

Independent Research Dissertation

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**The role of person-centred counselling in recovery from
eating disorders.**

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Acknowledgements

Upon starting my journey at Liverpool John Moores University to become a qualified psychotherapist/counsellor, it had been over twenty years since I had been in formal education – 21 years since my undergraduate graduation across the road at the University of Liverpool.

The intensity and emotional demands of this process took its toll at various points. Some of this pressure was the inevitable consequence of returning to the classroom after so long; some, the nature of the personal exploration required to learn, and to train to become a therapist; some, the result of a global pandemic interfering with my studies, placements and general life; and some, the unhelpful, unnecessary, unpleasant and unacceptable experiences I had at the university.

There were exceptions in my experience at the university. These included Dr Jeffrey Harrison (my supervisor for this research), Dr Peter Blundell (my skills and personal tutor across my studies) and Dr Kathleen Vandenberghe (my personal development tutor in my second year). They provided support, respect and held space for me throughout my studies, for which I am grateful. Dr Blundell, with whom I talked candidly a number of times, was particularly empathetic and supportive to me during my most difficult moments at the university. I will be forever grateful to him.

Throughout my studies, I have been sustained by my commitment to using my lived experience of a breakdown, recovery and living with depression and anxiety to help others, and by the love, support and inspiration of my darling wife and daughter.

Without Aileen, I would not have been able to get through this process. Without Aileen, I would not have been able to get through the last few years.

Two other women walked alongside me during this incredibly difficult time of studying and researching: my therapist, Anne, and my supervisor, Pam. Their calmness, thoughtfulness, empathy and unconditional positive regard throughout the last three years have meant a huge amount to me.

I am beyond grateful to the women who made this research possible, sharing their stories with me, often recalling deeply difficult and distressing experiences. It is with them, their courage and their experiences in mind that I hope this research can help improve the provision of counselling for those experiencing eating disorders. Lives are at stake.

Abstract

Background: This research study focuses on the role of person-centred counselling in recovery from eating disorders, trying to help plug a gap in existing research of this topic, in particular in relation to the participant group for this research: female students, aged 16-22, with eating disorders. The issue of eating disorders has gained increased prominence in public debate, given recent trends in society and in significant increases in demand for support and referrals within the NHS.

Theoretical framework and methodology: This study aims to understand the experience of participants, using interpretative phenomenological analysis (IPA): an approach that is rooted in phenomenology thinking and informed by related branches of philosophical thought, including hermeneutics.

Literature review: Three areas of existing literature were reviewed: the three person-centred concepts explored in this research; previous exploration of eating disorders and the role of therapy; and the role of person-centred therapy and eating disorder recovery. On the latter existing research, the literature was sparse, which highlighted the importance of making a contribution to this discussion.

Method: Engaged with five participants, who were recruited via social media, undertaking between 45 minute and 60-minute semi-structured interviews with each and then analysing the discussions and their experiences, using IPA.

Findings: Fifteen initial themes were derived from the interviews and were then summarised into three main findings: 1) Therapy was of limited benefit to the participants in supporting their recovery from eating disorder(s). The negatives of their experience of therapy greatly outweighed any positives they experienced. 2) Where positives existed in participant's experience of their therapy, it was mainly in the limited presence of two of the three core conditions: empathy and unconditional positive regard. Even though the three core conditions were not fully experienced by participants in their therapy, they viewed them as positive concepts and needed. 3) The experience of participants was that their therapy was too focused on food, eating and medical or clinical interventions, such as dietary and nutrition advice, and not enough on them as a person and on the source(s) of their eating disorder(s).

Discussion: The findings highlight the possibility that insufficient person-centred concepts, principles and practice (notably the three core conditions) existed within the therapy experienced in this research study.

Conclusions: The findings and discussion of this research study raise a number of questions that would benefit from further exploration to test, validate or dispute the analysis produced, including whether too much focus in therapy is on food and not enough on the person.

Background

This research project focuses on the role of person-centred counselling in recovery from eating disorders, asking the question: can the core conditions of person-centred counselling support the recovery of female students, aged 16-22, with eating disorders?

This issue of eating disorders for females aged 16-22 is present in my daily counselling practice and has been present in my work since the first hour of my training placement, with my first client. It is an issue which receives significant media coverage and appears to have grown in profile and prominence since the onset of the COVID-19 pandemic. Some recently published research and evidence would support this observation, with the NHS reporting an 85% increase from 2017-2022 in hospital admissions for people referred for eating disorder-related therapy and support (Hansard, 2023). There has also been a reported 35% increase in 2022 alone (Hansard, 2023). Despite this, it appears to be an area of counselling practice, especially in relation to person-centred counselling, in which there is little existing academic research, particularly on the role that therapy can play in recovery from an eating disorder(s).

By focusing my research on this topic, I am hoping to contribute, at least in some small way, to help filling that gap and helping person-centred practitioners, as well as other counselling practitioners from different modalities, with their own practice. My study may also encourage others to undertake further research and/or discuss and consider the issues I raise in my research in more detail. It is also helping me to

reflect on, and develop, my own practice, both on my own and in discussion with my supervisor.

Choice of research topic

Since starting my training placement in September 2021, through my 100 hours of training, and now in my private practice, young women and girls with eating disorders (a set of conditions I will define shortly) have made up a large proportion of my clients. Although it is impossible to say with absolute certainty the exact proportion, as some clients may have not disclosed concerns about disordered eating or their experience of an eating disorder(s), my counselling log indicates that at least 50% of all my clients have discussed disordered eating and/or an eating disorder(s) in their therapy with me. Of these, the vast majority are female, under the age of 22.

That reflects a number of things. Firstly, I have chosen to work a lot with young people, initially on my placement with students aged 16-18 in the sixth form of a high school, and then in my private practice, where alongside clients who contact me directly, I have built relationships with three schools who recommend me to their students and parents. In my private practice, I offer a discounted rate for students which is 30% less than the rate I charge for other clients.

As a result, a large number of the total clients I have worked with - 55% at the time of writing - have been under 25 and this age group are more likely to present in counselling with an eating disorder, according to research published in 2023 from

University of Manchester, Keele University and University of Exeter (Trafford et al., 2023). Their data examined the medical records, held by GPs, of nine million people across the UK, aged 10-24. It showed that around 2,700 diagnoses of eating disorders were expected from a sub-set of this group – those aged 13-16-year-olds – but that in fact 3,862 diagnoses occurred (Trafford et al., 2023). This is 42% more than the expected figure (Trafford et al., 2023).

Secondly, partly driven by the impact of COVID lockdowns in the United Kingdom in 2020 and 2021, the number of people identifying with an eating disorder has increased significantly, with 100,000 young people (aged up to 18) beginning treatment on the NHS between April 2022 and December 2022. COVID was cited as a major factor in this increase (NHS, 2022). As I highlighted earlier, there has also been a significant increase in referrals for eating disorder services in general for other age groups, over the last two years, (NHS, 2022)

Thirdly, a factor which is impossible to fully quantify, is that I have attracted a number of clients to my practice because of the public ways in which I have talked about my work and focus on eating disorders, including through my blog, social media outputs (which I will often use to comment on and share eating disorder-related content) and, through my website (AMJ, 2023) where I have made clear my interest in working with clients with eating disorders. A number of my clients have communicated with me, verbally and/or in writing, that my interest, and some perceived expertise, in eating disorders was a factor in their decision to make contact to start therapy with me.

These three factors have contributed to me developing a deep interest in eating disorders and working with clients who have experienced, and/or are continuing to experience, eating disorder(s). This professional interest and exposure to clients with eating disorders has supplemented my personal experience of knowing a number of friends who had discussed their eating disorder(s) with me or have exhibited disordered eating behaviours.

Before becoming a therapist, I was interested to learn more about eating disorders and their impact, and now as a therapist I am fascinated by the experience of clients with eating disorders and specifically the role that therapy can play in aiding a possible recovery from an eating disorder(s). It is, therefore, little surprise to me, that for my masters dissertation, which you are reading now, I chose to focus on this aspect of therapy and mental health.

In doing this research, I am hoping specifically to help, in a small way, plug an important gap in the existing research, as there is very little published on these three key person-centred therapy principles and the role, they may play in supporting recovery from eating disorders. I am hoping to build on the limited existing literature that is in place examining counselling and eating disorders, specifically experienced by females between the ages of 16-22, but also to help fill the gap which exists in the research literature into the role that person-centred therapy can play in helping to support client's recovery from eating disorder(s).

Definitions

Before setting out the theoretical framework that underpins this research, and the philosophical approach I have taken to it, I want to provide definitions for some of the key terms that will occur often during this dissertation, and that I have already begun to use.

For the purposes of this work, I am using the The National Institute for Health and Care Excellence (NICE) definitions of 'eating disorder', which states that: "eating disorders are characterised by persistent disturbance of eating or eating-related behaviour which leads to altered intake or absorption of food and causes significant impairment to health and psychosocial functioning." (NICE, 2023).

NICE defines in detail the three main eating disorders which are discussed by participants in this research: anorexia nervosa, which is characterised by "restriction of food intake or persistent behaviour which interferes with weight gain and leads to low body weight"; bulimia nervosa, which presents often as "episodes of uncontrolled eating of an abnormally large amount of food over a short time period (binge eating) followed by compensatory behaviour such as self-induced vomiting, laxative abuse or excessive exercise", and, binge eating disorder, which involves "recurrent episodes of binge eating in the absence of compensatory behaviour". (NICE, 2023).

I will sometimes refer, as I have already, to 'eating disorder(s)' to indicate that some clients have spoken about their experience of multiple eating disorders or set of disorders. Sometimes they feel their eating disorder has changed and become a different disorder, for example beginning as anorexia and moving into binge eating disorder. The internationally-recognised (and much-debated), Diagnostic and

Statistical Manual of Mental Disorders (DSM–5), published by the American Psychiatric Association (Nuckols, 2013) was updated in 2013 and, like NICE in the UK, recognised three representations of eating disorders, including for the first time the inclusion of binge eating disorder as a discrete eating disorder (APA, 2013).

At other times, I have used this terminology because clients have told me that they have experienced multiple, distinct eating disorders at the same time, for example having anorexia and bulimia concurrently, as with at least two of my recent clients and three of the five participants I interviewed for this research project.

The UK eating disorder charity, Beat, has extensive online resources and provides printed materials, often made available in GP surgeries, for those who experience and eating disorder(s), or support or care for, people experiencing an eating disorder(s). In this material they state that: “They (eating disorders) aren’t the same as changing your diet – they can take over someone’s life and the lives of those around them. While unhealthy eating behaviour is involved, they aren’t about food. Instead, they are about feeling in control or coping with something else.” (Beat, 2020).

As well as helping to define and explain eating disorders, Beat also provide statistics on the scale and prevalence of eating disorder(s) in the UK. They believe that 1.25m people in the UK have an eating disorder (Beat, 2021). According to the National Institute for Clinical and Health and Care Excellence (NICE) around 10% of people affected by an eating disorder suffer from anorexia nervosa and 40% of people affected by an eating disorder suffer from bulimia nervosa (NICE, 2020). For binge

eating disorder, 22% of all eating disorders present in this way, according to Beat, (Beat 2022).

I also have used the term 'recovered' or 'in recovery' to help identify participants for the research I have conducted. As I made clear in the inclusion criteria and supporting participant information for my research, I have not sought to codify a definition of this experience and have left this to participants to self-identify as meeting this requirement. I have not sought to be the arbiter as to whether someone has recovered, or is in recovery, from their eating disorder(s): I have left that in the hands of those who responded to my request for participation in the study, having shared with them the documentation for the study, which included the inclusion criteria. I have followed this approach of self-identification to also be consistent with the principles of person-centred work and the idea that the client is the expert in their life, not the therapist, and arguably consistent with the concept of the actualising tendency, (Bohart in Cooper et al., 2013, p87).

This brings me to key tenets of the person-centred approach to counselling and therapy, as defined by Carl Rogers. (Rogers, 1951; Rogers, 1957a) (Rogers, 1995a). My research focused on the widely acknowledged 'core conditions' of person-centred therapy: congruence, unconditional positive regard and empathy. I set out in some detail definitions and theoretical debate about these terms, starting with Rogers (in 1957). These ideas have been debated and discussed from that day until this, including by many contemporary scholars, such as Bohart, Barrett-Lennard, Bozarth, Freire and Sanders, all of whom feature in the Handbook of Person-Centred Psychotherapy and Counselling, each authoring at least one chapter (Schmid,

2013). I explore these ideas further in the literature review section of this dissertation.

Expectations and personal agendas

As I embarked on this research project, I captured my thoughts and expectations of how I imagined the research would progress in my own journal. I spent time reflecting on my biases within this work, based on my personal interest and professional experience of eating disorders and therapy. I have engaged positively and proactively with the concept of bracketing as defined by Husserl (Ricoeur, 1967) and have tried to park my own personal views and experiences, sufficient so they did not unduly influence my interpretation of the information I uncovered during this work, both during the literature review and the primary research as I undertook interviews with participants. The notion of bracketing and related ideas are explored in greater detail in the subsequent theoretical framework and methodology section of this dissertation. In working through this study, I documented in my journal, my initial views and expectations of this project, which helped me to engage with this concept of bracketing, as it formally highlighted my own preconceived ideas and assumptions. I will develop this discussion about bracketing in the next section.

Theoretical framework and methodology

In order to conduct this research study and produce robust analysis, discussion and conclusions, I first considered the philosophical underpinning of this work. As I have used interpretative phenomenological analysis (IPA) as the research method for this

study, I have gone back to the roots of this thinking and considered my own position on the philosophy of this research approach and the thinking upon which the theory is based.

It is not possible in this dissertation to cover in detail the deep and complex history of phenomenology thinking, or related branches of philosophical thought which has, at least in some part, informed my own study, including the field of hermeneutics.

However, I do wish to reflect a little on some of the key principles and thoughts in the philosophy of phenomenology, including on bracketing (Qutoshi, 2018) and to offer some critical analysis on them in relation to my own work. To do this, I have examined the influence of many thinkers in this field and beyond, including Husserl and Heidegger, and their relevance to my study and to the field of phenomenology.

As my research is primarily interested in the experience of a specific group of clients and the impact of therapy on their recovery, I was drawn to phenomenology as the philosophical approach to the study of experience (Larkin, Flowers and Smith, 2021) and to Husserl's belief that people's experience should be examined in the way it occurs: on its own terms (Eatough and Smith, 2017). There was something unfiltered, perhaps somehow pure, about this way of understanding individual's experience, as Husserl said: 'going back to the things themselves' and not fitting the experience into an expected order (Tindall, 2009).

This approach feels like it fits well with the person-centred approach and the 19 propositions (Bozarth, 1993) which are inherently phenomenological. Indeed, Rogers uses the word phenomenological in his work on the necessary and sufficient

conditions (Rogers, 1957a). In this regard, the theory of this research fits with the theory of the person-centred approach to therapy.

In the field of eating disorder therapy and research, I have seen many lazy and unfounded assumptions and commentaries made, for example, stating that most eating disorder sufferers were plagued by body image pressures generated by social media, the mainstream media, and the image portrayed by celebrities of what constitutes a desirable body, weight, and size. This analysis is often offered without evidence to support it or, in my own experience of working with clients with eating disorders, without asking those involved about their views and experiences. My experience leads me to conclude that often there is a deeper pain, distress or incongruence (Rogers, 2013), for which the eating disorder(s) is a soothing or coping mechanism.

I wanted therefore, when considering the experience of eating disorder clients in therapy, to avoid these types of cliches and non-evidence-based assumptions about what was effective in therapy and what made the most difference to clients in their recovery. This required me to do two things.

Firstly, to try to 'disengage from the activity' (Tindall, 2009) and focus instead on 'that which is experienced'. For this study, that meant looking beyond the therapeutic activity (e.g., how it was conducted and what was said and done in the room) and instead focus more on what the client experienced: a greater focus on the core conditions and how they were experienced, than on technique, settings and labels attached to different types of therapy. This notion felt in line with Rogers' thinking

that the focus of therapist's work shouldn't be on tools and techniques but on a 'way of being' (Rogers, 1995b).

Secondly, to bracket (LeVasseur, 2003), or 'put to one side' (Kasket, 2017) our 'taken for granted ways of living', (Kasket, 2017) including my own assumptions and beliefs. I am aware that my interest, passion and any expertise or knowledge I have developed when working with eating disorder clients, can bring with them views and ideas which may have obscured what participants were telling me if I was not careful. This is where bracketing comes in. Husserl is clear that in order to achieve a 'phenomenological attitude' (Zahavi, 2003) he needed to develop a 'phenomenological method' (Ricoeur, 1967) in which he adopted the idea of bracketing. This method involved metaphorically putting aside our perceptions and perceived ideas and, using mathematic terminology, using bracelets to place those ideals and beliefs separately.

There is a nuance here which is important to state. This approach, as perceived by Husserl, didn't mean that all our taken-for-granted ideas, 'our world' (Larkin, Flowers and Smith, 2021) disappeared. His idea was that bracketing was achieved sufficient to allow the inquirer to focus on the core or 'eidon' (Zahavi, 2003) of the experience. This 'eidetic reduction' (Zahavi, 2003), which he explained using the analogy of a house and 'houseness', which tries to make the distinction between the make-up of a house – it's properties and features, such as windows and doors – and instead in how it was experienced by those in it, perhaps as a home (Eatough and Smith, 2017), was to encourage the enquirer at the very least to engage in a process of

reflection and to see what is being described not to see what is familiar and based on assumptions and preconceptions.

There is a debate as to whether the idea of bracketing is realistic – as highlighted by Merleau-Ponty who was sceptical (Tindall, 2009) and whether there are other aspects of the philosophy that underpins phenomenology which should be more central and important. One of the key thinkers who picked up Husserl's ideas was one of his students, Martin Heidegger. Although building on Husserl's work, Heidegger was more focused on hermeneutics and saw Husserl as too conceptual (Tindall, 2009).

For Heidegger, he saw it as important to ground his thinking in the lived world and he felt set him apart from Husserl. His focus on hermeneutics - the study of texts, contexts and the originator's intention which had its origins long before phenomenology, in the analysis of biblical texts, appears to have been an attempt to say that all description or discussion of experience is shaped by the interpretation of the person experiencing it, making bracketing feel less relevant and indeed less possible. Heidegger's development of the idea of '*Dasein*' - the focus on existence and being - further underscored this attempt to place his work on a more contextual footing, moving away from a conceptual idea (Ricoeur, 1967). It was important therefore for me to focus on the specific experience of participants, leaving assumptions or theories about their experience of their eating disorder(s) to the side, but recognising that there is a limit to how far one can put aside their experience and knowledge, however efforts should be made to try to focus on the participants words and feelings, and away from one's own beliefs and ideas.

As a person-centred counsellor/psychotherapist, I was interested in the how the participants involved in this study (16-22 years old females who experienced eating disorders and had therapy as part of their recovery or ongoing recovery) experienced therapy in relation to three key person-centred principles: congruence, unconditional positive regard and empathy. I wanted to hear about the work clients and their therapist did in the therapy room and specifically how it was experienced by the client, hearing about the positives and negatives of the therapy, and to what extent it helped their recovery.

To explore these experiences, I used a phenomenological approach to my study, using a qualitative research method: interpretive phenomenological analysis (IPA) to help understand the experience of participants (Levitt et al., 2017). I chose this approach to help understand what it is like from the point of view of the participants (Pietkiewicz and Smith, 2014). IPA is a flexible approach (Larkin, Flowers and Smith, 2021) and one which helped me to focus on the meaning of the lived experience of participants. I was able to use this approach to bring my own interpretation to the stories and experiences shared by participants, focusing on their words and descriptions. IPA's flexibility – unlike that of other methods I ruled out using, such as transaction analysis or grounded theory – gave me the confidence to know that it was the participant's experience, not the method that drove my conclusions. I appreciated the opportunity to use IPA in a way that didn't feel there was 'a right or wrong way' of doing it (Tindall, 2009). It helped me to focus on the participant and not on other factors, by placing their words, tone, body language and emphasis at the centre of my analysis.

Literature review

The focus of my literature research determined that I would look at three distinct fields of literature. The first was literature that examined the core conditions of the person-centred approach. In this area, the primary materials were that of Carl Rogers himself and his definitions and discussion of the three key terms and ideas: congruence, unconditional positive regard, and empathy. Alongside Rogers, I have considered a number of contemporary thinkers and practitioners, who have written extensively on the three core conditions and on how these conditions are applied and demonstrated in practice (Bozarth, 1998) (Wilkins, 2003; Sanders, 2012) (Schmid, 2013).

The second was to look literature which examined eating disorder(s) and therapy (regardless of modality). In this field, there is a significant volume of material, mostly developed in the US and mostly focused on CBT and psychodynamic therapy, as they are the most-commonly recommended therapy for eating disorders, and the therapy with most research conducted into it to help prove its effectiveness.

The third was to look at literature concerning eating disorder(s) and person-centred therapy. In this area, literature was sparse and was often focused on specific eating disorders, such as anorexia and person-centred therapy, or a narrow aspect of therapy and anorexia, such as empathy and anorexia. However, despite their

limitations, these sources provided some helpful insights into the application of person-centred thinking.

As I had been reading around this topic for some time, based on my professional interest in eating disorders, I was aware of the challenge of finding literature that homed in directly on my research question. Although this presented me with some limitations, it also helpfully highlighted one of the major themes of experience shared by participants: the feeling that the technique of the therapy and the focus of the therapy was more prominent in the literature, looking at the modality and the condition rather than the person. The feelings expressed by a number of participants was that they felt like their therapy was “painting by numbers” or that the focus was on the food and the therapy not on them as a person. It could be argued that the literature’s lack of focus on clients and participant’s experience at the expense of the experience of the therapist or focusing on information about the presenting condition, underlined this.

Alongside these three main areas of academic research, I also considered two other sources of literature. I examined both academic literature and specialist online material, for example from eating disorder charities, which helped to define eating disorder(s) and provide an overview on the scale of the challenge of eating disorders in the UK. I also examined literature which helped to explain some of the key philosophical concepts and approaches which underpinned this research, including those relating to phenomenology and hermeneutics. I will now take each of these three main areas of existing literature in turn.

Literature on the core conditions

In relation to the literature on the core conditions of person-centred therapy, I was spoilt for choice, both based on Rogers' original thinking from the 1950s which he then built on for the next three decades, or from contemporary thinkers who studied Rogers. Rogers himself used his 19 propositions and six necessary and sufficient conditions, in which he stated that 'for constructive personality change to occur, it is necessary that these conditions exist and continue over a period of time.' (Rogers, 1957a). These ideas, alongside other fundamentals of Rogerian person-centred theory, such as the actualising tendency, locus of evaluation, conditions of worth, non-directivity and the focus on 'the self' (Sanders, 2012) have been studied and considered for many decades.

Rogers saw the three core conditions as being at the heart – the core – of the therapeutic relationship (Sanders, 2012). All six conditions were viewed by Rogers as being 'necessary and sufficient' to help clients achieve personality change, with others focusing on what they considered to be the key conditions - three of the six - which became widely regarded as the 'core conditions' (Sanders, 2012).

On each of these, both Rogers and many other person-centred thinkers have written extensively. In 1951, Rogers defined empathy and explored the role of empathy, suggesting that the therapist needed to assume the client's frame of reference, and in proposition seven of his nineteen propositions that empathy was the 'best vantage point for understanding' (Rogers, 1951). Barrett-Lennard took up the idea of empathy and spoke of it being something that can help clients lead to 'self-empathy' (Barrett-

Lennard, 1998) and Rogers himself described how empathy can help the therapist reflect feelings experienced by the client (Moller and Vossler, 2014).

In relation to unconditional positive regard (UPR), Rogers frames UPR by speaking about 'integration' (Rogers, 1951), and 'warmth and respect', (Rogers, 1951) which enables the acceptance that therapists can offer to their clients and help clients feel safe enough to explore their feelings. In order to offer this acceptance, a therapist must by definition, according to Rogers, integrate, at least to some degree, themselves with the client's frame of reference. Tellingly, Rogers doesn't just speak about acceptance as a thought or feeling held by the therapist, but one that is communicated to the client (Rogers, 1957a) and one that is rooted in being genuine (through congruence) towards the client. This congruence, is as he described it in the third of the six necessary and sufficient condition is 'genuine' and not presented as a 'facade' (Rogers, 1957a).

This notion of communicating the therapist's regard, genuineness and 'empathetic understanding' (Rogers, 1957a) is at the heart of the core conditions that Roger's defines. As both Rogers and others explored congruence and unconditional positive regard alongside empathy, an argument was made that they are in effect one condition, something Mearns named 'genuine empathetic acceptance' (Mearns in Cooper et al, 2003, p172), which seems to encapsulate all three concepts in one three-word phrase. Bozarth, reflecting on Rogers' work on the core conditions concluded that the three conditions were as one, describing them as 'functionally one condition' (Bozarth, 1998).

Overall, the literature helps us understand the key tenets of these three principles – the core conditions – and how they can be provided during therapy to support client's efforts to change and deal with their incongruence (Rogers, 1957a). The positions established by Rogers and then built upon by others, show that these conditions need to be present, whether seen as separate conditions, or essentially one, linked and overlapping, for clients to have effective therapy. We will see in the discussion of the findings for this research study, the implications on their inclusion or exclusion during therapy for participants.

Literature on therapy and eating disorders

In looking at the existing literature on eating disorder(s) and therapy a number of things stood out. Firstly, although there is a significant volume of academic research available on eating disorder(s) and there is some literature in relation to eating disorder(s) and therapy and therapeutic interventions, but there is very little published research on eating disorder(s) and person-centred therapy. Perhaps in keeping with how, at least in the United Kingdom from where this research was conducted, there is often a medical focus in relation to people with eating disorder(s), the focus of much of the literature was fairly clinical, for example looking at diagnosis, treatment plans, and medical interventions.

This is reflected in much of the clinical language used, for example, writing often about 'treatment' and 'patients'. Included in the material I reviewed were also national guidelines for the NHS and other UK healthcare providers, who are seeking to support individuals with eating disorders, such as from the National Institute for

Clinical and Health and Care Excellence (NICE). Their guidelines on the treatment of eating disorders and supporting materials, including: 'Eating disorders: recognition and treatment', which was last updated in December 2020 (NICE, 2020), focuses on therapy and other interventions. These other interventions were emphasised in this type of guidance (Wilson and Shafran, 2005), more than the detail or description of the therapy required. This can be seen in the number of words and pages dedicated to both topics and the heavy emphasis placed – in simple word count alone – on the other interventions over the therapy.

However, perhaps helpfully for the purposes of this study, the literature that is available is more focused on female clients or 'patients' than males. There is also a helpful focus in some of the literature on the age group for this study. In keeping with the mainstream media interest in the issues of mental health of students, including the BBC (BBC, 2023), a number of colleges, universities and other interested parties, such as the Office for Students, and mental health charities, like Young Minds, have published, commissioned or sponsored research in this area.

The BACP, of which I am a registered member, has also published relevant literature on its website. This includes, in 'Eating disorders: What therapy can help with Pinchin (BACP, 2021)', and via a journal: the University and College Counselling Journal, including in a piece from March 2013, titled 'Eating disorders: features, causes, treatments and outcomes' (BACP, 2013b). This latter article specifically highlights pressures felt by higher education students, highly relevant for my study. Within its Healthcare Counselling and Psychotherapy Journal from January 2018 (BACP, 2018) it talked about many of the possible root causes of eating disorders

but also explored what it considered would be helpful in therapy to support students with eating disorders, including them experiencing 'non-judgmental' support (BACP, 2018).

These sources provide useful descriptions of the presenting issues faced by students, in part, relevant for this study, and the types of experiences that participants in this study have also experienced in relation to accessing services, but they do not explore the detail of the therapy, whether the core conditions were provided, and the outcomes from these therapeutic interventions. As a result, they were of limited help for this study. The literature consistently regards therapy as an important component of the things individuals need to do as part of their recovery from an eating disorder(s), but they place the therapy on an equal footing, or perhaps even slightly less important than of the other interventions it recommends.

This can be judged by the amount of material covering these interventions, which vastly exceeds that on therapy, in almost all of the literature. These include dietary and nutrition advice, and medical inventions like blood tests and regular weigh-ins. As I will highlight throughout this study, the focus of the research, and it appears much of the therapy offered to the participants in the study, has the disorder, or the condition at its core, not the client/participant or patient. This is the view often expressed through participant's experience which highlight a number of key questions, which I address in my findings, discussion and conclusion.

In the literature specifically focused on eating disorder(s) and mental health amongst students, there is attention given to the root causes or possible causes of the

distress experienced by students. (Murphy et al, 2010) summarises these factors, stating they include the impact of academic pressure, possibly living away from home and the day-to-day support of family for the first time, and the developing identity individuals may be exploring at this stage of their life, which may explain why some eating disorder(s) may thrive. However, it is fascinating to see how little attention was paid during the therapy described by participants, and explored in the published research, on these sorts of factors for the participants in this research, with the eating disorder(s) being treated a food issue and not an emotional issue, something Marchant highlights (Marchant and Payne, 2002).

Secondly, much of the literature originates from, or focuses its discussion in, the US, which means the language is often that of 'patient' and not 'client' and describes how therapy was accessed in the US system, which is vastly different from the UK model, with most therapy for eating disorders offered through the NHS. Although some of this US-based literature was helpful in exploring issues such as the broad causes of eating disorders, it came with limitations. It also often focused on a medical approach to the treatment, even that word, 'treatment', illustrates the limitation of the literature, which invariably meant that much of the discussion of the eating disorder(s) and/or the therapy that was provided to help those experiencing it, was concerned with the physical aspects of the attempted recovery, including blood tests, dietician involvement and practical activities like meal-planning and weighing.

The term 'patient centred' is used in a range of books and in other articles, including in 'Enhancing motivation for change in treatment-resistant eating disorders' (Vitousek, Watson and Wilson, 1998), which starts to examine the relationship

between motivation and treatment and touches on the role that empathy from the counsellor can have on the effectiveness of the therapy. This work, in line with much of the literature, although making passing reference to concepts such as empathy, doesn't address in any detail the role that the core conditions, or similar concepts from other modalities, or principles such as acceptance and being non-judgmental in therapy, can play in the recovery from an eating disorder(s). The core conditions and other similar concept are mostly only mentioned in passing.

There were two notable exceptions, which provided highly focused and relevant insights for this study. In their work on 'The experience of counselling for female clients with anorexia nervosa: A person-centred perspective' (Marchant and Payne, 2002) focused directly on my research topic, drawing a fascinating conclusion (in relation to clients with anorexia): two of the six conditions identified by Rogers were of huge importance to clients, that of unconditional positive regard and congruence.

Their work expresses surprise at the lack of research done on therapy and eating disorders and the specific intervention, concepts or approaches, that would assist clients, and especially the 'absence within the literature of any discussion of the value of person-centred concepts' (Marchant and Payne, 2002). They sought to help plug this gap with their work. Their research, which was phenomenological in nature, exploring the experience of participants, examined Rogers' core conditions, highlighting their value to clients.

Marchant and colleagues focused on the implications for counselling practice, identifying what they considered to be the three main areas for further consideration.

Firstly, the counsellor's knowledge about eating disorders (specifically on anorexia), which they saw as essential to help build trust with the client. Secondly, the role of congruence (echoing Rogers), in enabling the client to 'engage fully' (Marchant and Payne, 2002) with the therapy. Thirdly, that the therapy should take place in a 'supportive;' way, which one could equate to the importance of ensuring the presence of empathy and UPR.

Although Marchant's work is the most relevant to my research study, and provides helpful insights and analysis, it also carries with it some limitations. Its focus on one eating disorder, anorexia, means that it does not provide information or insights on the other eating disorders. This narrowness of focus, and its exclusion of discussion about bulimia and/or binge eating disorder, is important to acknowledge and is a limitation of this source.

Despite being from a different modality, 'A comprehensive review of psychodynamic treatments for eating disorders', (Murphy, Russell and Waller, 2005) provided highly relevant insights. It focused on the critical role that a strong therapeutic relationship and the presence of empathy and being non-judgmental (Cameron and Tolan, 2016) plays in therapy for eating disorders and the holding of space - not the providing of approval from the therapist (Merry, 2002).

These two examples made up the small number of sources which brought together eating disorders, therapy, and at least some of the core conditions, or highly relevant and similar concepts. These gaps and the sparsity of the literature to support this study, highlights the need for further research in this area and provided me with a

challenge in being able to relate the findings from the participants interviews back to the theory set out by the literature.

Overall, the literature makes clear that therapy can play a role in the recovery from eating disorder(s), although it rarely specific about how and which concepts play the most significant role. Where it does focus on the specific characteristics of successful therapy, it highlights the core conditions (or similarly described concepts) as being essential but provided limited commentary on this, or a focus on the causes or drivers of the eating disorders, focusing more often on food and the disorder itself.

Method

I had two main options in choosing participants for my study: understanding the experience of therapists, or the experience of clients, by speaking directly to either group. I choose to focus on the experience of clients by interviewing them. Although I was initially concerned that I may be asking people to relive experiences that may have been difficult for them, I also recognised that in order to understand the potential impact of therapy on recovery, the most relevant and insightful source of information would be from those who themselves experienced the therapy as part of their recovery. There was a risk that in interviewing therapists, I may have heard their frame of reference and interpretation on their own performance as therapists and not fully understanding who it mattered to most: the clients. Ultimately, like Carl Rogers, I subscribe to the view that the therapy is about the client not the therapist of the therapy (Rogers, 1986).

Ethics approval

I did however discuss my ethical concerns about the potential for interviews with clients to be triggering or unsettling for those taking part with academics at the university before finalising my approach and my ethics application. Following their advice to focus on clients' experience, I choose to ensure that all participants were aged over eighteen at the time of interview – even if their experience was when aged sixteen or seventeen – and to include clear messages in the participants information and during the interviews on participants' right to stop or withdraw at any moment, for any reason, including if the discussion was becoming upsetting or unsettling. These actions reduced some of the risk involved and provided me with some reassurances that I have necessary ethical safeguards in place to support participants.

In advance of starting my research, I sought and received ethics approval from the university. This involved both the submission of a detailed ethics form, which covered key ethical considerations, including the age and vulnerability of possible participants (Counselling and Psychotherapy, 2018), and the inclusion of several documents to support the recruitment of participants, i.e., a participant consent form and participant information sheet. Before making my ethics application, I completed the university's ethics training, on 16 September 2022.

Alongside these documents and the detailed inclusion criteria I wished to use to ensure only appropriate and supported participants were involved in the research, I also submitted the texts of various participant recruitment messages for approval,

e.g., the social media adverts I proposed to use to recruit participants to my study. My ethics application, including the supporting materials (which are included in the appendices to this document), were approved by the university's ethics committee on 17 October 2022.

Participant interviews

I engaged with five participants during this research study, undertaking between 35 minute and 60-minute semi-structured interviews with each. The interviews were conducted between Monday 6 February 2023 and Wednesday 8 March 2023. In line with my inclusion criteria, all those participants were females, now over the age of 18, but between the ages of 16-22 at the time they had therapy as part of their recovery from an eating disorder(s).

The participants were recruited via social media, with me posting a call for volunteer participants on Twitter, LinkedIn, Instagram and Mastodon. All potential participants who responded to the social media advert were sent the participant information sheet and participant consent form, which contained the inclusion criteria. I asked participants to self-identify as being recovered, or in recovery, from an eating disorder(s) having had therapy related to their eating disorder(s) whilst being a student, aged 16-22. I did not restrict participants to those who had person-centred therapy.

Several times in the participant documents, and in any subsequent email exchange(s) to set up the interview, and then verbally at the start of each interview, I

made clear to participants that they could stop and/or withdraw their participation at any time, and that I would not ask for a reason, or follow up with them again.

All five interviewees responded to my call for participants on social media and then made direct email contact with me at my university address, in line with the message I posted on social media. All five interviews took place on Zoom, with both audio and video functionality in operation. With the permission of each participant (included on the consent form and then reiterated verbally at the start of each interview) I recorded the interviews using the Zoom recording option contained within the Zoom user screen.

Transcripts and analysis

I then used Otter software to make an initial transcription of each interview, before reviewing the transcripts and correcting any errors and quality-assuring the accuracy of the transcript against the audio recording.

In line with the approach, I set out in my ethics application and on the subsequent participant information sheet, I saved both the audio recording and the transcript on the university's encrypted One Drive system to maintain high standards of data security and privacy, deleting any copies from my devices.

Upon starting, all five participants continued with the interviews, confirming their consent and completing all the interviews. None of the participants withdrew their consent or asked for any breaks, or for the interview to be ended. In total, I

completed 201 minutes and 12 seconds of recordings and transcripts from the five interviews.

In order to conduct the data analysis, I undertook the following steps, in line with IPA. I produced a verbatim transcript for each interview, reviewing each one in turn and ensuring they were accurate, checking them against the audio recording. I then conducted three read-throughs of each transcript, examining the language to identifying key 'themes and patterns' (Tindall, 2009) that arose in each discussion, making detailed notes. I was looking for participant's general experience of therapy and how it helped – or not – their recovery, but then also specific examples and details of their experiences. I used the read-throughs to also highlight direct quotes from the participants, which I felt helped to describe their experiences. I sought to include many of these in my findings.

Throughout the read-throughs, I would often return to the audio recording to check I had heard the experience clearly and the tone and intonation of the participant, to make sure I wasn't missing a key message, perhaps sarcasm, some humour, or a specific emotion which may not be as easy to discern in the written transcript alone. I recognised when reviewing the first transcript, that I needed a more structured way of confirming what I was finding with each discussion. I therefore produced a table to try to capture the key themes and experiences. In this table, I tried to identify the key positives and negatives expressed by participant, their comments on the three core conditions I was examining, and any specific examples the participants have to highlight their experience.

Findings

After undertaking my analysis of transcripts and recordings, I initially identified 15 themes. These can be seen in the photograph below (figure 1), which shows my contemporaneous notes made at the time of analysing the transcripts. Also included is a sample of one of the participant interviews to show how I went through each transcript, applying the IPA approach (figure 2). A full transcript from this participant interview is included at Appendix H.

modality	(+)	(-)	Y3 RA Concepts		other
Female being able to see a counsellor	nothing!	not picked up "made it worse" not doing therapy - didn't / didn't	(+) E situation	(-) UPR con	distort
PCA in session	therapist let me talk out in built confidence to talk not judged	- I worked through - Directed to tell parents - thought / under early	E at home	UPR con	first readed
12 steps group therapy	- connecting - felt connected - being believed	- lack of time, 121)		E con	12 steps
CBT	- connecting - a community	- felt more burden - focused on just not feelings	UPR	con E	spiritualism
Various - mostly CBT	- hope - therapist belief - just saying was possible - especially - focused but caring	- Being labelled - too much focus on just - "big picture" thinking	E in very depth	con UPR	"Genuinely out of it?"

Themes x15

Therapy was of limited - or no - value - in the experience of participants
 have limited / felt rather
 connection
 whose agenda
 listened
 told. what to think/do
 too much focus on just - not the causes/roots
 lack of UPR
 Care - correlation - ✓ valuable BUT not after experience
 properly open but in consistency
 Coping hard to see
 Counsellors were anonymous / early forgotten / details forgotten
 Expectations unclear
 Contracting flaky
 lots of surprises

Figure 1. Initial contemporaneous notes on identifying total themes from transcript.

So I went to work for Shell it was like academia straight to working on it. And while I was at Shell, it was just horrendous. Like, I had a moment of I was working 18 hour days I was absolutely shattered living on no food, whatever food I did eat, I was throwing up and I just had enough of it. It took me six months to be able to go to my doctor and say I have an eating disorder and I need to do something about this.

Exposure before therapy

And I wasn't even able to say it, in fact. I had to write it on a piece of paper and hand that over to my doctor. I'd already gone for two doctor's appointments and completely failed to actually say it, because I didn't see it. I couldn't tell a doctor. And then in the end, I wrote a note and handed it over to the doctor. That then resulted in I was referred then to therapy which actually took place. It was weekly sessions. But it took six months to get that started and they were really unsympathetic.

Exposure anyway/after therapy

Ben Jones 05:47

Yeah. Okay.

05:48

[Redacted]

Plus of therapy?

Exposure of therapy

- 4 -

no difference at all. The point at which it changed - the person who had the biggest impact on my eating disorder treatment was my dentist. If somebody had pointed out to me the damage I was doing to my teeth, as a result of throwing up multiple times a week, I think I may have done something a lot earlier.

Point of change

Warning from dentist

+ - dentist

Ben Jones 06:49

Okay. Okay. There's so much to go through.

Figure 2. Sample of one of the participant interviews (above).

These 15 initial themes were then aggregated and grouped under key headings and summarised into three main, overarching themes. The three themes are included in the table below (table 1).

<p>Finding 1 - <i>the benefits of therapy</i></p>	<p>Therapy was of limited benefit to the participants in supporting their recovery from eating disorder(s). The negatives of their experience of therapy greatly outweighed any positives they experienced.</p>
<p>Finding 2 - <i>the core conditions</i></p>	<p>Where positives existed in participant's experience of their therapy, it was mainly in the limited presence of two of the three core conditions: empathy and unconditional positive regard.</p> <p>Even though the three core conditions were not fully experienced by participants in their therapy, they viewed them as positive concepts and needed.</p>
<p>Finding 3 - <i>the focus of therapy</i></p>	<p>The experience of participants was that their therapy was too focused on food, eating and medical or clinical interventions, such as dietary and nutrition advice, and not enough on them</p>

	as a person and on the source(s) of their eating disorder(s).
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Table 1. Summary of findings.

These three findings that emerged from the participant interviews provide significant pause for thought. Taken as a whole, they left me feeling disappointed for the clients who shared their experiences. Although I expected there to be some areas for further research and opportunities for professional development and improvement for therapists working with clients with eating disorder(s), the scale and consistency of negativity expressed by the participants took me a little by surprise.

It was sobering to hear the experience of participants and to then reflect on what this may say about the profession of which I am a part and to focus on what I can do in my practice to learn from these experiences: something I have discussed in detail within my own practice supervision since hearing the feedback from participants, whilst of course maintaining the confidentiality of the research interviews. These findings are especially thought-provoking for person-centred therapists, who, by definition, are perhaps more likely to subscribe to the core conditions (Rogers, 1957a) as set out by Carl Rogers, when hearing the experience of participants to the study.

I will set out the key findings in turn in the discussion section, exploring them in detail, drawing on both the participant experiences (and my analysis) as well as the theory and literature I have outlined. I take each of these findings and discuss

whether they support or conflict with the existing literature I reviewed during this study.

Discussion

At the start of this research study, I asked the question: can the core conditions of person-centred counselling support the recovery of female students, aged 16-22, with eating disorders? By using IPA to help test the existing theories in relation to therapy and eating disorders; person-centred therapy and eating disorders; and, the importance of the three core conditions being present in therapy, against the lived experience of participants, the answer is, perhaps unsurprisingly, it depends.

This equivocation comes not because I am challenging the principles expressed in the existing literature, or the underpinning philosophy behind them, which participants supported during this research, but in how the principles and theories were adopted and implemented in counselling practice.

Overall, it would appear that it depends whether the principles and theories that describe the importance of the core conditions, or therapy being person/client/patient-focused (these terms are used inter-changeably across the literature depending on modality and geography), are fully adopted by the therapists involved in the therapy, and whether they focus on their clients and not the client's disorder. It is clear from the experiences shared by participants that in moments in which they felt the presence of the core conditions in their therapy, or were able to imagine the presence of the core conditions in therapy, they felt more positively

about their therapy. When they did not experience the core conditions, and felt unheard or unseen, their experiences were more negative.

The findings from this research not only validate some of the key aspects for the literature – for example how vital empathy, unconditional positive regard and congruence are to developing an effective therapeutic relationship - but also raise significant questions that require further discussion.

I will take each of the three main findings from my research in turn and reflect on the experience of participants, testing them against the existing research to draw out further analysis and possible questions for further exploration. Where quotes are included and are not attributed or referenced, they belong to the participants in the research interviews. In keeping with the ethical approval I received and my agreement with all participants, I have included some of their words as direct quotes to provide real-life examples of their experience (in line with the phenomenological approach I have taken) but did not attribute them to ensure they cannot be identified from the quotations.

Finding one – The benefits of therapy.

Therapy was of limited benefit to the participants in supporting their recovery from eating disorder(s). The negatives of their experience of therapy greatly outweighed any positives they experienced.

The five participants entered therapy with some optimism and hope about what it could help them achieve. They were all prepared to engage with the process and, despite the negative experiences that were described, they appeared reluctant to criticise the individual therapists they encountered. They often expressed gratitude for the opportunity to enter therapy and for the offer of help they received.

One of the few positives to be shared in the interviews was how the participants welcomed the opportunity to talk about the challenges they were facing and, at least in theory (as their reality didn't always feel like it matched the theory for them), there was someone prepared to listen to them. As clients, the participants appreciated the value of receiving dedicated support and help through therapy and were willing to participate fully with it. This reflects the literature which sees therapy as helpful and something required for most people dealing with an eating disorder (Wilson and Shafran, 2005). Despite significant disappointment and frustrations with their therapy, all five participants continued to attend sessions with their therapist and felt they engaged fully with the therapy that was offered.

For one participant, they did experience a feeling of being "heard" and "believed", which they valued. That participant however also went on to say that the listening did not seem to last beyond the first session and that they felt that the therapy was "not pitched right".

Overall, participants expressed the view explicitly that often they felt the therapy "made it worse" for them and far from being the positive, helpful experience they hoped, it was a negative process, which at best had no positive impact on their

recovery and, at worse, actually made their recovery harder. Participants expressed frustration at the lack of guidance and support from the therapists. This may have been the result of a misunderstanding or mismanagement of expectations of what the therapy was designed to deliver, but this is hard to categorically state.

Interestingly, two of the five participants received CBT and also expressed this view, despite it being a type of therapy that is often seen as more likely to focus on practical measures and tools and techniques (Wilkins, 2003). Regardless of the modality of the therapy that was offered, all five participants characterised their experience as one of disappointment.

One participant said directly that: “I wanted direction” and “didn’t get it”, finding the therapist evasive when asked direct questions, such as “what should I do?” or, “what would you recommend I do?”. Again, this may reflect a mismatch of expectations of the approach taken to the therapy, or what the therapy was designed to achieve, but the fact that it was the experience of participants suggests that something went wrong, even if that something was in effective expectation management from the therapist during contracting. (Bond, 2015).

Another theme that emerged from all five participants was a feeling that the therapy was somehow pre-defined or pre-determined and that the therapists were following a set formula for how the sessions should be undertaken. One participant said that the therapy “felt like box-ticking”. This sense of the therapy being ‘off the shelf’ (this researcher’s phrase) and not personalised to the individual client came up several times. At least two participants spoke about how they experienced a sense that the therapist listened at first and showed initial concern for the story being told by the

participant, but then they moved quickly to what they wanted to do and the issues and ideas they (the therapist) wanted to focus on. At least two of the participants had person-centred therapy, or what they believed was person-centred therapy, which suggests that this finding was not limited to those who had CBT or psychodynamic therapy. It would of course be necessary to undertake further research, including with a larger and more representative sample of clients and therapy modalities, to draw firm conclusions from these experiences about the apparent expectations mismanagement that appear to have arisen for these participants through their contracting and their therapy.

Time and again, participants talked about the therapist focussing on “food and not me”, with insufficient time or interest given to the whole person sat in the therapy room and what could be behind the presenting issues. Several participants said that they knew that food and/or body image wasn’t the main issue for them, despite this being part of their behaviours and language which were causing them distress, and yet they felt there was little or no space in the therapy room to explore the deeper causes or issues. This reflects the gap found in the literature, with insufficient attention paid to root causes or drivers of eating disorders (which can be explored in therapy) but instead a focus on behaviours and medical interventions. This issue is explored in further detail under finding three.

Several participants talked about feeling rushed with the therapy, as if there was a ticking clock and an impatience from the therapist for the therapy and the client to make progress, without enough acknowledgement that tackling these often deeply rooted issues could take more time to be explored and/or understood and

processed. This feeling was expressed by participants in situations where both expectations on session availability (i.e., only six CBT sessions would be offered) were managed up front during contracting, or where they were not (in one case when open-ended person-centred sessions were offered with no limit being discussed during contracting).

A number of participants lamented the experience they had of feeling that “I was being labelled”, with either specific eating disorder(s), such as anorexia or bulimia, when the participants felt it was more complicated and multi-layered than that, or being labelled as being “treatment-resistant” as one participant discussed and some recent research published in *The Lancet* explored (Downs, 2023). The use of these labels was experienced by participants as justifications as to why the therapy might not work had the effect, certainly for at least one participant, of significantly reducing their hope of making a full recovery. Conversely, the same participant had a positive experience with a subsequent experience of therapy in terms of the hope she felt after the first session. This hope arose, and was then sustained, because the therapist asked what goals the participant had from the therapy, who then expressed a desire to make a “full recovery”, which the therapist supported, saying that they believed that this outcome was possible. This left the participant feeling heard.

Perhaps the most disappointing aspects of the therapeutic experience that was described by the participants was the number of times they felt their experience of their eating disorder(s) - as they described it with their therapist - felt dismissed or invalidated. I heard many, many examples of participants being asked to share their feelings and experiences by their therapist only for the response from the therapist to

be dismissive, for example them saying: “you shouldn’t think like that”, or “that is not a helpful way to think about it”. One participant shared an example of an exercise they undertook at the request of their therapist. They were asked to bring into the next session photographs of themselves that represented times they were happy with themselves and/or in life in general and when they were both happy and unhappy with themselves and/or with life in general. Upon presenting the photos that depicted a time of being unhappy, the participant was asked why they were unhappy. When they spoke about feeling “fat” or “ugly” or “not good enough” in the photos, they were told “no, you’re not”.

Another participant recalled an example of being asked to keep a diary of their thoughts and feelings towards their body. They had a daily routine of checking their collarbones and assessing their body through this activity, allowing them to see how they felt that day. They tracked this activity, as requested by their therapist, in their journal. Each time they discussed this entry from their journal, they were told this is not helpful and that they shouldn’t undertake this activity (the collarbone checking). There was no effort to discuss, explore, or understand their behaviour and the deeper, psychological reasons it was being done. As a result, the participant, although continuing to conduct the daily collarbone check, just stopped writing about it in their journal to avoid the discussion with the therapist.

Overall, the participants for this study, despite appearing to try to be balanced and seek positives from their experience, were clear that the therapy did not contribute positively to their recovery. The participants cited other factors – in every case – for

what they believed make a difference to the recovery. One was an intervention from their dentist.

The therapy was not regarded by any of the five participants as a positive factor in their recovery, except perhaps for one participant who had multiple therapy experiences over multiple settings and years. It was hard for this participant to completely rule out a contribution the therapy may have made during their various different experiences of therapy. In all the interviews, each participant was given a number of opportunities to reflect on any positive aspects of their therapy experience and to say what were the 'best bits' (this researcher's phrase). The negative feedback included above speaks for itself as did the often-prolonged silences when participants were asked to try to recall a positive aspect of the therapy and/or when they felt they had experienced the core conditions (which I described and defined during the interviews).

Despite the limited benefit that participants described receiving from their own therapy, they validated the existing literature that stated that therapy is a valuable and important part of the support needed by people trying to recover from eating disorders. Participants expressed gratitude for being offered and receiving therapy and, despite negative experiences, still valued therapy as an important tool for aiding recovery. They wanted therapy and felt it could help them.

Participants were able to discuss the theory behind the therapy – as a safe place to be seen and heard, not feel judged and to be offered a listening ear whilst they discussed their experiences and sought a way forward – whilst acknowledging they

did not feel they received all, or indeed at times any, of these things. Despite negative experiences, participants continued with their therapy and, in a number of cases, returned to therapy later in life (after they sought therapy as part of their efforts to recovery from their eating disorder(s)), as they looked to handle other challenges in life. It is reasonable to assume that if they sought out therapy again, they saw some value in trying it again.

Upon revisiting the research done by Marchant et al (Marchant and Payne, 2002), it is clear that the findings from my research resonated with theirs. In particular, the experience of clients in both studies that the presence of Rogers three core conditions were valued and important for clients as they sought therapy for their eating disorder(s). For clients to feel 'safe' as Marchant describes it, they need to feel totally supported (Marchant and Payne, 2002) by their therapist, and, as many of the experiences of participants in my study expressed, that was not always the case. Perhaps that lack of support, or put differently, the lack of empathy, congruence and unconditional positive regard, was a factor, or indeed the major factor, why their experience of therapy was so negative.

Finding two – the core conditions.

Where positives existed in participant's experience of their therapy, it was mainly in the limited presence of two of the three core conditions: empathy and unconditional positive regard. Even though the three core conditions were not fully experienced by participants in their therapy, they viewed them as positive concepts and needed.

In exploring the presence, absence and importance of the three core conditions of empathy, unconditional positive regard and congruence that participants experienced in their therapy, some interesting experiences and themes emerged.

Every participant, whether they experienced it or not – and most did not – felt that the presence of a) empathy and b) being accepted, or, in other words, feeling they have been shown unconditional positive regard, was critical to a positive therapeutic experience. These two concepts - empathy and unconditional positive regard - felt easier to explain and seemed easier for participants to engage with and share their direct experience of either feeling them, or not, in the therapy. Participants appeared to find it simpler to describe their experience of empathy or unconditional positive regard and could draw on specific examples from their therapy. Often in this study, they described the absence of empathy and unconditional positive regard, and yet reflected that they felt it would have been helpful had it been present in their therapy.

One participant reflected that: “I just talked (and cried) and felt he listened to me – for the first session”, but they went on to say that from the second session the listening felt like it stopped, and that the therapist appeared focused on their method, or moved to ask about what the participant perceived as their (the therapist’s) agenda. This participant reflected a view that was shared by others, that when the participants felt like the therapists were not driving sessions, they (the participant) felt heard, valued and accepted. When the participant felt the therapist had “taken charge” of the sessions, the participants felt less heard and less accepted.

When asked specifically about empathy, participants spoke about its importance and how they appreciated it when they experienced in the therapy. They often described a lack of empathy in their therapy experiences when the therapist appeared to judge or comment on their actions, thoughts, or feelings. One participant said: “I needed to not feel judged and to be accepted” and when it worked, they said that (it was good) “to be believed”. But, as referenced in discussing the first finding, there were examples, including the discussion about collarbone checking for one participant, and the dismissal of the views of the participant about the old photographs, which left these participants feeling unheard and judged. A number of participants made reference to the importance of feeling a “connection” with their therapist and that this feeling was often aligned with how understood or “held” they felt by the therapist.

Congruence was, on the whole, a more difficult concept for participants to engage with, although I did find participants talking about the importance of feeling like the therapist was alongside them, being ‘real’ or ‘genuine’, (Kolden et al., 2018) and showing that they cared about the participants. One participant had a simple phrase which captured what they wanted in relation to congruence: they said they wanted the therapist to be “focused but caring”. In their paper exploring congruence in school counselling (Scott, Blundell and Dougan, 2023), reminded us that there isn’t a primary definition of counsellor congruence. It is therefore not easy to describe succinctly what congruence is for clients, although Rogers’ exploration of it in relation to the therapist being genuine and not providing any façade (Rogers, 1957a) is helpful in illustrating what it could look like and feel for clients. This notion of being “genuine” is the one which resonated most with the participants in this study.

One participant talked about feeling that the therapists didn't care about them (the participant) and was just going through the motions, nodding along at various moments during the therapy. Another participant spoke about their experience of the therapist appearing distant or "cold" and this lack of warmth conveyed to them both a lack of empathy but also a lack of genuine commitment to the client. This reflects perhaps the important idea of the therapist being 'integrated into the relationship' and of warmth, which this participant did not experience (Rogers, 1957a).

In discussing the concept of congruence, I found participants reflecting that it sounded to them like something that you know when you see it or experience it. They appeared comfortable thinking about how present it felt to them in their therapy when asked about it, but participants said they rarely felt they experienced it in their sessions. Strikingly, when asked simple, factual questions about the therapist, for example, could you remember their name or anything about them, including their age or appearance, nearly every participant struggled to recall these details. They described their therapists as neutral figures who had left very little impression – certainly not positive impressions – on participants. This opens up many possibilities of explanation, which further research would need to investigate fully to understand, but it is at least possible that part of the reason for this lack of personal connection and the failure of the therapist to make a memorable or lasting impression on their client was the lack of congruence in the space.

Once again, despite participants sharing significant amounts of negative experiences in relation to the existence of the core conditions within their therapy, they do validate the theory put forward within existing literature, including from (Barrett-

Lennard, 1997), that the core conditions are important and beneficial. Participants do this with their general reflections on the core conditions, speaking about the value they perceive there to be in experiencing empathy, unconditional positive regard and congruence during therapy– but also in their experience of them, especially empathy and unconditional positive regard, within their own experiences of therapy.

One of the ideas that would be worth exploring further in additional research, is whether it would have made a difference to clients/participants, had they experienced greater person-centred concepts and whether the focus of current eating disorder therapy is insufficiently aligned to the ideas of acceptance and support. The absence of feeling accepted and supported comes out in the experience of all five participants in this study.

As described, the three conditions were seen as important but were not always present in participant's therapy, with UPR and empathy the most appreciated and valued. There is a therefore question as to whether this is because these were the two condition most often experienced by the participants in this study. It also raises the question as to whether the issues with the therapy being a negative experience for participants may have been down to the lack of embodiment of the conditions within the therapists/therapy (Bozarth, 2001) and perhaps not an issue with the concepts themselves.

The findings may suggest that a person-centred approach should have a greater role in eating disorder recovery work, as so often the core conditions were valued by the participants but missing. It could be argued that these findings highlight the value of

the person-centred approach and the need for more of it and/or for all therapists to embody its' key tenets – especially the core conditions. These three conditions were universally seen as valuable and positive by all participants, even though many of them only experienced some in a limited way during their therapy.

Finding three – the focus of therapy.

The experience of participants was that their therapy was too focused on food, eating and medical or clinical interventions, such as dietary and nutrition advice, and not enough on them as a person and on the source(s) of their eating disorder(s).

Something the literature highlights and was prominent in the participant's experience explored through the interviews for this research, was the apparent focus and emphasis of the therapy they received. Participants spoke over and over again about their experience of the therapy as being “too focussed on food” and not enough on helping them get to the “root causes” or their “underlining issues”. Every participant spoke, with varying degrees of frustration, and two speaking directly of their “anger”, that the therapy focused on treating an issue or a condition: the eating disorder(s), and not on the person sat in front of the therapist. One participant said: “the focus was on food all the time and not on me”, and another said: “the therapist focused on food not feelings”.

This experience highlighted a disconnect between therapist and the client (the participant in this study) in the therapy. One person in the relationship was seeing a medical or psychological issue that needs treating - that is a word that is prominent

in the literature, which speaks to a focus on a medical model - and one person in the relationship was seeing a whole person who needs to be seen and heard.

From hearing the participants' experiences of their therapy, it appears that therapy that has the core conditions of empathy, unconditional positive regard and congruence marbled through it would have helped participants to feel more accepted and understood and subsequently having a more positive experience in therapy. It is clear from listening to participants that part of what left them feeling negatively towards their therapy was that it didn't feel like their therapy – it felt like the therapy belonged to the therapist and/or was about their eating disorder(s) and not about them.

They shared experiences which they said, “didn't help” or at times “made it worse” and their feedback suggested strongly that often it was the lack of focus on what they wanted to focus on – themselves and not food – which contributed to this feeling. It is conjecture to identify what may have caused this disconnect but the expressed lack of empathy, unconditional positive regard, and congruence for the participant, may be part of this phenomenon, linking findings two and three.

One participant spoke emotionally about how she knew “the causes of my eating disorder”. She disclosed information about childhood traumas she experienced following the death of her mother and the circumstances in which that happened and how it was handled. She said directly: “managing my eating was how I coped”, and yet she didn't feel this was explored during her therapy. She felt the therapy focused straight away on her restrictive eating and how that manifested in her behaviours

and not on what caused it and the distress or 'incongruence' (Rogers, 1961) that she was experiencing. She eventually stopped the therapy, after engaging with it for several months, when it became clear that the discussions would continue to be centred around food, eating, feelings about body image and patterns of behaviour, and not on her deeper feelings, which at that time she only partly understood.

These findings reflect the experiences of participants in this research and highlight a number of areas which both validate and conflict with the existing literature and thinking on the role of therapy in recovery from eating disorders. The focus on interventions other than therapy, which were present in the literature and again in the therapy experience described by participants, perhaps shows this is the wrong focus in the view of the participants, with too much focus on the condition/disorder and not enough on the client/participant.

Earlier, I quoted from the eating disorder Charity, Beat, which stated that eating disorders: 'can take over someone's life and the lives of those around them. While unhealthy eating behaviour is involved, they aren't about food. Instead, they are about feeling in control or coping with something else.' (Beat, 2020). This description is particularly interesting when we consider the focus of much of the therapy offered, which didn't focus on the need to cope with something else, but instead on food. This feels like a significant disconnect between the therapist and the client in the therapy (my participants).

Overall, we can examine the three findings from this research and ask three follow-up questions. Firstly, do the findings suggest that there has been too much focus in

supporting clients with eating disorders on a medical or medicalised model, which places emphasis on interventions outside therapy and on food and the condition and not enough on the individual?

Secondly, do the participant experiences documented in this research highlight that not enough of a person-centred approach was taken to their therapy, with insufficient focus on the core conditions as set out by Carl Rogers? Therefore, as a result, the participants were then left feeling negatively about their therapy, which they felt lacked empathy, acceptance and them being heard and seen by a therapist who was genuinely invested in them?

Thirdly, would greater transparency and up-front explanation of the approach being followed by the therapist during the therapy help to manage expectations and help the clients know what kind of support would be offered, perhaps during the contracting phase of the therapy?

Conclusions

The findings and discussion of this research study raise a number of further questions, supporting the three key questions summarised above, that would benefit from further exploration to test, validate or dispute the analysis produced. By using IPA, I have been able to generalise and extrapolate my findings and apply them, but this is not totally satisfactory, not if some of the feedback from this work was to be considered by policy makers and/or other therapists in practice, who sought to make changes based on this research.

There is evidence from my research that therapy in which clients experience the three core conditions of empathy, unconditional positive regard and congruence, would be more positively-received than the therapy that the participants in this study experienced. There is evidence too that clients who are looking to recover from eating disorder(s) would value therapy that is focused on them and not their disorder – in which their feelings and not their food and behaviours are the focus. There is also evidence of the importance of managing expectations, perhaps through contracting, so that clients who enter counselling know the goals of the therapy and the ways in which it can help, not leaving clients frustrated by a lack of direction or advice from the therapist they are unlikely to receive.

These conclusions follow the findings and discussion in this study and are based on the evidence available, but they should carry caveats. In order to fully validate these conclusions and state them with greater certainty, further research would be required. This further research would help to answer the fundamental question: what are the reasons for these findings?

Those reasons may be possible to discern with more certainty than is possible in this dissertation, by undertaking several further actions. These would include conducting similar research as was undertaken during this study but with a larger sample size, using more participants, and perhaps specific cohorts of participants who received the same type of therapy. It may also be helpful to develop a quantitative research project which tests some of the key questions raised during this research study to try to test the findings with a robust data set. This could include getting a large sample

of participants to complete a questionnaire, or some other data collection method, which asks them about the importance of the three core conditions within their experience of therapy and the prevalence of them within their therapy. This data may provide a more robust evidence base to see whether the experience of participants in this study was representative of clients in therapy across the board, examining a range of modalities.

When reflecting on the findings from this research study, I am left wondering whether I have seen what I have seen because of the mix of modalities, or it is because of some other reason(s). This would require further research to establish an answer(s), perhaps developing specific cohorts of participants, split into separate groups of those who have received the same modality of therapy, e.g., person-centred, cognitive behavioural therapy and psychodynamic therapy. It would be interesting to see whether the experience within and across these cohorts (split by modality) differed and/or what similarity of themes and patterns emerged.

This completed research leaves a further open question, which again would require more detailed exploration and further research. This would focus on whether the findings would have been different – perhaps more positive in relation to the participants' experience of their therapy and the prevalence of the three conditions – if more participants had undertaken person-centred therapy. In other words, is the reason for the consistently negative experience for participants because they were not offered a person-centred experience?

There is one further area in which further exploration may be helpful: examining the focus of formal guidance that may be currently driving decisions about the type of therapy being used – including in some cases being prescribed within the NHS - to support the provision of therapy/support. This would include examining whether the focus of the formal guidance, including from NICE, of therapy and other interventions discussed under finding three of this research, is too general and not sufficiently tailored to the individual needs and circumstances of each person. It could examine whether a more individually focused, perhaps person-centred approach, would produce more satisfaction from clients and better outcomes and results.

Overall, this research highlights a major issue for participants in their experience of therapy, in that too much emphasis was placed in food and their eating disorder(s) and not enough on them, the root causes of their disorder(s) and their overall emotional wellbeing. It would be interesting to test the hypothesis that some of the unhelpful focus (as described by participants) is because of the emphasis in the formal guidance and perhaps even the informal culture of therapy in relation to eating disorder(s) placing too much emphasis on medical interventions, and the condition/disorder, and not enough on the core conditions which focus on the person and the causes of their distress? It would be also interesting to pose the question: if the above is proven, does it therefore make the case for greater use of person-centred therapy in the area of eating disorders, something it is currently excluded from in the formal guidance, including from NICE.

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Appendices

Appendix A - Ethics Form

Appendix B - Participant Consent Form

Appendix C - Participant Information Sheet

Appendix D – Social Media Advert

Appendix E – Gatekeeper Information Sheet

Appendix F – Gatekeeper Consent Form

Appendix G - Participant Recruitment Email

Appendix H - Sample Participant Interview Transcript

NAH FREC Ethics application form – UG & PGT NAH students - studies requiring NAH FREC approval

NAH STUDENT – Important – please check the information on this webpage and ONLY complete this form if your study can be registered/reviewed by NAH FREC.

1. Students must discuss their study / ethics application with their supervisor in formal tutorials. An ethics application may require a number of revisions before the supervisor decides the application is of a standard whereby it can be submitted to the NAH FREC
2. Students must allow a reasonable period of time for supervisors to read an ethics application prior to any ethical review submission deadlines (please discuss this with the supervisor)
3. The ethics application form must only be submitted to NAH FREC by the supervisor

SUPERVISOR – Once you are satisfied with the content of this application form and you have completed the “[student project decision tool](#)” email the completed form to HEAFREC@ljmu.ac.uk

Section A: General Information

A1. Title of the study [*If the title is not self-explanatory to a lay person then a secondary title should be given to clarify and used in any participant facing documents*]:

The role of person-centred counselling in recovery from eating disorders.

Secondary title [*if required*]

A2. Principal Investigator (PI) [*Note that the in the case of postgraduate or undergraduate projects the student is designated the PI.*]

Title First Name Surname

Status

School / Faculty

LJMU username

LJMU Email address

Experience / Qualifications / training relevant to the co-applicant conducting/supervising the study

Current Masters student and qualified psychotherapist/counsellor.

What is the role of this investigator?

To conduct the research, including interviews with participants, and produce dissertation.

- The Principal Investigator (PI) has successfully completed the [LJMU Research Ethics Training](#) and a copy of the certificate of completion emailed to the PI has been appended. Please type YES or NO in the box below

YES

[Please note all students MUST have completed the LJMU Research Ethics Training BEFORE they start to complete this form]

A3. Supervisor

Title First Name Surname

Status

School / Faculty

LJMU username

LJMU Email address

Experience / Qualifications / training relevant to the co-applicant conducting/supervising the study

Lecturer on MA in Counselling and Psychotherapy programme at LJMU.
Experienced and accredited counsellor with a PhD

What is the role of this investigator?

Research supervisor

A4. Co-applicant

Title First Name Surname

Status

School / Faculty

LJMU username

LJMU Email address

Experience / Qualifications / training relevant to the co-applicant conducting/supervising the study

What is the role of this investigator?

[Where there are more than one co-applicant, please append an additional page to your application containing the relevant details]

SECTION B – STUDY OVERVIEW

B1. Anticipated start date *[Enter the date when you propose to start recruiting participants, obtaining gatekeeper consent etc. – note that no recruitment can take place without full, unconditional ethical approval. The start date must be a reasonable period of time after the application was submitted for ethical review to allow the REC to ethically review the application and for applicants to respond to any deferral comments. (e.g. at least four weeks after an application was submitted for proportionate review or if the applications is submitted for full review, at least 2 weeks after the REC meeting)]*

Start date: 05 December 2022

B2. What are the aims and objectives of the study? *[Provide the academic/scientific Justification of the study/project. Provide an overview in plain English (comprehensible to a layperson) - avoid abbreviations and explain technical terms (Note Do not simply refer to the protocol. Maximum length – 1 side of A4)]*

My research question is: Can the core conditions of person-centred counselling support the recovery of female students, aged 16-22, with eating disorders? The participants need to be 18 and over at the time of taking part in the study, even if their experience was when they were 16 or 17.

In undertaking this research, I am seeking to build on the existing research in place which looks at eating disorders, specifically experienced by females between the ages of 16-22, but specifically to plug a gap in the research into the role of person-centred therapy in helping to support recovery from eating disorders, of which there appears to be very little.

In undertaking this research, I would aim to achieve a number of objectives. I would be seeking to critically assess the effectiveness of the person-centred approach to working with clients with eating disorders, examining the impact of the three core conditions as part of the six necessary and sufficient conditions (Rogers, 1957b). I would seek to examine the role therapy played in recovery and what aspects of the therapy were most valued by the client and helpful to their recovery. I would then look at how these aspects map against, or are related to, the three core conditions, regardless of which modality of therapy was used in the therapy.

I would seek to understand the existing literature on eating disorders in general and then specifically in relation to the impact that person-centred therapy can have on these clients. The literature review would look at causes of eating disorder, referred to as the “interplay of a number of forces.....the individual, family and cultural factors that enhance or interfere with the preparation of the child for the development tasks of adolescence”. (Chatoor, in Eating Disorders Reference Sourcebook, Lemberh and Cohn 1999, p18) as well as setting out some of the treatment options – specifically those relating to counselling – that are recommended for clients with an eating disorder(s).

I would also seek to briefly review the literature of different approaches to therapies offered to eating disorder clients, including possibly cognitive behavioural therapy provided by specialist eating disorder clinics, and family therapy (both recommended by the National Institute for Health and Care Excellence -

NICE), before focusing more closely on the person-centred approach (PCA) to eating disorders. In setting out the PCA, it will be necessary to explore in detail the three core conditions prescribed by Rogers – these are congruence, empathy (Rogers, 1986) and unconditional positive.

I would be seeking to critically assess whether these three main tenets of the PCA can help this specific client group and how present they are – even if not labelled as such in line with person-centred taxonomy – in the range of therapies offered to these clients.

My early analysis suggests that although the literature and widely available guidance on the appropriate therapy for eating disorder clients makes little explicit reference to the person-centred approach, it does draw heavily upon its fundamental aspects, including a focus on building a relationship, empathy, unconditional positive regard and acceptance. This research project would seek to establish how much of a person-centred approach (using the three core conditions) was taken to eating disorder therapy, even if the language of person-centred therapy was not used and the role therapy played in the client's recovery.

B3a Give a summary of the design and methodology of the planned study. What do you propose to do and how do you propose to do it? *[Provide information as appropriate in plain English (comprehensible to a layperson) to help the REC understand and approve your application. Include the required information within this section, do not refer the reviewer to a protocol– as the information for reviewers must be in lay language and easily accessible within the ethics application form].* For example:

- a) Participants – who are they? What will happen to them? How many times? In what order? Where? When? How? How long will it take them? Etc.
- b) Interventions/procedures/data collection methods - Give details (How? When? Where? How often? For how long? Etc.) of all interventions/procedures that will be received by the participants as part of the study protocol (intervention/procedures might include seeking consent, screening questionnaires, interviews, questionnaires for data collection, exercise, what will be measured etc.)
- c) Ingestion of any substance – please include details such as the name of the product, dose, number of doses, whether the dose is considered high or low, how the product will be stored/dispensed and route of administration etc.

To undertake this research and try to understand the capacity of person-centred counselling to help female clients aged 16-22 with an eating disorder, I need to supplement a detailed review of the available literature with my own primary research. As a person-centred counsellor/psychotherapist, I am especially interested in the experience of those involved in the therapy space and the extent to which the therapy can help this specific client group. I want to hear directly about the work done in the therapy room, how it felt, and how it was experienced. The participants need to be 18 and over at the time of taking part in the study, even if their experience was when they were 16 or 17.

I am therefore proposing to take a phenomenological approach (Wertz, 2005) to the research and use interpretive phenomenological analysis (IPA) to help me understand the experience of participants. Following this approach is intended to help me 'to understand what it is like, from the point of view of the participants, to take their side'. (Smith and Shinebourne, 2012).

There are two main sources of qualitative feedback on the effectiveness of counselling to help clients experiencing eating disorders: hearing from the therapists or hearing from the clients. I have decided to focus on the experience of clients in this research project. I propose engaging with at least four clients, who would self-identify as being recovered or in recovery from an eating disorder(s) having had therapy related to their eating disorder(s) whilst being a student, aged 16-22. I am not proposing to restrict client's experience to those who had only person-centred therapy.

As person-centred therapy is not prescribed within the NHS - under NICE guidelines - for the treatment of eating disorders, it would be interesting to explore whether the therapy that is prescribed and used is closer to person-centred approach than the label or describing language could imply. The original 2004 guidance (since updated) emphasises the need to “encourage and support a good therapeutic relationship, at times as important as the specific treatment offered” (Wilson and Shafran, 2005) . This would suggest that the choice of modality is less important than the quality of the relationship built between the client and therapist, something that Carl Rogers states throughout his work. This begs the question whether too much emphasis is currently given to specific modalities in the choice of treatment by GPs and others, at the expense of focusing on the contents of the therapy delivered. Perhaps this is something that could be discussed during this project.

As well as these important intellectual considerations/questions I would like the research to address, there are also significant practical and ethical considerations at play. Recruiting participants will take some concerted effort, initially using social media or direct email appeals for help from students within LJMU or elsewhere to advertise the research. I would plan to recruit participants using public communications through advert and email contact and making use of a gatekeeper to send an email to students at the university.

All participants in this study would be aged 18 and over at the time of participation, although their experience of therapy may have taken place when under 18.

I intend gathering qualitative data from research participants using semi-structured interviews (Longhurst, 2003), asking a range of questions of each interviewee but also having some scope for follow up questions in response to specific answers provided. To support the questions, I propose developing a scheme or language table, in which I would map the core conditions (Rogers, 1957b) against language that clients may use to describe how the therapy they undertook helped their recovery or they found most valuable, which they may not necessarily consider to be part of the person-centred approach.

I would propose analysing the available literature and outputs from the 60 minute interviews with participants, including the language they use to describe their practice and how that relates to the scheme/language table and seek to draw out some themes and conclusions.

B3b. Quality [*The REC understands the benefits and limitations of studies. For the study to be ethical, the benefits must outweigh the limitations. Therefore, please explain in few words the delimitations of the study and how the quality of the study will be maximised. For example:*

- a) *How do you propose to limit the threats to internal validity (quantitative data) or maximise trustworthiness (qualitative data)?*
- b) *How do you proposed to maximise external validity / generalisability?*
- c) *What are the limitations?*
- d) *What are the measurements/recordings tools – are they valid/reliable/credible?*
- e) *How will you process / analyse your data/content*

The focus of my research is on the experience of clients who undertook therapy as part of their recovery from an eating disorder(s). I am interested in their personal experience, making any findings they provide valid for the purposes of my project. I will use interpretive phenomenological analysis (IPA) to help me understand the experience of participants.

The recruitment of participants is critical in ensuring that I engage with people who met the needs of my study but as I am focused on their experience, whatever they share will be helpful and valid.

There is of course a limit on the amount of insight I can derive from a small sample such as the one I am using but it will still provide helpful data to supplement my literature review and analysis.

B4. State the principal study question

Can the core conditions of person-centred counselling support the recovery of female students, aged 16-22, with eating disorders?

B5a. Give details of the proposed intervention(s) or procedure(s) and the groups of people involved (including psychological or physical interventions, interviews, observations or questionnaires)

intervention(s) or procedure(s) (e.g., interviews, questionnaires health-screening questionnaire etc.)	Participants (E.g. LJMU students, general public, health or social care professionals etc.)	Number of participants required	Avg. time to complete	Where will the intervention / procedure take place (LJMU classroom, public places, place of work, online etc.)
1. Interview (semi-structured)	General public	Four	60 minutes	Either face-to-face or online using Zoom or Teams
2.				
3.				
4.				
5.				
6.				

To include additional interventions place your mouse cursor in the last cell of the final column and press the tab button on your keyboard. A new row will be created for the above table.

B5b. Please confirm that the investigator who will be administering tests and or interventions and/or procedures and/or data collection methods is competent in the methods and that all relevant standard operating procedures, policies, codes of practice etc. will be adhered to.
[type YES, NO or NA in the box below]

YES

B5c. Studies involving questionnaires to collect data. Please confirm that you have [type YES or NA in the boxes below]:

- I. Appended the questionnaire as it would be presented to the participants. This might include an introduction, instructions for completing the questionnaire, instructions for returning/submitting the questionnaire and any signposting to support services where applicable. NA
- II. Included at the start of the questionnaire, a statement of implied consent and a tick box for participants to confirm implied consent, which you can copy from the consent form template. NA
- III. Included at the start of the questionnaire, a statement that makes it clear that participants have the option of not answering questions they do not want to answer. NA
- IV. Requested the age of the participant at the start of the questionnaire, state the age requirement and included instructions that those younger than the age requirement should not complete the questionnaire. NA

Have the questionnaires previously been validated?

[type YES, NO or NA in the box below]

NA

If questionnaires have not been validated, please confirm that non-validated questionnaires will not be presented to participants who are not LJMU staff or students.

[type YES, NO or NA in the box below]

NA

If questionnaires have been validated, please include the references and state the population in which the questionnaire was validated

B5d. Where interviews or focus groups (structured or semi-structured) are proposed you must append an outline of the questions you are going to ask your participants. Please confirm that you have attached an outline of your interview / focus group questions.

[type YES or NA in the box below]

YES

B6. How will the findings of the study be disseminated? (e.g. thesis, dissertation, peer-reviewed articles, conference presentations, reports)

- Dissertation
 - Peer-reviewed articles
 - Conference presentations
 - Blog posts
 - In podcast discussions
 - On social media

SECTION C – THE PARTICIPANTS

Please give separate details for different study groups where appropriate. *Participation must be entirely voluntary, and no one should be coerced to participate against their will. Investigators should avoid exerting undue influence when approaching potential participants. No sanctions should follow if the participant decides to withdraw from the study at any time.*

Gatekeepers - *A gatekeeper is any person or institution that acts as an intermediary between an investigator and potential participants (e.g., school authorities, sports club, treatment service providers, a coach, instructor etc.). The use of a gatekeeper may be necessary:*

- *To help identify participants where an investigator does not have legitimate access to personal data of potential participants (names and contact details or information related to identifying participants in relation to the inclusion/exclusion criteria of the study)*
- *Where it may also be more appropriate or good etiquette to ask a gatekeeper to make the first approach to potential participants – and in specific circumstances to take an active role in recruiting the participants*
- *To minimise and manage potential risks (e.g. to gain permissions to access facilities, use a gatekeeper's resources such as their facilities and their staff and to undertake the study within certain hours etc.)*

A gatekeeper may well give support in principle before the study has been ethically approved, but a gatekeeper must only provide specific consent once the study has been ethically approved.

C1. Detail your projected number of participants and provide justification for this sample size.

[Please note: For studies involving mixed methods and/or multiple participant groups, you should provide an estimate of the number of participants taking part in each method]

I am planning to interview four participants. They would all self-identify as being recovered or in recovery from an eating disorder(s) having had therapy whilst being a student, aged 16-22 but be 18+ at the time of participating in the study.

This sample size will provide me with insights on their own experience – talking a phenomenological approach. I do not therefore need large numbers to gain this information but simply participants who meet the criteria for inclusion and are prepared to share their own experience and views.

C2. What are the inclusion/exclusion criteria?

- *The answers to the questions below will help the REC understand how you will ensure the quality of the study, how you will minimise any potential risks/hazards and whether there is the potential for any particular participant groups to be exploited or unfairly excluded.*
- *Participants need to be fully informed about the inclusion/exclusion criteria – please include the relevant information in any recruitment materials and information sheets*

C2a. On what basis will individuals be included and excluded (eligible/ineligible) from your study in order to address the study question/objective? [Consider the characteristics of the target/study population]

The participants would self-identify as being recovered or in recovery from an eating disorder(s) having had therapy whilst being a student, aged 16-22.

I am not proposing to restrict client's experience to those who had only person-centred therapy.

All participants in this study would be aged 18 and over at the time of participation, although their experience of therapy may have taken place when under the age of 18.

They will self-identify as meeting the criteria in relation to being 'recovered' or 'in recovery' from their eating disorder(s). I will not be making any judgment or assessment upon this aspect of their participation, relying instead on their self-selection as meeting the criteria.

C2b. If applicable, on what basis will individuals be included and excluded (eligible/ineligible) from your study in order to minimise/manage risk? For each of the exclusion criteria explain what risks of harm will be minimised.

I will not be including any clients who are under 18, although their experience can have occurred when they were 16 or 17. I want participants in the study to be adults at the time of taking part in the study to remove any risks around gaining consent from children.

C2c. How will you apply/implement each of the inclusion and exclusion criteria? (e.g. will potential participants self-include/exclude themselves based on the information provided on the participant information sheet – or will you assess the potential participants in some way – such as with a health screening questionnaire or physiological measurements – please explain)

The participants to the study will self-identify that they meet the age and recovery status I have set out in the inclusion criteria.

C2d. What are the upper and lower age limits? [Provide justification for these where appropriate]

The lower age limit for participants will be 18. I want participants in the study to be adults at the same of taking part in the study to remove any risks around gaining consent from children.

There will not be an upper age limit for participation, but all participants must meet the inclusion criteria of being recovered or in recovery from an eating disorder(s) having had whilst being a student, aged 16-22.

C3. Please provide details that might help the REC understand any ethical issues related to the characteristics of the participants and how they might be addressed. (E.g. age of participants; location of participation for under 16 year olds; challenges to the capacity to consent; why participants might be considered vulnerable; ethical implications with regard to mental illness, drug users, young offenders etc.)

I will draw on my own personal and professional skills and experiences (please see list below) and the support of my supervisor for this study to manage ethical issues and risks during this project:

- My counselling skills developed over my formal training at LJMU, on my placement (over 100 hours) and my subsequent post-qualification practice (over 115 hours of client work).
- Experience of working with this client group on both my placement and within my current private practice.
- Safeguarding training and experience I have undertaken during my career.
- Previous work experience, including extensive line management and communication work in my 20+ year career working in large corporate organisations and higher education, including working with this participant group.

C4. Please indicate how potential participants will be identified (how you will know who to approach). [Where different groups of participants have been identified in section B5a above provide details on how each group will be identified]

	where applicable, type YES
Self identify by responding to an advertisement (e.g. presentation, poster, flyers left for individuals to pickup, social media post, included at the end of a questionnaire etc.), which will comply with LJMU templates and guidance	YES
Self-identify by previously agreeing to be contacted about future studies (e.g. participant database/registry/participant pools, questionnaire)	
Using information available in the public domain	
Individuals known to the investigator (e.g. personal acquaintances)	YES
Investigator will access personal data to which they have legitimate access (with gatekeeper permission if required)	
Individuals known by a gatekeeper	
A gatekeeper will access personal data to which they have legitimate access	
Referrals by other participants (snowballing)	
Research recruitment site	
Existing departmental contacts or volunteer database	
Observation of potential participants	
Other (please specify):	

C5. How, where and by whom will the potential participants be initially APPROACHED/CONTACTED?

where applicable, type YES	
Email / letter in compliance with LJMU templates	YES
Telephone	
Social media in compliance with LJMU guidance	YES
In person approach	
Display an advert in compliance with LJMU templates	
Other (please specify):	

where applicable, type YES	
The investigator	YES
A gatekeeper	
Other participants (snowballing)	
Research recruitment site	
Other (please specify):	

C6. If you have a current or prior relationship with any potential participants (This includes professional and/or personal relationships) and if this could give rise to a perceived pressure to participate (if you are in a position of influence or authority over potential participants) please outline the existing relationship(s) and explain how you will mitigate the potential pressure to participate. [Please note: If you are directly involved in the teaching or assessing of participants this is considered a perceived pressure to participate]

It is possible that some individuals I know personally or professionally may wish to volunteer to participate in the study, if they meet the inclusion criteria, although I am not planning to reach out to individuals directly to invite them to participate. They may respond to the advert on social media.

I would not be making individual contact or seeking to influence, pressure or ask anyone I know to take part in this study.

If any personal or professional contacts do wish to participate, I would communicate clearly with them the participant information and consent process – as with any other study participants.

C7. If you require an individual or organisation to grant you permission to approach/ access your intended participants (This includes gatekeepers contacting participants on your behalf) and if the gatekeeper is in a position of influence or authority over the participants, outline who the gatekeeper is, how they will be used to facilitate recruitment and explain how you will mitigate any pressure to participate that may be felt by potential participants as a result of the gatekeeper's position. [Please note: Participants must only be approached once appropriate gatekeeper permission has been obtained]

NA

SECTION D – INFORMED CONSENT

For most types of studies, it is both a legal and ethical requirement to obtain informed consent from participants able to consent for themselves. The investigator is responsible for obtaining an individual's consent to participate. The participant should be fully informed about their participation (ideally verbally and in writing) and should be free to refuse to participate or withdraw their participation.

D1. Will informed consent be obtained from: (Where applicable, please type YES in the box below)

The participants? YES

Gatekeeper?

(consent for their involvement in identifying/approaching/recruiting participants and/or permissions with regards to access and use of facilities/resources for recruitment and data collection purposes)

Not applicable

D2. Please explain (e.g. who, when, where, how) the process of fully informing participants about the purpose, methods and intended possible uses of the study, what participation in the study entails and what risks, if any, are involved. (Exclusively relying on simply handing out a participant information sheet should be avoided. Investigators should be able to verbally explain the study clearly to potential participants, provide a participant information sheet for participants to keep and be available to answer questions)

a. Verbally explained and provided with a participant information sheet and given the opportunity to ask the investigators questions YES

b. Provided with a participant information sheet and given the opportunity to ask the investigator questions YES

a. Other (Please explain (e.g. who, when, where, how) the process of fully informing participants about the purpose, methods and intended possible uses of the study, what participation in the study entails and what risks, if any, are involved) NO

D3. Confirm which of the following consent processes will be used:

c. **Written Consent:** A written description of the study will be provided to all potential participants and written consent will be recorded in either paper or electronic form in advance of participation YES

d. **Implied consent:** Whereby the participant does not interact with the investigator (e.g. completing a questionnaire without the investigator present) *If implied consent is to be assumed by return of questionnaires, the following statement (or similar) must be included on the questionnaire: "I have read the information sheet provided and I am happy to participate. I understand that by completing and returning this questionnaire I am consenting to be part of this study"* NO

and for my data to be used as described in the information sheet provided" – please include a tick box so that the participant can confirm they have read the statement and agree to it.

- b. **Verbal Consent:** Whereby written consent is not practical, or not appropriate, and compliance with LJMU guidance on gaining consent from participants verbally (Audio recordings of verbal consent will be made and stored separately from interview recordings) NO
- c. **Anonymous submission of survey/questionnaire/app based research tool data:** A written description of the study will be provided to all potential participants and it will be made clear that the submission of a completed survey/questionnaire/app data implies consent NO
- d. **Non-invasive observations** that do not involve any interaction with participants and no identifying information will be recorded. NO

D4. How long will the potential participants have to decide whether they would like to participate? (Potential participants need time to consider fully the implications of taking part. They should be able to ask questions and reflect. Participants should not be rushed into decisions)

- At least 24 hours YES
- Less than 24 hours

If less than 24 hours, please justify why,

D5. How will the investigator ensure that participation is voluntary and free from any coercion? (E.g. are there any pressures that might mean that individuals agree to participate against their better judgement).

- Please consider the relationship between a potential participant and the "recruiter" and whether the process of recruiting participants will be free from undue influence.
- For vulnerable participants who may be particularly susceptible to coercion please explain how their interests will be protected.
- Vulnerable adults & participants with a dependent relationship with the investigator: This question is designed to ascertain whether your participant groups are likely to need special consideration regarding issues of informed consent and the potential for perceived pressure to participate.
- For studies that involve participants in a dependent relationship with the study team (e.g. students participating in studies lead by their tutors, members of staff participating in studies carried out, or formally supported by, the management of their organisation, those being coached/trained by members of the study team), please explain what steps will be taken to avoid coercion and ensure consent is voluntary.

I would not be making individual contact or seeking to influence, pressure or ask anyone I know to take part in this study. I will not be seeking to recruit any vulnerable adults.

D6. Detail the process by which participants may withdraw from the study both during and after it has been completed.

Participants can withdraw at any point until the data has been analysed. They can notify me any time in writing (by email) and I will immediately end their involvement in the study and deleting all information they have provided, notifying them of that action.

This will be made very clear in the participant information sheet.

SECTION E – HAZARDS, RISKS AND BENEFITS

Risks – the potential physical or psychological harm, adverse effects, discomfort, distress, intrusion, inconvenience or changes to lifestyle

Benefits – as defined and perceived by the participant rather than the investigator. Benefits are sometimes “hoped-for”

The potential risks outlined in the ethics application form will inform the completion of any risk assessment conducted by the investigator before the study commences and whilst the study is ongoing.

E1. Explain any potential or hoped for benefits of the study.

- PLEASE BE REALISTIC and do not over-emphasise the potential direct benefits to individual participants. Where there are no direct benefits to individual participants, provide brief details of the potential or hoped for broader benefits of the study for example to society or to future service users.
- Participation might be a positive experience but it is probably best to refrain from claiming any therapeutic benefit simply from participation)

The benefits are that the participants may indirectly help others by sharing their experience to help inform the study and any conclusions or recommendations that I make.

There are unlikely to be any direct benefits to participants.

It is possible they may experience some validation or reinforcement of the success they have achieved in being recovered or in recovery from an eating disorder(s) but that is not in any way guaranteed.

E2. Please confirm that as necessary, you will complete a Risk Assessment Form which will be signed by the required individuals prior to commencing data collection. [Type YES in the box below]

YES

E3. Is there a risk that the study could cause psychological stress or anxiety, or produce humiliation or cause harm or negative consequences beyond the risks encountered in normal life? [Type YES or NO in the box below]

YES

If YES, explain how the nature of the study could cause/induce harm

It is possible that negative emotions may be stirred up for some participants.

Explain how you will mitigate any potential risks that may arise from the nature of the study

The participant information sheet will make it clear what the research is about, I will draw on my skills as a therapist to help contain and mitigate any distress or concerns and other external avenues of support (e.g., support groups/online resources) will be recommended if needed.

Outline your procedure in the event of a participant becoming harmed, distressed and/or requiring additional support as a result of participation.

E4. If there are any risks or burdens to participants that have not been addressed above, please provide further details and explain how these risks will be mitigated:

E5. Are there any potential risks for the investigators themselves? [Type YES or NO in the box below]

NO

If YES, explain the potential risks for the investigators

Explain how you will mitigate any potential risks to the investigators

SECTION F – DATA ACCESS, STORAGE & CONFIDENTIALITY

- **Privacy** – an individual’s control over the extent, timing, and circumstances of sharing themselves (physically, behaviourally, or intellectually) with others.
- **Confidentiality** - the treatment of information that an individual has disclosed in a relationship of trust and with the expectation that it will not be divulged to others without permission in ways that are inconsistent with the understanding of the original disclosure.
- **Anonymity** – where individuals cannot be directly and indirectly identified – this could be related to participation (no way of anyone, including the investigator, knowing that an individual has participated), data/information (no way for anyone, including the investigator, to identify the individual from the data/information collected) and publication (no way for an individual to be identified from data/information that is published).
- **Link-codes (pseudonymisation)** – used to help maintain confidentiality – data is coded so that that the data is unidentifiable simply by viewing the coded data but is identifiable when using the record that links the code to the identity of an individual. Data coded in this way is NOT anonymised, is still regarded as personal identifiable data and must be used/stored in accordance with the data protection act.
- **Personal identifiable data/information** - Data/information that can be identified with a participant through identifiers such as names, link-codes, postal/email addresses, telephone numbers, date of birth, full postcode, medical records, academic records, audio/video recordings

of individuals, images, voices etc.. The use of identifiable personal information should be reduced so far as possible consistent with achievement of the study aims. The "Caldecott Principles" set out an ethical framework for use of identifiable data:

- 1) Justify the purpose(s) for obtaining the information.
- 2) Do not use person-identifiable information unless it is absolutely necessary.
- 3) Use the minimum necessary person-identifiable information.
- 4) Access to person-identifiable information should be on a strict need-to-know basis.
- 5) Everyone with access to person-identifiable information should be aware of his or her responsibilities.
- 6) Understand and comply with the law.

F1a. Contact details. Please confirm that if contact details (emails, telephone numbers etc.) or social media accounts/contacts will be used in the study, they will be deleted and/or participants unfriended/unfollowed etc. once they are no longer required to conduct / administrate the study or to contact the participants about future studies? [Please type YES or NA in the box below]

YES

If no, please explain.

F1b. Study data. What safeguards will be applied to ensure confidentiality when COLLECTING/RECORDING study data? When and how will the safeguards be applied? (where applicable, please type YES in the box below):

- **Anonymisation** – study data will be anonymous or made anonymous (for example, by removing identifiers or deleting the link between the participant and a code when there is no requirement for data to be identifiable in order to conduct the study) YES
- **Pseudonymisation** – study data will be recorded using a code that is linked to the identity of the participant for methodological purposes and the record that links a code to the identity of an individual will be stored securely and separately from the study data YES
- **Audio/video recording devices** – recording devices will be password protected and the recording will be transferred to secure storage as soon as possible and then deleted from the recording device YES
- **If participants will return questionnaires** via a third party, explain how the potential for participants' answers to be directly or indirectly identifiable by people outside of the study team will be mitigated:

NA

- **If any other safeguards which have been approved by the supervisor, please explain here:**

F2. Storage. How will Consent forms and personal identifiable study data/information be securely stored. Please confirm where the consent forms will be stored (where applicable, please type YES in the box below):

[Please note, personal identifiable data/information must NOT be stored on home or personal computer/laptop or a portable storage device (such as a USB drive), if data cannot be stored on the LJMU OneDrive, data can be stored on an encrypted device, but only if justified below]

- With the supervisor
- Storage place approved by LJMU IT and DPO such as m:drive, OneDrive or LJMU computer that require an LJMU username and password to use
- Other place which has been approved by the supervisor
If other, please provide details:

F3. Data Access. Will anyone other than the student, the student's supervisor and LJMU authorised staff have access to participants' personal data during and after the study? (where applicable, please type YES or NO in the box below):

In YES, please explain below

F5a. Dissemination. How will findings be disseminated? (where applicable, please type YES in the box below):

- Participants will not be directly attributed to data/information that is disseminated
- Pseudonyms will be used to anonymise quotes from participants
- Names, images or other identifiers that could be combined with other information to identify participants will not be disseminated
- Other methods to ensure participants are not identifiable in reports and any other further outputs (please explain below)

- Identifying information about participants will be included in reports and any further outputs (e.g. participants name, image or voice etc.) with explicit consent

F5b. Following attempts to ensure privacy and confidentiality, if there is the possibility that individuals could be indirectly identified once the study has been disseminated please explain what you will do (including involving the participant in the decision making process) to minimise the potential for indirect identification, and how you will manage the potential for indirect identification.

- Participants with specific characteristics/certain profile or who belong to a specific group might be indirectly identifiable from the things they have said/done that are disseminated by the investigator.
- Care should be taken that the combination of incidental details e.g. details about occupation, location, age and ethnicity, do not lead to individuals being identifiable
- You might want to consult with the participant about how information will be disseminated and what information should not be disseminated.

[Please note: Participants must be made aware if it will be possible to indirectly identify them in the final report/study output and asked to provide their explicit consent for this prior to participation]

All participants information will be anonymised and no personal or identifiable details will be included in the dissemination of the findings.

DECLARATION OF THE APPLICANT[S]

- The information in this form is accurate to the best of my knowledge and belief and I/we take full responsibility for it.
- I/we undertake to abide by the ethical principles underlying the Declaration of Helsinki and LJMU's REC regulations and guidelines together with the codes of practice laid down by any relevant professional or learned society.
- If the study is approved, I/we undertake to adhere to the approved study procedures and any conditions set out by the REC in giving its favourable opinion.
- I/we undertake to seek an ethical opinion from UREC before implementing substantial amendments to the approved study plan.
- If, in the course of the administering any approved intervention, there are any serious adverse events, I/we understand that I/we am responsible for immediately stopping the intervention and alerting UREC.
- I/we am aware of my responsibility to comply with the requirements of the law and relevant guidelines relating to security and confidentiality of personal data.
- I/we understand that any records/data may be subject to inspection for audit purposes if required in the future.
- I/we understand that personal data about me as an investigator will be held by the University and this will be managed according to the principles of GDPR.
- I understand that the information contained in this application, any supporting documentation and all correspondence with UREC relating to the application will be subject to the provisions of the Freedom of Information Act. The information may be disclosed in response to requests made under the Act except where statutory exemptions apply.
- I/we understand that all conditions apply to my co-applicants and other investigators involved in the study.

Type YES to CONFIRM THAT YOU HAVE READ AND AGREE TO THE DECLARATION ABOVE.

By electronically submitting the ethics application you thereby agree to the declaration stated above

CHECKLIST OF DOCUMENTS SUBMITTED ELECTRONICALLY

(Please note that applications submitted without the required supporting documents will not be reviewed).

I confirm I have appended the following:

Where applicable, please type **YES** in the boxes below

YES	LJMU REC training certificate of completion (Mandatory for students)
YES	Copies of any recruitment/advertisement material e.g. letters, emails, posters etc.
	Health screen / readiness to exercise questionnaire
YES	Participant Information Sheets – based on the LJMU template
	Carer Information Sheet – based on the LJMU template
	Gatekeeper Information Sheet- based on the LJMU template
YES	Participant Consent Form – based on the LJMU template
	Carer Consent Form – based on the LJMU template
	Copies of questionnaires
YES	list of the interview questions
	Additional sheets as necessary

Appendix B - Participant Consent Form

PARTICIPANT CONSENT FORM – General public

Study title: The role of person-centred counselling in recovery from eating disorders.

Research Ethics Committee Reference Number: NAHPGT(CP)2027

Principal Investigator: *Ben Jones*

LJMU Email address: b.j.jones@2017.ljmu.ac.uk

LJMU School/Faculty: *Psychology*

If you are happy to participate, please complete and sign the consent form below

		<i>Please initial</i>	
1.	I confirm that I have read the information sheet dated 10/10/22 (version 1) for the above study, or it has been read to me. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.		
2.	I understand what taking part in the study involves		
3.	I consent voluntarily to be a participant in this study and understand that I can refuse to answer questions I can withdraw from the study at any time, without giving a reason and without penalty or my legal rights being affected.		
4.	I have been advised about potential risks associated with taking part in this study and have taken these into consideration before consenting to participate		
5.	I understand that the study involves taking audio recording of me and I am happy to proceed.		
6.	I agree that audio recordings can be taken of me during the study.	YES	NO
7.	I understand that personal data will be retained beyond the duration of the study		
8.	I understand that personal data will remain confidential and that all efforts will be made to ensure I cannot be identified in reports or any further outputs		
9.	I understand that parts of our conversation will be used verbatim in future publications or presentations and that all efforts will be made to ensure I cannot be identified in reports or any further outputs		
10.	I understand that even though all efforts will be made to ensure I cannot be identified, I may be indirectly identifiable when the study findings are disseminated.		
11.	I understand the potential risks of being identifiable in reports and any future outputs when the findings of the study are disseminated		
12.	I agree to take part in this study		

Name of Participant

Date

Signature

For participants unable to sign their name, mark the box instead of signing

I have witnessed the accurate reading of the consent form with the potential participant and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely

Name of Investigator

Date

Signature

Name of Person taking consent
(if different from investigator)

Date

Signature

Appendix C - Participant Information Sheet

PARTICIPANT INFORMATION SHEET - General public

Research Ethics Committee Reference Number: NAHPGT(CP)2027

Title of Study: The role of person-centred counselling in recovery from eating disorders.

You are being invited to take part in a research study. You do not have to take part if you do not want to. Please read this information, which may help you decide whether to participate.

1. What is the purpose of the study?

This research study forms part of my masters programme in Counselling and Psychotherapy Practice at Liverpool John Moores University.

I am interested in understanding the experience of female students (aged 16-22) who had therapy - any kind of therapy - and have recovered, or are in recovery, from eating disorders. I will be looking at the role of three key person-centred therapy principles and how they may have helped to support their recovery from eating disorders: congruence, empathy and unconditional positive.

In doing this study, I am hoping to build on the existing research in place which looks at eating disorders, specifically experienced by females between the ages of 16-22. I am hoping to help plug an important gap in this existing research, as there is very little published on these three person-centred therapy principles and the role they may play in supporting recovery from eating disorders.

The participants need to be 18 and over at the time of taking part in the study.

2. Why have I been invited to participate?

You have been invited because my study is looking at the experience of females who self-identify as being recovered or in recovery from an eating disorder(s) having had therapy whilst being a student, aged 16-22.

You need to be 18 now to take part in the study but your experience could have been when you were 16 or 17.

3. Do I have to take part?

No. You can ask questions about the research before deciding whether to take part. If you do not want to take part that is OK.

I will ask you to sign a consent form and will give you a copy for you to keep.

You can stop being part of the study at any time, without giving a reason.

To withdraw from the study, please contact me by email: b.j.jones@2017.ljmu.ac.uk

4. What will happen to me if I take part?

We would meet for around 60 minutes – either face to face or online, using Zoom or Teams, and I will ask you some questions about your experience of therapy.

The questions will focus on your experience of therapy, including how you felt during and after it, what aspects of therapy you found most helpful or unhelpful.

You will be offered regular breaks. You can also ask to pause or stop the interview at any time, without giving a reason.

Please remember, you have the right to decline to answer any questions you do not want to and withdraw from the study at any time without having to give a reason.

5. Will I be photographed or video/audio recorded and how will the recorded media be used?

I would like to audio-record the interview so that I can make an accurate transcript. This recording is essential to the study. If you wish me to stop the recording at any time, I will do that without questioning your request and you can withdraw from the study at any time without giving a reason.

When I write up my dissertation, your experience may appear, but they will not be attributed to you and your will not be identifiable by them. Once the recording has been transcribed it will be deleted.

The recording will be held on an encrypted device and on the LJMU secure file system, until the transcription is complete.

You will not be photographed during the interview.

6. Are there any potential risks in taking part?

Participating in the research is not anticipated to cause you any disadvantages or discomfort. The potential physical and/or psychological harm or distress will be the same as any experienced in everyday life

7. Are there any benefits in taking part?

The benefits are that the participants may indirectly help others by sharing their experience to help inform the study and any conclusions or recommendations that I make. There are unlikely to be any direct benefits to participants.

It is possible they may experience some validation or reinforcement of the success they have achieved in being recovered or in recovery from an eating disorder(s) but that is not in any way guaranteed.

8. Payments, reimbursements of expenses or any other benefit or incentive for taking part

There will be no payment or any benefit or incentive for taking part in this study. Unfortunately, I cannot reimburse any expenses you may incur.

9. What will happen to information/data provided?

The information you provide as part of the study is the **study data**. Any study data from which you can be identified (e.g. from identifiers such as your name, date of birth, audio recording etc.), is known as **personal data**. Your participation in this study will not involve the collection/use of personal data by the investigator.

Study data / records of consent / contact details will be kept until the dissertation is completed – by the autumn of 2023 and then they will be destroyed. The recordings of interviews will be held on an encrypted device and on the LJMU secure file system, until the transcription is complete and then destroyed.

10. Who is organising and who is funding/commissioning the study?

This study is organised by Liverpool John Moores University.

11. Whom do I contact if I have a concern about the study or I wish to complain?

If you have a concern about any aspect of this study, please contact Ben Jones (b.j.jones@2017.ljmu.ac.uk) and we will do our best to answer your query. You should expect a reply within 10 working days. If you remain unhappy or wish to make a formal complaint, please contact the Chair of the Research Ethics Committee at Liverpool John Moores University who will seek to resolve the matter as soon as possible:

Chair, Liverpool John Moores University Research Ethics Committee; Email: FullReviewUREC@ljmu.ac.uk; Tel: 0151 231 2121; Research Innovation Services, Liverpool John Moores University, Exchange Station, Liverpool L2 2QP

12. Contact details

Principal Investigator: *Ben Jones*

LJMU Email address: b.j.jones@2017.ljmu.ac.uk

LJMU School/Faculty: *Psychology*



Appendix D – Social media advert

Ref: NAHPGT(CP)2027

Eating disorders, recovery and therapy. Volunteers needed

My name is Ben Jones, and I am doing my Masters research in counselling at Liverpool John Moores University.

I am looking for volunteers to interview to discuss their experiences as female students (aged 16-22) who had therapy and have recovered, or are in recovery, from eating disorders. Participants need to be aged 18 and above, although their experience can have been when they were 16 or 17.

You would be invited to participate in an interview - either face to face or online (using Zoom or Teams). The interview would take about 60 minutes and you would be asked some questions about your experience of therapy.

Further information is provided in the participant information sheet that is attached to this email.

If you are interested and would like more information, please email Ben Jones (b.j.jones@2017.ljmu.ac.uk). There is no obligation to take part.

Thank you.

Principal Investigator: Ben Jones

LJMU Email address: b.j.jones@2017.ljmu.ac.uk

LJMU School/Faculty: Psychology

Appendix E – Gatekeeper Information Sheet

GATEKEEPER INFORMATION SHEET

My name is Ben Jones, and I am doing my Masters research in counselling at Liverpool John Moores University in the School of Psychology. I am the principal investigator of the study:

Title of Project: The role of person-centred counselling in recovery from eating disorders.

Research Ethics Committee Reference Number: NAHPGT(CP)2027

1. What is the reason for this information sheet?

You have been identified as a gatekeeper to individuals whom we would like to invite to participate in a research study.

2. What is the study?

This research study forms part of my masters programme in Counselling and Psychotherapy Practice at Liverpool John Moores University.

I am interested in understanding the experience of female students (aged 16-22) who had therapy - any kind of therapy - and have recovered, or are in recovery, from eating disorders. I will be looking at the role of three key person-centred therapy principles and how they may have helped to support their recovery from eating disorders: congruence, empathy and unconditional positive.

In doing this study, I am hoping to build on the existing research in place which looks at eating disorders, specifically experienced by females between the ages of 16-22. I am hoping to help plug an important gap in this existing research, as there is very little published on these three person-centred therapy principles and the role they may play in supporting recovery from eating disorders.

The participants need to be 18 and over at the time of taking part in the study.

This study is organised by Liverpool John Moores University.

3. Who are the participants?

I am looking for volunteers to interview to discuss their experiences as female students (aged 16-22) who had therapy and have recovered, or are in recovery, from eating disorders. Participants need to be aged 18 and above, although their experience can have been when they were 16 or 17.

4. What is involved for the participants?

The participants will be asked to be interviewed for around 60 minutes – either face to face or online, using Zoom or Teams, and I will ask you some questions about their experience of therapy. The questions will focus on their experience of therapy, including how they felt during and after it, what aspects of therapy they found most helpful or unhelpful.

5. What we are asking you to do?

On behalf of the investigator, make the initial contact with the potential participants by handing them the participant recruitment covering email and participant information sheet[s] which are attached to this gatekeeper sheet.

6. If you are willing and able to assist in the study what happens next?

Please return the completed gatekeeper consent form and make arrangements with the investigator.

7. Will the name of my organisation taking part in the study be kept confidential?

All participants information will be anonymised and no personal or identifiable details will be included in the dissemination of the findings. The details or the gatekeeper will not be included or identifiable at any stage in the dissemination of the findings.

8. Whom do I contact if I have a concern about the study or I wish to complain?

If you have a concern about any aspect of this study, please contact Ben Jones (details below) and we will do our best to answer your query. You should expect a reply within 10 working days.

If you remain unhappy or wish to make a formal complaint, please contact the Chair of the Research Ethics Committee at Liverpool John Moores University who will seek to resolve the matter as soon as possible:

Chair, Liverpool John Moores University Research Ethics Committee; Email: FullReviewUREC@ljmu.ac.uk; Tel: 0151 231 2121; Research Innovation Services, Liverpool John Moores University, Exchange Station, Liverpool L2 2QP

9. Contact details

Should you have any comments or questions regarding this research, please contact the investigator:

Principal Investigator: *Ben Jones*

LJMU Email address: b.j.jones@2017.ljmu.ac.uk

LJMU School/Faculty: *Psychology*

Appendix F - Gatekeeper Consent Form

GATEKEEPER CONSENT FORM

Research Ethics Committee Reference Number: NAHPGT(CP)2027

Study title: The role of person-centred counselling in recovery from eating disorders.

Principal Investigator: *Ben Jones*

LJMU Email address: b.j.jones@2017.ljmu.ac.uk

LJMU School/Faculty: *Psychology*

Please initial the boxes below where you agree with the corresponding statement.

		<i>Please initial</i>
13.	I confirm that I have read the information sheet dated 12/10/22, version 2, for the above study, or it has been read to me. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
14.	I have the authority to act as a gatekeeper between the investigator[s] and participants.	
15.	I agree to identify potential participants as requested	
16.	I agree to introduce the investigator to potential participants as requested	
17.	I permit the investigator to access personal data to which they have legitimate access for the purposes of identifying and contacting potential participants	

Name of Gatekeeper:

Date:

Signature:

Name of Investigator:

Date:

Signature:

Name of Person taking consent:
(if different from the investigator)

Date:

Signature:

Appendix G - Participant recruitment email

Subject: Participant recruitment email

Circular email for use for recruitment of volunteers for study ref: NAHPGT(CP)2027

Dear

My name is Ben Jones, and I am doing my Masters research in counselling at Liverpool John Moores University.

I am looking for volunteers to interview to discuss their experiences as female students (aged 16-22) who had therapy and have recovered, or are in recovery, from eating disorders. Participants need to be aged 18 and above, although their experience can have been when they were 16 or 17.

You would be invited to participate in an interview - either face to face or online (using Zoom or Teams). The interview would take around 60 minutes. The questions would focus on your experience of therapy, including how you felt during and after it and what aspects of therapy you found most helpful or unhelpful. You will be offered regular breaks and you can ask to pause or stop the interview at any time, without giving a reason.

Further information is provided in the participant information sheet that is attached to this email.

If you are interested in participating, please reply to this email. There is no obligation to take part.

Thank you.

Principal Investigator: Ben Jones

LJMU Email address: b.j.jones@2017.ljmu.ac.uk

LJMU School/Faculty: Psychology

Participant interview (1)

Date of interview: Thursday 19 January 2023, 09:00.

Duration of interview: 48:03

I included an anonymised full transcript in the submission of this dissertation

– I have removed it from this version (for publication).