

WHAT DO WOMEN IN THERAPY FOR AN EATING DISORDER FIND HELPFUL?

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Dedications

First, to the women who participated, for sharing with me some tough stories and some big laughs. I think about you frequently, and I wish you each the very best, and to Claire, without whose help none of this could have gotten an inch off the ground.

Second, to my classmate Beth, who encouraged me to keep at it with the statement that “if anyone would finish, Paige would finish”. Coming from Beth, for whom no project has a chance to get stale, this meant quite a bit.

Third, to Saliha, who took me in, literally, as I was sorting out the hardest moments I have ever lived. The fact that they overlapped my data collection was just coincidence.

Fourth, to my dad, who spent more time in Montana than he meant to because he could not bear to leave me there by myself, and my mom, whose steadfast prayers have sustained me in ways I can only imagine.

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What do Women Therapy for an Eating Disorder find Helpful? A Qualitative Study

by Jennifer Paige Kelley

ABSTRACT

The purpose of this research was to explore what women who are, or have been, in therapy for an eating disorder find helpful about that therapy. Since the perspectives and voices of women in therapy are largely absent from the treatment literature, participants were asked to talk about their experiences in therapy, particularly those aspects they identified as helping them change in desirable ways.

In-depth interviews were conducted with nine women and one therapist who treated each of them individually. Qualitative methods of analysis were employed that privileged the voices of participants and used the therapist's comments to add depth to the understanding of the results.

The results of this research are organized to help clinicians arrange their thinking about how to work with clients who have eating problems. Five categories, or aspects, of helpfulness were created: relationship aspects, self of therapist aspects, within therapy aspects, outside therapy but related to treatment aspects, and having nothing to do with therapy aspects. Participants' voices are used to add depth and details to each of these aspects. Suggestions for therapists are included.

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Chapter one: Introduction

Eating disorders are no longer rare phenomena to most people in Westernized societies. Covers of weekly news magazines have been devoted to startling pictures of young women who are starving themselves, and with every Olympic games, the discussion of anorexic gymnasts is brought up. School counselors are dispatched to make presentations to the girls' gym classes about body image and appropriate dietary intake in the same way that the school nurse once discussed young girls starting their menstrual cycles. However, young women particularly, although young men are not exempt and are becoming more likely to suffer from similar problems, continue to have startling relationships with food and body weight. Eighty percent of fourth-grade girls in the San Francisco Bay area were watching their weight when asked (Stein, 1989), and sixty-seven percent of girls aged 13 to 18 were trying to lose weight in a study of 3000 adolescents (Rosen and Gross, 1987).

Many of these children and adolescent girls will suffer problems with food at some point, and at a minimum, they will likely suffer weight and body image concerns. Girls between seven and nine years old in the United States are able to elucidate specific concerns with the appearance of their bodies and their body weight (Thelen, Powell, Lawrence, & Kuhner, 1992). Understanding dieting and body image problems as some of the precursors to eating disorders puts these statistics in a startling context.

So what to do? There is certainly much work to be done in the area of prevention (Shisslak & Crago, 1994), but there are many girls, young women, and mature women among us who are already facing an eating disorder. The question of how to treat people with these problems in a way that stops the physically and emotionally damaging behaviors while respecting the differences between people who experience eating problems must be addressed. This research takes up this question.

Significance of the study

Evidence in the psychotherapy outcome research literature supports the superiority of therapy to both placebo and no-treatment control groups (Miller, Duncan, and Hubble, 1997). For example, in a meta-analysis of over 475 studies comparing treated and untreated groups, Smith et al. (1980) found that the average treated person was better off than 80 percent of the untreated sample. Lambert and Bergin (1994) concluded that after reviewing a wide variety of methodologies and treatment outcomes there is now little doubt that psychological treatments are, in general, effective. However, what is less clear is the nature of the change process within the therapy context. Psychotherapy is effective, but how and why? Specifically on this topic, cognitive-behavioral therapy is effective in the treatment of bulimia nervosa, and family therapy is effective in the treatment of early-onset, short duration anorexia nervosa, but how and why?

In the past ten years, there has been a significant increase in the number of studies attempting to determine the process of change, and most of these studies have used quantitative research strategies (Christensen, et al, 1994). However, Elliott and Shapiro (1992) make a good case for the use of qualitative methods to learn more about the change process. They argue that psychotherapy research has long been dominated by premature quantitative, hypothesis-testing approaches when the field could benefit from qualitative, discovery-oriented approaches. In quantitative studies, clients' voices are represented infrequently. Utilizing research approaches that examine the therapy process from clients' perspectives can reveal important aspects of the change process that may have been neglected with quantitative methods. In regard to the study of treatment for eating disorders, Striegel-Moore (1994) makes the argument that bringing feminist research criteria to bear on both the topics and methods for research is necessary.

In relation to these arguments, this study has several implications. First, it does not presume anything about what is or is not useful about the treatment of eating disorders, waiting instead to discover what those in treatment say about their treatment, thereby remedying the problem postulated by Elliott and Shapiro (1992) of premature quantitative, hypothesis testing approaches. Second, it attempts to answer practical questions that clinicians ask about their work on a regular basis. Clients with eating disorders have long been understood to be difficult to treat (Kaplan and Garfinkel, 1999), making the questions of what therapists do that these clients find helpful all the more important. In regard to Striegel-Moore's (1994) suggestion of feminist research criteria, this study takes a contextual approach, studies a self-selected diverse group of women, and includes units of analysis larger than the individual.

Limitations of the study

The following weaknesses must be kept in mind when reading the results of this study. There were nine (n=9) participants, and each of the participants was self-selected. The participants' ages covered a broad range, as did their specific problems with eating. The participants each lived in a small mid-Atlantic city, and each of them appeared to be Caucasian. They were not asked to identify themselves ethnically or religiously. In addition, participants were at various points in relation to their treatment when the interviews were conducted. They also had wide-ranging experiences with previous treatments for the same problem. These weaknesses suggest little predictive value to this research, and it should not be read as suggesting otherwise.

Research topics

The following questions were intended as general guides for the study.

What was/is helpful about therapy for the treatment of participants' eating disorder?

What happened before, during, and after the therapy that was helpful?

What did the therapist do before, during, and after the session that was helpful?

What could the therapist have done before, during, and after the session to be helpful?

What was the participant's perception of the relationship between her and her therapist?

Theoretical perspective

Three streams of thought influence my conceptual assumptions about this research. The first is the movement toward discovery-oriented methods of research for psychotherapy (Elliott, 1984; Mahrer, 1988; Kazdin, 1986a; VandenBos, 1986), the second is the move toward postmodernism in the social sciences (Gergen & Gergen, 1986; Guba & Lincoln, 1994), and the third is the influence of feminist research perspectives (Striegel-Moore, 1994).

This research is discovery-oriented. I do not have established hypotheses, and my goals and methods are not connected to a specific theory or model. Discovery-oriented approaches differ from hypothesis-testing approaches “across the board, from the opening intent to do the research to the design and methodology of the study, and from the framing of the research question to the sense that is made of the findings” (Mahrer, 1988, 694).

Hypothesis-testing approaches presumably add to the body of knowledge about a given subject by confirming or disconfirming propositions that support the general theory in question. Rarely, however, is it the case that any psychotherapy theory is “disconfirmed” in the general sense because of the disconfirmation of its tenets. “It is simply a sad fact that in soft psychology theories rise and decline, come and go, more as a function of baffled boredom than anything else” (Meehl, 1978, 807).

Discovery-oriented research, however, is intended, not to confirm or disconfirm existing theories, but to take a close look at what happens that is of interest with the goal of “discovering” whatever exists to be discovered. A corollary presumption is that beginning research with a proposition in mind narrows the view of what is actually

happening to the extent that important and otherwise useful information is excluded simply because it was not pre-specified as important and useful.

Discovery-oriented research is granted provisionally-viable status by suggesting that it is a useful source for hypotheses (Kiesler, 1971), but the whole purpose of this type of research “is the intention to learn more; to be surprised; to find out what one does not already expect, predict, or hypothesize; to answer a question whose answer provides something one wants to know but might not have expected, predicted, or hypothesized” (Mahrer, 1988, 697), not to provide a source for future hypothesis-testing.

The second stream of thought influencing this research is postmodernism. Parker (1992) defined postmodernity as “the condition of culture which encloses and informs the abandonment of the grand narratives of humanised science” (p. 84). Rather than tie my thinking to a grand narrative, or theory, I am moving deliberately toward local knowledge and local narratives about participants’ experiences. Allowing participants to explain the reasons for their acts and the causes of happenings is critical to the method by which this research was conducted (Sarbin, 1986). I am asking people to comment on their lived experiences and to tell me *why* certain things were helpful to them.

I assume that people tell stories about their lived experiences in ways that are meaningful for persons trying to learn about those experiences. “Story telling, to put the argument simply, is what we do with our research materials and what informants do with us. The story metaphor emphasizes that we create order, construct texts in particular contexts” (Riessman, 1993, 1). I have worked to become “comfortable with narrative accounts [by] accepting the idea that the world has no fixed rules for assigning meaning to behavior” (Emihovich, 1995, 45). The assumption that there is no absolute truth about lived experiences allows me to accept what research participants say about their own behavior and the motives for that behavior.

I also assume that a variety of ways to address the construction of meaning exist. Rather than aiming for a standard of “truth,” I am aiming in this study for a variety of explanations that make sense. “Since the task is not to exhaust the singular meaning of an event but to reveal the multiplicity of meanings, and since it is through the observer’s encounter with the event that these meanings emerge, no standard format for collecting observations would be appropriate for different settings and purposes” (Mishler, 1979, 10).

The third stream of thought influencing this study is the perspective of feminist research. Feminist scholars have stressed the importance of giving place to the voices and narratives of women in research literature (Hare-Mustin and Maracek, 1990). In regard to no therapeutic phenomenon is this more important than in the treatment of eating disorders. Striegel-Moore (1994) asks, “What types of interventions are acceptable to patients? Why are the dropout rates high for some treatments but not others? To what factors do patients attribute their treatment successes or failures?” (447). This research gives place to the voices of the women participants, and it asks specifically, “What happened that was helpful to you?” Because the eating disorders treatment literature contains only two small studies (Shifts, et al, 1993; Protinsky and Marek, 1997) privileging the voices of women regarding eating disorders treatment, more research is needed to determine, from the perspectives of clients, what is helpful. This study is an attempt to meet that need.

Locating myself

Who these women are to me is likely very different from whom I am to them. We spent, at the most 3 hours together, and I have had minimal contact with only two of them by mail since then. However, I have spent countless hours poring over the words from our interviews and thinking about what they told me. I have recalled specific things they said, such as Leslie saying, “Do the food journal,” as she bent over my desk to get her mouth near the tape recorder. This comes to mind every time I sit with a client who hints that she

is not really interested in doing a food journal. I have remembered Julie telling me how truly helpful her dog was to her as she tried to make a recovery from her eating problems when I have sat with clients who had a pet that meant, some days, the difference between getting out of bed and not. I have also remembered her telling me that she listened to “power songs” to make herself feel better when I have had dark, hard days.

I enjoyed my interviews with these women, and because I so enjoyed interviewing them and thinking about what they told me, I have chosen to focus my clinical work on women who have eating problems. This is, almost exclusively, a function of having so enjoyed the people with whom this research was conducted. I had worked on the larger project of which this research was a part for several years before this piece became my dissertation research, and it did so in a default circumstance. I had been working on another subject, but when I was not getting the participants at the rate I needed and because I needed to leave town to take a job, my committee chair suggested that I make this piece of the research, for which I was already conducting interviews, my dissertation research. I was thrilled to be able to do it, but not because I necessarily wanted to do an “eating disorders dissertation.” I was, like all other doctoral candidates, I presume, just glad to know I could leave town with good data that could be turned into a completed degree. It was in the doing of the interviews and the following thinking about these women that my clinical focus shifted. I am grateful for that, and I am grateful for the opportunity I had to meet these women and hear their stories.

Chapter Two: Literature review

This chapter contains a literature review of treatment research for anorexia nervosa and bulimia nervosa as well as a review of studies that employed similar methodologies.

Content literature review

For the purpose of establishing a content framework for this research, I reviewed the literature concerning the diagnosis, prevalence, and psychological treatment for bulimia nervosa and anorexia nervosa. I limited my review to controlled studies of psychotherapeutic treatments. Considerable research on the efficacy of various pharmacological agents in the treatment of these eating disorders also has been conducted, but it is outside the scope of this research. In the Results and Discussion of Results chapters, I included what participants said directly about medications and their usefulness as that fits within my methodology.

The literature review indicates support for cognitive-behavioral therapy and family therapy as treatments for some persons with eating disorders, so I have included in Appendices B and C summaries of family therapy for anorexia nervosa and CBT for bulimia nervosa as each model was practiced in the research that lends credibility to their use.

Anorexia nervosa---history

Literature describing states similar to anorexia nervosa can be found from as far back as 1689. Dr. Richard Morton described instances of what was very similar to the disorder's current diagnosis in 1689 in his book, Phthisiologia seu Exercitationes de Phthisi. His work was translated into English in 1694, and in it, he described body wasting diseases caused by sadness and anxious cares in two patients, one a 20-year-old woman and the other, an 18-year-old man (Silverman, 1997). Similar cases were described in

1767 by Robert Whytt at the University of Edinburgh and in 1768 by De Valangin of the Royal College of Physicians in London.

The next significant articles came 100 years later in 1869 when Dr. Louis-Victor Marcé of the Hôpital Bicêtre of Paris described a condition with symptoms similar to anorexia nervosa at a conference. His important contribution was an assessment that the illness was psychiatric rather than biological in nature (Silverman, 1997).

Four years later, in 1873, Charles Lasègue, of the Faculty of Medicine of Paris, published "De L'Anorexie Hystérique". He recommended quiet watching by a physician who could resume some medical authority only when the patient had deteriorated to the point that her state caused enough anxiety in her family to shock her out of indifference (Silverman, 1997).

Sir William Gull, physician at Guy's Hospital, published articles in 1874 labeling a set of symptoms as "anorexia nervosa". Gull described three teenage patients who were starving themselves for which he recommended force-feeding the patient regardless of what she wanted. He was convinced that the lack of appetite was most certainly a mental condition. He recommended a diet of milk, cream, soup, eggs, fish, and chicken every two hours (Silverman, 1997).

Descriptions of anorexia nervosa were relatively common in the French, German, and English medical literature of the last years of the 19th century (Silverman, 1997). Jean-Martin Charcot recommended isolating the patient from family and friends unless she made progress, and Gilles de la Tourette distinguished subtypes based on whether the patient refused food voluntarily or because of gastric spasms (Silverman, 1997).

Pierre Janet also distinguished subtypes of anorexia nervosa: obsessional and hysterical. He theorized that the obsessional subtype refused food based on a fear of getting fat and becoming sexually mature, but he maintained they did so in spite of intense

hunger. The hysterical subtype was less common and resulted from an actual loss of appetite, according to his theory (Silverman, 1997).

Pituitary insufficiency was hypothesized as the cause of anorexia nervosa by Morris Simmonds in 1914, and until about 1930, this hypothesis was widely accepted. Various pituitary extracts and implants were utilized for treatment, and psychological variables were largely ignored or avoided. In 1930, Berkman discussed his treatment of 117 patients to whom he applied psychological explanations and treated with psychotherapy; the physiological aspects of anorexia were clearly secondary in Berkman's understanding. VENABLES, also in 1930, described nine patients with anorexia nervosa for whom he gave psychological explanations (Silverman, 1997).

John A. Ryle gave a presentation at the London Hospital in 1936 that was later published in the *Lancet* in which he recommended reversing starvation as the only treatment necessary, thereby sidestepping psychological explanations for the condition. He further recommended admitting the patient to a nursing home if the family could not satisfactorily implement the feeding program at home. He recommended against psychoanalytic methods, or any other method of direct inquiry (Silverman, 1997).

Psychoanalytic explanations were posited by Waller, Kaufman, and Deutsch in 1940. They suggested that oral impregnation fantasies and fears were at the root of the development of anorexia; the guilt associated with the fantasies and fears were held at bay by the starvation. This postulation formed the basis of subsequent psychoanalytic drive-related explanations for the etiology and maintenance of anorexia nervosa (Silverman, 1997).

Hilde Bruch (1962) made the next significant contribution to the field. She theorized that anorexia was the symptom of a struggle for autonomy, competence, and control, and that a failure on the part of a mother to recognize the need of the child for independence created deficits in the child that manifested themselves in body image

disturbance, interoceptive disturbance, and pervasive feelings of ineffectiveness. The approach Bruch recommended became the basis for cognitive therapy for anorexia nervosa (Garner & Bemis, 1982). She recommended a “fact-finding” approach that used the minute details of the life the patient discussed to correct her misperceptions about herself and the world she lived in with the goal of helping the patient discover a genuine self whose feelings and thoughts she recognized as her own.

Mara Selvini-Palazzoli (1974) proposed a similar view that suggested that separating oneself from the maternal object had to be achieved at any cost, even the cost of starvation. Minuchin et al. (1975) posited a “psychosomatic family model” in which they theorized that for anorexia to develop, three factors are necessary: a physiologically vulnerable child; a family that is characterized by enmeshment, overprotectiveness, rigidity, and lack of conflict resolution; and a symptomatic child who serves the purpose of helping the family avoid conflict.

Crisp (1967, 1980) proposed a developmental model in which anorexia nervosa is a misguided attempt to deal with fears and conflicts associated with achieving an adult weight. Russell (1970) stressed the variable presentations of anorexia nervosa. Different from his contemporaries, he maintained that the fear of fatness is the central element of psychopathology to which all other manifestations are tied. In spite of this, Russell maintained that the task for treatment was to correct the starvation state in order to stop the self-maintaining characteristics of the disorder. Russell’s theory most closely matches the DSM criteria for the diagnosis for anorexia nervosa.

Diagnosis

Anorexia nervosa is characterized by a refusal to maintain weight at a minimally normal level. Current DSM-IV-TR (APA, 2000) standards identify 85 percent of normal weight for age and height the cut-off point for diagnosis. The person will demonstrate an intense fear of fatness and gaining weight, and she will maintain a disturbed perception of

her own body weight and shape. In postmenarcheal females, amenorrhea of three consecutive periods is required for diagnosis. AN can be divided into two subtypes: restricting and binge-eating/purging type with the distinguishing characteristics being whether the person does or does not engage in binge-eating and vomiting behavior.

Prevalence

Prevalence data indicate a prevalence of 0.5 percent-1.0 percent among late adolescent and young adult females (APA, 1994). The incidence in males is largely unknown as the data are limited (APA, 1994). Looking at specific populations offers varying rates of prevalence for anorexia, however, with rates ranging from 15 percent (Pastore, Fisher, & Friedman, 1996) to 45 percent (Patton, Carlin, Shao, & Hibbert, 1997) for anorexia or its precursor, extreme dieting, when judged by scores on the Eating Attitudes Test (EAT 26). Another study (Fear, Bulik, & Sullivan, 1996) suggests that as many as 54 percent of adolescent females are dieting and 71 percent of the participants expressed a desire to be a smaller size. A meta-analysis of 29 prevalence studies done in the prior 25 years showed a lifetime prevalence rate for anorexia nervosa to be 1.3/1000 (Fombonne, 1995).

In addition to the prevalence of diagnosable disorders, adolescents, females in particular, demonstrate significant concerns about weight and body shape. In a large national, state, and local survey (Kolbe, 1990), 43.6 percent of female students reported currently trying to lose weight (where only 15.3 percent of males were doing the same), and 27.4 percent of the female students who considered themselves the right weight were trying to lose weight. In addition to the students who considered themselves overweight or who actually were overweight, over a quarter of the female students who believed they were the *appropriate* weight were trying to lose. The phenomenon of normal weight adolescent females attempting to lose weight had been documented prior to this study (Feldman, Feldman, & Goodman, 1988). These results taken together suggest that even

among females who have realistic assessments of their bodies, there is still a desire to reduce.

Girls who were as young as 9 years old have reported using harmful practices to lose weight (Maloney, McGuire, Daniels, & Specker, 1989; Mellin, 1988). A national survey (American School Health Association, 1989) found that of 8th and 10th-grade students, 32 percent had skipped meals, 22 percent had fasted, 7 percent had used diet pills, 5 percent had induced vomiting after meals, and 3 percent had used laxatives to lose weight.

Outcome research

Anorexia nervosa remains highly morbid with the highest mortality rate of any psychiatric disorder (APA, 1994). Long-term mortality rate estimates range from 10 percent (APA, 1994) to 20 percent (Theander, 1985).

A meta-analysis (Hsu, 1992) of seven intermediate-term and long-term outcome studies of anorexia nervosa showed that at a minimum of four years after the onset of anorexia nervosa about 75 percent of patients were improved, 20 percent were unimproved, and 5 percent had died. For longer-term outcome of anorexia nervosa, Hsu (1992) conducted a meta-analysis of two published studies and two unpublished studies to arrive at an overall mortality rate of 14 percent for patients diagnosed with anorexia nervosa.

A more recent study (Strober, Freeman, & Morrell, 1997) found that of adolescents with anorexia nervosa who were followed for 10-15 years, 75 percent had a complete recovery. Ten percent had a partial recovery, meaning they either had recovered weight but were not menstruating regularly or vice versa, and 14 percent had not recovered at all. They also found that complete recovery rarely occurred before 70 months, but once a person had fully recovered, they were unlikely to relapse. The median time to full recovery was 80 months, and the median time to partial recovery was 60 months. 30 percent of

patients had relapses following hospital discharge prior to recovery, and among those who were classified as restrictors at intake, nearly 30 percent developed binge eating within five years.

Contradicting this evidence, however, is a study in which it was found that only 33 percent of women with AN reached full recovery, and 40 percent relapsed after full recovery. (Herzog, Dorer, Keel, Selwyn, Ekeblad, & Flores, 1999). Anorexia nervosa remains highly morbid, and only acute refeeding techniques have shown to alter the long-term course of the illness (Vitiello & Lederlender, 2000).

Treatment research

In December 1998, the National Institute of Mental Health hosted a workshop to address the current state of research in the treatment of eating disorders and prospects for future research. The summarizing article states unequivocally, "There is no 'anti-anorexia nervosa' drug or psychotherapy, and no treatment seems to counteract the drive for thinness of AN patients. Virtually all the known pharmacological and psychological interventions have been suggested as a treatment of AN. Only limited empirical support exists for some of these interventions" (Vitiello & Lederhendler, 2000, 780). The group further states that, for the treatment of AN, the benefit of adding pharmacotherapy to psychosocial treatment seems to be negligible.

The only controlled trials of non-pharmacological therapy for anorexia nervosa are those in which family therapy is one of the modes of treatment under consideration. Various methods of family therapy have been used to attempt to treat anorexia nervosa. The following methods have some empirical support.

Family therapy vs. Supportive individual psychotherapy

The first controlled treatment trial of family therapy for anorexia nervosa was completed at the Maudsley Hospital in London (Russell, Szumukler, Dare, Eisler, 1987). Family therapy (to be described later) was compared to supportive individual

psychotherapy, which was designed to be educational and problem-centered. In the individual condition, therapists employed elements of cognitive, interpretive and strategic therapies, and they developed and posited hypotheses based on individual client symptoms. Patient weight was discussed frequently, and the effects of starvation on mood and thinking were stressed.

80 patients who had been inpatient at the Maudsley Hospital were allocated to one of four groups: anorexia of early onset with short history (onset younger than 18 years old and duration of less than 3 years); anorexia of early onset with long history (onset younger than 18 years old and duration of greater than 3 years); anorexia of late onset (onset older than 19 years); or anorexia combined with bulimic behaviors. After allocation, clients were randomly assigned to either family therapy or supportive therapy, with a total of 41 patients assigned to family therapy and 39 assigned to supportive therapy.

Results at one year after the start of treatment were categorized as good, intermediate, or poor. The anorexia only groups were classified differently from the group in which patients also demonstrated bulimic behaviors. Patients with good outcome in the anorexia-only groups had maintained body weight within 15 percent of the average body weight according to insurance tables, and they were having regular menstrual cycles. Patients with intermediate outcome had maintained weight within 15 percent of desired weight but still had amenorrhea. Patients with poor outcome were those whose body weight was more than 15 percent below appropriate weight or those patients who developed bulimic symptoms. In the combined anorexia/bulimia group, a good outcome was determined to be one in which there were no bulimic symptoms (no overeating or self-induced vomiting) and the patient had maintained body weight within 15 percent of the average body weight. Intermediate outcome was one in which bulimic symptoms were present but occurred less frequently than once per week and body weight was maintained within 15 percent of the normal body weight. Poor outcome was the determination when

bulimic symptoms occurred more frequently than once per week or when body weight was less than 15 percent of the average body weight in the presence of less frequent symptoms.

Patients with anorexia nervosa with early onset (≤ 18 years) and short history (3 years or less) had significantly better outcome if they received family therapy than if they were treated individually. Patients of anorexia nervosa of late onset (> 18 years old) had better outcomes with individual therapy than family therapy. Patients with early onset anorexia nervosa that lasted more than 3 years and patients with severe bulimia had poor outcomes regardless of modality (Russell, Szmukler, Dare, & Eisler, 1987).

Five-year follow-up for this study reported that in early onset, short history group, those who received family therapy continued to do better than those receiving individual therapy although both groups did well. In the early onset, long history group, there was no difference in benefits at the end of five years. In the late onset group, nearly 75 percent had an intermediate to good outcome at five years with a slightly better outcome for individual than family therapy that does not reach statistical significance. Clinical ratings in this group reached statistically significant differences in two subscales favoring individual over family therapy. In the anorexia/bulimia group, there were no statistically significant differences between groups (Eisler, Dare, Russell, Szmukler, le Grange, & Dodge, 1997).

Family therapy and individual therapy vs. dietary advice

Hall and Crisp (1983, 1987) conducted a comparison study between 12 sessions of nutritional advice and 12 sessions of individual and family therapy. At the end of one year after the 12 sessions, both groups had improved significantly. 4 participants in the therapy group were considered recovered, and the other 11 were referred for further therapy, which they all attended. All 15 members in the nutritional advice group were determined to need further treatment, but only 8 of them followed up on that advice. This

study did not attempt to determine differential effects of individual therapy, family therapy, and nutritional advice.

Crisp et al (1991) conducted a subsequent study in which 90 female patients were randomly assigned to one of four conditions: family and individual therapy plus dietary counseling, inpatient treatment, outpatient group therapy with separate groups for patients and parents, or no further treatment. At one year, all of the treatment options were significantly effective in terms of weight gain, return of menstruation, and social and psychosexual adjustment. It is unknown which elements in the various treatments accounted for improvements.

Behavioral family systems therapy vs. Ego-oriented individual therapy

Robin, Seigel, and Moye (1995) compared behavioral family systems therapy to ego-oriented individual therapy with 22 adolescents meeting DSM-III-R criteria for anorexia nervosa. The BFST condition consisted of three phases. First, parents were taught how to take charge of their daughter's eating under the presumption that she was unable to do so because the effects of starvation. When the daughter had begun to gain weight regularly, therapy shifted to phase two, which consisted of cognitive restructuring techniques related to unrealistic beliefs about food and body image and strategic interventions to assess and alter enmeshment, triangulation, coalitions, and reversed hierarchies within the family structure. Phase three began when the adolescent reached her target weight, and in this phase, the therapist guided the parents in relinquishing control of the daughter's eating back to the daughter.

In the EOIT condition, weekly individual sessions were conducted with the adolescent in which the adolescent's ego strength, coping skills, individuation, identity confusion and developmental worries were addressed. The therapist positioned herself as an authoritative nurturer who could guide the adolescent through the difficult developmental stage she was in without the adolescent having to resort to starving

herself. The therapist conducted “collateral” sessions with the parents bimonthly and educated them about normal adolescent development while instructing them to refrain from involving themselves with their daughter’s eating (Robin, Siegel, & Moye, 1995).

In both conditions, body mass index improved, menstruation was regained, and family interactions, both food-related and non food-related, improved. Positive communications also improved in both conditions. In two specific instances, statistically significant differential effects were noted: 1) adolescents in the BFST condition improved body mass index more than EOIT condition patients, but the amount was determined to be clinically insignificant, and 2) mothers in the BFST condition decreased negative communication around food and increased positive communication around food, but the EOIT mothers did not. One-year follow-ups showed that treatment gains were maintained in both conditions (Robin, Siegel, & Moye, 1995).

Bulimia nervosa---history

The first article describing bulimia nervosa, “Bulimia Nervosa: An Ominous Variant of Anorexia Nervosa,” by Bertrand Russell, was printed in 1979 and has become one of the 10 most cited papers in the psychiatric literature. The criteria Russell outlined were not much different from the DSM IV-TR (2000) criteria.

Current diagnosis

Bulimia nervosa is characterized by recurrent episodes of binge-eating and attendant compensatory behaviors such as vomiting or excessive exercise to rid oneself of the food or calories at least twice a week for three months. Self-image in persons suffering BN is unduly influenced by body weight and shape. BN can be divided into two subtypes: purging and non-purging with the distinguishing characteristic being whether the individual uses any means to purge the body of the food (vomiting, laxatives, diuretics, enemas), or whether they engage in other compensatory activities to eliminate the calories (excessive exercise or fasting) (APA, 1994).

Prevalence

The prevalence of bulimia nervosa among adolescent and young adult females is estimated to be between 1 percent and 3 percent of the population, and the occurrence in males is approximately 0.1 percent to 0.3 percent (APA, 1994). Statistical rates of bulimia nervosa, as defined by DSM criteria, are wide-ranging in specific populations. Stein and Brinza (1989) evaluated junior high aged girls and high school aged girls in the same community and found symptoms of bulimia at the rate of 2.2 percent in the younger girls and 4 percent in the high schoolers. Fear, Bulik, & Sullivan (1996) found that 38 percent of adolescent females are bingeing and 12 percent are purging.

Many studies have used college-aged women as research participants, and rates have varied across these studies as well. Drewnowski, Yee, and Krahn (1988) determined that 4.2 percent of women had bulimia nervosa symptoms in their first and second semesters of college. Another study (Martin & Wollitzer, 1988) found that 21 percent of the 277 respondents had practiced purging in the past without developing the complete array of symptoms necessary for a bulimia diagnosis. This study also found that only 58 percent of the purgers had ever told anyone about their purging, and only 2 percent had discussed it with their family doctor. Based on this evidence, the researchers hypothesized that the incidence of bulimia was actually underreported.

Rand and Kuldau (1992) looked at the rates of bulimia in the general population 18+ years old, and found that 1.1 percent of the total sample exhibited at least some symptoms necessary for a bulimia diagnosis. In the same study, among women 18-30 years, 4.1 percent reported enough criteria to actually be diagnosed. More recently, Garfinkel, Lin, Goering, and Spegg (1995) estimated the lifetime prevalence rate for bulimia in women to be 1.1 percent.

Outcome research

Keel and Mitchell (1997) conducted a meta-analysis of 88 studies that contained follow-ups with subjects diagnosed with bulimia, and they reported statistics for mortality, recovery, relapse, and crossover. Their review distinguished follow-up studies from treatment outcome studies. Follow-up studies employed naturalistic and specially selected samples, and follow-up in the studies they reviewed ranged from 6 months to 10 years. Treatment outcome studies were described as those in which women diagnosed with bulimia nervosa were randomized into treatment studies for various forms of treatment and then followed. The treatment outcome studies they reviewed had follow-up periods from 6 months to 9 years, but most followed participants from 6 months to 1 year post-treatment.

Based on their review, Keel and Mitchell (1997) calculated a crude mortality rate of 0.3 percent due to all causes of death, but the ascertainment rates of individual studies were low, follow-up periods were small, and they presume this was an underestimation. At five to 10 years post-presentation, approximately 50 percent of women diagnosed with bulimia nervosa had fully recovered, but nearly 20 percent would still meet DSM-IV (1994) diagnostic criteria for bulimia. Keel and Mitchell (1997) also found approximately 30 percent of women relapsing into bulimic symptoms at some point after having been in remission.

Between 6 months and 4 years following presentation, participants in treatment studies had lower rates of bulimia nervosa than those in naturalistic follow-up studies (Keel and Mitchell, 1997). When considering remission data as well, women in treatment studies appear to continue to do better than women who are simply followed over time. However, at five-years post presentation and beyond, differences between the two groups disappear, and rates of remission in follow-up studies continue to rise to approach the rates in treatment outcome studies, and cases of bulimia nervosa decrease over time in

follow-up studies while they remain relatively steady in treatment outcome studies. Taking together the results of meta-analyses of treatment outcome studies and follow-up studies, Keel and Mitchell (1997) reached the conclusion that 5-10 years after presentation, about 50 percent of women are fully recovered and 20 percent continue to meet diagnostic criteria for bulimia nervosa regardless of whether their condition was treated.

Fairburn, Cooper, Doll, Norman, O'Connor (2000), in the most comprehensive study of the natural outcome of bulimia nervosa in a community sample, followed for a 5-year period a cohort of 102 women in whom bulimia nervosa had been diagnosed. Ninety percent (n=92) of the 102 women who started the research were available at the 5-year follow-up point. Study participants were recontacted every 15 months over a five-year period, and those who agreed were interviewed face-to-face at each point. The Eating Disorder Examination (EDE) (Fairburn, Cooper, 1993) was used to evaluate the presence and severity of symptoms, participants were weighed, and they were asked about any treatment they had received since the previous evaluation.

At 5-year follow-up, 15 percent of the 92 women who remained in the study continued to meet DSM-IV criteria for a bulimia nervosa diagnosis. An additional 2 percent had anorexia nervosa, and 34 percent met criteria for an eating disorder-not otherwise specified (ED-NOS) (APA, 1994). In regard to symptoms, the frequency of binge eating decreased 56 percent, and 53 percent reported having had no episodes of binge eating in the previous 3 months. The average frequency of vomiting and laxative misuse decreased by 47 percent and 75 percent, respectively. At the 5-year follow-up point, 67 percent were not inducing vomiting, 87 percent were not misusing laxatives, and 62 percent reported having done neither in the previous 3 months. Forty-one percent of the cohort was completely abstinent; they reported no bulimic episodes, no vomiting, and no laxative misuse in the previous 3 months. Levels of general psychiatric symptoms also decreased in this cohort by an average of 30 percent. At the end of the 5-year period, 40 percent of

the cohort reported having had some treatment for an eating disorder at some point in their lives, and 28 percent of the cohort had treatment during the 5-year follow-up period. The rates of remission, that is, having no DSM-IV diagnosable eating disorder for the bulimia nervosa cohort were as follows during the five-year period (“months” refers to months after initial interview): 15 months, 34 percent in remission; 30 months, 20 percent in remission; 45 months, 28 percent in remission; and 60 months; 35 percent in remission. Rates of relapse to any DSM-IV eating disorder diagnosis among the bulimia nervosa cohort were as follows: 30 months, 32 percent; 45 months, 33 percent; 60 months, 26 percent (Fairburn et al, 2000). (Rates of relapse are not reported for the 15-month point.)

In this same study (Fairburn et al, 2000), with regard to the course of individual participants, findings were different if the presence of bulimia nervosa was assessed versus the presence of any diagnosable eating disorder. Sixty-nine percent did not fulfill criteria for the original diagnosis at three consecutive points of evaluation. However, only 24 percent did not meet criteria for *any* diagnosable eating disorder at three consecutive points of evaluation. Nine percent of the bulimia nervosa cohort maintained their original diagnosis for three consecutive points of evaluation, and 15 percent continued to meet the criteria for bulimia nervosa at the 5-year point. Fully 51 percent met the criteria for *any* diagnosable eating disorder at three consecutive points of evaluation. This demonstrates a good deal of flux among the bulimia nervosa sample in terms of actual diagnoses, and therefore demonstrates a considerable amount of symptom remission and acquisition. Each year about a third of the research participants remitted and a further third relapsed. These statistics are evidence for a relatively poor prognosis among a community sample of women diagnosed with bulimia nervosa.

Process research

Jones et al. (1993) studied the process of change during treatment for bulimia nervosa by examining the reduction in frequency of binge-eating and purging associated

with three treatments: cognitive-behavior therapy, behavior therapy, and interpersonal psychotherapy. In all groups there was an immediate reduction in binge-purge behaviors; this lasted four weeks in the interpersonal group and for eight weeks in the other two conditions. There were no clear differences on more global measures of eating behaviors and attitudes or on measures of self-esteem or depression. The researchers hypothesized that non-specific properties of psychotherapy that may be shared among the three treatment conditions can have an early influence on the behavior of patients with bulimia nervosa (Jones, Peverler, Hope, & Fairburn, 1993).

Model-specific research

“Bulimia nervosa is among the disorders for which ample research evidence documents the effectiveness of psychological treatment. The most substantial evidence supports the efficacy of cognitive-behavioral therapy (CBT) for bulimia” (Arnow, 1999, 770).

Mitchell and Raymond (1992) conducted a meta-analysis of 19 controlled studies of CBT for bulimia nervosa conducted between 1984 and 1992. All of the subjects in the 19 studies were outpatient, and the components of CBT varied only slightly from study to study. Mitchell and Raymond found each of the following components common to most of the 19 studies: education, self-monitoring, modifying eating pattern, meal planning, practicing feared foods, cognitive restructuring, cue restriction, altering behavior, delaying vomiting, exposure and response prevention, assertiveness training, and relaxation training. Mitchell and Raymond also found that the 19 studies used various measures to report outcome, but they again found each of the following measures in the preponderance of studies: reduced frequency of bingeing pre- to post treatment, reducing frequency of vomiting pre- to post treatment, abstinent last week of treatment, >50 percent reduction in binge eating frequency at follow-up, and abstinent at follow-up. (Each of the aforementioned is reported in percentages by the various studies.) The results of the

meta-analysis showed significant improvement in the CBT groups versus waiting list groups' results and patients' baselines. They found a reduced binge frequency ranging from 40 percent to 97 percent with most of the studies in the 70 percent to 80 percent range. They found a reduced vomit frequency ranging from 40 percent to 95 percent with most studies again in the 70 percent to 80 percent range. At follow-up, 50 percent to 83 percent of subjects reported reduced frequency of symptoms, however continued abstinence from bingeing and purging rates varied widely from 0 percent to 75 percent. Of the four studies that reported six month or longer follow up data, rates of abstinence were worse at follow up than at the end of treatment. There was one exception reported. A single study reported abstinence rates that increased at six month follow up for the CBT individual condition, and in the same study, abstinence rates decreased for the CBT individual plus exposure and response prevention and self-monitoring conditions (Agras et al, 1989).

In another meta-analysis of 21 studies (Mitchell et al, 1996) conducted from 1983 to 1994, CBT is shown to be convincingly efficacious in the treatment of bulimia, and follow up studies done at 6-month, 1-year (Agras et al, 1994; Cooper and Steere, 1995) and 6-year post-treatment (Fairburn et al, 1995) demonstrate that the changes accomplished by CBT in patients with bulimia are relatively well maintained.

Peterson and Mitchell (1999) summarize research findings to state that binge eating and purging frequencies are reduced an average of 75 percent with CBT, with ranges from 40 percent to 97 percent. Abstinence rates, however, are more modest ranging from 8 percent to 97 percent and averaging about 40 percent of those who initially enroll in CBT treatment.

CBT vs. IPT vs. BT In general, CBT is comparable or superior to other psychotherapies as evidenced by a series of studies by Fairburn and colleagues that compare CBT with two types of interpersonal therapies (IPT). The first compared CBT to

short-term focal therapy that is described as addressing underlying psychological issues and including education about bulimic symptoms and weight. CBT was superior in producing improvements in social functioning and reductions in general psychopathology, but both CBT and short-term focal therapy reduced bulimic symptoms.

In the second set of studies, CBT was compared to behavior therapy (BT) and IPT (Fairburn, Jones, Peveler, Carr, Solomon, O'Connor, Burton, & Hope, 1991). Behavioral therapy addressed the behavioral but not the thought-related symptoms of bulimia. IPT focused on addressing interpersonal problems and deficits. Again, all conditions produced a reduction in bingeing at the end of treatment. However, improvements in purging, weight and shape attitudes, and dieting behavior were greater in the CBT condition than IPT, and better than the BT group in weight and shape attitudes and dieting behavior. At one year follow-up, the IPT group had continued to improve and there were no significant differences between the CBT and IPT groups, and both continued to be superior to BT. At long-term follow up (ranging from 4 to 11 years with a mean of 5 years), there were no differences in absence of bingeing and purging between the CBT and IPT groups, and both continued to be superior to BT.

Agras, Walsh, Fairburn, Wilson, and Kraemer (2000) conducted a comparison of CBT to IPT in an attempt to confirm or disconfirm the results of the Fairburn et al (1991) study. They determined, in a multicenter comparison, that patients in the CBT are superior on all measures at the end of treatment, and at follow-up, there are no significant differences between the two groups. They repeated the findings of the previous study, which led them to make the suggestion that, although CBT and IPT become statistically equivalent at follow-up, CBT is the treatment of choice for bulimia because it works significantly faster than IPT in alleviating symptoms.

Comparison of CBT to BT alone yields mixed results (Peterson and Mitchell, 1999). Fairburn et al (1991) found that CBT and BT were comparable at the end of

treatment, but CBT was superior to BT at follow up. Three other studies have produced inconsistent findings. Two found that CBT and BT were comparable and one found that BT is superior to CBT in reducing binge eating.

CBT vs. Exposure and response prevention CBT has also been studied with the additional component of exposure and response prevention (ERP) and compared in one study to the purely behavioral treatment. Agras et al (1989), in a study, which randomly assigned 77 patients to one of four conditions (wait-list control, self-monitoring, CBT, CBT with response prevention of vomiting), found that CBT was the most successful in reducing purging. Fifty-six percent of patients in the CBT condition had ceased binge eating and purging at the end of treatment, and purging frequency declined by 77.2 percent during the same time period. At 6-month follow-up, 59 percent of the CBT group were still abstinent and purging had declined by 80 percent.

Wilson et al (1991) studied 20 sessions of CBT with and without ERP with 22 patients who binged and purged. They found that the groups had comparable degrees of reductions of binge-eating and purging and that these changes were maintained at 3-month and 12-month follow-ups, concluding that ERP does not hurt anything, but it does not add anything either. Cooper and Steere (1995) addressed the question in a study that assigned 13 patients to CBT and 14 patients to ERP alone. This study is unique in that the ERP condition only addresses the behavioral and anxiety aspects of bulimia without addressing the cognitive aspects at all. Both groups improved significantly in the short term, but at 1-year follow-up, the CBT group had maintained those improvements and nearly all of those who had improved with ERP alone had relapsed.

CBT vs. Psychodynamic approaches, Psychoeducational groups, and Self-help CBT has also been compared with psychodynamic approaches (Garner and Sackeyfio, 1993; Walsh et al, 1997) in which both groups in both studies showed improvements in the frequency of binge eating at the end of treatment, but the CBT

groups in both studies showed greater improvements in purging, dieting behaviors, general psychopathology, attitudes toward weight and shape, and self-esteem. CBT appears to be superior to general psychodynamic approaches as well when those psychodynamic approaches are structured to mimic typical psychodynamic therapy as it is rendered in short-term situations (Walsh et al, 1997).

CBT has been compared to a group psychoeducational intervention (Olmsted, Davis, Rockert, & Irvine, 1991) with results from 54 participants showing that CBT was generally more effective than the educational group. However, on several indices, for the healthiest 25-45 percent of the sample, the effects of the group and the individual CBT were nearly equivalent.

Self-help manualized forms of CBT combined with minimal therapist contact have been studied as well (Treasure et al, 1996; Cooper, Coker, & Fleming, 1996) with improvement rates of 25 percent (Treasure et al, 1996) to 41 percent (Cooper et al, 1996).

In another study, Wooley, Wolley, and Deddens (1993) evaluated the outcome of 132 women aged 18-38 who had participated in a one-month intensive residential program. The program consisted of group CBT, group to address emotional roots and body image problems, individual therapy, educational seminars, and multifamily therapy. At one year follow-up, 86 percent of participants had reduced their bingeing frequency and 38 percent had no symptoms. Only 1.5 percent had dropped out of therapy. This study did not attempt to distinguish the effects of group CBT on outcome vs. effects of the other methods, however.

Methodological literature review

There are two published studies related to the treatment of people with eating disorders that privilege the voices of the client. Shifts and Knapik-Esposito (1993) conducted interviews with a bulimic 17-year-old, her mother, and the therapist to determine what the clients described about therapy as effecting change and what the

therapist learned from the family over the course of therapy. The mother and daughter identified therapy as being like a conversation with a friend, unlike a lecture, suggesting they had been expecting that in therapy. They thought the therapist had focused on the good things in their lives and encouraged them to attend to positive changes as well as focusing time and energy on the problem, which they determined had been helpful.

Protinsky and Marek (1997) conducted an integrated, multi-modal treatment program, which they evaluated with both quantitative and qualitative methods. The authors determined two themes, differentiation and connection, that characterized the struggles and treatment of their problem. Participants found differentiating from their families-of-origin and establishing identities that felt like their real “selves” a difficult but necessary component to resolving their eating problems. The majority of participants also reported believing that they needed to “increase their social connectedness and improve their interpersonal relationships” (67) in order to achieve a full recovery.

In addition to these studies, there are several studies from different sets of literature that indicate a movement on the part of some researchers to discover clients’ perspectives on therapy and therapy outcomes. Llewelyn (1988) examined forty therapist-client pairs’ records of what they found helpful and unhelpful about each session. One thousand seventy-six events were collected, and the results suggest that insight, reassurance/relief, problem resolution, and personal contact were the helpful elements of therapy. Llewelyn also determined that without a good relationship, insight verbalized by the therapist was likely to be counterproductive.

Regan and Hill (1992) conducted a study in which 24 clients reported after each session what they had left unsaid, and their respective therapists tried to guess what they had left unsaid. Clients, primarily, did not reveal negative emotions, thoughts, or behaviors, and therapists did not reveal emotions and clinical “conjectures”. Therapists

were aware of only 17 percent of the things clients said, and in those situations where they guessed accurately, clients were the least satisfied with the session.

Wark (1994) studied five groups of participants, each one including a client couple, their therapist, and a supervisor who did live supervision, about their perceptions of therapeutic change and what events were meaningful in effecting that change. Therapists and clients had “vastly different” perceptions of what was helpful for change. Based on this, Wark reminds the reader that multiple versions of reality exist in any therapy situation, suggests that attending to client voice is necessary for effective outcome, and states that collaboration between therapist and client is necessary throughout the therapy process to gain access to the knowledge clients have about their own needs in therapy.

Sells, Smith, Coe, Yoshioka, and Robbins (1994) interviewed seven couples and five therapists twice about their experiences of reflecting team practices. Couples and therapists had strikingly different perceptions of the experience. Clients, rather than therapists, stated a need for equal gender representation on the reflecting team. Clients found the team helpful anytime they offered different ideas or views on the couple’s problem, while therapists thought the team was effective when they helped the couple collect their thoughts or when they interrupted an escalating communication. Couples also found it helpful that the team in the study was actually in the room with them so they could see their body language and hear everything they said in their discussion of them, rather than reporting in from the other room.

McCollum and Beer (1995) describes the first author’s experiences as a participant in the second author’s dissertation research. Beer videotaped McCollum and a client couple during therapy sessions, interviewed them after sessions and videotaped those interviews, and met with them all together to review various video tapes and discuss their perceptions of therapy. This experience, of talking with clients about therapy at all, much less as it continues to proceed, was unique for McCollum; he referred to the “excitement

of our experiment” (62), and wrote that since he stopped seeing the couple, they have continued to influence his thinking as a therapist, professor, supervisor, and editor, sensitizing him to the absence of client voices in a field (MFT) that proclaims collaboration and co-construction.

Stith, Rosen, McCollum, Coleman, and Herman (1996) interviewed 16 children between the ages of five and 13 who had participated in family therapy sessions. The primary opinion of the kids who participated was that they wanted to be included in therapy in a meaningful way, which typically meant *not* doing an hour of adult talk with them. The children participants were also more comfortable with therapy if they knew more about the reasons the family was in therapy in the first place, and it became clear to the parents and researchers that one conversation about those reasons was not enough. Lastly, the characteristics of the therapist were important; those who were interested in the kids, able to connect with them, and tried to do things in a childlike way were more successful at involving them in therapy.

Bischoff and McBride (1996) conducted 28 client interviews with nine family, 13 couple, and four individual cases asking them to comment on the process of therapy and what they found helpful and unhelpful. Their key finding was that clients highly valued a therapist who took an expert position with them and seemed in control of therapy, but this was only the case where the therapist also displayed the nonspecific factors of warmth, empathy, and mutuality.

Chapter three: Research design

This research is an discovery-oriented study employing loosely-structured interviews to gather participants' reports of their experiences in therapy for an eating problem. I am not confirming or disconfirming any hypotheses, and I am not, as in other methods of qualitative research (Glaser & Strauss, 1967), attempting or intending to develop theory. I am looking to see what I can find when I ask women to talk about what helped them in therapy.

The research design followed the six steps of interview research as outlined by Kvale (1996). Participants were engaged in the research, and the first step of the interview portion was to have them describe their lived experience while in treatment for an eating disorder. During this description, the second step occurred: participants themselves discovered new connections and meanings about their experiences as they talked about them. The third step in this research was that while doing the interviews, I condensed, interpreted and related to the participant what I understood her to be saying. She either agreed or disagreed and clarified if necessary. The back and forth of this occurred until each of us was satisfied that the other understood the point, thereby creating a "self-correcting" interview in which my goal was intersubjective agreement.

The last three stages of this research happened outside the interview. The fourth stage, as outlined by Kvale (1996), was for the interviews to be interpreted by the interviewer. This stage had three substages during which the material was 1) structured for analysis by transcription, 2) clarified by eliminating digressions and repetitions and distinguishing between essential and non-essential, and 3) analyzed.

The first of these substages, transcription, should not be considered a simplistic matter. The answer to the question of how to physically represent interviews is not an obvious one. Whether to include non-lexical remarks is not agreed upon (Riessman, 1993; Nespor & Barber, 1995). Nespor and Barber (1995) write that representing the starts,

pauses, hesitations, and repetitions in writing is preserving “artifacts of interview practices” (pg. 36) rather than remaining true to the ideas of participants. They remind their reader that “[p]eople do not speak on paper. Transcripts are written forms, and when we freeze interview speech into print, we construct those we have talked to as subordinate writers: We make them look ignorant” (pg. 57).

These interviews were transcribed by a paid transcriptionist who was instructed to record exactly what she heard. I treated this transcription as a framework, and I filled it in during the next substage of interpretation, clarification. I clarified the interview transcripts by listening closely to the audiotapes while following along with a copy of the written transcript to make any additions or corrections that I believed were appropriate. I also translated interview practices, “uhmmm’s, ahhhh’s, and “you knows” to standard written English. Participants were told that I would edit their interviews in this manner unless they wished otherwise. No participant requested that I *not* edit her interview. After reaching certainty that the transcripts closely reflected what was said in the interviews, minus the non-lexical remarks, I moved to the last substage of analysis.

In the last substage, I made deliberate attempts to attribute and develop meanings from the interviews. I have chosen in this research to analyze the interviews by categorizing information from them in ways that I believe makes the information accessible to therapists who work with people with eating disorders. Interview information lost some of its contextual relevance by using this method, but this method served the purpose of the research.

The last stage in Kvale’s (1996) method for interview research is to extend to action the information developed from the research. In this research, this will be accomplished at the local level by distributing the results to colleagues in the area who treat clients with eating disorders through discussions, presentations, and interactions.

Sampling procedures

This research employed an opportunistic sample. During the fall and winter of 1997, I sent letters to two area therapists who are known to my committee chairperson as therapists who primarily treat clients with eating disorders. The letter requested their participation in recruiting participants in a study that was being developed. One of the therapists responded by letter that she was dealing with a major illness and could not take on any additional responsibilities. The other therapist responded enthusiastically, and I proceeded to have several phone calls with her discussing what our study would look like and what she would have to do to participate. The central problem at that point was how to gain access to clients without violating their confidentiality and privacy. This required the therapist who agreed to participate to serve as the intermediary. I discussed with her the easiest way to get information about our study to her current or ex-clients; she suggested making copies of the letter we wanted to send to them, delivering them to her, and letting her attach a note to them and mail them. She agreed to address and mail the letters with a postcard that clients could use to contact me if they chose to participate. I delivered 100 sets of letters, addressed envelopes, and postcards to her office. Several weeks later, cards from prospective participants started arriving at the Family Therapy Center. I compiled a list of 21 women who responded and started calling them to make appointments for interviews.

The first appointment for an interview was made for February 1998. The last interview in this group took place in July 1998. Of the 21 women who returned postcards, 11 scheduled interviews with me. The other 10 were unreachable due to disconnected phones, unreturned messages, or some other unknown factor. One woman who had returned the postcard declined to participate when she found out participation entailed an in-person interview. She had thought we would just talk on the telephone or that she would fill out a questionnaire.

I made appointments with participants at the convenience of the participants. I interviewed clients in three different places: the private practice office of my committee chairperson, my office in a community family service agency, and the Family Therapy Center at the university. Following one particularly enjoyable and somewhat loud interview I conducted at my committee chair's private office, he was told that whoever had been in his space, i.e. me, had made so much noise that she was disturbing the therapist next door.

Interviews were conducted based loosely on the interview schedule in Appendix A. I audio taped the interviews with two tape recorders.

At the end of the first interview, I immediately rescheduled a second interview with the participant. She did not show up for her second interview. However, she called my home number (as evidenced by my caller identification box), but she did not leave a message. My attempts to further reach her were unfruitful.

For the following interviews, I asked participants to call me to schedule a second interview if they thought of anything that had been overlooked or left out of the first interview. The next two participants called me back within the week to schedule a second interview. Both of them called my home number and my work number and left multiple messages over the weekend wanting to talk again. I rescheduled interviews with them. Given the apparent success of this method at getting a second interview, I asked all further participants to call me if they thought of anything that had been overlooked in our interview. After the first two clients who called to schedule a second interview, I conducted five more interviews; at the end of each of these, I asked participants to call me to schedule. None of the next five called to schedule a second interview.

Between the next five interviews and the last 3, this research shifted from being research in which I was participating as part of a larger, ongoing research project in my department to being my dissertation research. During the last 8 weeks in which I was

conducting participant interviews, I was also arranging an interview with the therapist who treated all of the participants. My committee chair spoke with her about doing an interview for the first time when she called to say she had more clients to whom she could send letters requesting participation. Over the next several weeks, she and I discussed the interview particulars, i.e. what did I want to know? what was her schedule? what was my schedule? I met with her twice for approximately three hours each time to discuss how she thinks about treating her clients with eating disorders. We met the first time at the university and the second time at her office.

Data collection

I employed open-ended, unstructured interviews as the primary method for data collection following the question schedule in Appendix A. Kvale (1996) noted that interviews are “highly suited for studying people’s understandings of their meanings in their lived world, describing their experiences and self understanding, and clarifying and elaborating their own perspectives of their lived world” (p. 105).

I do not assume that people are like containers carrying around information that they will dispense with the appropriate stimulus such as an interview question. Meaning is constructed actively during the course of an interview and is constrained by the variety of forces that constrain most activity (Mishler, 1986a). My goal was to present myself as open to whatever participants wished to discuss. In this sense, the interviews were conducted in a therapeutic fashion. However, I was also attempting to get any information I could from the participants about their treatment. The interviews were conducted, therefore, in an open fashion with some definite steering toward specific subjects.

Kvale (1996) discusses therapeutic interviews as a potential ideal for researchers who conduct interviews. He warns against research interviews that are too much like therapeutic interviews, however, but this warning is for the sake of protecting research participants from getting into emotional material with an interviewer who is not trained to

handle such information. I conducted the interviews utilizing my clinical judgment about the effects of the interviews on the participants. Interviews would have been terminated and participants referred to their therapist (or another therapist, if they had chosen), if I had determined that the interviews were too difficult for them to complete. This did not occur in any case.

I audio taped interviews with two tape recorders, and the tapes from the interviews were delivered to a transcriptionist to develop an initial transcription. I then listened to the tapes and read the transcriptions for the purpose of filling in and correcting the version of the transcript created by the transcriptionist. I worked from these reviewed and clarified transcripts to analyze the data.

Data analysis and interpretation

“The key issue in selecting and making decisions about the appropriate unit of analysis is to decide what it is you want to be able to say something about at the end of the study” (Patton, 1990, 168). “It is . . . paralyzing to think that the analysis, when tackled, has to be exactly right and must conform precisely to one or other orthodoxy. . . there is no single right way to analyze data; equally, it is essential to find ways of using the data to think with” (Coffey and Atkinson, 1996, 2-6).

My purpose for analyzing these interviews was to understand and interpret what participants said about the helpful aspects of their previous or ongoing therapy in a way that makes it possible for other clinicians to learn how to be more helpful. My goal for the process was to maintain a reflexive stance in regard to my interpretations. In so doing, I hoped to avoid what Fontana and Frey (1994) point to as a fault of studies using unstructured interviews; they “are not reflexive enough about the interpreting process; common platitudes proclaim that data speak for themselves, that the researcher is neutral, unbiased, and ‘invisible’. Data reported tend to flow nicely, there are no contradictory data and no mention of what data were excluded and/or why. Improprieties never happen and

the main concern seems to be the proper, if unreflexive, filing, analyzing, and reporting of events” (pg. 372). Because my experience was not always smooth and because I certainly did not feel neutral or unbiased, I have attempted to be explicit about the difficulties I encountered and the biases of which I was, or am, aware. It is also for this reason that I will describe explicitly how I took the steps to deliberately “analyze” the data.

For the purposes of categorizing transcripts of the interviews, I would read one transcript and apply codes to the entire transcript. These codes consist of both indigenous typologies and analyst-constructed typologies (Patton, 1990). My goal was to use the language of participants where possible, but I did not leave a category without a label if one had not been suggested by participants’ voices. Since I had done these interviews with the goal of determining helpfulness and unhelpfulness, those were obvious “codes” to have in mind. Because I am a therapist trained in systemic and feminist ways of thinking, those theoretical codes also came quickly to mind. My experiences interviewing these women sensitized me to certain things in analyzing the interviews. Because I asked about, and most of the participants had experiences with, doctors and nutritionists, for example, I was also looking for their beliefs about the helpfulness or lack of helpfulness of these additional treatment providers. I also used as codes phrases suggested by participants, e.g. “testing therapist”, when those things became obvious shorthand for things participants reported having done. I could not have eliminated these ideas from the process, nor did I attempt to do so. They were a part of myself as I responded to readings of the transcripts.

After several readings in which I applied “codes,” I cut out those parts I had coded as helpful or unhelpful. I would then proceed to the next transcript. I read each carefully and marked those parts in which the participant was specifying a helpful or unhelpful aspect of her therapy. I then cut the helpful and unhelpful parts from the whole transcript. The result was a stack of pieces of transcripts labeled “helpful” and a stack labeled “not

helpful.” (Before I cut these parts from the whole, I labeled them as to their original locations.) This step took approximately two weeks of steady work.

The next step was to begin creating a larger set of meanings from the parts of interviews I had cut out. I stuck each piece of paper to the wall of my apartment and began reading them as a group. The challenges at this point were to try to grasp a sense of the whole and to keep all the pieces attached to the walls of my apartment. (Taping seemed, in the end, to be the best method. I started using plasti-tack, but I would wake up in the morning to find pieces of paper strewn all over the floors.) I read and re-read all of these parts of transcripts until I felt I had a sense of them as a whole. There was no mystical point at which I believed I had grasped everything, but I did reach the point when I knew where most pieces were physically in my space and re-reading them in that spot felt like re-reading passages in books that I have read to the point of memorization. If, at that point, I had not “memorized” all of the parts, I was intimately familiar with them, and I could locate them geographically in my home and recall exactly who had said them. This process also took approximately two weeks of reading. Some of it was planned, as in, “I will read the transcript parts for an hour and then watch TV,” and some of it was unplanned. Since the pieces were taped all over my apartment, I could not avoid reading them without leaving the house. As this part of my research was accomplished during the winter I lived in Montana, leaving the house was not an easy option. I do not know how much literal time I spent reading these parts, but it was a considerable amount.

When I reached this point, I began to try deliberately to determine how the whole could be deconstructed into parts that made sense to me and helped answer the questions I was asking through this research. The first thing I did was write out, “What was helpful in therapy?” on a piece of paper, and I taped it to a blank space of my wall. Then I started at the left side of the apartment, and I began reading each piece of transcript while asking that question: “What was helpful in therapy?” I realized pretty soon that I was

making a distinction between things that happened “in” therapy and things that happened “outside” therapy. That was a potentially useful distinction, so I pulled from the wall those things that happened in the office with the therapist present and placed them in their own space. Then I returned to the left side of the space and repeated the process with the question, “What was helpful outside of therapy?”

In addition to meanings I developed this way, I was also influenced by my discussions with these women to notice certain things. For example, in the first interview I conducted, the participant told me about an incident in which the therapist told her that her voice seemed “whiney”. This participant noted this as a turning point in therapy for her because it changed her relationship with the therapist for the better. She remarked that the therapist seemed more like a “real person” because she did not hide her feelings. When I was looking at the entire group of transcript parts, I had the idea of “turning point” in mind. I was also looking for parts that would fit the large category of “relationship” since this participant suggested this was an important and helpful part of her treatment.

After I had combed over all the transcript pieces thoroughly and believed I had removed all that fit a category I was constructing, I physically moved the transcript pieces from the wall to a file folder labeled with the category name I was using. Sometimes as I was moving things from the wall to a file folder, I would realize that a category I had still on the wall would be a better fit for the piece, and in those cases, I would put the piece in the different category. Sometimes, parts of transcripts would seem to fit in more than one area. When that was the case, I would cut the same part of the transcript from another copy of the transcript and keep the parts in both categories.

When I had categorized all (but two) of the “helpful” stack, I re-read each category as an entity to itself. As I read, I asked myself if everything in the folder fit with everything else in the folder. I continued to move transcript parts around with the goal of achieving a sense of fit in each category. In several instances at this stage, I recalled parts of

transcripts that had not been cut from the whole and placed in the “helpful” and “unhelpful” stacks that nonetheless seemed to fit in one of the smaller categories then. I would cut those parts from the copies of transcripts and place them in the appropriate category folder.

I then began reading each category for the purpose of making further distinctions within the category. At the time, I believed the actual “analysis proper” (Kvale, 1996) began at this point. Retrospectively, I see I was doing analysis all along, but I had reached the point where I was no longer arranging, rearranging, and sorting parts of transcripts, so I began trying to re-construct information that I thought would be useful to other therapists.

This is an important point to remember in attempting to understand how and why I have reached the conclusions I have reached. My overarching goal was to learn from women what makes therapy work for them. My experience as a therapist influences me to look for patterns and processes, and I chose to include that same type of “search” in my analysis. I wanted to know for my own purposes what works in therapy, and I wanted to be able to tell other therapists that I had learned something useful. This is certainly an imposition of my viewpoint on the data.

At this point, the point of reconstruction, I felt completely lost. I was able to cooperate with the notion that there was no “right” way to do the deconstruction part of the process, but not having a roadmap for the reconstruction part was frightening. I was certain that my way of putting things together would not be the way other people would do it, and I felt terror at the thought that someone might find out that I did most of this work sitting in my pajamas drinking too much coffee and making frequent trips to the grocery store for more ice cream. I just knew that “real” researchers got dressed up, sat at proper desks in book-lined offices, and never avoided thinking about their work by surfing the internet for hours at a time.

I eventually decided to make a go of it by drawing diagrams of what I thought I was learning from the categories I had organized, and in trying to create diagrams that showed connections between categories, I slowly began to put the data into its current state. As I began retyping the pieces of transcripts, which were themselves, pieces of interviews into paragraphs, I had the idea to read all the transcript parts in a particular folder until I could recall most of them without looking, and then I would sit at my computer and put the information in writing without referring back to the originals. This further decontextualization had a specific purpose. I wanted to connect similar remarks from different people in a way that gave the ideas the participants suggested primacy. I could not do this as long as the idea remained embedded in the whole of the interview or even in the whole of the entire data set. For this part of the analysis, I tried to keep each constituent category separate. I continued in this fashion until I had written up each category. Reissman's (1987) remark supports this "method", but it did not suggest it. It is only in retrospect that I see that the challenge I was facing is the challenge to which she is referring.

The challenge is to identify similarities across the moments into an aggregate, a summation. An investigator sits with pages of tape-recorded stories, snips away at the flow of talk to make it fit between the covers of a book, and tries to create sense and dramatic tension. There are decisions about form, ordering, style of presentation, and how the fragments of lives that have been given in interviews will be housed. . . In the end, the analyst creates a metastory about what happened by telling what the interview narratives signify, editing and reshaping what was told, and turning it into a hybrid story, a 'false document' [Behar, 1993]. Values,

politics, and theoretical commitments enter once again
(Riessman, 1987, 13-14).

Riessman (1993) writes elsewhere that the research process is not over when the analysis is complete. She considers reading of the text by someone other than the researcher (and presumably, her committee) the next step in the “analysis” phase. “The meaning of a text is always meaning to someone” (Riessman, 1993, 15).

Who are they?

The nine women who participated in this research are a diverse group unified by three specific things: their geographical location, their struggle with an eating disorder, and their therapist. Beyond that, they are very different from each other as I experienced them. I have written a very brief description of each woman and included her remarks about why she started therapy.

Anastasia was fifteen years old at time of our interview. She had started having anorexic symptoms when she was 13. She was 5'8" and had gotten down to 100 pounds at her lowest weight. She was, at our interview, steady at 120 pounds, which is her target weight. She has taken Prozac over course of treatment, which has been managed by two different psychiatrists and a family doctor. When she started therapy, Anastasia did not want to eat anything, and before she started therapy, her parents had been forcing her to eat. Her mother took her to a pediatrician who referred her for therapy.

I was in denial (laughingly). . . How can you say, ‘I’m sick?’

And then, yet, I knew that I was because I knew it wasn’t healthy to want to be underweight and be as skinny as a rail, you know? I knew that wasn’t healthy, I knew that wasn’t good, but I loved it. It was like a power, like a high for me.

Anybody that will take drugs. . . it was a high like that for me to not eat. . . then they told me that I had to eat. I said, ‘No’

because this is going to make this happiness go away. And I was scared, and yet I wanted attention and so I liked it, in a sort of twisted way I liked going to see Claire that first year.

Leslie was 21 years old when we met for our two interviews. She had started seeing Claire 18 months prior to our interviews. At that time, she had been eating 400 calories per day of vegetables, chicken, and tofu only. She was also running 6 miles every day and teaching aerobics. She had gotten down to 105 pounds. When we met, she weighted 150 pounds, which is her natural weight. She was a junior in a private college.

I lost my taste buds or something. And one of my best friends, who is older than I am, couldn't see me keep going on like this. She would be at the gym with me when I would be working out and she was afraid I was going to collapse. And there was another personal trainer there, an older woman, whose daughter had gone to Claire, and they kept bugging me to get help. I said, "No, no, no." Finally, though, I was so exhausted because I was working out all the time and I wasn't eating, that I was ready. I guess I was just ready for help, and I wanted help, even though I didn't want to gain weight, and I didn't want to eat more. I was kind of miserable. I thought I would be happy if I was skinny, because I'm basically a happy person, in a way. But I thought I would be happier if I was skinny, but I wasn't. I was just more miserable because I was afraid I'd gain weight. And so they finally talked me into getting help. We talked to my mom, and she checked with our insurance, and Claire was approved. So I started going to her and I was

about a hundred and ten pounds, maybe a hundred and five, but I have a solid build, so now I weigh a hundred and fifty. (Laugh) I was really thin, a hundred and ten for me was really, really thin. And so, I was eating nothing.

Julie was 28 years old when we met for two interviews. She had been diagnosed with chronic fatigue syndrome eight years earlier, and she had started dieting by using Slim Fast when she was about 15. Eventually, she started taking laxatives and got up to 15 laxatives per day, and while doing so, her weight got down to one hundred four pounds. She saw the therapist for four years, and she still sees her occasionally to address other areas of her life, but her eating is much better.

So then, one Sunday, I was supposed to go somewhere with my family and my heart almost stopped, I mean just horrible heart palpitations. I got sick, and it was from the laxatives. But to back up just a little bit, my regular MD, who I felt like I could talk to, did some blood work because I was losing so much weight and he said, "Are you starved? You know you can tell me because your blood work shows that you're getting no nutrients to yourself." And I said, "No, no," you know (laughing), "no way." And at home, I thought, "Maybe I am." Then I thought, "No. No! No, they're all wrong. I've got this under control, I can handle it. If I want to stop taking these laxatives I can stop." And I couldn't. I couldn't stop. And I was hiding them from my family, of course. Nobody knew that I was taking them. . . . Finally, when I really thought I was going to die, I said, then, "I'm

ready to get help. I don't want to die." And at that point, we didn't know if it was too late, you know.

Carrie was thirty one years old when we met. She had seen her first therapist at seventeen years old, and her eating has cycled up and down during those fourteen years. She was not in therapy when we spoke, and it had been one and a half years since she had stopped. She had seen four or five therapists over the previous eleven years. She saw Claire for seven months. When she started therapy with Claire, she was 5'8", one hundred nine pounds. She is married with one son.

It was a chance [going to a new therapist]. I mean, I'm tired. I am tired and was tired of trying to do it all myself. To fix it myself and just keep hoping. I guess every couple of years I try someone new. And Claire was good, don't get me wrong. It was just, I backed out, again. . . . And I wish now I would not have stopped going to Claire, and I've thought about going back, but now I'm embarrassed for having dropped out and not seeing her for a year. It's kind of weird going back. Like when she sent me the letter about this [the research interview], "I hope this letter finds you doing well." Underlined, you know. I thought, "Well, guess what?" (Laugh). You know.

I asked how she was doing.

It's still up and down. Good times and bad. I'll start to slip back in. I teach aerobics, too, and I'm a personal trainer, so I'm in front of mirrors all day, which is not a great thing. And, I'll just decide that I'm too fat and just won't eat for a week. I drink water for a week.

I told her [the therapist] I feel right now that I'm always going to have this problem, and quite honestly, no matter what you say or what you do, I don't think you'll be able to help me. I mean, not being rude, but I decided to tell her, "Not you, not anybody. I don't think anyone can help me not be like this . . ." And I still feel that way.

Sue was thirty-six years old when we met, and she had been undergoing severe diets and bingeing for years with some starving. She was put on diet at ten years old by doctor. When she had starved herself, she would eat nothing for days; she smoked and drank Coca-colas. She never purged, but she took diet medication prescribed by a doctor. She saw one other therapist years before we spoke, and then she was in therapy with Claire for two years. She had not seen her for a while when we talked. She was divorced.

This last time that I went [to therapy] , it started out with thinking that I was miserable because of my weight, and I had to get in and talk to her because I'd seen that she was new to the area or new to that clinic, and she specialized in women, and I thought, "Wow, this will be great." And I got in there and we started talking, and I came to realize that it wasn't my weight, it was the other things that were making me unhappy and that was what was causing the weight. . . I don't remember exactly what she did call it, but for years I've got through either severe dieting or bingeing. It wasn't to the point of anorexia or bulimia, but it was a compulsive kind of thing. Compulsive dieting, I read that term in one of the books I read. . . that was how I, for years, would deal with

my problems. When something would start bothering me, I'd focus on one of the diets or the binge.

Vivian was twenty-one years old when we talked. She was a college senior, and she said she had suffered from "manic depression" for a while. She had grown up in the area where we met and lived in the same house until she moved away to school. She had to leave her private college because of their concerns about her severe weight loss and their inability to provide adequate care, so she was back in her hometown and attending a local community college. She was eight weeks pregnant when we spoke.

I knew that I was at, not a crisis point, I wasn't really suicidal, but I was just at the point where I thought, "I can't do this anymore, I feel like I'm just pretending." The main focus of my treatment has always been my depression. I worked with Claire and my doctor for several months on my depression and dealing with it, and I finally got to the point where I thought, "Okay, I think I'm handling myself pretty well." And that's when Claire said, "Are you ready to tackle your eating now?" And it threw me into a tailspin, and I panicked. "Okay, this is a part of my life I'm not ready to touch yet." And I started losing weight very rapidly. As long as I had a bigger problem, it was okay--- whatever I did with my eating, because I thought, "Well, I can do that if I need to get by because surviving this depression is the really hard part right now." And then it became, "Okay, I'm capable of living with depression. I need to work on what I'm doing wrong to my body." I was a very moody eater. . . in the past four or six years, it's been very attached to punishment and deserving

to eat and not deserving to eat and whether or not my behavior, the way others reacted to me, made me deserve to nourish myself or not. So, there were cycles of not eating at all. . . if I got very depressed or very upset about something I would binge and sometimes throw up.

Sammie was thirty years old when we met. She said she had an eating disorder as early as eighteen, and maybe earlier. It had started like anorexia, but it soon shifted to bulimia. She binged and used laxatives to purge. She also had anxiety attacks. Sammie teaches special education, and she had spent time in Tunisia with the Peace Corps. She was taking Prozac when we spoke, and she had taken Zoloft and Paxil previously. She had not been in therapy for almost a year at the time of our interview, but she had seen Claire off and on for about four years. Sammie is married.

Actually I guess we had just been through a lot, and we've had all the mess with the Peace Corps, and then I was in a job for a year that I was not happy with. So we moved here where we have no family or anything so it was starting all over, and one night in the middle of the night I woke up, and I was crying, and I had this terrible feeling in my chest, and I didn't know what it was, although I always said it felt like there was a vacuum in my heart, not like vacuum cleaner, but a vacuum. And so then, one night I woke up and realized, "Oh my God, I'm having an anxiety attack." And I had had them before but did not realize exactly what it was, and so at the time, there was a commercial on about a referral service, so I talked to my husband about it, and God, that was when I finally admitted to him that I had an eating

disorder. By that time we had been together probably seven or eight years. . . So it was something that was hidden.

There were two times I ended up in the hospital because I was dehydrated and he didn't even know what the cause of it was. So I just opened up to him, I called a referral service, and they referred me to Claire.

Karen was twenty-five years old when we spoke. Her eating disorder had started when she was twenty-one. She had been in therapy for depression for three or four years, and it did not help. She started dieting when she reached one hundred forty pounds, and she had gotten down to 95 pounds when she started therapy at the Renfrew Center in another state where she had lived previously. She did an intensive outpatient program there in addition to individual therapy and seeing a nutritionist, and her eating got worse. She was told she needed to go inpatient or she could die, so she did. She found it very helpful. She and her husband had recently moved to the area, and she was referred by Renfrew to Claire to continue therapy, and she has been seeing her for six months.

After I moved down here, for a month or two, I started to eat a lot and then throw up, which shocked me because I didn't think I would ever, ever do that. I never throw up. I mean, I'm not the type of person that can make myself do that but I did. But that stopped, and I haven't done that anymore. I have weeks where I eat fine, and I'm always thinking 'I shouldn't be eating this' and fighting with myself, but I'll eat it anyway. And then there are days that I just won't eat, so I guess as long as those days don't turn into weeks and into months. . .

Lisa was twenty-six years old when I talked with her. She teaches special education in the public schools, and she had started therapy in another state a year before we spoke. She and her husband had moved to the area due to a job transfer. She was 5'4" and had reduced to ninety-five pounds in college at her lowest weight. She weighted ninety-seven pounds when we spoke. She said her eating disorder started twelve years previously in high school when she started dieting after getting up to one hundred twenty pounds.

I was crying a lot, hysterical over any little thing. Mostly changing my clothes at least six times in the morning (laugh), regardless of what my husband said. 'You look great.' His words didn't matter. The therapy part has helped a lot because I'm able to look at things more realistically. . . I'm able to process information, but the medication has helped the emotions. I put my clothes on once. I'm now capable of keeping that outfit on and going to work. I eat no meat or chicken. I basically live on vegetables and some pasta, stuff like that. I have this sugar need, which I had asked my therapist about, and she said those are things that you crave. I crave basically gummy bears and Pepsi. Those were the things I was living on before I went on medication. Everything I ate, regardless of what I ate, I would throw up because I was just afraid I would gain ten or twelve pounds a day. Now I just restrict, I restrict more of what I eat. I have made a conscious effort where at least one day a week, I try not to restrict. At home is my hardest time. But now, I eat so many vegetables that I don't ever want that anymore.

Sometimes I eat with my husband. He cooks a lot of meat and stuff like that. Sometimes I'll just have a sample of it because it smells good.

Chapter four: Results

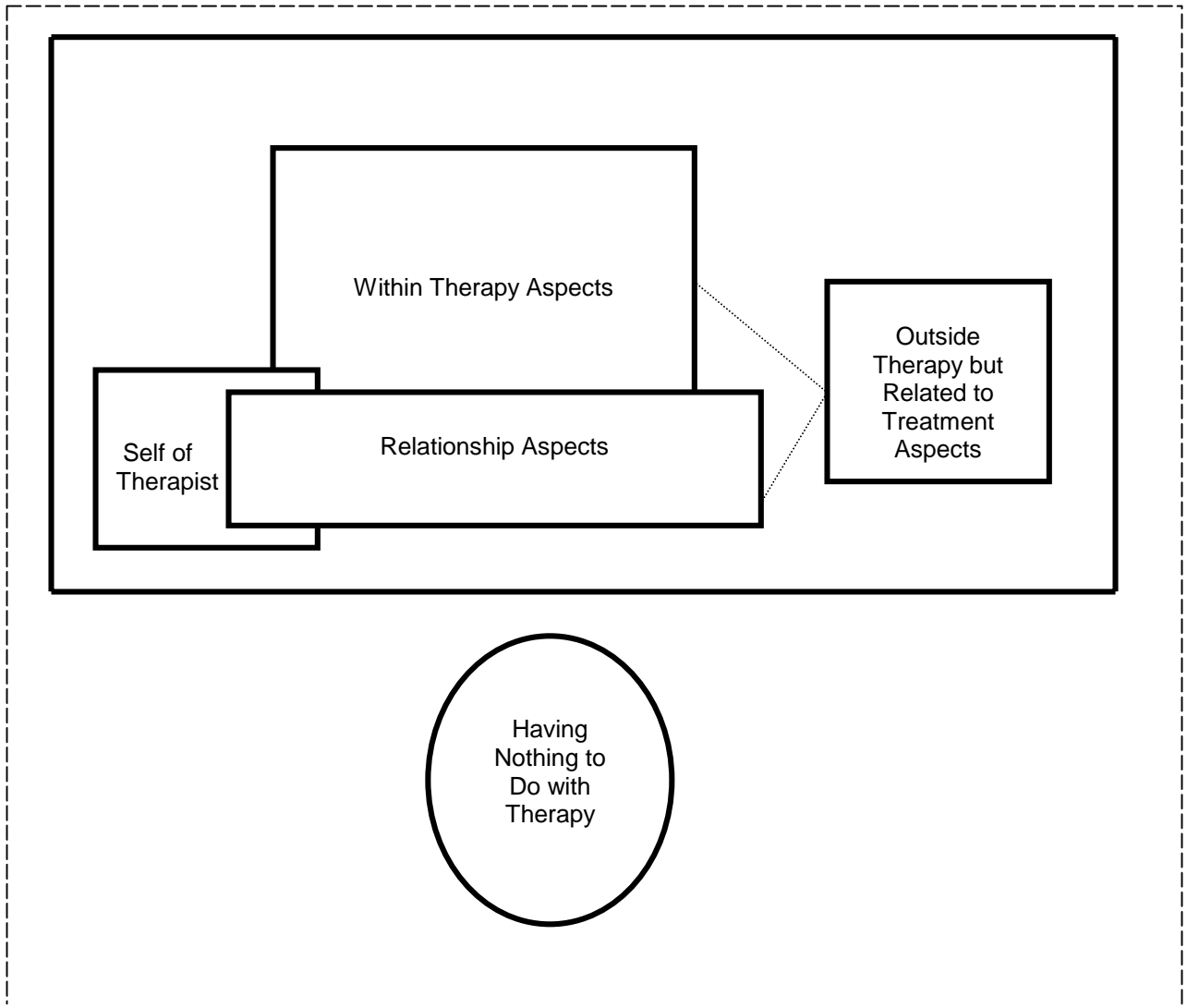
“Frequently writers are positioned outside, yet alongside, those Others they write about, never making clear where they stand in these hyphenated relationships that connect the Other to them. When Others are not allowed to speak, they remain ‘an absent presence without voice’ (hooks, 1990, p. 126). There are major problems with this approach to ‘Othering,’ and it has been extensively criticized. In such situations it is best to let Others do their own talking. However, even when ‘we’ allow the Other to speak, when we talk about or for them, we are taking over their voice. A multivoiced as opposed to single-voiced text can partially overcome this issue” (Denzin, 1994, 503).

The final sample consisted of nine (n=9) women diagnosed with an eating disorder and one (n=1) therapist whom they all had in common. Interviews were conducted with all participants, and the transcribed interviews were the source of data for this research.

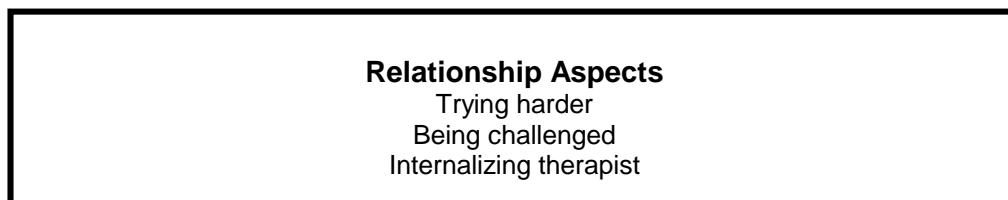
The goal of this study was to determine from the experiences of women, as they re-told those experiences, what was helpful about their therapy for an eating problem. The following is one way to organize that information. I will present a basic diagram, expanded diagrams, and participant and therapist voices in this chapter. “The postmodern sensibility encourages writers to put themselves into their texts, to engage writing as a creative act of discovery and inquiry” (Denzin, year, 504), and I have included my own voice from interviews where doing so clarifies contextual meaning. However, “post structuralism . . . frees us from trying to write a single text in which everything is said to everyone” (Richardson, 1994, 518), so I am not suggesting that by including these multiple voices I have exhausted all potential meaning from these interviews.

I will discuss each category by presenting participants' voices and the therapist's voice separately. There were aspects to the therapist's work with clients, based on my interviews with her, that are not discussed here because they did not come up in conversations with clients. Rather than construct "Claire's model of therapy" and allow participants to comment on that, I have done a version of the reverse. I constructed a model of helpfulness based on my conversations with participants, and I used the interviews with the therapist to expand on what participants said.

Helpfulness in Managing Eating Problems



Expansion of Helpfulness Diagram



This category addresses the relationship between individual participants and the therapist who participated in this research. I have foregrounded it in this diagram to

indicate its primacy and importance in the overall picture of “helpfulness” in therapy. I believe it is foundational to the other helpful aspects of therapy that participants elucidated.

Relationship aspects

Participants’ voices

Every research participant commented favorably on her relationship with this therapist, and every one of them stated that the relationship was very important in her attempt to manage her eating problems. Vivian stated explicitly that the relationship had been the thing that helped her the most. When I interviewed Vivian, she was pregnant with her first child and was planning to be raising her child alone. She had been “suspended” from her private college because of her eating disorder. The school reasoned that they did not have appropriate treatment available for her, and they determined their liability was too great for her to stay. She had read extensively about etiology and treatment for eating disorders, and she considered herself knowledgeable on the subject beyond her personal knowledge. The therapist’s acknowledgement of this was very important to Vivian who was sensitive to the notion of being patronized or “bossed around”. Vivian remarked that her therapist would tell her, for example, that what she was thinking was not normal, and she would repeat it until it “sunk in” and Vivian recognized where her thinking was wrong. When I asked Vivian if that would have worked without the close relationship, she said, “No, I think it is something that’s come from our close relationship.” She went on to say, “I decided that the thing that had helped me the most in therapy with Claire has been the relationship I’ve formed with her.”

Julie said, “I feel like she really cares about me, but she can also see it the way I can’t see it . . . it’s not like she’s looking down on you; it’s just one-on-one at the same level working together to get through something.” Carrie and Lisa each commented on the importance of Claire adapting her way of working to their specific needs.

Trying harder An additional helpful element of therapy that is a function of these close relationships is Claire's ability to convince clients to try things they might otherwise not try. Several participants indicated, without being specifically asked, that they wanted to "get better" because Claire wanted them to get better, and they did not want to disappoint her. After hearing this from the first two participants unasked, I started asking other participants if they did what Claire asked simply because she asked, and they wished to be cooperative. Several gave explicit and well-thought-out answers. "I don't want it to sound like her approval is all that matters because there is lot more to it than that. But she is somebody I respect, and I feel she treats me like more than a patient, and when she looks at me and says 'Vivian, you need to start eating; you have to stop losing weight,' then that means something to me." I asked if she would do things simply because Claire asked. She said that she would try harder because Claire's respect means something to her, but that she would not force-feed herself or drink excessive water before being weighed, for example, to make her therapist think she had gained weight. She said she would not lie because of the "honesty in the relationship".

Being challenged The solid relationships these participants experienced with the therapist also allowed her to challenge their thoughts and behaviors. Five of the nine women who participated referenced specific instances in which Claire confronted or challenged them. This specific category could be located in either within therapy aspects or relationship aspects, and I will discuss it here as a function of the relationship and remind the reader of it as an event in therapy in the within therapy category.

Claire confronted Vivian about her eating before she was ready to start changing it, and she said she was "very angry. . . not everyday angry," but that ultimately, the confrontation helped move her out of "denial". She was, at the time, eating about 100 calories a day, and Claire told her that she could die if she kept it up. "No one had ever

said that.” Although Vivian was angry about this, she also said “it makes me feel good about it—that she’s taking the time to really know me.”

Leslie remembered a time when Claire, frustrated with her, told her she could not help her unless she wanted help. Leslie recalled saying, “I do want help, but I don’t want to eat.” Leslie also experienced Claire as very patient and tolerant of her unwillingness to change as soon as she needed to change.

Other participants mentioned confrontations over things related to their person. Anastasia was told she had an annoyingly whiny voice. This confrontation over something not related to food changed the relationship Anastasia had with Claire and allowed her to truly express feelings she had kept hidden before out of shyness and fear.

Carrie was challenged by Claire’s demeanor as she began therapy, and she determined, that because Claire challenged her, that she could not bluff Claire. “I thought, ‘Okay, she’s going to listen. I’m not going to pull any shit on her; she’s going to pay attention to me. . . I won’t be able to trick her.’” This element of challenging Carrie, and thereby gaining her respect, was quite different from Carrie’s experience with other therapists.

Internalizing therapist Two participants extended the relationship to an internalized one. Both Julie and Leslie referred to hearing Claire’s voice talking to them when they are now tempted to go back to their eating disorder behaviors. Both of these women were well enough when we talked that they were only seeing Claire occasionally for maintenance. They had both gained enough weight to be medically stable, and they considered their major problems with eating as part of their pasts. One of them, Leslie, hears Claire’s voice tell her that she will not feel well if she goes back to her eating disorder behaviors, and “all these things come at me as reasons why I don’t want to do that again”. Julie heard Claire’s voice for a while, but now she says she is telling herself the things she needs to tell herself to stay well.

Therapist's voice

Claire discussed the importance of her relationship with clients in therapy in several ways. Development of a sound relationship is her initial goal for therapy, during the phase she refers to as orientation. "My goal is to have a connection with them. . . to get them to pay attention to how they're feeling and communicate that, at least to me, and then we'll figure out where else that might be appropriate." She came back to this point several times in the two interviews we conducted, reminding me that her first goal is to "build a relationship". She does not interpret or understand this relationship to be one-way, however. "I'm really into the relationship being mutual. . . I know with everybody, if it's effective therapy, I think we probably get to that stage where I'm just telling them I like to be with them."

Claire said the relationship with clients gives her a connection from which she can challenge her clients. ". . . Once I feel like I have some sense of relationship with them, even if it's just around them identifying, 'Yeah, she understands what I'm going through with the eating disorder, she understands the biology of it. . . ' then I can challenge them and try to pick critical areas of doing that. . . I'll try to hone in on the thing that I think is critical, and then I'll be really challenging with that. . . some of the challenging is just about trying to be real with them myself and then give them real feedback from me. Not so much feedback about the disorder, but just what it's like to be with them."

I asked, "What do you do to encourage the development of that relationship?"

"Okay, I try not to have lipstick on just perfect every session, which is real hard for me, I think. I try not to be too perfectionistic with them. I try, like now, to not always have good posture. I don't do it on purpose, but I do do it on purpose. . . I see it more as modeling. . . I just try to be really honest with them."

"In terms of trying to be honest with them. . . I want them to experience that I'm nice and all of that, but I want them to experience that I'll be really blunt with them. And so

part of that is just giving them information and feedback and reality testing kinds of stuff. . . helping them be a certain way themselves, like being more relaxed themselves and more open.”

The relationship does not necessarily end when therapy ends. Claire said that at the end of therapy “we talk about ending good things and what that means or how we’ll stay connected in some way, and I don’t mean, necessarily, we’ll talk to each other or they’ll write me a card every Christmas. . . I’ll talk about being sad, or that I’ll miss seeing them, but that it’s balanced by just being so happy that they don’t need me. . . Call me if you need me, but think of all the time you’re going to have. . . I try to be clear about the boundaries. . . it’s not like I’m their friend.”

I said, “That’s interesting, because several people have said that they feel like you are a new best friend for them, and one person said you feel like a big sister.”

Claire said, “I’ll feel that way. . . I’ll say as we’re terminating therapy, ‘Okay, I’m a little protective, I feel like your big sister or something. . . I know I’m going to miss you.’ ”

With some clients, it is important that they be able to stay connected to Claire in some way, and with them, she lets them know that she will be happy to get a letter from them five years later, but that it is not as if they will be writing letters back and forth to each other. She also gave the example of a client who was doing relatively well and was planning a move that would make it impossible for her to see Claire in therapy anymore. They had determined that she did not necessarily need to continue therapy in the new place, and they decided that it made sense for the client to continue writing in her journal, both as a means of feeling connected to Claire and as a means of maintaining an awareness of her own condition so she would be alert to the possibility of needing to re-start therapy in the new place.



This category includes those things that participants identified as helpful that “belonged to” the therapist who participated. Participants indicated the significance of these aspects by introducing them into our conversations, and I pulled them into one category and labeled it “self of therapist” because although some of these things, such as challenge or confrontation, happened in the context of the therapeutic relationship, participants seemed to suggest that the specific and individual characteristics listed had meaning to them that was, ultimately, helpful.

I have located this part of the diagram behind, below, and overlapping the relationship aspects because the characteristics of the therapist supported the development of the relationship. I have also located it to overlap the within therapy aspects to signify the importance of the person of the therapist in specific therapy situations or sessions.

Self of therapist Aspects

Participants’ voices

Participants said that the following characteristics of the self of the therapist were, in some way, helpful: personality, age, physical characteristics, sex, and skill or knowledge.

Personality Participants variously mentioned the therapist's sense of humor, her openness about herself, and her lack of judgment about their behaviors as helpful. "I kind of know what's going on with her . . . she got married recently, and . . . she shows me pictures . . . I want to see that kind of stuff because it's not like you're just talking to a machine . . . It's like you really are a person and so is she."

"She's just real easy-going . . .she would walk in and always joke about her coffee, she had pictures of her cat"

"I see emotion; I see expression. I see personality where she and I can laugh hysterically about something, and it's a good feeling."

Related to Claire's openness, Sue said that PMS had been an aggravating factor to her eating problems, but she had gone into therapy unaware that she had symptoms that could be diagnosed as PMS. Claire had her chart her cycle, her eating, and her feelings about all of them; she then looked the chart over and told her, "Yes, this is PMS." I asked if the therapist had told her whether or not she [the therapist] had PMS, and Sue answered that Claire had told her that she suffered from PMS. I asked what difference that made to Sue. "I think it helps when a therapist shares real things about themselves that pertain to how you are. It's makes you feel like they're really relating to you, they're not just sitting there saying, 'yeah, yeah, yeah' (laughing)."

Age The therapist in this research appeared to be in her mid-thirties when I interviewed her. I did not ask her age, and none of the participants indicated that they had, either. For several of them, however, believing a specific thing about her age was important. "She's about the same age as me, and I felt that made a difference."

". . . And I don't know if it was because she was so much closer to my age . . ."

"Yeah, it helped that . . .she was younger than anyone I'd seen."

Physical characteristics One participant mentioned the physical characteristics of the therapist specifically. My perception of the therapist was that she was of average

height and weight. Sue found that helpful. “I think, too, the fact that she’s not a skinny-minnie kind of person.” I asked how things would have been different if Claire had been 5’10” and 110 pounds. “I don’t think I would have kept going (laughing) not to her. I don’t think I would have felt comfortable with that. I would have felt inferior, I guess.”

Sex The therapist who participated in this research is female, and one participant who discussed her pre-menstrual syndrome extensively with her said, “I wouldn’t feel comfortable talking about all that to a man.” Another participant said that Claire’s “motherly” attitude of caring about her was helpful.

Skill or knowledge Participants assessed this therapist to be skillful in her management of them, and they believed she is knowledgeable about the physical and psychological components of eating problems. “She knows what she’s talking about . . . I think it’s really important.” Lisa used the same phrase—“she knows what she’s talking about”---to describe Claire. Because Lisa was transferring from a therapist in another state, she was worried about having to start from scratch with Claire. Since Claire spent the time to learn what had been helpful in her previous therapy, while at the same time insisting that Lisa see a doctor to get baseline medical information, Lisa felt a high degree of confidence in her abilities.

Therapist’s voice

Of all the personal characteristics participants noted as helpful, the only one that Claire commented on directly was the skill and knowledge aspect. I did not ask her questions about the other aspects, although by the time I talked to her, I had completed the interviews and knew that some of the participants found those characteristics helpful in some way. I do not recall deliberately avoiding the subject. I see now that it would have added another layer of understanding to hear the therapist talk about her “self” in the ways participants talked about her “self”.

In discussing her skills and knowledge, Claire told me how she began working with clients with eating disorders and how she learned what she knows about various aspects of treatment. Claire completed a master's degree in marriage and family therapy, and after several years with a court program, she began working in an inpatient unit for eating disorders in a psychiatric hospital where she worked for five years. "I really enjoy working with women of all ages, and I'm very interested in biology and medicine and body, and that seemed to be all tied together." While at the hospital, she worked both with clients who were admitted to the hospital because of an eating disorder diagnosis and clients in the general population who had sub clinical eating problems. Since she left the hospital, she has been in private practice in which about 50 percent of her clients have some problem related to eating.

Claire's eating disorder-specific training was done in three ways: on the job at the inpatient unit working with a multidisciplinary team, attending conferences and workshops, and reading. Trainings she found necessary and very helpful include the International Eating Disorder Conference through the Albert Einstein School of Medicine in New York, which dealt heavily with the medical aspects of eating disorders. She also found helpful the Conference of the National Eating Disorders Group in Columbia, South Carolina. This conference was more helpful in learning specifically "what to do" in therapy, and she attended it more frequently than the medical conference, but "you have to have both. I'll make this point until I drop. You have to have the medical information. If you're not paying attention to that, and if you don't have that in your work, then you'll be chasing things from a purely psychological or interactional viewpoint that are medical things."

Claire initially attended those conferences yearly until it became repetitious, and she decided she needed more specific training around treating problems that co-occur with eating disorders such as anxiety, depression, obsessive-compulsive disorder, and sexual abuse.



This category includes those things participants mentioned that happened in therapy sessions or as a direct result of therapy sessions. I have made this box larger and placed it near the center of the diagram because it is the focus of this research. I was asking, “What happened in therapy that was helpful?” I have placed this box behind relationship aspects and self of therapist because the helpfulness of within therapy aspects was dependent on the quality of the relationship, which was dependent, to some degree to these participants, on the self of therapist.

Within-therapy aspects

Participants’ voices

Participants said the following things that happened within therapy sessions or because of therapy sessions were helpful: talking, changing thinking, education, activities, group, others in therapy, managing others, reading, writing, changing food behaviors, and being challenged by the therapist.

Talking Six of the nine participants specifically referred to their own talking in therapy as helpful. One participant said that Claire had been “somebody to talk to and tell her fears.” Carrie said directly that talking was the most helpful aspect of therapy. “What

did we do? A lot of talking about past issues and things . . . she was easy to talk to.”

Sammie said, “Well, it was just really sitting down and talking things out, and I think more than anything with counseling, it wasn’t so much what was said to me, but what I said while I was there.”

Changing thinking Five of the nine participants said they changed the way they think as a result of therapy, and that change was helpful in managing their eating problems. Leslie and Julie both described learning to control their thoughts. Regarding her obsessive calorie-counting, Claire taught Leslie to write it down and then tell her herself either, “I’ll write it down later,” or “I’ve already written it down.” This led to her not needing to write it down at all. Julie learned to “clear my mind to work on something else” by thinking about her problems differently. Sue reported that “she taught me to look at the positive side of things . . . now when I catch myself eating a lot, I’ll stop and ask myself, ‘What’s wrong? What’s bothering you?’” This was a marked change for her.

Education Three participants learned specific things from their therapist that made a difference in their management of their eating. Julie learned how laxatives work, which helped her understand why she physically felt as if she needed them. She also learned to identify obsessive thought patterns, which had contributed to her eating difficulties. Leslie learned about and how to fuel her body so she could do the activities she wanted to do. Sammie learned what a binge is and is not.

Activities Three participants reported that specific activities in therapy had been helpful. Julie found it helpful to take pictures to therapy of when she had been happiest. Karen found art therapy, conducted at a previous treatment facility, helpful. She had drawn her body as she thought it looked and had it traced on the paper by the therapist. She also drew and sculpted her eating disorder. Sue found it helpful to role-play specific difficult situations in her life.

Group The therapist these participants had in common does not do groups, but many of the women had been in group therapy somewhere else, and three of them stated specifically that it had been helpful. Of those three, two had been in groups while inpatient. Karen found the support of other people with eating disorders really helped. Vivian stated that in the group setting, she was able to “acknowledge something was wrong and it was okay not to be perfect. It was okay to have something wrong. And it ended the denial.” Lisa appreciated group because “you’re not just by yourself . . . you’re not the only one.”

Others in therapy Seven of the research participants found it helpful to have family member or members join them in therapy sessions. Lisa was joined by her husband, and she was able to say that she was afraid he would leave her if she did not look a certain way, which he heartily refuted. Karen used her eating disorder to avoid dealing with things that were difficult, and having her husband join her forced her to address things with him. Her family-of-origin members also joined her, at various times, and she successfully addressed long-standing matters. Sue was joined by her mother, and said, “I felt like the weight of the world came off my shoulders that day. And that helped a lot.”

Managing others Another helpful aspect of therapy for participants was learning to manage others in their lives in ways that felt appropriate and effective. This is distinct from having others in therapy, because in the examples given, these family members did not join the participants in sessions.

Carrie and her mother had been in a long-term, subtle competition over who was thinner, and she began to address those issues with Claire. Sammie described loose family boundaries that complicated her eating problems; in therapy, she learned to solidify those boundaries in a way that felt appropriate.

Reading Reading specific things suggested by Claire was helpful to several participants. Sue read me a list of seven titles that had been suggested and helpful. She also stopped reading fashion magazines when, after noticing the incongruities inherent to them, Claire told her, “This is why I don’t buy magazines.” Sue let her subscriptions lapse, and she now only reads *Mode* magazine, which is marketed as using real-life sized models and not containing diet information. Julie reported reading specific non-fiction texts that were particularly helpful, including *The Boy Who Couldn’t Stop Washing* and *Transforming Body Image*.

Writing A variety of writing activities were identified as helpful. Most often mentioned were journals of varying sorts. Some participants found food journals, in which they recorded what and when they ate, very useful for therapy purposes. Others were unable to keep food journals, and they were not made a condition of therapy by this therapist. Others mentioned as helpful writing a regular journal in which they recorded their thoughts and feelings. The common helpful element to these journal-writing experiences was that the therapist actually read them. Leslie kept two journals so she could trade with Claire each week, leaving one for her to browse through, and taking back the other one to continue writing.

List-writing activities also were mentioned specifically as helpful. These included grocery lists made out with the therapist, lists of priorities to remind Lisa why she was working hard to manage her eating, lists of burdens so that Anastasia could rest at night without worrying that she would forget something, and a list of happy things for Sue to consult when she feels low and cannot remember happy things.

Changing food behaviors Four of the nine participants specifically referenced food behaviors they changed as a result of therapy as distinguished from food behaviors they changed from working with a nutritionist. Sue and Julie were encouraged by the therapist to slowly add some variety to their diet in an effort to have some balanced

nutrition. She worked out both menus and grocery lists with them so they were not left to sort them out on their own. For both of them, having the therapist simply suggest they eat three meals a day was a novel idea, but it was one they were not having suggested to them elsewhere.

Leslie began to increase her calories from 400 per day as a function of Claire's recommendations. Leslie, who refused to eat any bread, remembered Claire telling her that she did not care if she ate "a hundred pounds of broccoli" to add calories, to just get in some more calories. Lisa became less susceptible to after-work binges after she started preparing herself a snack that was waiting for her when she got home.

Being challenged by therapist Five of the nine participants mentioned as helpful specific instances that I have labeled as "challenge". Vivian got very angry when Claire insisted she start looking at her eating (although she had entered therapy to address depression), but she believed she would "have stayed in denial, and kept ignoring it" without that confrontation.

Leslie remembered Claire having been very frustrated with her and saying, "I can't help you unless you want help."

D confronted Anastasia about the whiney voice she used when she was scared. This changed her relationship to Claire because "I was really shy with her . . . not able to express my feelings . . . I think that really helped."

Therapist's voice

I have included the therapist's comments about the specific within therapy aspects mentioned above. Some of the aspects presented by participants as helpful were not part of my discussions with her. Where that is the case, I have said so.

Talking In her discussion with me about sending a client to a nutritionist, Claire said that while she wants to spend time talking about the nuts and bolts of eating, "What

are your eating habits this week? Show me the food log,” she does not want to spend so much time talking about food that they never get to anything else.

“So, there’s room in there for them to come in and [talk about] something that happened ten minutes ago. . .and I’m okay with that, but I’m not going to just let it happen for weeks.” She discussed a specific example of someone sitting and looking at her legs, saying, “My legs look really fat. Do they look fat to you?” She said that she would tell them truthfully that it looked like they were “getting some swelling from getting off laxatives,” but that she would not let them carry on about it for the whole therapy hour.

Changing thinking Claire labeled her therapy “cognitive behavioral insight systemic” and said this is what she writes on insurance reimbursement forms. In asking her about CBT, she said, “It’s a large, large part of what I do. When I am doing the family piece, I’m looking at the meanings that people give things, I’m learning about their cognitions, and I’m doing cognitive-behavioral work on how they can change the way they think about certain things in the family, about how they view themselves, the rational and irrational thoughts they have, and how to change that. Myths about food, sensations in their body, what they’re experiencing in terms of fullness and rearranging how they think about that.”

Education A large part of what Claire does with clients is educating them about self-care. Not only their need for it, but specifically what that means and how to do it. “I always think of that as an umbrella. . . put everything underneath that in terms of what I’m doing in the session with them. . .so it tends to be self-care, but looking at perfectionism, looking at nutrition, looking at assertiveness, looking at setting boundaries for family members or boyfriends.”

Activities Claire did not discuss any of the activities participants mentioned as helpful.

Group Claire said that she does not do groups, although she may do a group at some point in the future to address the needs of women who have been through treatment and are needing support as they get back to a normal-paced life. She had concerns about the helpfulness of groups, and had seen, in her inpatient work, that groups were venues for establishing competition with other patients. She said she believes they are probably helpful for some people in some circumstances, but she is more likely to send a person to a support group that focuses on one aspect of the client's problem, e.g. a support group for persons suffering with obsessive-compulsive disorder, rather than an eating disorder support group.

Others in therapy Claire's approach to working with others in therapy falls into 2 categories: educational and therapeutic. Her initial task when she gets a new client is to reassure everyone involved that the ED is, generally speaking, a known entity in that it can be treated. At other points in therapy, Claire will have the client bring in parents, husbands, boyfriends, best friends, and/or other relatives. "I always bring family members. . . to educate them about how they can be supportive. . . tell them the diagnosis and prognosis. . . I'm trying to help them, again, reassure them, give them a few guidelines."

When family members or spouses insist on discussing matters in the relationship that are not specifically connected to the eating problem, she asks if they "put that on hold" until the client is stable enough to manage those discussions. Her rationale for this position is that when she's gone into those issues too soon in the therapy, before the client can safely handle those discussions, "the eating disorder gets worse, and you're dealing with a crisis." She does tell the family member or spouse that the concern is important, and she lets them know that they will get around to addressing it as soon as it is feasible to do so. . "I'm careful to let them know that we're going to address whatever needs to be addressed in order to help them cope with whatever issues are there. But that the first order of business is to get them to be a little bit more stable and to get them to

where they're better able to take better care of themselves. Part of the reason for that is that families so quickly blame themselves. . . and if you start going on this family or marital issue real quickly, then it's really easy for them to think, 'Ah, this therapist thinks I'm the reason for this eating disorder.' "

With adolescent clients, Claire also does a genogram of their social world, and as part of that, she may invite the client's best friend to the session. Claire also does a multigenerational genogram with every client to which she refers and discusses in relation to different themes. She discusses family rules, roles, issues of weight, appearance, perfectionism, loss, and death. She does this genogram sitting next to the person or where the client can see what Claire is writing. She does this in the "orientation phase" (her term) and includes family members if possible.

Claire is also likely to bring in the husband or boyfriend of the client to address issues related to body image. This is sometimes connected to working on their sexual relationship, and Claire sees her role as helping their partner support them. She will work with them as a couple to get the partner to focus on what the client looks like. She says this work is very appearance-focused, and the goal is for the partner to give the client feedback about how he sees the client. The example she gives is one in which the client had been sexually abused but was wanting to start improving her sexual relationship with her partner. She worked with the partner to support the client and to understand the client's need to slow down or stop if necessary. She worked with the client to strengthen her ability to continue to be sexual if she chose even though she might have a fleeting image of something uncomfortable, thereby working to increase the client's sense of self-efficacy around starting and stopping behaving sexually as she wishes.

Claire also does what she said is "regular family therapy". She labels her personal model for this as "Getting Back to Normal". This framework requires her to look at the structure that existed in the family before the eating disorder and the structure that is still

there. She takes note of the structure that existed during the problems with eating, but she is less interested in that than she is interested in what would be healthy at this point for the family or the couple and encouraging them in that direction so that they are no longer organized around the eating problems. She observed that most families are willing to “spring back” to a healthier way of life, but if they do not or cannot, then she begins to deal with that issue based on the family’s current, rather than their worst, functioning. She normalizes this to the family.

Claire is very careful in her description of doing family work to make clear that she does not assume family-related etiology based on how she sees a family behaving while their loved one is managing an eating problem. She asks the family in the orientation phase what they were like before the eating problem, and she tucks away that information. Even if the family describes itself in a way indicating enmeshment before the eating problem, she does not track that into the present to begin addressing those issues. She will look at the developmental stage of the family as the client is getting back to normal and encourage them to do those things that are developmentally appropriate. She said that many clients want to “blame their mother” for the whole thing, and her approach is to address the problem in the present. If the current problem is enmeshment between mother and daughter, she addresses that, but she does not actively use that information to account for etiology of the eating disorder.

Managing others Claire does a lot of “individual work; it’s really family work, but it’s with individuals, whether it’s through the genogram or looking at rules and roles and all that. . . a lot of times it’s through letter writing.” She describes looking at issues that are bothering the client in the context of the family and initiating a letter in the session that may express a concern or a feeling or may set a boundary with a family member. She said that clients may not mail these letters, sometimes they wait for a while to mail them, and other times they walk out of the session and put them directly in the mailbox.

Reading “I’ve done a lot of searching for work for clients [to read] because I do ask them to read a lot. . . . I try to be careful in what I give people to read.” She gave the example of Hilde Bruch, and said “she’d roll over in her grave knowing that she’s done a great job of educating people, but at the same time a lot of people learn tricks on how to be sicker in reading some of what she’s written.” She said that she tries not to suggest anything to read that would suggest new ways of doing things, like purging, for example. If the client is unaware of syrup of ipecac, she will not recommend anything that contains information about it.

Writing “I want almost everybody to keep a journal. There are some people, if you fight with them, or you shame them for not keeping a journal, lie. . . . I think it is a wonderful, useful thing for people to journal, and I think it is a wonderful, useful thing, most of the time for people to keep a food log, at least in the beginning. However, there are always exceptions. . . . I don’t make those issues conditions of treatment.” Claire uses the food log as a tool to get information about what they ate, but also about their feelings and thoughts. “It’s usually a food-feeling log. . . . I try to teach them about cravings, about food myths by doing the food journal.” She also uses it to gather process information. She gave the example of clients who bring in their food log typed perfectly from their computers and apologizing for a single typing error.

Claire also uses writing specifically in helping clients manage intense emotions. “I really see difficulty across the board in dealing with intense emotions.” Rather than move directly from the awareness of the intense emotion to trying to express it in a way that is useful, Claire will frequently suggest that the client write in her journal about the emotion.

Changing food behaviors Claire described her way of working with clients in relation to food as “very gradual”. She does not immediately send clients to nutritionists, particularly if they are starving. In the situation with a client who is starving, for example, she works to increase the client’s food intake, regardless of what they actually eat. She

asks, “What are you willing to eat right now? What are you willing to increase? What feels safe to you right now?” in an attempt to help the client begin increasing intake.

Claire does nutritional education with clients herself, particularly around common myths about food (e.g. that dietary fat necessarily becomes body fat), but she does not sit down with a food groups chart and do lectures. She discussed working with clients to develop a three-part list: safe foods, willing-to-try foods, and scary foods. She will work to make choices gradually from the willing-to-try and the scary list, but she lets the client choose the food and respects their need to take it very slowly. She believes this serves a desensitization function.

Claire does not do sessions in which she tries to force the client to eat or tries to get the family to force-feed the client. She recalled situations in which she offered food to clients who were lightheaded and needed food to be able to drive home, and a situation with a dissociative client in which she tried to use food to help the client feel more grounded, but she does not typically offer food.

Related to eating, Claire always teaches her clients about metabolic rate, digestion, and delayed gastric emptying. She draws a diagram of the body that each client, she said, could probably duplicate at my request, and she uses it to describe the mechanical components of digestion and how vomiting and laxatives interfere with that. She tries early to get clients to eat regularly, even if a very small amount, because she is trying to get their digestion functioning more normally again.

**Outside Therapy but
Related to Treatment
Aspects**

Doctors
Nutritionists/Dietitians
Medications

This category includes those things that have to do with treating the participants' eating disorders but do not have a direct connection to therapy as participants experienced it. I have located this within the box including all the helpful aspects of treatment, but I have connected it to both within therapy aspects and relationship aspects with a dashed line to denote the sometimes-tenuous connection that participants experienced. I connected this to within therapy aspects because the therapist involved insists that clients have a doctor who knows about their eating problem before she will agree to do therapy with them. If they do not have a doctor, she will recommend one. I have connected it to relationship aspects because some of the participants were helped by the relationship to see the necessity for some of these aspects, such as the helpfulness of seeing a nutritionist or dietitian, or the helpfulness of taking an antidepressant. Some of these later-to-be-recognized-as-helpful aspects would not have had a place in treatment were it not for the relationship between the therapist and client.

Outside therapy but related to treatment aspects

Participants' voices

Some participants said that seeing a doctor was helpful. It was important to them that the doctor have some familiarity with eating disorders, and it was equally important to some that the doctor be sensitive to their feelings. On the other hand, several participants said that having the doctor bluntly reveal the effects of eating disordered behavior on the body was helpful.

Sammie said that having her doctor weigh her backwards on the scale and not tell her the amount was helpful. He sensitively answered all of her questions about medication, as well, which was equally important.

Working with nutritionists was helpful for some participants. Lisa learned useful strategies for managing eating in restaurants from her nutritionist such as having the waiter package half the meal to take home at the beginning of the meal, and setting down

her fork after each bite to increase the time it took her to eat her meals. She also learned exactly how much she could eat without gaining weight, and she said this helped her eat more regularly, which interrupted the binge-purge cycle she had maintained.

Karen had worked with two nutritionists in another state, and although she called one of them the “food police” who made “unreasonable” suggestions, she thought it had been useful for someone other than her therapist to monitor her food intake. She believed she would have hated her therapist if she had functioned as “food police.”

Five of the nine women said they had taken an antidepressant of some form at some time. Three of the five thought it may have been helpful. Lisa said that had “really helped” because it helped her put her anxieties “on a back burner and get a grip on what’s going on.” Leslie thought that taking Prozac for a brief period of time might have been somewhat helpful. Anastasia was continuing to take Prozac, which was administered and managed by a psychiatrist, and she did not have an idea about its helpfulness. The other two of the five said that anti-depressants were not helpful in managing their eating problems.

Therapist’s voice

The only thing that Claire said was definitely a requirement for treatment is that each client have a physician with whom she has a relationship who also knows she has an eating problem. If it is possible, she tries to work with the client’s current physician, although sometimes the physician will tell her that she is no longer comfortable managing the client’s health, and Claire will refer the client to another physician who is more comfortable. Occasionally, Claire will call the client’s physician and make the disclosure about the eating problem because the client cannot do it herself. “Sometimes the patient really wants the physician to know, but they’re too scared to tell them. They keep hoping the physician will pick up on it and talk to them.” She said that, in those instances, the clients are always relieved that they can go to the doctor with him or her already knowing

about the eating problem. The goal for the physician-therapist-client relationship is to provide a safety net, both for the therapist and the client. Claire does not want therapy to be crisis-oriented, so she needs a physician involved who will help her make the determination about how frequently the patient needs to be seen and when or if to hospitalize the patient. Claire also makes psychiatric referrals for many of her clients; this sometimes happens in the context of their current physician becoming uncomfortable managing three or four medicines, but it also happens that she will refer directly to a psychiatrist at the beginning of treatment. In some situations, the family physician will make the referral to a psychiatrist.

For Claire, the question of referring directly to a psychiatrist is connected to the question of whether the client needs medication and whether the family physician or internist is comfortable with that. I asked, “Do you make specific suggestions for medications?”

“Yes, yes. I try very hard not to play doctor. . . but sometimes the physician will call me and say, ‘what do you want me to put them on?’ ”

“Do you ever make medications a condition of treatment?” I asked.

“I wouldn’t say a condition of treatment, but pretty close. . . I’ll say to a person, ‘We’ve done all of these things. . .and I’ve seen that [medicine] be so helpful to many people’. . . it ends up being a pretty pressured thing although I don’t make it a condition of treatment.”

Regarding dietitians and nutritionists, Claire said, “I’ve basically hand-picked a dietitian. . .I have to really trust that person, otherwise I feel like it’s detrimental for them to go to a nutritionist.” She does not, for example, want an overweight client who binge eats seeing a nutritionist who will put them on a restrictive low-fat diet because that would set her up to binge again, so she will call and discuss the client’s needs with the nutritionist before the nutritionist meets with the client, and she requests copies of the nutritionist’s

notes from each session with their mutual clients. She gave another example of sending a client who had been on a series of diet to a nutritionist and calling and telling the nutritionist that she would rather the nutritionist not give her a diet, per se, but work with her on eating regularly so she did not become ravenous and find herself in a position to binge-eat.



This category includes those things that participants indicated made a difference in their lives and ability to manage their eating problems that were completely outside the parameters of therapy. I asked participants specifically about extra therapeutic things in my interviews, describing them as “things going on outside therapy that helped you manage what you were in therapy for.” I have located this part of the diagram outside the treatment box, but I have included it in the “helpful” box, because these things contributed in significant ways to the participants who experienced them.

Having nothing to do with therapy

Participants’ voices

Three participants mentioned friendships that made a difference in their ability to manage their eating. Sammie had a really good friend who was helpful to her generally

because Sammie had been recently transplanted to the area and had not had any close friends. This friend had died prior to our interview, and Sammie was tearful in her discussion of her.

A friend who told her she was proud of her for being able to order and eat half a dessert when they were eating in a restaurant encouraged Leslie. Julie and Leslie both had friends who were also diagnosed with eating disorders, and both friends continued to get worse as Julie and Leslie improved. "That was one thing that was making it better . . . seeing how much pain she was in . . . when I would talk to her, she didn't have any sparkle in her eyes. She was dead . . . she would just stare through me . . . I really I think that may have helped, just seeing somebody else do the same thing I did."

Julie was encouraged to get better because of the unconditional love of her dog for her. She remembered thinking at one point that she had to get well because she did not want to abandon her dog, which she would be doing if she died.

Julie also used music to alter her mood when she was feeling depressed. She mentioned specific songs that "boosted her up" when she was feeling low.

Leslie gained weight so she could play soccer. Unfortunately, gaining weight in the spring and losing it after the season was over became a pattern, but eventually, she was able to put on the appropriate weight and keep it on. "I'd rather have a few extra pounds and be on the field playing than sitting on the bench getting skinny."

Leslie noticed that, over time, she lost many friends because she never wanted to do anything but exercise. Her current boyfriend, who had been her boyfriend during the period of time that she started therapy to treat anorexia, ended his relationship with her, saying that he could not watch her die. Over time, Leslie realized she was losing all of her important relationships because of the anorexia, and asked herself, "Which one is more important here? Having friends, or being skinny?" She and the boyfriend started seeing

each other again and have talked specifically about how his actions helped her learn that healthy was better than skinny.

Therapist's voice

The topic of extratherapeutic change, or things that have nothing to do with therapy and their helpfulness, was not part of my discussions with the therapist.

Chapter five: Discussion of Results

Introduction

This chapter includes an expansion of the results as they were presented diagrammatically in the last chapter. The categories, constructed by using information from interviews with the participants, excluding the therapist participant, serve as the basis for additional commentary.

Because the voices of women in treatment for an eating disorder are under-represented in the academic literature, my goal for this research was to develop an understanding of what some women in treatment for an eating disorder found helpful about their treatment and to use their own words to explain those aspects of helpfulness to the reader. I envision the diagram I have created being used in conjunction with existing models of therapy, as something to organize clinicians' thinking, and I will discuss ways I believe this can be done. I am using this diagram in my own work with women with eating problems to remind me of some things to do, some things to be, and some things to call attention to. I will discuss the ways this has influenced my own work.

Importance of method

Only three small studies (Shifts and Knapik-Esposito, 1993; Protinsky and Marek, 1997), including this one, in the academic literature privilege women's voices about treatment for eating disorders despite the fact that women are the primary sufferers of eating disorders. This study is the only one of the three to have as its primary goal hearing what clients find helpful about treatment. The results of this study support the general results found in the other two studies conducted with an orientation toward understanding treatment of eating disorders. It also supports discovery-oriented research conducted with the goal of understanding helpful therapy generally.

Results that support existing research

Some of the results of this research support existing research about the generally helpful elements of therapy. I learned that women with an eating problem want their therapist to be knowledgeable about eating disorders and skillful about conducting therapy, supporting the results of Bischoff and MacBride (1996) that clients want an expert therapist who is also warm, empathic, and capable of engaging in a relationship that is mutual. Additionally, I women in therapy said that they required a good relationship with their therapist to benefit from the other aspects of therapy, supporting the results of Llewelyn (1988) who found that, without a good relationship, insights by the therapist were likely to be counterproductive.

Expansion of the diagram of helpful aspects of therapy

In this section of the discussion, I will expand on the following aspects of helpful therapy: self of therapist, relationship with therapist, within therapy aspects, and aspects having nothing to do with therapy.

Self of therapist

Therapists do not observe therapy objectively and separately from the “doing” of it. The therapist has “an inescapable, inextricable involvement in all that goes on in the interview; and to the extent that he is unconscious or unwitting of his participation in the interview, to that extent he does not know what is happening” (Sullivan, 1954, 19). Claire’s awareness of the mutuality of her relationships displays an understanding of this that positively influenced participants. However, she did not lose the necessary element of expertness; mutuality does not imply symmetry (Aron, 1996). In regard to roles in therapy, an asymmetry favoring the role-knowledge and skill of the therapist may not only be impossible to shake off, but desirable (Llewelyn, year). Hoffman (1994) suggests that therapists cannot escape this aura of asymmetry and to attempt to do so is disingenuous and inauthentic, and to strike a balance between the role requirements of “therapist” and

behaving in an authentic and self-disclosing fashion that allows a genuine bond to develop is the task of therapy for the therapist. Claire, as participants experienced it, seemed to find this balance. She was described as both an expert in her knowledge and management of therapy and a “friend” who could joke about her need for coffee and display pictures of her cat.

Specific things participants knew or believed about the therapist influenced them in two different ways. Some clients were influenced to engage in therapy, such as Lisa, who transferred to Claire from another state, and some were influenced to disclose more personal information to the therapist once engaged, such as Sue, who said she would not have been able to discuss PMS with a man. The skill or knowledge the therapist demonstrated was the element that seemed to influence clients in the direction of engaging in therapy, and the other elements—personality, age, physical characteristics, and sex—served to encourage a deepening of the relationship between the therapist and the client.

Research is unclear about which therapist variables influence outcome and process of therapy, and this state of affairs is likely to continue because of the complex interactional effects between client characteristics, therapist characteristics, situational characteristics, and the type of therapy being practiced (Beutler, Machado, Neufeldt, 1994). However, the development of a significant relationship with a therapist may be affected by a strong preference for the therapist, and clients may make more effort to communicate with a preferred therapist than a therapist who is less strongly preferred (Simon, 1973), so even though specific research support does not exist for the “helpfulness” of any particular aspect of therapist personality or behavior, those that are preferred by the client seem to be necessary for the development of a therapeutic relationship.

Age of the therapist, as a single variable, seems to bear little relationship to the outcome of therapy (Sexton & Whiston, 1991), the efficacy of therapy, or to premature dropout (Beck, 1988; Greenspan & Kulish, 1985). But additional research looking at the interaction between client age and therapist age, however, suggests that there is a positive relationship between age similarity and treatment benefit (Luborsky, et al., 1980; Morgan, Luborsky, Crits-Christoph, Curtis, & Solomon, 1982). Age similarity may be most important to clients aged 18 to 30 whose therapist's age falls into the same age range (Dembo, Ikle, & Ciarlo, 1983), which supports the beliefs by two participants who had seen multiple therapists that Claire's age was a helpful element in therapy because "she was younger than anyone I'd seen".

Sex of the therapist as an influential factor in therapy outcome does not have hearty support in the literature (Beutler, Machado, & Neufeldt, 1994). The only study that is not naturalistic in design to find some difference between male and female therapists found greater symptomatic improvement with female therapists, but the study did not have male client participants (Jones, Krupnick, & Kerig, 1987). Client-therapist matching effects are largely missing from the research (Beutler, Machado, & Neufeldt, 1994). One participant gave specific examples for her belief that the therapist's sex was significant and important, and for this participant, it was the therapist's advertisement of herself as working with women that got her to make the phone call to initiate therapy in the first place. Perhaps this suggests that for people to whom it matters, the sex of the therapist may determine whether therapy begins at all, and for those who do not care enough to seek out a therapist of a specific sex, it does not matter.

The personality element of helpfulness contains those characteristics of the therapist that can be presumed to be relatively stable and enduring, and it contains a therapist behavior, self-disclosure, that participants seemed to connect to personality. Personality of therapist as an efficacious element in therapy outcome does not have any

research support, but it is not because it has not been studied. Beutler, Machado, & Neufeldt (1994), in their review of the literature, state that the demise of empirical interest in the subject is likely a function of the fact that a large number of well-designed studies have failed to find any support for the idea.

Self-disclosure can mean a variety of things, ranging from having a picture of family members on one's desk to discussing one's personal experiences with a client. Self-disclosure as a helpful element of outcome is not supported by considerable research, but one study that employed an experimental design (Barret & Berman, 1991) produced results indicating that self-disclosure by therapists produced greater symptomatic improvement than similarly conducted therapy minus the self-disclosures. At one end of the spectrum, Julie found it helpful to see the pictures that Claire kept in her office and to know that she had recently gotten married, which both seem relatively low on the self-disclosure spectrum, and at the other end of the spectrum, Sue said that talking about PMS with Claire was helpful because Claire discussed her own experiences with her, which seems pretty high on the spectrum.

The physical characteristics of the therapist were significant to one participant in the way that might be expected. Sue said that she thought she would not have felt comfortable going to a therapist who was "a skinny-minnie" kind of person, and given her struggle with overeating brought on by diets to lose weight, it is expectable that a therapist who embodied her thin ideal might not have been able to help her accept her natural body weight and stop dieting.

Research regarding therapist skill, measured by training and experience, is mixed with regard to its effect on outcome (Herman, 1993; Bennun and Schindler, 1988). Durlak (1979) reviewed 42 studies comparing the effects of professionals to paraprofessionals in regard to therapy outcome. The paraprofessionals had equivalent, or better, results with their clients. Hattie, Sharpley, and Rogers (1984) confirmed Durlak's previous

conclusions. Berman and Norton (1985) reanalyzed Hattie et al's data, given the counter-intuitiveness of the findings, and after eliminating studies due to methodological weaknesses, determined that the original conclusions were, in fact, supported by the data and that no research supported the notion that effectiveness of therapy was enhanced by increased training, knowledge, or experience by the therapist. In addition to the lack of support for the superiority of experienced therapists over less experienced therapists, theoretical orientation of the therapist is not predictive of outcome (Shapiro & Shapiro, 1982).

Relationship with therapist

The meaning constructed in this research in this category is remarkable only in the sense that it comes to the question of helpfulness from a specific population of clients and their perspectives. The results are similar to results found from other studies that privilege the voices of clients (Bischoff & McBride, 1996; Llewelyn, 1988; Shifts & Knack-Esposito, 1993; Stith, Rosen, McCollum, Coleman, & Herman, 1996). Participants found the relationship with the therapist to be most helpful thing about therapy, and as I have constructed it and understand it, the relationship was the foundation for the other helpful things that happened.

On this aspect of helpfulness, the literature is clear. "*The quality of the interpersonal context* is the sine qua non in all forms of psychotherapy" (Hans Strupp, 1995, 70; emphasis in original). Clients identify being respected, understood and cared for as helpful aspects of their therapy as opposed to techniques or model-applicable stuff (Miller, Duncan, & Hubble, 1997). Other research suggests that the single most important determinant of outcome is the client's participation in the relationship (Orlinsky, Grawe, & Parks, 1994). No matter how difficult the presenting problem, clients who view their relationship as favorable are more likely to change (Duncan et al., 1997), and 30 percent of variance in outcome is due to relationship factors (Lambert, 1992).

Two of the participants, Vivian and Carrie, who discussed the therapeutic relationship as central to the helpfulness of therapy, specified that the relationship fit their needs and desires around how it would unfold. Carrie commented several times on Claire's ability to "play it the way they [other clients] need her to" suggesting that Claire would adapt her way of working to the needs of the individual clients, rather than vice versa, which had been Carrie's experience with a multitude of therapists who she was able to list quite easily. Vivian was also certain that Claire treated her as an individual and accorded her the respect, and importantly to Vivian, the variation in treatment, that matched her level of understanding. This supports previous research suggesting that the therapeutic relationship must match the individual client's definition of empathy, respect, and genuineness to be most helpful (Patterson, 1984; Duncan, Solovey, & Rusk, 1992). I did not discuss individual clients with the therapist in this research, so I do not know how she would rate her relationships with specific clients, but other research suggests that may be irrelevant, and that it is actually clients' ratings of therapeutic alliance rather than therapists' that is more highly correlated with outcome (Horvath & Luborsky, 1993; Orlinsky et al, 1994).

The importance of the relationship to helpfulness is not surprising; as I understood participants, however, it was not just a nice addition to otherwise technically-appropriate therapy that would have helped them anyway. I understood participants to say that the relationship was *necessary* to the development of a working relationship within which helpful therapeutic behaviors could then take place. This is in concert with two other studies that privilege the voices of clients (Llewelyn, year; Bischoff and McBride, year).

Interestingly, neither of the therapies that have some research support in the literature for the treatment of eating disorders, CBT for bulimia nervosa and family therapy for anorexia nervosa, support the relationship as a necessary and foundational element in therapy. Descriptions of family therapy in the Maudsley trials advocate the use of "guile" if

necessary to get the entire family to the first session, whereupon the therapist is to behave “intensely, gravely, empathically, warmly, sincerely, and portentously. A priest meeting the family of the bereaved at a funeral is a possible model” (33). The authors then suggest that the therapist should then determine how much physical contact each family member can easily tolerate and then do a bit more, using two hands for a handshake or holding it a little longer than would be the person’s preference (Reference, year). While the therapist is instructed to behave “empathically and warmly,” and while the authors give reasons for everything they suggest, I wonder about the ability of any therapist to develop a genuine connection to a family when she is having to remember how to “act”. Presumably, the therapist could actually feel empathy and warmth for the family members and demonstrate that, and if she did not, perhaps that would be a reason to refer the family to another therapist rather than a cue for the therapist to “behave” empathic and warm when she feels anything but.

Instructions for the conduct of CBT include, for sessions one through eight, the establishment of a sound therapeutic relationship. This is treated, however, in the same manner as the instruction to educate the patient about the cognitive-behavioral model of bulimia and the establishment of weekly weighing—as things done by the therapist to the client. It is doubtful whether a sound therapeutic relationship that is perceived as mutually-influenced can be established as easily as that, and having the establishment of weekly weighing and the insistence on self-monitoring by food journal as concurrent goals for the first eight sessions may work against the development of the relationship for those clients who will ultimately be unable to do either, or both.

What has been described by participants in this research is not “establishment of relationship in eight sessions,” but an ongoing, mutual, and mutually-influenced relationship that seems to be more in keeping with psychodynamic literature (Nickerson, 1991) and some recent additions to the MFT literature. Protinsky and Coward (2001)

found that seasoned marriage and family therapists who had been trained systemically reported that they had begun, over the years, to recognize the central importance of the therapeutic relationship to the helpfulness of therapy and to work more relationally. For those study participants, this involved an increase in self-disclosure, fitting with Claire's behavior as reported by clients and herself as someone who was open with clients. Participants in the Protinsky and Coward study also reported going back to their "warm nature," which had been trained out of them by graduate school, leading to more flexible and permeable boundaries than those taught in typical graduate school ethics courses. These participants were not blurring or crossing boundaries; their understanding of those boundaries changed. Claire's statement that she reaches a point where she can say to clients that she enjoys being with them is, I believe, illustrative of this notion.

I asked Claire specifically about this point, and I believe it is relevant to other therapists' treatment of eating disorder clients. "What do you do to encourage that relationship?" First and foremost, her goal is to have a connection and build a relationship with clients; in regard to every aspect of what she does, Claire emphasized a good relationship. For example, when we discussed how she ends therapy, the aspect Claire discussed was how she helped clients manage the ending of the relationship. She said that she specifically tells clients that she will miss them (when this is the case) and that she will be sad about not seeing them. She also helps them see how much free time they will have for other things, but for those clients who need to stay connected in some way, she lets them know that she would be happy to get a letter from them in five years.

Would CBT be more effective with additional attention to the relationship? I believe so. Claire does many things that are components of CBT, and clients found many of those things helpful. Self-monitoring through food diaries, changing patterns of thinking, challenging cognitive incongruities, education about digestion and nutrition, and changing food behaviors are aspects of therapy found to be helpful by the participants in this

research, and they are all aspects of CBT. Claire labeled her therapy as “cognitive-behavioral insight systemic,” which demonstrates the importance of CBT components to what she thinks she is doing. Where she differs from manualized versions of CBT, however, is in her flexibility with regard to conditions of therapy, and she differs in the extent to which she emphasizes the relationship as a fundamentally important aspect of treatment. Other research suggests that clients are more likely to be satisfied with treatment when the therapist is flexible and does not try to convince them of rightness of her approach (Kuehl, Newfield, & Joanning, 1990), and this is supported in this research. In regard to flexibility, for example, Claire does not require clients to keep food diaries. She believes it is helpful, but she does not insist on it if the client maintains its impossibility. This is in stark distinction to CBT for BN, for example, in which self-monitoring by diary or journal is a necessary condition for therapy to continue past the first several sessions.

It is possible that in the actual practice of CBT by non-research-participating clinicians, that relationship factors are given more weight. This was found to be the case in MFT's (Protinsky and Coward, 2001). It is not clear from the literature, and is therefore not known except by the therapists who are doing it, what CBT actually looks like in the “doing” of it and how it is perceived by clients. Research to hear from therapists who practice CBT and their clients could potentially answer this question

Jones, Peverler, Hope, and Fairburn (1993) looked at the process of change during treatment for bulimia nervosa across CBT, behavioral therapy, and IPT. In all three groups, there was an immediate reduction in binge-purge behaviors that lasted either four or eight weeks. In relation to this element, the pertinent point is that the reduction in binge-purge behaviors happened too fast for the technical aspects of therapy to account for them. The authors hypothesized that non-specific properties could account for the relatively equivalent levels of helpfulness among the three therapies, and I believe the

non-specific factors could have possibly been identified as relationship factors. This would suggest that, even though manualized CBT, for example, does not place heavy emphasis on the ongoing development of a mutually-disclosing relationship, that seasoned therapists adjust the “doing” of CBT by behaving more intentionally in this area.

Internalizing therapist Change as a function of internalizing the therapist is a psychoanalytic concept (Karon, 1998) that I would have suspected would have no place in my understanding of these results. Two participants described specifically how they now, after therapy, hear the voice of the therapist when they are tempted to engage in eating disordered behaviors now, and one of them has progressed to the point that she now hears her own voice, suggesting a successful adoption, or deep-seated change, of the therapist’s more healthy belief and cognitions (Karon, 1998). It is not clear if the process by which these participant’s “internalized” the therapist are in concert with psychoanalytic or object-relations theory, however, as those theories did not guide my thinking or questioning, leaving me without adequate information to make the determination. It would be left for psychoanalytically-oriented theorists to draw those conclusions.

Trying harder because of the relationship The aspect that participants discussed as “trying harder” because of the relationship can perhaps be understood in terms of therapeutic alliance. Bordin (1979) suggested that a good alliance is the foundation for change, regardless of the type of therapy, and that the alliance consists of agreement between the therapist and client on three components of therapy: tasks, goals, and the relationship bond. Safran and Muran’s (2000) reconceptualization of Bordin’s ideas is useful for two reasons that are pertinent here. First, the ability of the client to “trust, hope, and have faith in the therapist’s ability” (13) plays a central role in therapeutic change. Secondly, this conceptualization of an alliance emphasizes the mutuality of the alliance and the fact that it requires negotiation between client and therapist about therapeutic tasks and goals of therapy. The authors suggest that, in everyday practice,

much of the alliance-building work that goes on between clients and therapists is directed at the surface level, and they use the example of clarifying for a client the rationale behind a particular therapeutic task. At the surface level, this suggests that the client is taken seriously by the therapist, thereby strengthening the alliance sufficiently to encourage the client to do the task.

Bordin (1979) emphasized the importance of negotiating the tasks and goals of therapy, which Claire exemplified in her flexibility around food diaries. Although she would prefer that everyone keep a food diary, if the client gave her sufficient reason to believe that she could not, as Lisa did, she let go of her desire for the client to do it, thereby strengthening the alliance with the client by not insisting on therapy proceeding in the manner that might be prescribed by CBT, for example. This flexibility with regard to tasks of therapy, or this negotiating (Bordin, 1979) the tasks of therapy, demonstrates the importance to the client of the alliance over the specific task. This was instrumental, I believe, in getting clients to attempt tasks they had initially refused. Participants reported this as **trying harder because of the relationship**. The process of negotiating tasks and goals for therapy strengthens the alliance, which as it becomes stronger, can be used in the service of encouraging clients in directions they would not choose to go on their own.

Motivation to change There is little information on the subject of motivational issues in clients with eating disorders in the research literature (Feld, Woodside, Kaplan, Olmsted, & Carter, 2001). For some participants, therapy was hard work, and required considerable effort on their parts, lending some credibility to research suggesting that activities that require high effort are more likely to produce results that last than activities that require low effort (Axsom and Cooper, 1985).

One of the central questions any therapist deals with regularly has to do with the reasons people leave therapy prematurely. ("Prematurity" is, of necessity, in the eye of the beholder, and for therapists working with clients with eating disorders, it may be presumed

to be a little more accurately reflecting a concrete reality if there is a doctor involved who agrees.) As a therapist, I sometimes suspect I know why clients leave therapy without an explanation, and sometimes I do not. There are times when I am not worried about them and presume they have changed enough that they no longer need therapy, and there are times I try to make contact with the person to satisfy my own worry that they are still living. With clients who have life-threatening eating problems, other treatment personnel are involved, and there is often a way to “track” what has happened to the client. However, none of these things speaks to the question of what to do to engage the person in therapy in a way that will make her want to stay until she is physically healthy. I believe the weight given the relationship by the participants in this research speaks to this question.

Within Therapy

Confrontation or challenge Ivey (1987) defines confrontation as “the pointing out of discrepancies between or among attitudes, thoughts or behaviors” (84). In most of the instances of confrontation or challenge mentioned by participants, the helpful mechanism did seem to be a function of being made aware of the discrepancies between what the participant said she wanted and what she did. Leslie described being confronted about not eating anything above 400 calories. The therapist told her she could not help her if she did not eat and that she would not get well if she did not eat. She remembered saying, “I want to get well, but I don’t want to eat,” which is obviously incongruous; even as she recollected the event, Leslie reiterated how patient and understanding the therapist had been with her.

Vivian had been very angry with the therapist because she confronted her with the information that she could die if she did not increase her caloric intake over 100 calories per day. She said she left therapy very frustrated that day, but in her recollection of the incident she acknowledged that she moved from “denial” about the reality of her situation because of the confrontation. In her experience, the confrontation had relationship

meaning. Vivian said she felt “understood and cared for” because the therapist had confronted her about her eating.

Carrie felt challenged by the therapist's manner of presentation in their first meeting, and she decided, based on that interaction, that she would not be able to fool this therapist as she had been able to do with previous therapists. She had been challenged by the demeanor of the therapist, and this also had meaning related to her assessment of the therapist and what she could expect from her.

In one of the instances cited by participants in which they felt challenged or confronted, the above-mentioned definition of confrontation does not fit. Anastasia was confronted about her whiney voice, and this confrontation enabled her to relate to the therapist in a new and different way; there was nothing in her recollection of the event that would make it a pointing out of a discrepancy—her voice was irritating to listen to, as she told it, and being made aware of that influenced her in a positive direction.

With some participants, the recollected confrontations did have the effect of reducing ambiguities or incongruities in communication (Carkhuff and Berenson, 1967), but even in those situations, relational meaning was attributed to the interaction. For Vivian, the confrontation had the effect of forcing her to confront the fact that she could die because of her behavior, which she says she was not ready to think about, but the confrontation happened in a way that made her feel more connected with the therapist who made the confrontation. Berenson, Mitchell, and Laney (1968) concluded that more effective therapists confront their clients more frequently than less effective therapists. With anorexic clients, effectiveness in therapy does involve getting them to increase caloric intake, and confrontation seems to have played a role, mediated by the relationship effect, in helping some of the participants in this study.

Reading Reading as an adjunct to therapy, or bibliotherapy, can be considered as informed by one of two streams of thought: Shrodes's (1950) classic

psychotherapeutic theory, and more recent cognitive learning (Cohen, 1989a) theory. Shrodes hypothesized that imaginative or fictional literature could be used to diagnose and treat problems similarly to psychotherapy, but her theory has not been subjected to much published research (Cohen, 1994). More recent uses of bibliotherapy have emphasized non-fiction or self-help literature that is connected to the type of problem the client is experiencing.

Cohen (1994) conducted a phenomenological study of the experiences of reading that suggest some of the potentially helpful elements of reading. Participants in her study, who were recruited by flyer from a library and may or may not have been in therapy, suggested two thematically different categories: the experience of therapeutic reading and the characteristics of therapeutic reading, with “therapeutic” having been defined as something that was helpful in a difficult situation. In the experience of reading theme, participants suggested recognition of self, shared experience, validation, comfort, hope, inspiration, catharsis, understanding, and information gathering as useful aspects. In the characteristics of therapeutic reading theme, participants suggested that their reading was purposeful. They reported having reread and recalled what they had read. Other characteristics of reading including a relational aspect; some participants reported that therapeutic reading was an individual experience that they did not easily share with others, but other participants discussed having talked about what they read with others and having been enriched by those discussions. Regardless of whether they discussed their reading with others, participants suggested that reading was like relating to a friend or even an alternate form of therapy in which they easily became immersed or through which they escaped their problems temporarily.

The phenomenological experience of Cohen’s (1994) participants is supported by the participants in this study who mentioned reading as helpful. Julie and Sue were able to give me lists of specific texts that had been helpful, and in both situations, they reported

similar helpful aspects. Cohen (1994) suggests that, because recognition of self was a key experience of therapeutic reading, therapists ask clients about the type of reading they may be doing on their own for the purpose of amplifying helpful activities already being engaged in by the client. She also suggests that when therapists make recommendations to clients for reading specific texts, they do it with intention and thoughtfulness toward the recognition of self aspects.

Writing Pennebaker and Beall (1986) found that college students who spent 15 minutes for four consecutive days writing about traumatic events in their lives reduced their rate of doctor visits over the following year compared to the controls who wrote about trivial topics; these results set off a new field of research, which Pennebaker and Seagal (1999) summarized. In summary, Pennebaker and Seagal found that the benefits of writing hold across different populations with the exceptions of persons who have disordered cognitive processing and recently bereaved elderly Dutch residents. Writing positively influences immune system functioning, and it seems to have long-term positive effects on mood. Writing has been found to have comparable effects to talking to a psychotherapist among a sample of healthy adults, with men seeming to benefit somewhat more than women and hostile and suspicious persons benefiting more than persons who do not display those traits. Audience for the writing does not seem to be associated with the effects of the writing, and the authors cite a study in which the participants wrote on a magic pad from which the results were erased by lifting the film sheet that covered the pad as soon as they had written. Some studies suggest that longer periods of time spent writing are associated with increased effects, but those results have not been tested experimentally. Comparable effects have been achieved with participants writing about a variety of topics, and Pennebaker and Seagal cite a study in which a group of students who had experienced trauma were asked to write about an imaginary trauma rather than the one they had experienced, which produced effects comparable to those

achieved in the group who wrote about their own trauma. Writing by members of stigmatized groups has variable effects depending on the visibility of the stigma and the topic of writing. It seems that members of stigmatized groups who are visibly identifiable (e.g., being Latino or overweight) benefit more from writing about their commonalities with the general community as measured by increases in collective self-esteem than by writing about the stigmatized parts of themselves. Persons with invisible stigma (e.g., being gay or Jewish) benefited most from writing about being a member of that stigmatized group. F

For the participants who found writing helpful, it was important that the writing be a part of therapy and that Claire be a part of the writing audiences. One participant, Leslie, went to the extent of using two different notebooks in which to record her journal so she could leave one with the therapist to be read between sessions. She addressed Claire in her journal and said she felt like writing to her was like talking to her. She also used the journal to record events that she might otherwise forget, but that were important as background information for Claire to understand Leslie's experience of trying to beat anorexia. Others, including Anastasia, specifically referenced talking with Claire about what was in their journals as helpful. It seems, then, that audience for the writing does seem to matter for some people.

Participants associated a sense of relief, or "laying down my burdens," with writing in a journal or in writing lists, expressing what is, I believe, the phenomenological experience of the benefits found in Pennebaker and Beall (1986). I did not ask participants about their rate of doctor visits following writing, but several mentioned specifically that writing helped them feel better.

Having Nothing to Do with Therapy or Extratherapeutic

This category closely matches what the literature refers to as "extratherapeutic," and I actually used that term in my interviews with clients to find out what was going on outside the therapy that helped them get better. I did not ask the therapist involved if she

discusses those things with clients specifically, and she did not say anything about them. Extratherapeutic factors account for up to 40 percent of the variance in outcome (Lambert, 1992). The two participants, Julie and Leslie, who gave me the most examples of extratherapeutic factors were two of the participants who had recovered the most. Neither of them was in therapy weekly anymore, and each of them had come to the point of accepting her natural weight as considerably higher than her anorexic, previously-desired weight. They each clearly stated several things that had happened outside therapy that promoted their move toward physical health. Each of them also had a friend who was anorexic, and they both stated that seeing the friend suffer pushed them to continue with therapy even when they did not wish to gain weight.

Pets Julie had a dog to which she attributed a good deal of helpfulness. Her report is consistent with research indicating that pet ownership is related to happiness among elderly women (Ory and Goldberg, 1983), fewer headaches, swallowing problems, cold sores, persistent fears, feelings of panic, and less constipation among recently widowed elderly women (Akiyama, Holtzman, and Britz, 1986-1987), increased survival rate among heart attack survivors of all ages (Friedmann, Katcher, Lynch, and Thomas, 1980), increased morale among men in VA home care program (Robb, 1983).

Siegel (1993) found that, of the 938 elderly participants in her study, dog owners, as compared to cat and bird owners or people with no pets, had fewer doctor contacts than might be anticipated given the number of stressful life events they endured. Compared to cat and bird owners, the dog owners spent more time outdoors with their pets, spent more time talking to them, and felt more attached to their pets. They also were more likely than owners of cats or birds to report that their pet made them feel secure and provided love to them. Cat and bird owners were more likely to report that their pet cheered or entertained them.

In a review of the relevant literature, Brasic (1998) notes that, although the extant studies lack rigor, there is enough evidence to seriously consider the effects of animal companionship on persons in psychotherapy. He summarizes research suggesting that petting dogs lowers blood pressure in healthy young adults and reduces blood pressure and heart rates of children reading poetry. Ownership of a new pet (dog or cat) is associated with improved general health in the first month, and dog owners report continued improving health for ten months. On the other side of the issue, rural women report decreased health and morale with pet ownership, and in college students, high affection for dogs is associated with moderate affection for people.

Influencing my model of therapy

This research has influenced my way of doing therapy in ways I can identify, and I presume it has influenced it in ways that I cannot. For example, I was specifically thinking about Julie saying that she knew about Claire's wedding (and had given her a wedding present), and liked knowing those things about her, when the incident in the upcoming recollection took place. I did not think, "Oh, here is an opportunity to behave mutually." I experienced the exchange as more of one in which I sensed permission to do what I, as a "person" rather than a therapist, wanted to do, which was ask my client for advice.

As I was finishing the discussion of these results, I took a vacation to hike across the Grand Canyon. Before I left, I was setting an after-vacation appointment with a client, and she asked where I was going. I told her, and we briefly chatted about how beautiful and hot the canyon would be in August. As we stood up to go, the thought occurred to me, that since this young woman had spent many years as a wilderness guide, she might have some useful advice about managing the heat. She paused just a second at the door, and I asked what she would suggest about keeping safe. She turned and came back into the office and sat down and cheerfully suggested several specific things. The entire interaction may have lasted five minutes, and we said our good-byes, and she left.

The effect of this interaction on me was, in addition to bringing this young woman to mind as I implemented her suggestions while hiking, to alter my vision of her from someone struggling with something that most adults do not give much thought—how to feed oneself—to someone who has figured out how to manage nature at its most complicated and difficult and, therefore, in possession of considerable resources and personal competence. I am encouraged and reminded to see all of her, which further influences me to be more fully myself with her, including the parts of me that are scared of heat stroke and mountain lions. I experienced a give and take in our relationship that I would describe as mutuality.

In regard to self of therapist, the aspects identified as helpful by participants I have labeled personality, age, sex, physical characteristics, and skill/knowledge. For some of these, age, sex, and physical characteristics, I am pretty certainly who I am. In regard to aspects of personality and skill or knowledge, however, some of my ways of being with clients have changed. Rather than seeing my behavior as an adoption of someone else's way of working, I experience myself as feeling permission, granted by these participants, to be who I am with them, even if that does not necessarily fit with standard therapy procedure.

I am much more likely to discuss aspects of my life that clients ask about. For example, a current client, after reading my resume included with disclosure documents at the beginning of therapy, commented that she hoped I would be in Seattle for while since it looked like I had moved around quite a bit. There was a time when I probably would have simply said that Seattle is now my home, but I engaged in a brief conversation with this person about having moved to go to school and take jobs for brief periods of time. This discussion was directly pertinent when she later wanted to discuss how difficult it was to be new to the area. She specifically said that she was sure I would know "how she felt" since I had been new in town several times. I did not presume that I knew how she felt,

but it was an area of connection between us that allowed her to believe that I might have some personal experience with her specific concern. I am more self-disclosing as a result of this research, and I feel less guilt about it.

I remember research participants telling me that it was important that Claire was happy to see them at each session, and I remind myself to demonstrate the happiness I feel at seeing clients when I walk into the lobby. In regard to skill or knowledge, I am more likely to present myself as actually having specialized knowledge about eating problems and the treatment of eating problems than I was previously. My levels of skill and knowledge have increased, but my ease with claiming that level of skill and knowledge is partially a function of learning from women in therapy that it is important to them that their therapist know what she is doing. I remind myself of the ways participants determined their therapist was skillful and knowledgeable, and I am more comfortable insisting, for example, that a client see a doctor before our next appointment than I would have been before learning that some women, even if they do not like the idea of seeing the doctor, feel comforted when their therapist takes a strong position in regard to that element of treatment because they translate that as the therapist “knowing what she is doing”.

In regard to the relationship aspect of therapy, I have probably changed the most. My academic training was in marriage and family therapy, and I became proficient with several models of therapy. None of them emphasized the development of a therapeutic relationship. Now, regardless of the “model” of therapy I do, my main goal is to find some way to connect with clients in a way that feels like a relationship. Participants in this research identified trying harder, being challenged, and internalizing therapist as behaviors that I believe occurred as functions of their relationships. I use these as markers for relationship development. When I can see that a client is “trying harder” because I ask her to, I consider our relationship strong enough to withstand a challenge over aspects of her behavior that need to be changed. (I have not yet, and may never, tell

a client that I think she has a whiny voice; however, if I find myself thinking that with a client who has demonstrated by “trying harder” to change her behavior that we have a sound relationship, I just may.) If a client tells me, as some have, that she thought about bingeing, for example, but heard my voice suggesting that she call a friend or go for a walk instead, I consider her to have internalized some aspects of me that are encouraging her toward better choices. I am not working toward these as goals, per se, but goals as they are indicative of other important conditions of therapy.

Within therapy aspects of my therapy work that have been influenced by this research include reading, writing, changing food behaviors, and having and managing others in therapy. I encourage every client to read, to write in a journal, to change food behaviors gradually, and I always invite other pertinent people to therapy sessions. If those people are unavailable, I encourage letter-writing and phone calls, from my office if necessary, to friends and family who hold some influence in regard to eating. With some clients, their relationships with others are clearly factors maintaining their eating problems, and in those instances, when I believe their eating is stable, I will shift therapy to “relationship therapy” and specifically focus on those things that are problematic to the client or are maintaining disordered eating. However, I am flexible about the implementation of all of these activities. If a client does not like to read or refuses to do a food diary or keep a journal, I continue to see them in therapy. When I believe we are at a point where doing a food diary or keeping a journal, for example, would help therapy proceed better, or differently, I will say so. In some instances, I have developed enough relationship collateral to get a client to change her mind, and in those instances, the activity is typically useful. Some clients have not changed their minds, however, and that may or may not be a function of our relationship.

Integrating with other models of therapy

CBT and family therapy have long histories of theoretical and research support for the treatment of eating disorders, and this research is but a minor contribution to either. The contribution is, however, a real one. Women in therapy who found aspects CBT and family therapy helpful also said that without the foundation of a good relationship with their therapist, they would not have gotten the benefits of those components.

What does that mean for these models? It depends on the clinician. If the clinician practicing CBT or family therapy is already focusing on the relationship as a goal of therapy and remaining flexible about the implementation of the cognitive-behavioral or family therapy elements of treatment, it is possible that the clinician is already conducting therapy according to that model in the best manner that research supports. If the clinician practicing CBT or family therapy is not making a good relationship with the client a goal of therapy, there is likely room for improvement. It is also certain that this cannot be judged beyond the specific client-therapist pair, and it does require action on the part of clinicians to examine their way of working with individual clients. The following questions may be helpful in that regard.

- Do you like your client?
- Are you glad to see her when she gets to your office?
- Do you demonstrate that by smiling at her when you meet her in the lobby?
- Does she smile back?
- Do you feel a warm connection with your client?
- Are you able to laugh with your client?
- Are you able to show your sense of humor with your client?
- Do you answer your client's questions about pictures in your office?
- Do you disclose personal information to clients in a way that strengthens your relationship?

- Are you able to feel relaxed in the presence of your client?
- Do you demonstrate skill and knowledge by showing your client you know what you are doing?
- Are you letting your client just talk for some period of time each session?
- Are you helping your client change her self-defeating thought patterns?
- Are you suggesting that your client keep a journal?
- Do you read and comment on that journal?
- Are you recommending that your client read specific things?
- Do you ask about that reading and encourage discussion if the client wishes to discuss it?
- Are you actively educating your client about the physical and emotional aspects of eating disorders?
- Are you including important people in therapy?
- Are you helping the client manage important people who may or may not be a part of therapy?
- Are you specifically encouraging your client to change her unhealthy food behaviors?
- Are you challenging your client about those behaviors that continue to present a problem?
- Are you insisting your client see a doctor who is comfortable managing eating disorders?
- Are you maintaining contact with that doctor?
- Are you referring your client to a nutritionist when she has stabilized enough to benefit from seeing a nutritionist?
- Are you maintaining contact with that nutritionist?

- Are you encouraging your client to discuss any medication questions with her doctor?
- Are you encouraging your client to ask her doctor about medications if nothing else has seemed to change her eating disordered behavior?
- Are you encouraging your client to maintain and develop friendships?
- Are you asking about your client's pets?
- Are you telling your client about the benefits of owning a pet, particularly a dog?
- Are you encouraging your client to identify music that helps her feel better?
- Are you asking your client about other things outside therapy that may be helping her get better?
- Are you emphasizing the importance of those extratherapeutic factors?

Areas for future research

Future research that asks the same questions I asked of people in treatment for an eating disorder with therapists who practice “pure” models of CBT or family therapy would add important voices to these participants' voices. It is unknown what those clients find helpful about therapy, and it is difficult to make recommendations for improving those models without determining what is already right about them for the perspective of clients.

Appendix A

Interview Question Guide

First interview:

“I am interested in what therapy is like for young women who have or have had an eating disorder. I am also curious about your suggestions or ideas for therapists. Since you have been, or are in, therapy for this problem, I believe you are the best person to help me understand this. The information you give me will help therapists in their work with other women. Do you have any questions?”

Areas of focus: women’s experience in therapy
 interaction between therapist and woman
 suggestions for therapists

1. Tell me about your therapy experience. What was it like for you?
2. What was going on that got you into therapy in the first place?
3. How do you feel the therapist relates (or related) to you personally?
4. What has your therapist done that has been helpful to you?
5. What has your therapist done that has not been helpful for you?
6. If you found out a friend your age had a problem with eating and was going to start therapy, what would you tell her about what to expect?
7. On a scale of 1 to 10, with 10 meaning therapy was a great experience and 1 meaning therapy was an awful experience, how would you rate your experience in therapy? What could your therapist do that would increase your rating?

8. What advice would you offer a therapist so she/he can improve therapy for people with eating problems?
9. What questions did I forget to ask you that I could ask the next person?

Appendix B

Family Therapy in the Maudsley trials

Dare and Szmukler (1991) describe the family therapy that was conducted in the Maudsley studies. These findings have special importance since they are the result of the only controlled trials of family therapy for anorexia nervosa. The methods used by the group have been explained in detail, and I believe they are significant enough to warrant detailed review.

The family therapy done in their research consisted of three phases. The first phase of treatment involves setting up family meetings, engaging the family, assessing the family, and training the family to change of the problematic eating behavior. The therapists followed specific guidelines for each of these stages.

First phase

Setting up the first meeting The entire family, including extended family members if they are living in the same household, is required by the therapist to attend the first meeting. The therapist is instructed that it may require “firmness, tact, and some guile” (31) to achieve this end, and various attempts by the family to pre-empt this requirement are anticipated and solutions are suggested. Szmukler and Dare (1991) anticipate the parents or the patient wishing to meet separately. The therapist must insist on a conjoint meeting. They anticipate parents suggesting the patient will not speak if they are in the room. The therapist must insist that the patient will not be made to talk if she does not wish to talk. They anticipate the parents stating that they are unable to make child attend. The therapist is to insist that if the child is still legally a minor, they can require her attendance. Parents are to be told that grown siblings of the patient would be helpful, but since they cannot be required to attend, they are to be invited. One or the other parents may attempt to miss the appointment due to other obligations. The therapist is to emphasize the crisis nature of the situation and insist that other obligations be

postponed. When parents are separated or divorced, the custodial parent and his or her household should be required to attend. If the child has access to the other parent, that parent should be invited as well. Stepparents and cohabitants are to be invited as well, and they should be assured that the invitation is for the purpose of managing this crisis and that no attempts to reconvene previous relationships will be made.

The attitude of the therapist while having conversations to set the first meeting should be one of firmness and sincere concern about the seriousness of the matter. Refusal to equivocate about the matter of attendance demonstrates the level of crisis, and it requires the family to begin organizing itself differently to respond to unwanted demands. The authors state that even if the patient is still in the hospital, the entire family is required to attend the first meeting. If the patient is no longer in the hospital, lab facilities to monitor weight, height, blood chemistry, and cardiac and enzyme status must be available and a route for accessing them quickly should be established.

Engaging the family The first meeting must be conducted “intensely, gravely, empathically, warmly, sincerely, and portentously. A priest meeting the family of the bereaved at a funeral is a possible model” (33). The therapist should then determine how much physical contact each family member can easily tolerate and then do a bit more, using two hands for a handshake or holding it a little longer than would be the person’s preference. The therapists in the Maudsley trials conducted family therapy sessions in a consulting room with one-way mirrors and with video cameras for monitoring, and these were all pointed out to the family as they entered the room. The patient’s weight chart should be waiting for the family and the therapist when they enter the room.

The first task is to determine what is each family member’s understanding about why they are attending the session. The repetition by each person will highlight the seriousness of the situation, and the therapist should express appropriate despair, panic, horror, and hopelessness. This should be done while maintaining a warm, empathic, and

friendly manner that conveys to the family the therapist's real desire to understand them and their situation accurately. All the while, the therapist is trying to increase the anxiety of the family about the situation.

As soon as possible, the therapist should "orchestrate an intense scene that neither scapegoats the patient, blames the parents, nor exempts the siblings. All of those involved should be held focused on the horror" (34). They anticipate that this will perturb the patient whose true level of fear about herself is being expressed openly for probably the first time. The therapist must demonstrate authentic sympathy for the family and remain decidedly uncritical of the symptoms the patient demonstrates. The task for the therapist at this point is difficult, because she must demonstrate accurate distress about the toll anorexia nervosa is taking on the patient's life, but she has to remain noncritical of the family, the patient, and the symptoms while so doing. Each family member must feel a sympathetic connection to the therapist, but their level of anxiety must be increased considerably.

The "climax of the session is reached when the therapist gently but forcefully and relentlessly points out" that the family will have to find a way to make the patient eat, gain weight, and stop purging activities (35). The family will, undoubtedly, express their inability to accomplish this task because they will believe that they have been attempting to do nothing else for the entire duration of the problem. The therapist is to sympathize but point out the lack of alternatives. Even if the patient has been hospitalized and gained weight, the family should be advised that statistics suggest that she will likely lose weight after departing, and the family will find themselves in the same situation at some point in the future. The therapist is to end the session by scheduling another appointment within a few days and requesting that the family bring a picnic lunch to the session, which the therapist will share with them. They are also instructed to bring as much food for the patient as they believe she needs, regardless of how much she may want. Dare and Szmukler (1991)

refer to the position in which this puts the family as a therapeutic double bind. The therapist has been warm, sympathetic, friendly, and she has also told them to do what they believe they cannot do thereby intensifying the existing anxiety in the family. Typically, according to Dare and Szumler, anxiety-provoking individuals are considered hostile and difficult. "The *bind* (its orig) is the mixture of panic induction and loving warmth. If this mixture can be authentically and powerfully mobilized, the family will return with the picnic" (35).

Assessing the family The therapist will have been assessing the family through every interaction at both individual and collective levels. Dare and Szumler (1991) that these assessments be discussed and validated with observers or others outside the therapy room due to the powerful ability of the family to influence the therapist into behaving in ways that, while socially appropriate, do not push the family enough to change. The goal for the therapist is to develop a knowledge of the family structure. "This consists of the stable often-repeated patterns of communicating, controlling, nurturing, socializing, forming boundaries, making alliances and coalitions, and solving problems" (36). One of the goals of the therapy will be to disrupt these patterns when they are identified as helping to maintain the problem. The therapist will challenge the patterns by direct instruction and the ways in which family members are addressed and meetings are conducted. "The therapist hopes to enforce change by disrupting old and familiar patterns, taking advantage of the family's disorientation in the strange setting of the family therapy unit and under the impact of the therapeutic bind" (37).

It is necessary for the therapist to develop an understanding of the family's belief system, as well, if interventions are to directly change the attitudes that underlie many of the behaviors the family displays. In the example the authors give, a father may never participate with the mother in insisting that the daughter eat; while the family members may be aware of the "taboo"-like nature of requesting such, they may be unaware that the

father feels extraordinarily guilty over the suicide of his sister and that the subject of young women doing things to threaten their own lives is such a difficult subject that the father has been allowed to opt out of effectively managing his daughter's behavior. It is necessary that the therapist tap into this information in order to design interventions that actually fit the circumstances of the unique family.

Dealing with symptoms Belief systems, family patterns, and family structure do not create the symptoms of anorexia nervosa (Dare and Szukler, 1991), but those belief systems, family patterns, and family structure must be well-understood and respected by the therapist. However, for the patient to get better, she must eat. The aim of family therapy is to enable the parents

“to set up a meal regimen, such as occurs in a well-functioning hospital inpatient unit for eating disorders. There must be a culture such that eating and completing a meal promptly occurs, because the expectation for that occurrence is relentlessly powerful. The culture created must be such that there is no alternative to compliance”

(Dare and Szukler, 1991, 38).

The authors acknowledge that for some families this is actually impossible, but all families come to therapy with the belief that it is impossible, but with guidance, many families are able to do just that. The beginning of this “revolution” happens during the family picnic at the second session in which the therapist helps the parents make the daughter eat one bite more than she wishes to eat. The family picnic is, by definition, as widely varying as the families who have them. The parents are instructed to take charge of the patient's eating, sitting close on each side, and insisting that she eat. They are by no means to consult her about her wishes regarding what or how much she is to eat, and they are to use whatever means necessary to make this happen. They state that the therapist may need to instruct the parents to treat the patient like a toddler who refuses to

take her medicine. This may lead to one parent holding the patient's nose while the other forces food in. The authors acknowledge that this is inelegant and humiliating, and clearly age-inappropriate. They state that a remarkable change in the relationship between the parents, the patient, and food occurs, however, when everyone involved sees firsthand that the parents can force the patient to eat.

Frequently, the patient will begin to eat but will not gain weight because she will be allowed to eat low or no calorie foods. If this occurs, the therapist must then begin instructing the family in ways to get more calories into the patient so that when fights occur they are over foods that will make a difference rather than over lettuce or celery.

The authors caution that the patient can attempt to sabotage therapy by eating the family picnic without a fuss, and they state that this is a bad prognostic sign, which should be pre-empted by encouraging the patient to resist. The explanation accompanying this should be paradoxical in that the therapist is encouraging the patient to both resist and cooperate, so that whatever she does is complying with the therapist's wishes. The patient often fears that her parents cannot stop her from starving herself, and if she gives in without a fight, her belief about this matter cannot be demonstrated untrue. If she puts up a fight and the parents still win, the point that the parents can step in at any future point necessary will have been made experientially (Dare and Szukler, 1991).

When parents are separated, each set of parents must be instructed in this method, and if a parent is single, a friend or grandparent will have to substitute for the other parent. Siblings are not to be used in this role; their position throughout the refeeding should be one of sympathy and support for the patient.

Second phase

The emphasis of therapy shifts in the second phase after it is clear to all involved that the daughter will not be allowed to starve herself while living with her parents. Parents must maintain close enough supervision and surveillance of their daughter that regular,

balanced meals are eaten, and if they need to take leave of work to do so and have the child miss school, they must. As soon as the patient has been steadily gaining weight, sessions are spaced to every 2 or 3 weeks, and the emphasis shifts to helping the family appropriately engage the outside world in regular activities.

At the beginning of each session in this phase, the patient is weighed, the weight is charted, and the progression is discussed. If the graph does not show a weight gain, this is the focus of the discussion. How can this be made to happen? Rather than setting a target weight, the appropriate weight will be one at which the patient, if a girl, begins to menstruate and stops worrying so much about food. At that point, the family should be guided in discussing developmentally appropriate concerns such as school, holidays, curfew, etc. The authors suggest that in successful cases this happens fairly quickly, but that in unsuccessful cases, this pattern can persist for months or years.

5 to 7 sessions are usually needed to achieve the appropriate shift in the family, but the authors acknowledge that the insistence by the therapist that the parents make the patient eat creates a volatile situation in therapy. Since the family is seriously conflict avoidant in the first place, the easiest thing for all concerned is to resist the therapist's advice and attack the therapist instead. The therapist "has to neutralize that possibility preemptively by using great warmth and authority" (43). Then, at the end of the second phase, the therapist must demote herself and help the family replace her authority with their own.

Third phase

This phase is a very short period during which the family and therapist are certain that the starving behaviors will not occur again and do not need to be discussed. The two tasks for the therapist during this period are to explore with the parents their plans for themselves as a couple, and to explore leaving-home plans of the patient. Both of these must be discussed explicitly because anorexic patients often hold the belief, true or

untrue, that their parents live only to take care of the patient and that their relationship is not powerful on its own to exist without children at its center. While this may be true in some instances, it needs to be made clear to the patient that the parents' lives will carry on without them in the family home, and that the parents have plans that do not involve their children. This will encourage and free the patient to pursue her own life without responsibility for keeping the family together as it sometimes seems her symptoms may have done (Dare and Szmulker, 1991).

The authors recognize that there are failures with this approach. Some families are unable to accomplish the refeeding necessary for the patient to gain enough weight to eliminate starvation symptoms. The failure is most likely to occur in the second phase because although refeeding may happen to some degree, the patient's weight gain is insufficient to return her to normal status and she remains chronically anorexic. In this situation, the authors extend treatment, try other family therapy techniques, engage in individual therapy, or attempt marital therapy if that seems warranted (Dare and Szmulker, 1991).

Appendix C

Description of CBT for BN

Clear standards exist for conducting CBT, and ample research demonstrates the efficacy of CBT for bulimia nervosa. Because elements of CBT are evident in the results of this research, I have outlined the basic elements of treatment for the reader. CBT for bulimia nervosa was introduced by Fairburn (1981) two years after Russell (1979) outlined the criteria for diagnosis. Fairburn (1981) adapted Beck's (1976) treatment for depression as a treatment for bulimia nervosa, and by 1985, he had manualized the treatment.

Cognitive behavioral therapy for bulimia is based in the model of bulimia nervosa that emphasizes the thought and action factors that maintain the disorder (Fairburn, 1981). Persons who develop the disorder have at the foundation an idealized body image that they highly overvalue. This leads them to restrict food intake in an attempt to become more slender, which makes them physiologically and psychologically susceptible to losing control over food intake, or binge eating. Binge eating leads to increased feelings of guilt and worthlessness, and attempts are made to rid the self of these feelings by ridding the self of the binged food. Vomiting, laxative misuse, diuretic misuse, and excessive exercise are attempts by the person to reduce the anxiety associated with having binged. Purging the calories inappropriately leads to increased feelings of worthlessness, guilt, and anxiety, and the person is even more vulnerable to overvaluations of idealized body images, increasing the likelihood that the cycle will continue. Based on this model of the problem, Fairburn (1981) developed a model for treatment that emphasizes the development of normal eating patterns and the replacement of dysfunctional thoughts and feelings with less harmful thoughts and feelings.

In his 1985 manualized version of CBT, Fairburn divided treatment into three stages to consist of a total of 19 sessions over a course of 20 weeks. Throughout the therapy, the position of the therapist is one of helpful support and encouragement.

Stage one

Stage one lasts for eight sessions and has the following goals:

Establishment of a sound therapeutic relationship;

Education of the patient about the model of bulimia with an understanding that both cognitive and behavioral changes will be necessary;

Establishment of weekly weighing;

Education of the patient about body weight regulation, adverse effects of dieting, and the physical consequences of bulimic behaviors;

Reduction of the frequency of overeating by establishing regular meals and the use of alternative behaviors.

The goals of stage one are achieved with self-monitoring, which is introduced in the first session and forms the basis for the rest of treatment. Self-monitoring serves two purposes: it creates a record for the therapist to use to make assessments of the status of the patient and whatever progress occurs, and it increases the self-awareness of the patient regarding when, where, and what she eats and how that may be related to bingeing, thereby helping her regain control.

Self-monitoring consists of instructing the client to record when, where, and what they eat, and whether they judge it to be a meal, snack or binge and whether it led to purging. Clients are also encouraged to record their thoughts and feelings at the time they ate and discouraged from counting calories.

Clients are instructed to weigh themselves once per week. Most clients will have either been weighing themselves at least once daily (and sometimes much more frequently) or not at all. Their faulty beliefs and feelings of what normal food intake will do to their weight cannot be challenged without a weight record. The therapist will begin to encourage the client to accept as a goal a weight range of about 6 pounds rather than a specific number.

The client is taught specific facts about weight regulation, negative effects of rigid dieting and binge eating, and the physical consequences of all of the above. The facts about the ineffectiveness of laxative use for weight control are explicated, and the limited ability of vomiting to remove calories is explained. The negative reinforcement of relief after purging is explained.

A prescribed eating plan is a necessary part of cognitive-behavioral therapy since most people with bulimia nervosa restrict their eating considerably, thereby setting themselves up for binge eating. As soon as the third session, the client is asked to begin eating three meals and two snacks a day even though this typically meets with great resistance. Clients are reassured that most people who cease bingeing and purging do not gain weight because as they eat more regularly, they stop bingeing and considerable amounts of calories they would have consumed in binges are not consumed. It can usually be demonstrated to clients at this point with a history of their own weight that their weight was more likely to increase when they were engaging in binge/purge cycle. Clients are encouraged to eat whatever types of foods they wish to eat at this point, as the emphasis is on *when* rather than *what* the client eats. The direct goal for this step is to establish an eating pattern that will preclude the urge to binge.

The pattern of the therapist explaining things to the client in terms of the cognitive behavioral model can be established when the client complains, as most will, that they feel too full when they eat regular meals. It is important that the client understand that her subjective appraisal of her experience, i.e. feeling too full, is likely the consequence of having eaten so irregularly in the past. In addition, clients are typically overly sensitive to feelings of fullness because they associate feelings of fullness with getting “fat”. Clients are encouraged to “wait out” the feeling of fullness and the attendant anxiety as it will necessarily diminish with time. Clients may be encouraged to try distracting activities after eating if the urge to purge is too strong to ignore.

Various additional self-control strategies should be taught the client during this stage of therapy. One strategy is to determine times and places where the client is at high risk for bingeing. The task is then to identify a list of pleasurable alternatives that would preclude bingeing that the client can try when the urge to binge becomes strong. These might include taking a hot bath, talking on the phone with a friend, or taking a walk. Another strategy is to limit or eliminate the stimuli for bingeing. These might include not going to the grocery store when hungry or feeling a particular lack of self-confidence, and it may include not keeping “binge” foods in the house. It may also include encouraging the client to have meals at specific times and regular places rather than eating while driving, for example.

Stage two

Stage two consists of sessions 9 through 16. The goals for stage two are:

Reducing dietary restraint, and

Developing cognitive and behavioral coping skills for resisting binge eating.

The goal of reducing dietary restraint is achieved by working with the client to alter what and how much they eat. Clients are asked to make a list of forbidden foods, which are foods that they avoid because they are afraid they will trigger a binge eating episode, and then they are asked to rank them from least threatening to most threatening. They are then asked to start including them in their regular diet, starting with the least threatening food. The food should not take the place of regular meal; it should be incorporated into what the client would normally eat. Systematic experimentation with previously forbidden foods as part of regular meals and not experiencing loss of control challenges the anxiety associated with fear of losing control. This exposure helps disconfirm dysfunctional expectations and increase self-efficacy. Once the client is eating a wide variety of foods, the emphasis should be switched to ensuring they eat enough. During this stage, clients

should also be encouraged to experiment with eating in a variety of situations such as the homes of friends and restaurants.

Teaching the client specific problem-solving techniques is also part of stage two. Since, according to the cognitive behavioral theory of bulimia, binge eating is the consequence of specific thoughts, negative emotions, and interpersonal stressors, it is important that the client be taught specific skills for managing these situations without resorting to the maladaptive pattern of binge eating. Problem-solving consists of several steps: 1) identifying the specific problem; 2) generating several different ways of coping with the problem; 3) evaluating effectiveness and feasibility of each option; 4) choosing the best alternative and determining how to implement it; 5) carrying out the chosen alternative; and 6) evaluating the outcome. Clients should be encouraged to record their attempts at problem-solving, and therapists should review these with the client in each session.

Although some dysfunctional cognitions will have been addressed prior to this point in therapy, the formal treatment of problematic thoughts and attitudes begins in earnest with cognitive restructuring, which is adapted from Beck's therapy for depression. The four steps are: 1) identify a specific problematic thought and its context; 2) evaluate evidence supporting the thought; 3) evaluate evidence contradicting the validity of the thought; 4) make a conclusion about the validity of the thought based on the four steps. This should lead to a change in the client's behavior as it evolved from the problematic thought. Patients should write down the results of each of these specific steps so they can discuss them with their therapist, and therapists should explicitly demonstrate how to do this. Therapists can ask additional questions about the effects of clinging to the problematic beliefs, such as "What is the effect of keeping this belief?" "What are the advantages/disadvantages of believing this way?" "How does this belief affect the way you

feel and what you do?” “What are some alternative ways to view this that might be more helpful to you?”

Stage three

The goal for the third stage of cognitive behavioral therapy for bulimia nervosa is to anticipate future difficulties and develop strategies to prevent relapse. Sessions are typically scheduled every two weeks. Clients are told they may always be vulnerable to eating problems, particularly during periods of great stress, but they can anticipate overcoming those setbacks before they turn into complete relapses with the skills they learned during therapy.

In order to actually be useful, the client must be encouraged to anticipate specific difficulties. For example, clients who are planning a big beach vacation might anticipate feeling self-conscious about being seen in a swimsuit and being vulnerable to the urge to diet. The client will have learned how dieting sets up the conditions for bingeing, and in the last stage of therapy she will have developed a maintenance plan to follow after therapy ends. The plan should include the following points: 1) If a problem occurs, the first step is to be aware of what is happening. 2) The patient will reinstitute self-monitoring of all eating. This will allow the client to determine which situations give her difficulties. 3) The client tries to repeat what worked before and goes back to eating three regular meals and two snacks per day. 4) The client uses problem-solving strategies to cope with whatever difficult circumstances might be contributing to the re-emergence of her eating problem. 5) The client will use cognitive restructuring techniques in an attempt to reduce her concern with weight and shape. 6) The client will set short-term, realistic goals and work on them one day at a time with the understanding that one binge does not constitute a complete relapse.

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Education

Ph.D. in Human Development: Specialization in Marriage and Family Therapy
 Virginia Tech, Blacksburg, Virginia
 Anticipated Graduation: December 2001

Master of Arts in Marriage and Family Therapy
 Northeast Louisiana University
 Monroe, Louisiana
 Graduation: May 1995

Bachelor of Arts in English
 Lamar University
 Beaumont, Texas
 Graduation: December 1989

Professional Experience

October 2000—present

Private therapy practice

Specializations: Eating Disorders in adolescence and young adulthood
 Feeding Disorders of infancy and early childhood

Seattle, Washington

June 1999—September 2000

Clinical and Administrative Team Leader, Mentor Health Northwest
 Bellevue, Washington

August 1998—May 1999

Adjunct Professor of Marriage and Family Therapy
 Montana State University
 Bozeman, Montana

May 1997—July 1998

Family Therapist, Doctoral Internship
 Family Service of Roanoke Valley
 Roanoke, Virginia

January 1996—May 1997

Marriage and Family Therapist
 Family Therapy Center of Virginia Tech
 Blacksburg, Virginia

January 1994—May 1995

Marriage and Family Therapist Intern
 Northeast Louisiana University MFT Center
 Monroe, Louisiana

September 1994—May 1995
 Family Therapist Intern
 Jack Hayes Elementary School
 Monroe, Louisiana

May 1994—September 1994
 Family Therapist Intern
 Adolescents-at-Risk of the City of Monroe
 Monroe, Louisiana

August 1993—May 1995
 Instructor, Dept. of Educational Leadership and Counseling
 Northeast Louisiana University
 Monroe, Louisiana

August 1992—May 1993
 Teacher, English
 Vidor High School
 Vidor, Texas

August 1990—May 1992
 Teacher, Language Arts
 Colbert Middle School
 Dayton, Texas

December 1989—August 1990
 Contract Administrator
 Mobil Oil Corporation Beaumont Refinery
 Beaumont, Texas

Presentations and Workshops Conducted

“Managing the Stress of Parenting”
 Invited Presenter at King County Parents’ Group
 Kent Regional Justice Center
 September 5, 2001

“The ABC’s of SST (Single-Session Therapy)”
 In-service training
 Family Service of Roanoke Valley
 November 20, 1997

“Beauty and the Beast: Disney’s Messages about Gender and Domestic Violence”
 Invited presentation
 Red Cross Health Forum
 Salem High School, Salem, Virginia
 October 7, 1997

Southeastern Symposium on Child and Family Relations
 Conference Chairperson and Co-Organizer
 Virginia Tech
 March 1997

“Postmodern Research: My Experience”

Invited Panel Member

March 1997

Southeastern Symposium on Child and Family Relations

“They Keep Going and Going and Going: Sustainable Community-Based Programs that Promote Resiliency among At-Risk Children, Youth, and Families”

Poster Presentation with Jay Mancini, Ph.D., Lydia Marek, Ph.D., and Mark Benson, Ph.D.

November 1996

National Council on Family Relations Annual Conference

“Resource-Focused Therapy with At-Risk Adolescents”

Presentation with Wendel Ray, Ph.D., Leah Young, M.A., and Laina Banister, M.A.

January 1995

Texas Association for Marriage and Family Therapists State Conference

“Creating Resourceful Contexts for Therapy with At-Risk Adolescents”

Presentation with Wendel Ray, Ph.D., Leah Young, M.A., and Laina Banister, M.A.

October 1994

Louisiana Counselors' Association Annual State Conference

“A Healthy Family Model for Sexual Expression in Children”

Presentation with Lamar Woodham, Ed.D. and Laina Banister, M.A.

October 1994

Louisiana Counselors' Association Annual State Conference

Sex Education Workshop for Teens and Parents

Presented and developed with Melinda Czuchra, M.A.

Faith United Methodist Church

March 1995

West Monroe, Louisiana

Systematic Training for Effective Parenting (STEP) Classes

Jack Hayes Elementary School

September 1994 to May 1995

Monroe, Louisiana