anorexia aims to establish commonality between sufferers who have similar fears of weight gain, restrictive dietary behaviours and distorted body image. It is not however intended to communicate something about all sufferers alike, and the concern is that the individual differences of each person will be overshadowed by the generalisability of the label and its associations (Hobbs, 1975).

Megan described her experiences of ambivalence towards recovery when working with this particular client group. She explained that, from her perspective, there is 'a part of them that want to sabotage the group a lot of the time'. Whilst it is probable that Megan has many experiences to support such a claim, she, perhaps unintentionally, generalises the client group and assumes something of all individuals experiencing anorexia. The individual differences, as discussed previously, may include significant levels of motivation towards recovery with an absence of ambivalence, however Megan's experiences do not appear to consider such variances.

The DSM-V (APA, 2013) emphasises that those sharing the same diagnosis are not necessarily 'alike', and reflects the significance of considering individual differences due to the impact these differences may have on one's clinical presentation

and the effectiveness of treatment outcomes. With this in mind, perhaps this needs to be brought to the attention of those who then use these diagnoses, such as the participants in this study for example, in part, to inform their understanding of groups of individuals, focusing on the language they use to describe these individuals.

According to Ross (1980), individuals use of language is considered to have a significant effect on the difficulties; as previously highlighted; associated with labelling. For simplicity and efficiency clinicians and lay persons will describe those who, for instance, are experiencing symptoms of anorexia, as 'anorexic'. Although these may appear as descriptors of two sides of the same coin, the connotations ascribed to these two identifiers may be considerably different. The first suggests an individual who is independent of their difficulties and the label associated with it, the second implies an overall sense of identification and loss of independence from the label.

The language used throughout the current study was of significance, particularly in the way the participants described the client group. It is possible that the participants used the term 'anorexic' or 'anorexia' as a shorthand way of describing this particular client group, however it is also possible that with this shorthand, came a set of assumptions and underlying beliefs about these particular individuals that informed their experiences. Possible limitations of the researcher's use of language will be discussed further in the limitations section of the discussion.

4.5 Implications for Clinical Practice

4.5.1 Language. In terms of the already explored impact of diagnosis as a label on clinical populations, and specifically anorexia, it would be useful for practitioners to be aware of the language they use to frame this specific client group. As previously addressed, all of the participants in this study reflected, some more so than others, a

sense of their understanding of the 'anorexic pathology', and used this to support their individual experiences with this population. It could be considered advantageous to readdress and negotiate the expectations and assumptions they hold in a bid to support these clients, to ensure they do not 'assume' something of the individual, and to avoid the understood negative implications of labelling through diagnostic criteria. In addition, if clinical staff endeavoured to alter the language with which they describe this specific client group, literature supports a more positive outcome towards a clients' sense of identification of their illness (Ross, 1980).

4.5.2 The structure of the group. As proposed by the participants in the theme 'Connecting with others', and further supported by existing literature (Spitz & Spitz, 1999; Yalom & Leszcz, 2005), the groups ability to normalise experiences, and in turn reduce shameful feelings surrounding these experiences, was addressed. Matt suggested that in order to encourage the process of sharing, which can cultivate a normalisation of shameful feelings, emphasis of the 'frame' in which group therapy is carried out was considered integral. He asserted that the facilitators' responsibility was to ensure that within this 'frame', the maintenance of structure and containment in the group space was assumed.

Existing literature extended this assertion, and emphasised the importance of sustaining boundaries in the group (Howard, 2009). For Birmingham and Treasure (2010), maintaining clear professional boundaries is imperative in the treatment of eating disorders and anorexia specifically, in order to ensure there is a focus, for both the client and the professional, as to the treatment of care. Without suggested boundaries, it is considered difficult for professionals to set effective limits that support the recovery of the individuals (Birmingham & Treasure, 2010). Therefore, it could be useful for practitioners to ensure explicit group 'rules' are communicated clearly and

abided by, including but not exclusively, absence policies, the significance of being active in the group, and the importance of confidentiality (Kleinberg, 2015). Thereby ensuring feelings of safety and containment for the group.

Likewise, existing literature encourages open dialogue if there are any changes to the 'frame' (Hardy et al, 2007). With this in mind, it may be considered useful for facilitators to encourage group members to explore their feelings towards, for example, a group member's absence, and/or when someone leaves or joins the group. In so doing, the group may feel more supported and contained by the clinical staff.

4.5.3 Interventions. When reflecting on how the participants' narratives could have implications on clinical practice, several valuable interventions were highlighted. Alongside previous comments on the benefits of the group in normalising individuals' experiences, several participants voiced their perceptions' on the role the therapeutic relationship plays in aiding this process. Within the subtheme 'Create a safe space', participants shared their experiences of the perceived benefits of practitioners reflecting an empathic, non-judgmental stance to clients' experiences, and how this could benefit the normalisation process. The narratives were considered alongside Roger's (1951) determinants for therapy, and his proposition towards the value of an empathic stance in helping clients perceive their difficulties in an alternative way (Rogers, 1951). For those suffering from anorexia specifically, feelings of being understood by the therapist is considered to be particularly supportive in encouraging progression in treatment, and is seen as 'to be understood is to be vulnerable to control' (National Collaborating Centre for Mental Health, 2004). It could therefore be considered advantageous for facilitators of group therapy for those experiencing anorexia to recall Roger's determinants for therapy (1951), and to reflect an empathic, nonjudgmental approach when appropriate.

In a similar vein, participants' findings placed significant emphasis on practitioners' ability to 'make the unspoken, spoken'. Within this subtheme the idea that clinicians should 'break' the observed 'rules' of the group, which permit some things to 'not be spoken', was explored. With this in mind, it could be considered useful for facilitators to observe what is 'unspoken' in the group and address these concepts, and as Matt implied 'make it transparent and known'. For future clinical endeavours, it is possible that group members will avoid addressing the more 'shameful' parts of their illness, aspects in anorexia commonly seen as the compensatory behaviours associated with the illness (Sanftner et al, 1995). These include, purging behaviours, excessive exercise, and other attributed behaviours such as weighing themselves and calorie counting (Fairburn, 2008). According to these findings, it may be valuable to address these concepts in an open forum from the outset, in order to encourage transparency in the group.

The findings produced from the participants' accounts saw both positive and negative experiences, as a result of the groups sense of cohesion. In one respect, many participants shared their experiences of the group cultivating a supportive dynamic, where group members encouraged each other, and provided a 'different type' of supportive relationship, compared to that of the practitioner and the client. Subsequently, it may be useful for facilitators to remain mindful of the positive interactions between group members, and encourage member-to-member support when appropriate. For instance, pair work is considered an effective way to encourage interactions (Argyle, 1973). Conversely, participants shared their concerns of the negative impact group cohesion can have on individuals' recovery. Lisa shared her experiences of the negative implications of a 'we're all in this together' mentality in group treatment for those suffering from anorexia. With this in mind, it may be prudent

that clinical staff stress the importance of remaining independent in one's own recovery journey, to ensure than each group member maintains a focus on moving forward despite what their peers may or may not be doing.

In addition to the proposed skills and interventions elicited from participants' accounts detailed above, was the idea of modelling feelings. Within this subtheme, participants shared their experiences of the perceived benefits of sharing their own feelings and vulnerabilities in order to encourage group members to feel safe enough to do the same. Within participants' extracts, the notion that by reflecting openness, transparency and vulnerability, a sense of 'its ok to feel', is generated. According to Wildes, Ringham, & Marcus (2010), anorexic suffers are likely to experience a numbness and/or disconnect towards feeling and emotion, and anxiety towards regaining their experiences of emotion is heightened. This more compassionate, accepting stance may be considered useful to demonstrate to clients, with the aim that this may encourage more compassion and acceptance in themselves.

The idea of promoting acceptance was widespread amongst the participants and echoed the benefits put forward by the existing theoretical approach; acceptance and commitment therapy (ACT). Within this comprehensive model for therapy lies a focus on values (Hayes & Lillis, 2012). Participants such as Megan articulated in her narrative the importance of values in aiding in change. She explained that encouraging clients to explore their personal values aligns them away from their eating difficulties. Broadly, theorists support Megan's notion that a focus on values can support in change for anorexic sufferers, by adapting behaviours that interfere with their values (Sandoz, Wilson, & DuFrene, 2011). It may be considered prudent therefore for future clinical endeavours to review the ACT model, and consider ways to incorporate this mode of

therapy, in order to challenge clients' positive perceptions of their eating disorder, as proposed by the participants, and instead vitalise them towards change.

This idea that clients' place a 'positive spot' on their eating disorder was discussed extensively throughout participants' narratives, and key ways to manage this were addressed. In the subtheme 'Expose the anorexia', participants' described the importance of recognising the perceived helpful role and value clients place on their illness. The participants shared their experiences of clients becoming protective or defensive of their eating disorder, should clinicians not reference the importance of it in their individual circumstances. It may be useful therefore that facilitators acknowledge the presence and importance of clients' eating difficulties, whilst considering the negative implications of their current state. Motivational interviewing encourages exploring both the pros and cons of change to address this predicament, and is seen to have an advantageous impact on clients feeling understood whilst also motivating them to move forward, away from their eating difficulties (Miller & Rollnick, 2012).

Existing literature suggests that the effectiveness of group treatment for those suffering with anorexia is based largely on its group members (Wanlass et al, 2005; Corey & Corey, 2006, Rich, 2006). Participants in this study provided a plethora of accounts describing the implications of peer interaction in the group dynamic. They provided in their observations the perception that clients benefit from interacting with those who are in a different place to themselves. Specifically, Megan provided an example of a client's accounts of her experiences which illustrated movement away from her eating difficulties. Megan suggested that this gave the other group members hope that they could also achieve a similar experience should they continue moving towards change. This notion of the instillation of hope was considered an intrinsic therapeutic factor for Yalom & Leszcz (2005). Therefore, in future clinical practice it

may be considered beneficial to have 'recovered' individuals share their stories with group members, addressing their journey through change and what they have been able to achieve.

4.5.4 The relational approach. It was explicit through many of the participants' accounts that paying attention to the relational dynamics amongst the group members was integral. An interesting theme that permeated the findings was that of 'the group- a symbol of family'. Within this theme, participants' accounts eluded to the dynamic activity in the group representing that of an individual's relational patterns outside of the treatment setting. Future clinical practice may want to consider this interpretative approach when exploring the dynamics in a group, as it may provide further insight into individuals' relational conflicts more generally.

Exploration of the dynamics within the group was considered advantageous in the theme 'Addressing the elephant in the room'. Participants shared their observations of the benefits of being attentive towards group dynamics. They proposed that initial interpretation by the facilitators is necessary, following this, they will then feedback to the group their observations. It is with the intention, as proposed by the participants, that the group community explore some of the more unhelpful dynamics that may be at play; such as competition (Fairburn, 2008). Vandereycken (2011) explores competition, comparison, and social contagion in group therapeutic settings for anorexic sufferers and argues that these concerns have the potential to exacerbate eating disorders and jeopardise recovery. It is important that facilitators consider the consequences of not addressing such dynamics, and the impact this could have on the group process and the group members individually. If, for instance, the clients become very competitive, this could, without appropriate interventions addressing such behaviour, lead to internalising negative feelings about oneself, resulting in further unresolved conflict.

4.6 Critical Appraisal of the Study

4.6.1 Strengths. As previously addressed, the research findings produced from participants' accounts have presented possible changes and areas for development of the structure of the group and interventions implemented by facilitators.

Various individuals that agreed to participate in the current research have also made contact to receive feedback on the overall findings of the study. Their continued involvement and keen interest in the outcome of the research suggests a curiosity as to how the outcome could support them in their continued professional development, and aid in the improvement of the quality of care and clinical practice. This type of reflective practice is seen as a valuable component in developing clinical practice in mental health provisions and healthcare more generally (Reid, 1993). According to Schon (1983), a practitioner adept in reflective practice will continually reflect on his or her experiences, showing an impetus to learn for the benefit of future actions. Reflection of clinical experiences as opposed to a more formal academic learning, is regarded as the most valuable source for clinical and personal development (Jasper, 2003).

Critique of qualitative research is commonly placed around the subjectivity of the findings (Spagg & Cahill, 2015). However, as previously established in the methodology, it was the intention of the research to provide a detailed, rich account of the experiences of the psychologists that were recruited as a part of the particular subject group, but did not claim to say something about all psychologists alike. To restate, it was not the intention of this research study to produce transferable, generalisable findings or causal results, but aimed to provide insight into the experiences of psychologists in this context. Criteria traditionally set to ascertain the strengths of a study's findings are reliability, validity and generalisability, however these conditions are more meaningful in quantitative approaches and have less emphasis

in qualitative research (Willig, 2001).

The quality of enquiry does however have to be assessed in qualitative research, despite its subjectivity, Henwood & Pidgeon (1992) established clear guidelines in order to do so. One particular condition put forward by Henwood & Pidgeon (1992) was considered extensively in the process when carrying out this research, the 'importance of fit' criterion stressed the significance of reviewing the analysis with the support of independent readers, as noted by Spragg & Cahill (2015). The project supervisor played a pinnacle role in reviewing the suitability of the themes, their titles, and the following subthemes, and paid close attention to the relevance of the example extracts and the even distribution of the participants' through the analysis. In addition, further criteria insist on the 'integration of theory' in the research. The research saw assimilation of various theoretical perspectives, including CBT for eating disorders (Fairburn, 2008), the person-centred approach to therapy (Rogers, 1951), Bion's theory on group process (1961), a sociological perspective on the theory of labelling (Becker, 1963), and the theory and practice of group psychotherapy (Yalom, 1995; Yalom & Leszcz, 2005).

Participants subjective experience was at the forefront of this study, as stressed by the IPA methodological approach chosen. As a Counselling Psychologist researcher it was particularly important to engage in a rich and in-depth exploration of individuals' experiences (BPS, 2005). Evidence of this process was seen through many phases of the research, particularly within the recruitment process. It was integral to ensure participants felt that they were partaking in the research voluntarily, in order to support the subjectivity of their accounts, as observed in the study by Spragg & Cahill (2015). A comprehensive information sheet was supplied to many practitioners, to support them in understanding the nature and expectations of the study, and to encourage those who

were interested in taking part to step forward voluntarily. Subjectivity was also greatly considered within the interview schedule, and the use of open-ended, non-directive questioning. This was essential to create an opportunity for participants to direct the interview dependent on their individual experiences (Smith & Osborn, 2003).

As previously mentioned, being reflective is considered fundamental in all clinical endeavours (Jasper, 2003), alongside which, reflexivity is also of paramount importance when engaging in research. To restate, this investigation, which assumes a critical realist position, placed emphasis on personal reflexivity which attended to the researcher's role in the study, as a Counselling Psychologist researcher; making herself a distinct and visible part of the process. In addition, personal reflexivity aims to generate an understanding of the emotional involvement the researcher has in the project (Clarke & Braun, 2013), and as Elliott et al (1999) would state 'owning one's own perspective'. This was accomplished by engaging in reflexivity at various stages of the research process. It was ensured that the beliefs and assumptions held by the researcher, which would ultimately influence the findings, were made known to the reader (Landridge, 2007; Spragg & Cahill, 2015). For instance, in the description of the interview phase of the research, the implications of the researcher's pre-existing assumptions on the interview process were addressed, particularly the lack of exploration into the detail of a participant's account. It was noted how this understanding provided the researcher the opportunity to develop her interview skills.

4.6.2 Limitations.

4.6.2.1 Participant sample. Following an IPA methodology meant that exploration of participants' individual subjective experiences was at the forefront of the investigation (Biggerstaff & Thompson, 2008). The aim of the research was to gain an

in-depth and rich understanding of individuals' 'lived reality' (Wertz, 2005). Through the initial stages of the analysis reflection as to whether the findings lacked this level of detail was illustrated. Following Smith et al (2009) guidelines on interpretative analysis, key descriptive, linguistic, and conceptual concepts in the transcripts were highlighted. It was observed that the analysis was lacking in the linguistic detail of the findings.

Through discussion with the project supervisor, it may be possible that, due to the participants' sharing their observations of how clients may experience group therapy, the more emotive language to describe their own experiences, in some cases, was lost. Participants' largely commented on how clients experience the group, as opposed to how they experience the group, this was therefore less likely to evoke emotive responses. This was particularly evident in the subtheme 'Self doubt', where participants shared their accounts of feelings elicited when working in this context. It was here that a greater level of emotional language was observed and interpreted, than in other areas of the findings. It could be considered that when qualitative research is carried out exploring the perspectives of the facilitators of group therapy, the participants pay close attention to their own unique experiences, as opposed to their interpretations of clients' experiences. Examination of the chosen interview questions could be considered in order to understand this limitation.

4.6.2.2 The role of the researcher. Several considerations of the role the researcher has played in various stages of the research have been addressed. Initial reflections deliberated the ability to 'bracket' one's own assumptions as to the nature of the study (Ahern, 1999), taking into account the extensive experience the researcher has obtained in this field. McLeod (2001) claims that the bracketing of one's assumptions is a challenging process when the researcher is also a therapist, and has a developed

sense of their preferred theoretical orientation and ways to understand mental distress, and the best approaches to enable change.

As previously noted, the researcher has, for several years, facilitated group therapy for those experiencing anorexia, and therefore holds her own beliefs around the benefits and pitfalls of working in this context. She made reference to the impact of her own assumptions in earlier reflexivity sections, this included the inclusion and exclusion of various themes. According to McLeod (2001), researchers who do not hold an 'allegiance' to the discipline under investigation are considered more likely to be open-minded when reviewing the findings, as noted by Spragg & Cahill (2015).

Further considerations of the researcher's role were applied when reflecting on the use of colleagues as some of the participants of the study. It is possible that, given the nature of the dual relationship with the participants, that this compromised their self-disclosure in the interview phase. The researcher's personal and professional relationship with some of the participants could have jeopardised the ability to obtain a rich account of their experiences, as they may have felt uncomfortable disclosing specific, intimate details in this context. With this in mind, suggestions are made from various theorists as to how to manage these challenges. Cooper (2008) for instance, advises that when conducting experience of therapy studies, it would be beneficial for the research to be carried out by 'genuinely independent' individuals, who are not aligned with the subject under investigation, as suggested in the study by Spragg & Cahill (2015).

Finally, the second-order analysis identified a recurrent theme that ran throughout all of the superordinate themes. This theme related to participants use of labels when describing their experiences of this specific client group. It was imperative

that the researcher explored her own use of such labels, and consider her role as the researcher, in order to reflect further on the potential impact this had on the participants' use of such language. Reviewing the research questions, minimal use of specific labels or diagnostic categories was seen, and instead the client group were referred to as 'those suffering from anorexia'. However, within the interview schedule, the use of diagnostic categories was present, and questions referred to clients as 'anorexic'.

This type of 'labelling' does not fit with the critical realist position underpinning the study, and the researcher's position as a Counselling Psychologist researcher. Both domains emphasise the importance of individuality and subjectivity to understand an individual's world view (Larkin et al, 2006; BPS; 2005). It is possible that for simplicity and efficiency the researcher described those experiencing symptoms of anorexia, as 'anorexic', as suggested by Ross (1980). However, future research endeavours should remain mindful of the type of language used in research and interview questions, as these may well influence the participants, and subsequently impact the overall findings (Biggerstaff & Thompson, 2008).

4.6.2.3 The suitability of the research questions. IPA studies encourage the development of open-ended research questions to support the research and be directed by participants' individual experiences. Smith & Osborn (2003) stipulate that 'how' and 'what' questions are deemed best fit in this instance. The central research question aimed to explore what psychologists perceive to be useful and not so useful about running therapeutic groups for those experiencing anorexia. The open-ended, explorative nature of this question is suitable for an IPA study, as it does not attempt to 'explain something' (Landridge, 2007; Spragg & Cahill, 2015). This style of questioning is traditionally considered too specific for an IPA investigation. Alternative approaches, such as grounded theory and thematic analysis, are typically more

appropriate methods when exploring helpful and hindering effects of therapy (Rennie, 1990; Sherwood, 2001; Spragg & Cahill, 2015). With this being said, due to the explorative nature of the study in obtaining accounts of participants' experiences, as stipulated in the research sub questions, the chosen methodology was IPA.

The research sub question which specified, 'how do these experiences compare to other experiences of facilitating groups with other presenting difficulties? was unexplored within the analysis. This was due to a lack of interpretative findings from participants' transcripts. When analysing individuals' accounts, only three of the participants had responded to this enquiry. These responses lacked the depth required for analysis, and for subsequent themes to be generated. It may be possible, that the participant sample did not have a suitable amount of alternative experience facilitating group therapy with different clinical populations, in order to sufficiently explore this line of enquiry. Alternatively, it may be that participants did not view any significant differences in their experiences of facilitation with those experiencing anorexia and other client groups, thus meaning that this question lacked relevance. It is also possible that the inclusion of this particular research question was generated from the researcher's own interest, and may therefore explain why the participants could not provide further insight.

4.7 Conclusion and Future Directions

It is evident, from the participants' perspectives, that the group is a unique and powerful tool in encouraging a plethora of positive therapeutic factors. It is noted, that the benefits described by the participants, may not be gained from an individual therapeutic setting alone, as this environment may not lend itself to encouraging many of the interpersonal and relational aspects ascribed to group therapy, as observed by Spragg & Cahill (2015). Yalom & Leszcz (2005) argue that awareness, insight and

interpretation, typical to the work that takes place in an individual setting, are insufficient, and the relational aspect, unique to group therapy, is paramount in challenging clients beliefs and dysfunctional relational patterns.

The unique qualities attributed to this setting, proposed by the participants, saw many positive implications for clients meeting others who share similar difficulties. It is considered that the group process is capable of alleviating individuals' social isolation, commonly attributed to those suffering from anorexia (Hall & Ostroff, 2013), and aid those in establishing a support network and building interpersonal relationships. Likewise, the process of being in a group and sharing with others is perceived to have the inherent ability to increase motivation and instil hope. The participants claimed that interacting with others can have a significant effect on reducing a proposed sense of shame, which can profit in normalising experiences. Philips (2009) argues that isolation from self and others is the most pervasive experience in those struggling with mental health difficulties. Instilling connection between those struggling, and encouraging interaction is fundamental for recovery, therefore group therapy in this context could be considered an invaluable resource.

The outcome of the research informs the reader of participants' accounts of the challenges they experience in this setting, and how they manage these challenges. The participants described in their narratives the importance of creating a safe space for group members. Likewise, they shared their observations of the importance of speaking the unspoken dynamics of the group, to aid in the development of cohesion, and to manage interpersonal conflicts. These findings aspire to fulfill the aim of the research, which was to address the possible challenges faced when working in a group therapy setting for those experiencing anorexia, and offer insight into how clinicians could manage these perceived challenges, and equally to inform practitioners, to support their

understanding, and develop their awareness of the demands this setting could have on their professional practice.

The findings illustrated here, would arguably be more problematic to determine using quantitative measures, such as standardised questionnaires alone, thereby reaffirming the use of a qualitative approach in this instance. The research aimed to supplement existing qualitative research, which has sought to determine the benefits and pitfalls of group therapy with anorexic suffers (Wanlass et al, 2005). The findings hope to endorse a more comprehensive understanding of the group therapy process, encouraging practitioners to learn from one another and develop their clinical practice.

It could be considered advantageous for future research endeavours to consider a mix methods design, incorporating both quantitative and qualitative approaches. This may reduce the limitations of qualitative designs, which compromise the ability to generalise findings, whilst also maintaining the subjectivity pertaining to more qualitative methods (Lyons & Cole, 2007; Spragg & Cahill, 2015). Incorporation of statistical outcome measures, typical in the researcher's experience whilst working with those suffering from anorexia, may include the EDEQ (Fairburn, 2008), measuring the levels of restraint, weight concern, shape concern, and eating concern, the PHQ-9 (Kroenke et al, 2001), a brief depression severity measure, and GAD7 (Spitzer, Kroenke, Williams, & Lowe, 2006), a brief measure for assessing generalised anxiety disorder.

In the researcher's experience, significant reduction in these scores is seen from the onset of group treatment to discharge. Combining these findings with more qualitative, semi-structured interview questions pre and post treatment, may see a more cohesive understanding. This may be of value to practitioners, with the use of such

outcome measures being routinely exercised in clinical practice, it is considered advantageous to incorporate these within the research design (Burke- Johnson & Onwuegbuzie, 2004; Spragg & Cahill, 2015).

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Appendices

Appendix A: Example email for recruitment

Dear team,

I am contacting you to enquire as to whether any clinicians would be willing to take part in my research project. I currently work as an Assistant Psychologist in the Eating Disorder Service in Berkshire NHS and have done so for 5 years. Alongside which I am in my 3 year of my Counselling Psychology Doctorate and have taken the opportunity to undertake my Doctoral thesis exploring the experience of group therapy for Anorexia Nervosa, from Psychologists perspectives. I have attached the information sheet for further clarity.

My project aims to explore the experiences of psychologists who run group therapy, working specifically with clients struggling with anorexia nervosa, in contrast to previous studies which have focused predominately on the experiences of the client. I endeavour to produce findings that will support and expand on limited existing literature, and provide a key resource in the development of clinical practice.

If you are interested in taking part, it would be great to establish a convenient time to come and meet with you. The interview should take approximately 45 minutes and will require you to think about and reflect on your experiences of facilitating group therapy for anorexics, and your perception on the usefulness of this type of treatment for those struggling with anorexia.

I look forward to hearing from you,

Many Thanks,

Rachael Phillips

Appendix B: Participant information sheet

UNIVERSITY OF EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

The Principal Investigator
Miss Rachael Phillips
u1017318@uel.ac.uk, 07791998784

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you may need to support you in deciding whether to participate in my research study. The study is being conducted as part of my Doctorate in Counselling Psychology at the University of East London.

Project Title

The Experience of Group Therapy for Anorexia Nervosa: A Qualitative Study from Psychologists' Perspectives.

Project Description

My project aims to explore the experiences of clinicians who have run group therapy, working specifically with clients struggling with anorexia nervosa, in contrast to previous studies which have focused predominately on the experiences of the client. I endeavor to produce findings that will support and expand on limited existing literature, and provide a key resource in the development of clinical practice. Therefore, I aim to interview 8-10 qualified Clinical Psychologists/Counselling Psychologists who have facilitated group therapy for anorexics for a minimum of 3 months. The interviews will ideally be face-to-face, in a context that is mutually convenient, and will take approximately 45 minutes. The interviews will engage participants in reflective thinking around their experiences of facilitating group therapy for anorexics, and their perception on the usefulness of this type of treatment for those struggling with anorexia.

Confidentiality of the Data

Participants' anonymity is taken into consideration throughout the course of the research and is of paramount importance to ensure all participants feel safe in their disclosure throughout. Consent forms will be required to be completed before any data collection will take place, at which point participants will be given a unique study number which will be used to identify them going forward. All material containing participant information will be stored in a locked cabinet and on a password-protected electronic data sheet. Such information will be stored for up to 5 years post submission of the research.

Location

The interviews will be carried out in a location that is mutually convenient for both the participant and the researcher. This will be agreed on an individual basis.

Disclaimer

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason.

This research may be put forward for publication in the future, please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact my supervisor [Dr Melanie Spragg, School of Psychology, University of East London, Water Lane, London E15 4LZ. m.spragg@uel.ac.uk]

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)

Thank you in anticipation.

Yours sincerely,

Miss Rachael Phillips

Appendix C: Participant consent form

UNIVERSITY OF EAST LONDON

Consent to participate in a research study;

'THE EXPERIENCE OF GROUP THERAPY FOR ANOREXIA NERVOSA: A QUALITATIVE STUDY FROM PSYCHOLOGISTS' PERSPECTIVES.'

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)

……

Participant's Signature

……

Researcher's Name (BLOCK CAPITALS)

……

Researcher's Signature

……

Date: ……

Appendix D: Ethical approval- University of East London's research ethics committee (UREC)

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

SUPERVISOR: Melanie Spragg **REVIEWER: Libby Watson**

STUDENT: Rachael Phillips

Title of proposed study: The experience of group therapy within a specialist treatment facility for anorexia nervosa: a qualitative study from psychologists' perspectives

Course: Professional Doctorate in Counselling Psychology

DECISION *(Delete as necessary)***:**

***APPROVED, BUT MINOR CONDITIONS ARE REQUIRED BEFORE THE RESEARCH COMMENCES**

APPROVED: Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

Minor amendments required *(for reviewer)*:

Supervisor of the project needs to sign and date the proposed research study before commencement. A minor clarification should be made to the participant information sheet pertaining to the possibility that the research might be published (e.g. in a journal) in the future. This is alluded to but not stated explicitly and is required should the researcher wish to publish.

Major amendments required *(for reviewer):*

NA

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature): RACHAEL PHILLIPS*

Student number: 1017318

Date: 5th September 2015

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

☐ MEDIUM

☒ LOW

Reviewer comments in relation to researcher risk (if any):

Reviewer *(Typed name to act as signature)*: *Libby Watson*

Date: 6th August 2015

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee (moderator of School ethics approvals)

PLEASE NOTE:

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here:

http://www.uel.ac.uk/gradschool/ethics/fieldwork/

Appendix E: Ethical Approval- Research and development department at Berkshire NHS Foundation Trust.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Rachael Phillips
Assistant Psychologist
Berkshire Eating Disorders Service
Block 22, St Marks Hospital
112 St Marks Road
Maidenhead, Berkshire
SL6 6DU

Research & Development
Fitzwilliam House · Skimped Hill Lane
Bracknell · Berkshire · RG12 1BQ
t: **01344 415825**
f: **01344 415666**
e: **research@berkshire.nhs.uk**

4th April 2016

Our Ref: 2016/36 REC Ref: N/A

Study title: The Experience of Group Therapy within a Specialist Day Treatment Programme. For Anorexia Nervosa: A Qualitative Study From Therapists' Perspectives.

Start date: 04/04/2016 End date: 04/04/2017

Dear Rachael Phillips

Confirmation of Trust Management Approval

On behalf of Berkshire Healthcare NHS Foundation Trust, I am pleased to confirm Trust Management Approval for the above research on the basis described in the application, protocol and other supporting documents. Approval is conditional on reporting up-to-date recruitment when requested and the submission of a brief final report of research findings. Failure to do so may result in approval being withdrawn.

If there are any changes to the study protocol, the R&D Department must be informed immediately and supplied with any amended documentation as necessary, including confirmation that the amendments have been favourably reviewed by the Sponsor and the Ethics Committee. If the end date changes from that shown above, then please inform BHFT R&D Manager. Trust approval will cease on the end date above. Please contact the R&D Manager to discuss any extension.

The R&D Department is required to monitor the progress of all research in the Trust under the Department of Health's Research Governance Framework. You will be contacted in due course with a request for reports of progress, and for a brief final report of research findings.

If you have any questions about the above, or you require any other assistance, then please contact the R&D Department.

I wish you every success with the study.

Yours sincerely

Gwen Bonner
Director for Research (BHFT)

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To help protect our staff and people who use our services from the harmful effects of tobacco smoke, please do not smoke anywhere on our sites, or during appointments when our staff are at your home. If you would like support to quit please speak to your healthcare professional or contact **Smoke Free Life Berkshire** on **0800 622 6360** or text **QUIT** to **66777**

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Appendix F: Interview schedule

- Age.
- Gender.
- Qualifications.
- Where practicing.
- Theoretical orientation.
- Can you tell me how you experience facilitating group therapy for anorexic clients?
- What do you think is helpful about running groups for this population?
- Can you give me an example of when you believe group therapy has been helpful in supporting those with anorexia?
- What do you think is not so useful about running therapeutic groups for this client group?
- What's it like in the group when …..happens?
- How do you think your experiences differ to working with other populations in a group setting?
- How would you describe the challenges you experience when working in this context?
- How would you say you manage these?
- Could you provide a specific example of a situation where this happened?
- Can you tell me about your experiences of group dynamic?
- How do you manage the changes in the group dynamic?
- Is there anything else you think would be important for me to know about your experiences of working with anorexia in a group setting?

<u>Prompt Questions:</u>

- What's it like?
- How do you find it?
- How did you do that?
- How does that help?
- Why do you think that's particularly important?
- Can you tell me more about…..?
- Can you give me an example of….?

Appendix G: Example of Interview Transcript

Key:
R: Researcher, I: Interviewee
Descriptive comments
Linguistic comments
Conceptual comments

Emergent Themes	**Original Transcript** **(l: 28-38)**	**Exploratory comments**
	R: Okay, so first question's just thinking about whether... about how you experience facilitating group therapy for anorexic clients, how your experience is.	
Challenging Impact of client group on clinician	I: Challenging, difficult... Patients don't sort of give a lot that you have to give a lot to patients. That's how they sort of... which is not a good thing to do. That's what I've learned... is that they	*Use of negative language to describe experience* Clinician 'giving a lot. What are they having to give? Idea of having to take responsibility.
Resistance Ambivalence	observe you and stay sort of... stand back quite a lot before they agree to join in, because I think they really want to know what you're about and what they... what you're going to do with them. So they don't join in very easily, and they... Yes, so... Yes, difficult. Challenging, but I think that's...	*'stand back'- language used to describe perception of passivity, or resistance?* Sense of being evaluated or judged by the clients?
Questioning self Judged or criticised	They probably get more out of the group than you think, and [inaudible] think that they did, because they don't give a lot in return, so...	Sense of unknown of what they're getting out of the group, possible feelings of uncertainty resulting in anxiety or worry?

	(l: 162- 183) R: Is there anything else that you think is maybe not so useful about having... seeing anorexic clients in a group as opposed to, say, individually? Is there anything about the environment? I: I don't think it's... I think that there are sort of, you say, you know, pitfalls or case... You... I think you don't learn to run a group with anorexics	
Challenging Time and experience is key	by doing, you know, one block. It takes a lot of time. [unclear] a lot of things that you become aware by running it again and again, and for instance, I can see how difficult it is for some	Learning to work with anorexics takes time. Emphasis on idea that it is a challenge and experience is needed?
Standing alone Defying the group	patients, depending on their personality, to single themselves out of the group by starting to recover.	Singling themselves out by wanting to recover. *Idea of being 'single' meaning you are one, alone, not a part of the majority.* How might this impact? Emphasis on the idea of *difficult.*
Role of facilitator Responsibility	So, again, if as a facilitator you're not aware of that, the group can then hinder the recovery of the patient. I think structure and rules are important to	Facilitator needs to be aware. Responsibility or heightened role of the facilitator.
The holder Creating safety in a group	make the group feel held, and it's for the facilitator to create this, and the space around that person so that person is safe and they can then disclose the relational and interpersonal difficulties they are struggling with. We make the group support that patient rather than make them feel, oh, you're	*'Held', associated with structure and rules, the facilitator as the 'holder'.* Facilitators role to encourage safety for the group. The importance of safety. Impact of safety on ability to disclose and share.
A need to 'fit in' Belonging	different to us, and it's hard enough for those patients to come into the group. They have to fit in. That's sort of, you know, human nature. They have to be part of the group, but at some point, it's about them, and they're own recovery.	*Being different? Idea of singular again* *To 'fit in'*- The importance of being a part of the group, and a movement away from a focus on the group towards a focus on themselves. This is seen as a '*hard'* process.

End.