EXISTENTIAL INTERVENTIONS

IN

EATING DISORDERS

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ABSTRACT

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This study provides the result of a doctorate research into the impact of existential psychotherapeutic interventions with people experiencing chronic eating disorders. The results indicate that positive outcomes are correlated to therapeutic interventions which concentrate on the clients own perception of control and choice over their own eating habits.

The research aim was to explore both the effects and the effectiveness of existential therapy in altering the individuals subjective interpretation of their Self when they are deeply immersed in the experience of disordered eating.

Interventions went beyond the cognitive-behavioural approaches into the implementation of existential psychotherapy which helped individuals to explore the existential concerns of life, choice, hope, social inclusion and love within the context of their own sense of Being. This focus led to an improvement in all study subjects and a reduction in the use of mental health resources.

All individuals entered the study following an assessment criteria which included chronicity, lengthy use of mental health services and past therapeutic interventions. Three diagnostic criterias were included, Anorexia Nervosa, Bulimia Nervosa and Morbid Obesity. Data presented in the study supported the original premise that all three eating disorders share underlying similarities and justify the inclusion of the diagnostic criteria of morbid obesity within the study. Therapy was either in closed groups or individual and consisted of a fixed number of one-hour sessions.

Therapeutic techniques included cognitive-behavioural therapy and person-centred counselling focusing on self-esteem and self-assertion, as well as an existential focus on dualistic perception of the mind/body, the conscious sense of the present and the affective bond with food itself. A series of therapeutic phases were structured to demonstrate the progress from interventions in self-esteem and self-assertion to existential concerns and principles.

Taking therapy beyond cognitive-behavioural techniques involved the application of Yaloms' (1980) and Strasser and Strassers' (1997) Existential Therapy and an exploration of Duker and Slades' (1988) concepts of the fragmentation of the sense of Self in individuals experiencing eating disorders. The research demonstrated important differences between the professional perception of appropriate eating and alteration in weight as successful clinical outcomes, and the clients dependency on disordered eating as a source of release from interacting

with others. Mental health interventions were perceived by clients as attempts to stop such a release without providing a substitute. A clear sense of loss was presented by all study subjects when eating was controlled by others. In most cases disordered eating was habitual and the emotional effects of raised or lowered glucose levels gave a sense of numbness and nothingness which was actively pursued. This was also attained when disordered eating was combined with other self-harm behaviours. Mental health practitioners inadvertently prevented the attainment of a sense of numbness by their focus on eating and body weight. The encouragement of food regimes causes increased anxiety for all clients leading to poor compliance levels.

The research results have the potential to impact on mental health education and clinical services as the data indicates that individuals with disordered eating gain more benefit when the therapeutic focus is less on restoring appropriate eating habits and more on the individuals sense of Self; the importance of food intake as a source of escape from others and escape from the internal awareness of Self.

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INTRODUCTION

In this thesis I want to explore the effects of existential interventions in eating disorders and whether there are any clinical or educational implications when the existential approach is used in therapeutic practice. There were several reasons for a systematic study. I have been a practising therapist since nineteen eighty-six, initially working with individuals who had experienced bereavement, then moving into the related area of loss by working with people who had undergone alterations in body image such as colo-rectal surgery, breast surgery and failed cosmetic surgery. In nineteen eighty-nine I accepted a referral to work with a client who had severe scarring due to self-harm and in the course of therapy discovered a hidden bulimic pattern. The cause of this behaviour fascinated me and I became curious about the reasons behind purging behaviours. I accepted more and more referrals in this area and for the last ten years have concentrated mostly on anorexia nervosa, bulimia nervosa and morbid obesity in therapeutic practice. However there are fairly strict referral criterias. I work only with clients with chronic eating disorders who have a history of several in-patient admissions; a history of long therapeutic support and usually have the term "intractable condition" applied.

In the early nineties after seeing several clients and adopting a mixture of cognitive-behavioural therapy and person-centred counselling with a respectful fifty to sixty percent success outcome I met a woman who was immovable in her approach to a severely restricted diet. In my frustration I sat down with her and baldly asked what she gained by refusing to eat. In the

next few hours she informed me more about the isolation experienced with anorexia nervosa than I had found in any book or article. We then agreed that therapy would focus on her and not on eating and she would still attend sessions without any reference to her food intake, weight or nutritional state. She got better.

I wondered why and tried the same approach with the next client. She also improved. I was aware of the debate in psychological circles at this time surrounding whether cognitive-behavioural interventions should, or should not, immediately progress to schema levels (Beck, 1976). I was also aware of Fairburn's (1985) work in the field of eating disorders but I began to question whether this phenomena was something different. I began to search the literature.

In the mid-nineties successful therapeutic outcome was above seventy percent. I was implementing the existential principles outlined by Erich Fromm and Irving Yalom and became engrossed in the subject of Self-hood and existence. Eating disorders appeared to be a miserable state, (I have never encountered a happy person with an eating disorder), yet attempts to help were resented by clients. I began to suspect that the condition gave some sort of hidden reassurance which would be removed if treatment programmes were followed. I heard more and more about a state of consciousness wherein the clients existed in a state of automatic pilot, feeling and thinking nothing. The numbness described by Malson (1998) was much more common in chronic

conditions. I wondered if this numbness gave comfort but was puzzled by the response to physical deterioration which appeared very uncomfortable.

I noted that clients had unhappy childhoods, that the clients diagnosed as anorexia nervosa were very anxious in social interactions, that those diagnosed as obese suffered verbal abuse and mockery, that many clients were very angry. Eating disordered behaviours did not so much appear as cries for attention as cries to be unnoticed. There appeared to be little hope for the individual in the continuation of their poor eating habits. The worse their physical and psychological condition became the more they were noticed so the more they tried to achieve numbness. Therapeutic interventions began to focus on these issues and success outcomes remained high. By this I mean that clients appeared to gain weight, lose weight or decrease the number of bingeing episodes and were discharged.

When the opportunity came to carry out a systematic, objective study on the effects of existential psychotherapy in eating disorders I jumped at the chance. The study had been provisionally accepted by several universities but I was repeatedly disappointed in discovering institutions which could provide supervisors knowledgeable about existentialism but not about eating disorders; or supervisors who were familiar with traditional psychological interventions in eating disorders but not with existentialism. It took nearly two years to find an institution with the expertise in both areas and this gives some insight into the dearth of knowledge in existential psychotherapy and eating disorders.

The thesis takes the form of an initial introduction to the three medical classifications of eating disorders; anorexia nervosa, bulimia nervosa and morbid obesity. It then examines the three classifications in detail, with their various aetiologies and theoretical schools. After the three types of eating disorders have been examined the thesis progresses into a literature review of the most dominant treatment interventions and compares these approaches with the principles of existential interventions. The thesis also presents the underlying common themes which are shared in all three eating disorders and which justify the inclusion of morbid obesity which is often portrayed as the antithesis of anorexia nervosa and bulimia nervosa. The mid-sections of the thesis examines the grounded theory methodology adopted for data analysis. This is compared to the transcript analysis approach and a rationale for choosing grounded theory is presented and the methodological procedure given in detail.

The final section examines the data and presents the perceptions of clients, co-therapists, review reports and treatment outcomes within an existential structure. The emerging theory is presented with possible ramifications for further research, clinical practice and educational content.

MEDICAL CLASSIFICATION AND DIAGNOSIS - ANOREXIA NERVOSA, BULIMIA NERVOSA AND MORBID OBESITY

Each of the three classifications will be broadly introduced in turn but a more detailed presentation of possible causes follows in the thesis.

Anorexia Nervosa

Several authorities agree that anorexia nervosa is diagnosed most commonly during adolescence and most commonly amongst young girls (gender ratio of one boy to ten girls). Such authorities include the Diagnostic and Statistical Manual of Mental Disorders 4th ed. (1994) and the Merck Manual of Diagnosis and Therapy (1977) both of which find agreement with the Association of American Family Physician (1997) and the American Anorexia/Bulimia Association (1997) that anorexia nervosa is characterised by excessive weight loss brought about by deliberate self-starvation. The conscious effort to starve often follows extreme dieting. This leads to a series of physical and emotional disturbances ranging from vitamin and mineral deficiencies, anaemia, amenorrhoea, dental problems, brittle hair, gastric and intestinal problems, cardiopulmonary problems related to peripheral blood flow and peripheral oxygen supply, hypothermia, distorted body image, food and eating phobias, intolerance of others and depression. The condition is viewed as severe and chronic and can result in death.

One estimate by the American Anorexia/Bulimia Association (1997) suggest at least one thousand new cases are diagnosed in the United States each year. They go on to suggest that five percent of adolescents and young women

experience anorexia nervosa, bulimia nervosa or binge-eating disorders at any one time. The figure for men is put at one percent in the USA whilst Young (1998) puts the figure higher for the UK. He suggests that there are two men for every ten women who are diagnosed with anorexia nervosa. Outside of these "diagnostic" figures are those which highlight the much higher percentage of the population who engage in what could be termed disordered eating behaviours or attitudes.

Although anorexia nervosa is substantially a young peoples' disorder it also occurs in older people. Hewitt and Coren (1996) in their research demonstrated that the disorder occurs amongst the over fifties and has a more malignant effect upon the older age group with seventy-eight percent of those diagnosed with anorexia nervosa dying of the disorder. They also found that with age the percentage of men with anorectic behaviour rose to twenty-one percent of the total diagnosed as anorexia nervosa.

The medical criteria provided for a diagnosis of anorexia nervosa is one where the patient's weight is less than eighty-five percent of the normal minimum for age and height and other potential diagnosis have been discounted (for example cancer, anaemia, hormonal dysfunction). The weight loss is due to a conscious effort by the individual to decrease food intake.

It is important to note the differences between a diagnosis of anorexia per se and anorexia nervosa as the medical condition called anorexia itself may be induced by a multitude of factors which are clearly different from anorexia

nervosa. These can be as diverse as shock (sudden loss of blood pressure), pain, raised intra-cranial pressure, inadequate blood supply to the brain (particularly related to the medulla oblongata), upper gastrointestinal tract problems, (such as ulcers, infection in the mouth, ill-fitting dentures, dental cavities), lower gastrointestinal tract problems such as obstruction, kidney dysfunction, liver dysfunction, food allergies and the effects of drug treatments or addiction. In other words there are clear extrinsic causes for sudden loss of weight. The term "nervosa" indicates the psychological focus of both anorexia and bulimia and hence the medical treatment is from a Mental Health perspective.

In comparison with a disease-based disorder, individuals with anorexia nervosa appear to share a number of common behavioural and psychological characteristics. These include;

- a great strength of will (for instance the ability to consistently lose and maintain weight loss, and the ability to suppress appetite and feelings of hunger),
- a rigid control of diet,
- avoidance of fattening foodstuff,
- a general knowledge of calorie percentage of foodstuff and weight,
- a deep fear of being fat, which often, (but not always) leads to
- a distorted body image whereby they see their mirror image as being much larger, fatter or having more cellulite.

Prior to weight loss the individual will often be perceived as socially achieving, conforming and well behaved. Evidence of self-doubt, a sense of unworthiness and a yearning for expressions of affection are often found during history taking or self-reporting by individuals who reflect on pre-dieting periods. There are similarities in ages, gender and family make-up as well as class (one percent of middle-class women are anorexic) and often some precipitating event such as a family trauma, loss, peer group pressure or academic pressure. A large number of individuals report early life traumas particularly related to nurturing, affection and parental love.

Bulimia Nervosa

Individuals who engage in habitual eating binges with self induced vomiting or intestinal purging behaviours over a lengthy period (minimum would be twice a week for a period of approximately three months) are usually diagnosed with the condition bulimia nervosa. They have similar characteristics to individuals diagnosed with anorexia nervosa and often sometimes the two conditions occur simultaneously. Bulimia nervosa sometimes follows a period of anorexia nervosa. According to the WWW health helpline (1997) eighty-five percent of patients begin binge eating during a period of dieting. The ratio of those with the diagnosis of bulimia nervosa in the United States of America are also similar to those diagnosed with anorexia nervosa, namely one to two percent of the population and with the ratio of women to men also being ninety percent female to ten percent male. The habitual effects of vomiting and purging cause a series of physical conditions particularly in the gastro-intestinal tract. This includes ulcers from the mouth down to the stomach, as well as oesophagus blistering, heartburn, loose stools or constipation due to laxative overuse, malnourishment, electrolyte imbalances, vitamin and mineral deficiencies and long-term dental problems.

The Association of American Family Physician (1997) attempts to differentiate between anorexia nervosa and bulimia nervosa by stating that people experiencing anorexia nervosa starve themselves, avoid high calorie foods and exercise excessively whilst those with bulimia nervosa eat excessively and then immediately or soon afterwards expel the food via vomiting. They also over-indulge in the use of laxatives and diuretics and

generally lose weight at a slower rate than individuals experiencing anorexia nervosa. This slower weight loss means that the majority of those diagnosed as bulimic are near normal weight but those with a diagnosis of anorexia nervosa can still indulge in binge eating and purging behaviours and the trait may be missed. The same can be said of those individuals diagnosed as obese. However the diagnosis of bulimia nervosa also includes over-compensatory behaviours to prevent weight gain during periods of bingeing and purging. These behaviours often take the form of excessive fasting, occasionally for days at a time but more commonly over a twenty-four hour period and over-exercising between periods of vomiting or purging. The bingeing behaviours occur at regular intervals but do occasionally occur on a constant basis and can last over many years.

Both anorexia nervosa and bulimia nervosa appear to occur only in those affluent societies where an excess of food is apparent, where food is embedded in the cultural and leisure activities and where food availability is taken for granted.

Morbid Obesity

Morbid obesity is the opposite of anorexia nervosa in clinical and behavioural terms although as above it occurs only in those societies where there is an abundance of food. It becomes a serious and health threatening condition when the excess intake of food occurs alongside a decreased amount of physical activity. It is clinically defined as the outcome of three possible underlying conditions:

- Central-nervous disorders such as hypothalamic abnormalities (ie Froelich's syndrome; which leads to retardation of sexual development and increased appetite),
- Endocrine and metabolic disorders such as Cushing's syndrome, (characterised by obesity, hypertension and diabetes) or the physiological condition of Diabetes mellitus itself,
- Overeating defined as an intake of food in excess of body requirement. (Merck Manual of Diagnosis and Therapy, 1977),

Overeating is the principal cause of obesity. It is also the commonest nutritional disorder in affluent societies and is generally credited with precipitating the onset of a variety of health threatening disorders such as coronary artery disease, cardiac disease, diabetes mellitus, hypertension, abdominal hernias, osteoarthritis (particular in weight bearing joints); and poor respiratory function.

Obesity itself is caused by an intake of calories in excess of the body needs. The excess is retained in the body as adipose (fat). The body quickly adapts to adipose storage and is thereafter reluctant to release the altered calories. It becomes progressively more difficult to lose weight and progressively easier to store more fat. Prevention is therefore a high priority. Unfortunately this does not appear to be effective as the number of obese people in affluent societies is continuing to rise. One intervention to deal with obesity invariably involves a strict adherence to a reduced calorie intake that has to be balanced alongside sufficient calories to maintain health. Starvation results in a loss of

body fat but at the expense of overall health. Nutritional advice is therefore of great importance and this has led to a spate of dietary gurus, wonder diets and breakthroughs; most of which have failed scientific scrutiny. However the high number of self-help groups such as Weight Watchers do seem to have some beneficial effects during the dietary period itself. It has to be noted that interventions are virtually useless unless the individual is motivated to help themselves. A presentation of chronic overweight in conjunction with related health threatening conditions can be diagnosed as morbid obesity.

A major problem for the overweight individual is that morbid obesity on such a long-term continuum also appears to generate physiological adaptation to increased body mass. The storage of triglyceride fat from the product of non-lipid elements (chiefly carbohydrates) requires a higher level of insulin to be produced in order for lipogenesis (fat storage) to commence. Obesity itself increases the metabolic need for insulin and diabetes mellitus, (alongside disturbed responses to amino acids and glucose metabolism) and is commonly associated with morbid obesity. This diabetic condition is a consequence of obesity and not the cause. A reduction in body mass invariably leads to the return of normal insulin production. However weight gain increases the size of the fat cells characterised by both hyperplasia (an increase in the number of cells) and hypertrophy (an increase in the size of individual cells) and despite later weight loss leading to shrinkage of the fat cells the number remains the same. This in turn means that any return to over-eating causes the existing cells to distend once again and the body to produce more fat cells. Despite such an eating regime the digestion and food absorption of the obese

individual does not respond by becoming more effective. Unfortunately the opposite occurs. The human body does not cope well with excess mass.

Eating habits can have an influential effect on lipogenesis which appears to increase when a high calorie intake is concentrated into one or two meals per day. In other words the effects of an obese person missing meals such as breakfast or lunch and concentrating on one large meal later in the day as a method of attempting to reduce daily calorie intake is of little benefit. Small regular food intake appears to produce less stimulation of insulin and therefore reduce lipogenesis. The difficulty is balancing the regularity in order to maintain weight loss. Fasting for example appears to stimulate the body to adapt to the decreased calorie intake by conserving energy through more fat storage as a normal physiological adaptation. Attempting to diet by this method is counter-productive and can be demotivating.

CAUSES OF EATING DISORDERS

The causes and treatment of eating disorders will be discussed within the theoretical perspectives of three broad "schools" each with its own sub-sets and specialities. These three being the biomedical model; the life styles and habit model and the psychodynamic model. All three have strategies which dictate the interventions in anorexia nervosa, bulimia nervosa and morbid obesity and each claim a modicum of success. The influence of the three models also demonstrates the similarities found in the psychodynamic presentations of anorexia nervosa, bulimia nervosa and morbid obesity.

Anorexia Nervosa

Malson (1998) points out in a twentieth century historical overview of the various viewpoints taken towards anorexia nervosa that today there are several different and competing theories regarding the cause of the condition. These range from genetic predisposition, physiological dysfunction, cognitive problems, familial dysfunction, social modelling, behavioural reinforcers, post-traumatic repression and cultural gender issues. Malson concludes with the statement that there are now many competing theories attempting to lay claim to the cause of anorexia nervosa.

The bio-medical model however retains the pre-eminent position as the most widespread and dominant approach to treatment. Both the Diagnostic and Statistical Manual of Mental Disorders (fourth revision) (1994), known usually as DSM IV and the International Classification of Diseases (ICD tenth

revision 1994) which are major reference sources for the medical professions (physicians and psychiatrists) give a diagnostic classification for the "disorder". The DSM(IV) (1994) incorporated the World Health Organisations ICD classification and here the tenth revision is therefore dated as in the DSM (fourth revision). Both the DSM IV and ICD-10 offer similar diagnostic presentations. The ICD-10 (1994) defines anorexia nervosa as "….. a disorder characterised by deliberate weight-loss, induced and/or sustained by the patient. The disorder occurs most commonly in adolescent girls and young women, but adolescent boys and young men may be affected more rarely, as may children approaching puberty and older women up to the menopause. Anorexia nervosa constitutes an independant syndrome in the following sense:

a) the clinical features of the syndrome are easily recognised so that diagnosis is reliable with a high level of agreement between clinicians;

b) follow-up studies have shown that, among patients who do not recover, a considerable number continue to show the main features of anorexia nervosa in chronic form"

(ICD-10 (1994) Chapter 5 Code 539)

ICD-10 provides a diagnostic first line criteria, which provides a definitive diagnosis if fully met. The criteria includes body weight fifteen percent below the norm for height/weight ratio, conscious attempt to lose weight by dieting and one of the following; vomiting, purging, excessive exercise or the use of appetite suppressants, aperients and/or diuretics; a dread of being fat, self-body image distortion, widespread endocrine disorders (involving the

hypothalamic/pituitary/adrenal axis) and delayed puberty where relevant. In case the diagnosis does not capture the classical features of anorexia nervosa ICD-10 also advises that assessments for depression, obsessive/compulsive traits or personality disorders should also be completed.

However it is of some importance when accepting the biomedical "diagnosis" of anorexia nervosa to remember that there is no conclusive evidence of underlying physiological causes. To elaborate, Weiner and Katz (1983) show that there are measurable hypothalamic-pituitary-adrenal axis disturbances in women diagnosed with anorexia nervosa whilst Mehler (1996) indicates that there may be abnormalities in growth hormones and growth hormone release mechanisms, highlighting the common finding of premature osteoporosis in adolescent females. Hornbacher (1998) (who actually experienced anorexia nervosa from age fifteen) comments that she gained three inches in height in the four years from hospitalised discharge at nineteen years of age to writing her reflective article. In 1997 Long published on the Internet the summary views of the Harvard Mental Health letter (1992/1993) which gives a strong statement under the heading of Biological Factors that it is "clear that eating disorders run in families" citing comparative studies which indicated that children of mothers diagnosed as anorexia nervosa had a two percent rate of having the same diagnosis and the rate amongst sisters rose to ten percent in some cases.

On the internet anorexia nervosa page found within the Patients Network site (1997) there are a number of papers which allude to biomedical causes ranging

from possible viral infections to biological vulnerability causing a predisposition towards anorexia nervosa. The use of the word "disease" is applied to the condition as a means of signifying its biological basis.

Yet for each study claiming a biomedical precipitating factor for the diagnosis of anorexia nervosa there is another which purports to refute the study or offers a different perception.

In both Weiner and Katz (1983) and Mehlers (1996) work the question of cause and effect arises. Malson (1998) cites Wakeling (1985) view that endocrinal abnormalities are more likely to be due to the cumulative effects of anorexic behaviours rather than endocrinal dysfunctions causing anorexic behaviours. The previous discussion on the digestive process also indicates that the disruption effects on metabolism due to anorexic behaviours directly affect the hypothalamic–pituitary–adrenal axis. One of the major problems for the biomedical school is trying to overcome the fact that research and clinical studies are carried out on individuals who are malnourished, are recovering from long phases of malnutrition or are in the state of change known as puberty.

There is some interest in the possible genetic aetiology of anorexic nervosa but the role of social conditioning and modelling may also be an influencing factor in the presentation of anorexic behaviours. Hill and Franklin (1998) provide a detailed view that the role of mothers in the transmission of cultural values regarding weight and appearance is important. They also found that family

dysfunctions, particularly within social interactions play a strong role in determining early dieting behaviours.

The case for a biomedical cause remains unproven. Lucas et al (1988) found that when examining medical records in the Mayo Clinic, Rochester, Minnesota, USA over a period from 1935 to 1979 that eighty-nine out of one hundred and fifty-five patients with a medical diagnosis of anorexia nervosa didn't match existing accepted definitions and had to be excluded from Lucas' et al study. On the other hand of one hundred and forty patients who did meet the criteria for a diagnosis of anorexia nervosa only sixty-six had the condition explicitly written in their medical records. Whilst Lucas et al implies that they believe in the biomedical basis of severe anorexia nervosa they state that milder forms of anorexia nervosa "are more strongly influenced by culture than biology".

An interesting study by Margo (1987) which concentrated on males diagnosed with anorexia nervosa found that the majority of the men were shorter than average and had been clinically overweight before stopping eating yet a comparative female group indicated that the women were taller than average. Furthermore both the males and females were members of dysfunctional families with either a sibling or parent experiencing mental illness (mainly mood disorders) or the families had serious interpersonal problems. Margo suggests the idea that family vulnerability to mood disorders may take the form of anorexia nervosa in individuals who are concerned about their body shape. A genetic predisposition may therefore be related to the limbic system

and hormones which affect mood rather than a genetic predisposition for anorexia nervosa as a disorder in its own right.

Social and cultural factors have long been associated with anorexia nervosa. Holmes (1985) highlights the adoption of cultural values regarding food habits and specified that the knowledge, attitudes and routines of society towards food were important reinforcers of food behaviours. Holmes suggested that the role of the mother was often the most influential agent for passsing on food values in the infants early life as the mother is often the individual who shops (and therefore chooses food) who presents food and who oversees the eating ritual. As a result children often learn to eat the food the mother likes, or believes the family will like. The later influences of peers, colleagues and their own families means the alteration of food habits is very hard to achieve. The habits are long ingrained.

Food and eating habits also allow the individual to feel integrated into groups. There is a strong positive effect associated with pleasurable food habits. As Holmes (1985) points out creating a new dish may make a person feel proud, eating in an expensive restaurant may create a feeling of high self-esteem, storing large amounts of food may create feelings of security, the weekend drinking and eating take-away may bring a sense of group belonging. Enjoying meals within a functional family unit creates an environment for sharing (food, ideas, conversation, humour) and the clichéd candle-lit meal provides a sense of intimacy.

Because of its strong association with emotions food inevitably has negative effects. Malson (1998) talks about the desirability of food and its profound temptation for those individuals who wish to control its intake. In transcripts interviewees talk about their "love" for food and their extreme fear about giving in to the "temptation" to eat and put on weight. Whilst simultaneously talking about their love, desire and need for certain foods their anxieties about its effects on weight also made food a "taboo" subject, with descriptions of foods given as "poison", "horrible", "disgusting".

Habits also play a part. Holmes (1985) points out that individuals often become irritable or anxious if they cannot eat what they want to eat and cannot eat when they want to eat it. She also states that some people wish to eat in company, to "share a meal", others may become anxious if eating in public places. The Patients Network (1997) attempts to differentiate between "normal" eating patterns and abnormal habits suggesting that whilst some individuals have ritualistic eating habits (such as cutting food into tiny pieces) in people with anorexia nervosa these are extremely exaggerated.

Food also becomes a method of displaying hidden feelings. Bruch (1985) posits that the strict control of eating habits is a desperate attempt to control day-to-day life and prevent feelings of helplessness whilst the Association of American Family Planning website (1997) inform the reader that people with anorexia nervosa are generally good students, and often involved in school and community activities but are quick to blame themselves if they achieve poor grades or if other things in their lives are not "perfect". They therefore begin

to believe life would be happier and they would be more successful if they were thin.

Holmes (1985) discusses the many reasons for hospitalised patients to be non-compliant with nutritional regimes and points out that one reason may be anger and depression about actually being in hospital which may be displayed through hostility towards food.

Food habit is deeply ingrained by social and cultural values through the actions and modelling effects of the media, the beauty and diet industry, education, health and religion although they often follow opposing agendas. Nevertheless the internal pleasures or fears regarding food habits are externalised within Western culture. Woolf (1990) elaborates on the effects of the beauty industry and the media (particularly marketing devices) with their emphasis on body shape and successful lives. The recent fashion for models with the "waif" look, the "heroin" look in the New York modelling fraternity and the "hermaphrodite" look used in marketing body perfume aimed at both genders are examples of what Woolf would view as exploitation of body shapes creating a negative effect. Malson (1998) discusses in depth the social pressures women endure to be "thin" particularly the impact of the beauty and diet industry on the concept of thinness and health. This message is further reinforced by the media's reluctance to hail anyone who is overweight as a good social role model. Nevertheless Maslon rejects the idea that women who experience anorexia nervosa are driven by social stereotyping of thinness as too simple and the term "slimmers-disease" as a profound over-simplification

of a complex process. In interviews with people who are, or have been, strictly controlling their eating habits the picture that emerges is one which demonstrates that anorexia nervosa is a method of rejecting cultural values of slimness. The point that dieting is influenced by social and cultural values is generally accepted and dieting is shown to be one of the first active behavioural steps towards full anorexia nervosa.

Van Vark Caspar (1998) presents interviews with homosexual men which highlights one gay adolescent who had "hidden" homosexual awareness and took out his anger and frustration through extreme dieting with bulimic patterns of behaviour. The article quotes the psychologist Young as stating that young people uncertain of their sexuality may focus their energies into controlling eating habits in a bid to avoid confronting their "self". This self is in the context of sexual orientation and should not be confused with existential concepts which are discussed later. The younger overweight gay men felt particularly alienated when they joined the gay community only to be rejected because of the pressure to be slim and muscular. There is less pressure on heterosexual young men to be slim although Woolf (1990) suggests that as the fashion and fitness industries increasingly concentrate on an "ideal" male shape the number of men on diets will begin to rise.

The influence of educational policies on anorexia nervosa is due to the increasing obesity of individuals in the Western world. This means that health and education professionals become involved in eating habits. In 1983 the Health Education Council published its report of the National Advisory

committee on Nutrition Education which began to lay down guidelines on healthy eating for use by health and educational professionals. In North America the Department of Health and Human Services put forward a similar position. Alongside the growth in the diet and exercise industries a unified message is marketed towards the population that slimness equates with health and is therefore socially desirable. The sense of cognitive dissonance arises when the food and drink industry markets many of its products on similar lines. Fast food outlets, convenience foods, snacks, confectionery and so on are aggressively marketed towards target groups. Foodstuffs which cause weight gain if eaten in excess are displayed as causing more control of ones lifestyles, bringing sensual pleasures, creating family unity via shared behaviours or encourage inclusion in socially desirable groups.

Individuals are therefore bombarded with multiple messages regarding food intake but evidence of causative effects in eating disorders are inconclusive. The effects of a service-orientated capitalist society are noted as influential in encouraging and reinforcing poor eating habits but the main reinforcers appear to be family members themselves and early exposure to eating habits.

Stein, et al (1994) observed that mothers with eating problems interfere with their childs eating habits when the infant is as young as twelve months old. The mothers were found to be more controlling during meal times, used more negative emotions and experienced more conflict in persuading the child when compared with a control group.

Hill and Franklin (1998) demonstrated that mothers of adolescent girls who frequently dieted and who themselves had regular dieting patterns viewed their daughters as less attractive than mothers whose daughters were not on frequent diets. The daughters in the study sample were only eleven years old.

Hill and Franklin moreover found that the families of dieting children scored significantly lower on perceived family cohesion, inter-family organisation and emphasis on moral and religious mores. They conclude that mothers continue to be the dominant figure for the transmission of cultural values regarding body image and perhaps of more significance that early dieting behaviours can be precipitated by the family's dissatisfaction with its own internal functioning.

Their study followed an earlier study by Pike and Rodin (1991) who found that there was a high correlation between sixteen year old girls with disordered eating patterns and their mothers eating patterns which also showed an inclination towards dieting. Such mothers also displayed disaffection with family functioning and were active in encouraging weight control in their daughters.

The picture of the young person with anorexia nervosa being predominantly based in the white middle classes can be traced to Hsu's (1990) book. Hsu stresses the biomedical basis of familial relationships putting forward a case for a genetic basis for eating disorders. Other studies support Hsu's view of inter-family relationships being dysfunctional when one member has an eating

disorder. Minuchin, Rosman and Baker (1987) suggested that such dysfunctions can be seen in a family with rigid rules of behaviour, poor conflict resolution skills and heavy emphasis on cultural values such as success and ambition with a consequent parental over-interference and over-protection in their children's life. Dysfunctional interpersonal relationships were also found in studies by Brechin and Quallo (1995) who also suggest a biological predeterment for anorexic behaviours.

Bruch (1985) provides an interesting point regarding dysfunctional interpersonal relationships when discussing the self-discipline required to stop eating. Bruch suggests that long before the outward effects of anorexia nervosa are apparent the child has learnt to be over-dependant on her parents and are furthermore experienced in feeling helpless and lacking confidence in directing their own lives. There is also a reluctance to develop abstract thinking with many adolescents continuing to remain in the preoperational and concrete phases of Piaget's (1973) child development. The strict control required to control food intake is seen by Bruch as the child desperately attempting to push away feelings of powerlessness and anxiety.

Grothaus (1998) quotes her own work of ten years earlier by restating the continuing evidence that inter-family relationships of adolescents with anorexia nervosa is strained with over-protective parents and poor conflict-resolution skills. Grothaus' work supports Pike and Rodin's (1991) and Hill and Franklin's (1998) views of a generational transmission of cultures. Grothaus observed characteristics between both generations and siblings with

very little individualist traits. The child experiencing anorexia nervosa within such a family system has learned to become subordinate to the family, has difficulty in self-expression and behaves in ways which appear to gain parental approval. The child has great difficulty in expressing anger externally and represses emotions which are viewed as negative by the family. The parents often stay together within a troubled marital relationship.

The Patients Network (1997) support Grothaus' assertions by noting that problems within the family contribute to the loss of control whilst Connors (1996) links eating disorders to early experience of childhood traumas. These early experiences continue to operate as the child grows and leads to a sense of disconnection from others, overwhelming emotions with consequent anxieties of how to manage such feelings and a profound sense of inadequacy. The worldview of the child makes sense of events and their connections and there is a marked reluctance to move towards more mature outlooks, particularly within relationships. Connor's view on this issue correlates with Bruchs' (1985) work on the psychological development of many adolescents experiencing anorexia nervosa. Connors goes on to suggest that if eating disorders are viewed as self-injurious behaviours then they may serve as an effective method of expressing feelings such as anger, guilt or shame about being needy or dependant on others.

Summary

It is apparent that a life-style pattern involving extreme control of food intake and cultural eating habits are shared by many individuals. Their conscious

effort to control food behaviours has enough common characteristics for the life-style to be categorised as anorexia nervosa. It has debilitating physical, cognitive and emotional repercussions and in extreme cases leads to death. It is usually given a medical diagnosis during an individuals early puberty or adolescence and is more commonly seen in families with dysfunctional interpersonal relationships who adopt social values of externally presented success, who are socially conformist and who exhibit low levels of conflict resolution skills.

There is some evidence of eating disorders between generations and siblings within families who have one member diagnosed with anorexia nervosa although it is still unclear whether this is due to genetic causes, poor inter-family relationship or modelling. The influence of social organisations such as the media, the beauty, health, diet, and food industries, as well as education and health policies are accepted as agents of behavioural conformity but are not viewed as causative agents regarding eating disorders. Evidence is available which indicates that parental influences (and mothers more than fathers) are more instrumental in passing on food habits between generations but again are not proven to cause eating disorders as extreme as anorexia nervosa.

There is as yet no biomedical foundation for a precipitating factor causing anorexia nervosa but evidence indicating affective disorders (particularly depression and anxiety), as well as endocrinal disorders being high amongst

adolescence with the diagnosis of anorexia nervosa is leading biomedical researchers to explore this area further.

People with the diagnosis are mainly female although a rise in male diagnosis is continuing and despite its prominence amongst adolescents there is a growing awareness that older people (particularly the elderly) experience the condition.

In conclusion there is a condition known as anorexia nervosa. Knowledge exists which presents details of who actually experiences anorexia nervosa, when anorexia nervosa is experienced; and what are the effects of anorexia nervosa. There are however only assumptions regarding cause but no conclusive evidence. It remains a complex experience and involves a variety of interventions to help the individual cope.

Bulimia Nervosa

There is widespread acceptance of the view that bulimia is a categorised disorder distinctly different from anorexia nervosa to earn its own label. The Diagnostic Statistical Manual IV (DSMIV) (1994) gives the criteria for bulimia nervosa as recurrent episode of binge-eating large amounts of food in a fixed short period of time, the loss of control of the binge-eating during its occurrence, misuse of laxatives, diuretics, or aperients in order to prevent weight gain, excessive exercising, and that the binge-eating episodes last at least twice a week over a three month period. Grothaus (1998) notes that DSM IV gives two "types" of bulimics. The purging and non-purging types. The

difference being that the purging type engages in self-induced vomiting or other purging behaviour whilst the non-purging type utilises non-compensatory behaviour such as fasting or excessive exercises but does not self-induce vomiting.

Root et al (1986) posit a feminist perspective suggesting that family dynamics are problematic in areas of emotional compromise and since men exert greater social, economic, physical and political power they exert a more destructive force. This interpersonal struggle to fix emotional boundaries has been explored in depth by Fromm (1956) who takes an existentialist approach and reaches a similar conclusion, that interpersonal intimate relationships have the greatest stresses in areas of compromise and boundary settings. However Root et al (1986) do not explore existential concepts. Fromm's work will be examined in depth later in the thesis.

Hsu (1990) found that individuals with bulimic behaviours were often found to be in a less emaciated state than patients with anorexia nervosa. Still there is often severe upper and lower gastrointestinal problems causing serious illness and Hsu goes on to note that the person with bulimia nervosa is often addicted to drugs or alcohol and have family members who are substance misusers. Wooley (1994), Root et al (1986) and Grouthaus (1998) suggest that the individual may have been sexually or physically abused, as there is a prevalence of such histories in eating disorder clients generally. Connors (1996) found the same histories from the opposite position. Working with victims of sexual and physically abuse. Connors found eating disorders

prevalent (particularly bulimia nervosa) amongst individuals trying to control their anger and humiliation through self-harming behaviours.

Vanderlinden et al (1992) gives the characteristics of families which have members diagnosed as bulimia nervosa as often belonging to the upper middle classes (or high social class in the USA) with close family members who present medical histories of addictions, eating disorders or affective disorders. As in families with a member diagnosed with anorexia nervosa there is a high degree of interpersonal control, emotional dependence by the children on their parents, reluctance to openly express negative emotions and poor conflict resolution skills. There was often strong repressed tension within the whole family. Blouin et al (1990) found a similar pattern to those discussed by Pike and Rodin (1991) and Hill and Franklin (1998) when they investigated the influence of depression amongst the families of women with bulimia nervosa. Blouin et al found that the women perceived and rated their families as unable to focus well together, were less close, and had a higher level of emotional disorders. Such families were also perceived to discourage independent behaviour by other family members, were more confirming, followed a more capitalist work ethic (with less time spent on creative or recreational pursuits), approved of social achievement and attempted to control the behaviour of family members in order to pursue social achievements.

Both the Harvard Mental Health Letters (1992) and Grothaus (1998) point out some personality differences between the person with anorexia nervosa and the person with bulimia nervosa. The client with bulimia is more likely to come forward for treatment and is generally more impulsive and rebellious

than the client with anorexia nervosa. This lack of social conformity can often be seen in a criminal history for crimes such as shoplifting for aperients, diet pills or food. When infants they tended to be fed when not hungry to keep them quiet or to help them sleep. Food may have therefore been used as a substitute for love and affection.

The Harvard Mental Health Letters (1992/1993) state that bulimia nervosa was only given its present name as recently as 1987 although it appears "much more common" than anorexia nervosa a point raised in Malson's (1998) feminist post-structuralist essay. Bulimia is viewed as at least twice as likely to occur than anorexia nervosa. Interestingly the Harvard Mental Health Letters (1992) notes that half of people with anorexia also have bulimia nervosa and that up to ten percent of all women have episodes of bulimia at some point in their lives whilst forty per cent of people with bulimia previously experienced anorexia nervosa. Both conditions can be stimulated by dieting although another major difference between the two is that individuals with bulimia nervosa also eat normally at times. Like anorexia nervosa the condition of bulimia appears to have been present for a long period before its clinical diagnosis. This can be seen in the fact that clinicians see medically serious effects of bulimic behaviours several years after its first commencement. The person with bulimia is generally found to be, at treatment, older than anorexic nervosa patients with a general acceptance that whilst it can commence during adolescence it is viewed as a "womens" rather than a "girls" eating disorder.

Like the studies mentioned earlier the Harvard Mental Health Letters (1992) highlight the fact that people with a bulimic condition are likely to be anxious, depressed, addicted to drugs or alcohol, much slower to "recover" than people with anorexia nervosa and with a higher incidence of suicide. The number of dysfunctional families with a member experiencing bulimic behaviours is high. Consequently a genetic or biological cause has been postulated. The Harvard Mental Health Letters suggest a fifty-five percent chance of genetic susceptibility to bulimia nervosa if one parent has the condition. The high levels of depression is correlated with studies on hormonal and neurotransmitter functions. Bulimia nervosa correlates with low levels of serotonin in the hypothalamus which directly affects sex hormones, the thyroxin levels and adrenal hormones. The fact that anti-depressant drugs decrease binge eating but not normal appetite provide some support for this theory.

The glass ceiling web site (1997) providing health guidelines quotes the DSM IV diagnostic criteria for bulimia nervosa and defines fasting as both short and long term as long as hunger signals are ignored. Frequent bingeing and purging causes a number of physical problems. Nevertheless treatment of choice is often anti-depressants whilst responding simultaneously to the presenting clinical complications of bulimic behaviours. The Mental Health Foundation (1999) finds that as well as emotional, familial and physical problems the need to constantly binge-eat and purge has a heavy financial effect on a persons daily living standard and that this creates a feeling of

shame and secrecy about the activity. Again depression is an outcome of such hidden behaviours.

Schneider et al (1987) found that individuals with bulimia experienced intense fear of being fat and purged to excess in an attempt to control eating and weight. Taking a broadly cognitive behavioural approach Schneider et al postulated the idea that the person with bulimia has lost the ability to manage normal methods of food and body weight. Schneider et al's study covered a variety of self-efficacy areas regarding the control of binge-eating from resisting the urge to binge, a reduction in temptation, distraction behaviours, and resisting binge eating when feeling depressed, angry or lonely. An interesting area concerned the individuals perceived importance in developing personal relationships and being "assertive" within such relationships. Like other researchers and clinicians investigating the condition Schneider et al made the assumption that unsatisfactory relationships contribute to bulimia nervosa and also impede "recovery". They also suggested that there was a correlation between negative mood states and substance misuse. Two problems appeared to be deeply ingrained in the individuals with bulimia nervosa who took part in Schneider et al's study. One was the fact that resisting the temptation to binge-eat could be reinforced but the person had great difficulty in coping without such temptations in their lives. Secondly despite commencing a process of controlling eating and reducing bingeing the fear of even a minimal weight gain meant the frequency of vomiting did not reduce.

Malson (1998) found that the pattern of purging was viewed both ambivalently and paradoxically by her interviewees. Women who carried out frequent abuse of laxatives for example stated that purging "cleansed" and "purified" them whilst simultaneously "punishing" them. The ideal state for the person with bulimia nervosa is to be internally empty, to be "no thing", to be without an identity. (Malson found a similar picture amongst women who are anorexic). One interviewee stated that this state of numbness felt like being "stoned all the time". Malson argues that this goal of purging to reach a state of emptiness is not an act of self-destruction but a method of erasing meaningful subjective thinking from their lives. This theory supports the high level of substance misuse found in individuals with bulimia nervosa. The Harvard Mental Health Letters (1992) for instance suggest that one-third of women who were bulimic also had drug or alcohol problems. Conversely one third of alcoholic women had been bulimic at some time. Alcoholism was also found to be four times more common within families of individuals who were both anorexic and bulimic. Like Malsons work the Harvard Mental Health Letters (1993) in a follow up paper suggested a distorted form of asceticism in binge eating and purging with certain religious imitations. The discipline, self control and preoccupation with rituals are similar and again like Malsons (1998) view the Harvard Mental Health Letter suggest that the fear of gaining weight and becoming fat may in fact be secondary to a deep-seated need for "purification". Dieting can become fasting, the cultural emphasis to be slim can become self-abnegation.

Such a picture matches the ideas put forward by Bruch (1985) with its emphasis on the inability for abstract thinking often found in individuals with anorexia nervosa. The rituals, patterns and obsessions with food, weight and self-control would be viewed here as within the concrete phase of Piagets (1973) child development. Connors (1996) also put forward a similar thought, that the traumatised individual is overwhelmed by emotions and attempts to cope by remaining in a more childlike world view. The relationship between being stoned through substance abuse and religious contemplative objectives is also similar and like Schneiders et al (1997) findings the removal of purging behaviours leaves a sense of helplessness because people with bulimia nervosa have no other similar types of replacements for such intense experiences.

Edelstein (1989) points out that the medical profession, particularly psychiatry, views such ascetic behaviour as "moral masochism" because the asceticism is not supported by an accepted religious lifestyle. There is a certain rigour in such a stance. The person with bulimia nervosa carries out purging rituals to both cleanse and punish the self and as a process towards the state of non-sense known as numbness. But the behaviours are carried out within cultural values which lack religious knowledge. The effects of disrupted digestive processes causes physical, emotional and cognitive problems which often makes eating even harder. Hunger may be dealt with by binge eating followed by purging through vomiting or use of aperients or laxatives. This behaviour in conjuction with secrecy and within dysfunctional family relationships strengthens episodes of depression, guilt and anger. The

state of numbness brings relief. It is difficult to gain a sense of spirituality in such suffering.

Duker and Slade (1988) like Connors (1996), found individuals with both bulimia and anorexia nervosa are emmeshed in frustration and anxiety with a sense of fragmented self. The lack of self-assertion regarding choice and decision-making means the individual does not try to enhance the known self through control but attempts to totally escape the self. Duker and Slade suggest that there is a need to supplant a new self-hood within the individual rather than try to help existing concepts of identity. In fact they state that one of the signs of "recovery" is that the sense of nothingness diminishes. Duker and Slade use phrases and concepts which mirror existential principles. Certainly the concept of Self is close to Sartre's view (1943). However, the "concept" nothing has special consideration in existential approaches and will be explored in depth in later sections.

Returning to ascetic behaviours Edelstein (1989) points out that some orthodox religions do support the practice of ascetic fasting either for spiritual growth or religious knowledge or rituals. But not all faiths support asceticism. In Judaism for example asceticism is seen as rigorous abstention from any form of self-indulgence which is based on a belief that such "renunciation of the flesh and self-mortification brings man to a higher spiritual plain". However Jewish law rejects such strictures tolerating fasting only to a limited degree. Rabbis teach that asceticism and privation is a sin against the will of God and that individuals should honour God by enjoying the gift of life.

Christianity on the other hand sees asceticism as the sanctification of the body by its subjection to Gods will. An important element here is that the individual cannot and should not disown the body. The Christian ascetic has to struggle with a monotheist religion which incorporates both the material and spiritual world. Both are created by God. Evil is viewed by the ascetic as any deprivation of Goodness. Early Christian ascetics such as the Gnostics, Arians, and Manichaeans accepted a dualistic reality but were contemptuous of the body and material world which were seen as the evil which deprived the Spirit of goodness. Retreating from the material world and rejecting pleasure were therefore ascetic acts to preserve the spiritual Good. The early Christian ascetics took many of their beliefs from a mainly Eastern tradition and their rejection of equity between the material and spiritual worlds eventually caused their demise as heretics.

This early asceticism may have its roots in Buddhism. Buddhist ascetics make a conscious effort to retreat from the world to achieve Nirvana, the state of bodiless existence. Asceticism is institutionalised within the Four Steps of learning which attempts to systematically suppress emotional existence. There is a certain loose similarity with anorexia and bulimia nervosa but it would be an over-simplification of both the Buddhist faith and the nervosa conditions to make formal links. Nevertheless Buddhist ascetics attempt the first step by deliberately inducing a sense of depression (melancholy). In the second step they pursue a sense of obsession with the self (narcissism). In the third step they lose strength of will (apathy) and in the fourth step the ascetic practices mental emptiness. Such steps are close to the stages the purging bulimic

person describes to Malson (1998). If all four steps are reached and practised correctly the Buddhist ascetic reaches the stage of Nirvana described by Alexandra (1931) in Edelsteins (1989) book as "the womblike state where one finds no perception, no wishes, the peace, in which there is no death nor being reborn, no here, no beyond, only an intermediate kingdom that is even the end of sorrow" (page 18 Edelstein 1989). Whilst the quote is old the description would have meaning for the individual with bulimic purging behaviours presented in the works of Duker and Slade (1988), Schneider et al (1987), Connors (1996) and Malson (1998). It is clear however that the physical damage, the psychological harm and the interpersonal unhappiness found in the condition bulimia nervosa that the purging behaviour is an individual coping mechanism used not to go on a spiritual journey based on religious knowledge or belief but to flee from the subjective reality within which the individual finds her or himself.

Summary

Like anorexia nervosa there are enough characteristics commonly found amongst enough people for bulimia nervosa to have its own classification. The treatment is based on a biomedical model but there is no conclusive proof that it has a biomedical cause. The high incidence of substance abuse and mental health problems within families of individual with bulimia nervosa may be as likely to be due to genetic predisposition as poor inter-familial relationships. Both theories have their advocates and it may be possible that a dysfunctional family may precipitate a bulimic lifestyle if there is already a genetic predisposition for additive behaviours.

A close link with depression is found with the condition but not significantly different to the level of depression found in other conditions such as obsessive compulsive disorders, and anxiety (Harvard Mental Health Letters, 1992). Binge-eating appears to have an affect on endocrinial processes or alternatively be affected by endocrinial processes. For instance the levels of the peptide hormone cholecystokinin is lower in people with bulimia following a standard sized meal. Cholecystokinin causes the body to be aware it is "full" and provides a sense of satiation (Glassceiling, 1997; Harvard Mental Health Letter, 1992). It is unclear whether frequent bingeing causes such a reaction or whether such a state of feeling full causes bingeing.

Family dynamics are similar to those found in families with a member experiencing anorexia nervosa except that the person with bulimia nervosa has a tendency to be more rebellious and come forward for treatment more readily.

Being thin and being obsessed with weight is culturally influenced but as in anorexia nervosa the modelling influence of parents, particularly mothers appear to be of more significance in promoting and maintaining bulimic behaviours.

Bulimia nervosa is more common amongst females but a growing number of males are being treated. The age range at treatment is older than that found with anorexia nervosa but both conditions tend to have been established for a considerable time before treatment. Bulimia nervosa does not cause as many acute and life threatening physical damage as anorexia nervosa but has the potential to eventually cause serious illness and the levels of suicide are significant in bulimia nervosa. The condition is chronic and difficult to stop. Purging can be viewed as both simultaneously a form of punishment and purification. The use of chemical compounds to aid purging causes a degree of dependence. (The individual can be constipated on cessation of long-term laxative use).

As in anorexia nervosa knowledge exists which provides guidance as to who is more likely to experience bulimia nervosa, when the condition can appear and what are the effects of the condition. And as with anorexia nervosa cause remains unknown.

Morbid Obesity

The Merck Manual of Diagnosis and Therapy (1977) encapsulates the main point regarding obesity. Its incidence occurs only where there is an abundance

of food. Obesity does not occur during famine. In economically wealthy countries where food is readily available it is a serious public health problem. The decrease in physical activities amongst the population increases the number of obese individuals. The National Institute of Health Consensus Development (NIHCD) (1985) suggested that in North America 34 million adults have a body mass index greater than 27.8 in men and 27.3 in women. A weight increase of nearly twenty percent. The body mass index is the most common method of measuring the amount of body fat and is calculated by a formula of body weight in kilograms divided by height in metres. It is accepted that such measurement is only an approximation due to the differing levels of actual body shapes amongst adults but its usefulness in determining potential adverse effects on health for the individual maintains its widespread application.

The Merck Manual (1977) is adamant in maintaining that overeating is the principal cause of obesity but does acknowledge that overeating may be affected by the endocrine system and may be affected by genetic factors. Dolan (1994) broadly agrees with this reluctance to take a biomedical approach and instead suggests that overeating may have a symbolic and emotional value for the individual. Overeating is viewed in this context as a substitute for the attention and love that is needed but is not provided. The NIHCD (1985) however, rejects the notion of obesity being caused by overeating when there is an abundance of food as too simplistic and states that the cause is a complex network of psychosocial and cultural factors which make the human animal susceptible to obesity and therefore it is a

"disease.....deeply rooted in biological systems". The Medical Sciences Bulletin (1994) goes further by pushing the view that obesity is not caused by uncontrolled eating behaviour nor a disorder of weight regulation but is a "chronic medical condition" caused possibly by a neurotransmitter disorder which directly affects hunger and satiation control. Obesity should therefore be approached as a treatable entity in a similar fashion to hypertension or diabetes.

Such conditions are already recognised in the medical community. Hypothalamic obesity for example is a recognised clinical condition whereby the individual is not physically made aware of satiation and eating continuous without inhibitory neurosignals. Whilst Froelich's syndrome is an abnormality of the hypothalamic function which causes retardation of sexual development and increased appetite leading to obesity. Brain trauma such as encephalitis may also cause increased appetite. Such conditions can be clinically identified. The argument for a neurotransmitter dysfunction in morbid obesity is not, to date, supported by clear evidence.

A genetic predisposition for certain somatic shapes is self-explanatory. Tall adults tend to have tall children and so on. The constitution of the body mass itself may be hereditary but the evidence is contradictory. Adipose tissue does not, for instance, collect in a uniform mass around the body. Fat cells around the waist collect more readily than around the thighs and buttocks and whilst excessive fat storage can be externally observed (skinfold thickness) fat also accumulates around the peritoneal tissues, mesentery, perineal tissues,

mediastinum and pericardium. In chronic obesity an increase in fats within each cell is measurable alongside a huge increase in the total number of cells (hyperplasia). This means that the liver, heart, spleen and the skeleton all increase in size and are larger than non-obese persons of the same gender, age and height. The increase in fat cells can lead to cardiac hyperatrophy, fat infiltration in the liver, kidneys and other organs and degenerative arthritic changes, particularly in weight-bearing joints. The NIHC (1985) postulates that there is probably a genetic predisposition for the increase in cell size and number and that this genetic mechanism coupled with environmental factors triggers the imbalance between energy intake and expenditure. These in turn encourage a lifestyle which maintains an excessive calorie intake, decreased physical activity and metabolic and endocrine disorders.

This is an important point as the debate about causative factors continues. Like the condition anorexia nervosa it is difficult to clearly separate cause and effect. The endocrinal disorders found in individuals experiencing anorexia nervosa may be caused by malnutrition. On the other hand the endocrinal disorders may precipitate anorexia nervosa. A similar problem is found in the condition of morbid obesity. The Merck Manual (1977) states that endocrine factors are rarely the cause of obesity yet endocrinal disorders themselves can be closely related to the onset of obesity suggesting at least some connection between the hypothalamic/ pituitary/adrenal axis. For example in Cushings syndrome a series of clinical abnormalities can be traced to the chronic effects of excessive cortical or corticosteroids. The excessive cortisol secretion is due to the hyperfuntion of the adrenal cortex overriding normal

Adrenalcorticotrophin Hormone (ACTH). ACTH maintain normal function of the adrenal cortex and stimulates secretion of cortisol and corticosteroids. The adrenal cortex atrophies in the absence of ACTH with a virtual cessation of cortisol and cortisoteroids release. Hyperfunction of the adrenal cortex may be due to too much ACTH secretion by the pituitary gland, over secretion of ACTH through nonpituitary carcinoma tumours or through the direct external administration of cortiosteriods.

Its clinical presentation include the rounded so-called "moon" face, truncal obesity with particular supraclavicular and dorsal cervical layers of fat (often referred to as the "buffalo hump"). The difference with the appearance of obesity however is that in Cushings syndrome there is muscle wasting and weakness, thin skin particularly in the extremities, with poor skin healing and tendency to bruising. Yet like obesity there is hypertension, renal calculi, osteoporosis, glucose intolerance, mental health disturbances and menstrual irregularities in females. However because of its diagnostic response to specific clinical tests the syndrome can be identified and treatment instigated. (Correcting the hyperfunction of the pituitary gland or adrenal cortex via pharmaceutical inhibitors, irradiation or surgery.) There are no known clinical tests which lead to a diagnostic criteria and therefore specific interventions in morbid obesity.

The metabolic picture also hints at a disturbance in function. Glucose intolerance is often abnormal in the obese individual and obesity-related diabetes mellitus is common. Like anorexia nervosa and bulimia nervosa the

relationship between a metabolic disorder and an eating disorder is interconnected and difficult to separate. One of the actions of insulin for instance is to regulate lipogenesis, the storage of triglyceride fat formed from non-lipid precursors such as carbohydrates. Obesity prevents this physiological action and increases the metabolic need for more insulin. In chronic obesity this non-insulin-dependant diabetes shows an increased number of enlarged pancreatic islet cells which produce insulin alongside abnormal responses to glucose and amino acids. This hyperinsulinism is a direct result of obesity and not the cause of obesity. Weight reduction correlates with a restoration of normal insulin production. The hyperinsulin is possible due to fatness itself. The increased adipocyte (fat cell) size is thought to require more insulin when distended. What is interesting in non-insulin dependant diabetes is that obesity is shown by hypertrophy (increased adipocyte size) and in adults hyperplasia (increased number of fat cells). With weight loss the adipocyte shrink in size but there is never a relevant decrease in cell number. Yet normal insulin production adapts to meet the needs of the increased cellular number. This process can continue over many years with a return to overeating and consequent lipogenesis causing the fat cells to distend and increase in number.

Other metabolic dysfunctions include a reduction in the muscle cells response to insulin actions, a diminished response by growth hormones (particularly in moving fatty acids from adipose storage areas), increased cholesterol levels, triglycerides, and free fatty acids. This increase in free fatty acids in the blood occurs alongside lowered glucose oxidation. As weight increases there is

increased cortical and ketosteroid secretion (which decreases as weight is lost). This endocrine process may also be related to adrenal production of aldosterone and the pituitary release of vasopressin (a polypeptide hormone secreted from the hypothalamus and stored in the posterior pituitary). Vasopressin is generally released from the pituitary storage site in response to neural stimuli such as stress or increased blood osmolality. In obese women vasopressin in conjunction with aldosterone creates an antidiuretic effect which may cause water retention. Nevertheless basal metabolic rate, digestion and food absorption is normal in the obese.

The search for an endocrine link continues within the biomedical establishment. The Medical Science Bulletin (1994) cite the work of Wurtman and Wurtman (1994) who suggest that lipogenesis and increased insulin activity raises the levels of the amino acid tryptophan in the brain. Tryptophan is a precursor to the hormone serotonin which regulates mood and contributes to a sense of well-being. The correlation appears to be that obese individuals eat more carbohydrates to raise their mood state. Wurtman and Wurtman found that obese women had an improved mood state after eating high-carbohydrated snacks. Their work led them to patent and commercially produce the pharmaceutical agent dexfenfluramine (a serotonin affecting drug which inhibits food intake) sold through their company Interneuron. The drug is aimed at the morbidly obese but is not seen as a single approach to obesity with the company pointedly stating the drug should be used along with a strict diet and exercise regime.

Despite continued research exploring physiological causes for obesity the sociocultural and psychological precipitators continues to have a strong hold. Dolan (1994) although discussing bulimic patterns points out that comfort eating leads to a great deal of emotional and cognitive dissonance. The resultant body shape as a direct consequence of overeating creates anxiety that the sociocultural and sexualised female shape has been exceeded. Dolan goes on to discuss the specific gender problems for women in this context and the high prevalence of females to males with bulimic disorders. However the same valid point of sociocultural anxieties can be sustained when applied to the obese individual, male or female. Bullerwell-Ravar (1994) provides the view that body image is part symbolic and part fantasy for the individual. Despite the scientific attempt to define body size (as in the Body Mass Index) the population at large provides the subjective perception of the body which dictates its social acceptance or rejection. The psychological comfort derived from an acceptable body image is further complicated by physiological, social and cultural factors such as the body shapes of the immediate family, familial food habits and social groups. Ravar quotes the words of Fisher (1986) in recognition of the lack of definition; that body image is "how individuals view and assign meaning to their own body".

In obese children and adolescents the social exclusion by peers may cause depression and create a deeply ingrained pattern of comfort eating. In adults a serious and intense form of emotional support is required whilst the individual attempts to maintain control of their weight. Losing weight (Merck Manual, 1977) is easier than controlling weight with most people regaining an obese

state within six months from the cessation of a supervised weight loss programme.

Social exclusion is particularly marked as sociocultural values cause rejection of the obese individual. This social exclusion can be particularly painful over time with weight loss reinforcing inclusion followed by weight gain reinforcing social undesirability. A state which may be made worse by what Cooper (1995) calls the "Yo-yo dieting". Losing and gaining weight over time gradually trains the body to be efficient at storing fat so even a low calorie diet will not lead to much weight loss. Attempts to eat even a normal diet thereafter leads to rapid weight gain, often exceeding the original weight at which dieting commenced.

The social value of slimness is discussed by Waller and Shaw (1994) who provide a perception which outlines the effects of the media as a means of disseminating such a value and also supporting a system whereby individuals are not encouraged to believe they can control their own environment. Waller and Shaw discuss the media's role within three social psychological models. They suggest that the media presents images implying social acceptance for thin females thus reinforcing slimness as highly desirable.

Within the social identity model self-image is a combination of personal and social identity. If social identity is gained through a subjective identification with certain social groups then the level of personal satisfaction increases in groups which are more socially desirable. Whilst Waller and Shaw were

discussing a feminist perspective of eating disorders which excluded obesity their views can be generalised to the obese condition. Obesity is not socially desirable with a consequent reduction in social identification by the obese person which may cause frustration, embarrassment and depression. Within Banduras' (1977) Social learning theory Waller and Shaw suggest that the sense of a female ideal body type is proved by gender-related role models during childhood and adolescence. The media pressurises young girls and women to conform to the ideal body type because the role models projected are those which individuals perceive as most similar to themselves. For the overweight child such stereotyping not only reinforces peer exclusion but also encourages obese-related behaviour. The need to be loved and accepted sublimated into further over-eating.

In the social comparison model the argument is forwarded that the views of other people are used to measure the individuals own attitude. The media preoccupation with thinness as the ideal shape may cause anxiety and low mood for the vast majority of women who fail to reach the ideal. Waller and Shaw (1994) go on to suggest that whilst such media images are predominantly aimed at women there is growing evidence that men are also the target. If the role of the media in any of the three social psychology models mentioned above is of significance then an expectancy of a rise in the number of men with eating disorders should be confirmed in the next few years.

The figures for obesity is already available and men are at a high risk. The Medical Science Bulletin (1994) cite both the US National Institute of Health and the US Centres for Disease Control which show that nearly a third of all Americans are overweight and that one third of females and a quarter of males are attempting to lose weight at any given time. Whilst a clear gender ratio difference is demonstrated in the figures for anorexia nervosa and bulimia nervosa (ten female cases for every male case Hsu. 1989), in obesity both genders experience the condition on a much more equal basis. This may, in part at least, be attributable to the medias' influence. For example Wainwright (1998) writing in the Guardian newspaper under the headline "British children will go to US style "fat" camp" reported on a new approach by Gateley, a lecturer in exercise physiology at Leeds Metropolitan University. Gateley is reported as saying that "apart from a small number of cases due to other medical reasons, child obesity is overwhelmingly the result of too little exercise and, very much the secondary cause, too much food". To access the camps the child has to be referred by a doctor who has diagnosed a serious obesity problem. No mention is made of gender in the article.

Lacey (1998) discusses the pharmaceutical and medical approach to dealing with obesity in her article in the Independent on Sunday. No gender preference is shown whilst Boseley (1999) reporting on a possible genetic link between adipose storage in the abdominal cavity and heart disease specifically mentions the waist measurements of both male and female.

The media colludes with politicians, health educators, the medical establishment and the dietary and fashion industries to promote the negative effects of obesity. The Medical Science Bulletin (1994) takes a more honest stance of clearly stating that the health hazards of being moderately overweight are "exaggerated" with excess mortality not readily observed until the body has above forty percent of excess weight using weight tables of life insurance actuaries. The Bulletin concedes that obesity has considerable social hazards. A point reinforced in the Merck Manual (1997) which suggest a "gloomy prognosis" regarding weight control with often a loss of motivation alongside calorie increase and poor health education regarding the body's own compensatory reaction to any attempt at restricting food intake. Obesity is seen medically as an "incurable but manageable disease". In contradiction to the Medical Science Bulletin (1994) the National Institute of Health Consensus Development (NIMCD) (1985) state that whilst quantitative definitions of obesity have to take account of individual differences within the population and at best is a guidance measurement nevertheless an increase in body weight of more than twenty percent constitutes an "established health hazard".

The NIHCD cite the National Health and Examination surveys carried out between 1971 and 1980 showing obesity as linked with a variety of illnesses including mental health problems. Hypertension is nearly three times higher for the overweight person and amongst the twenty to forty year old the prevalence is five and a half times higher. The level of cholesterol amongst young overweight adults is over two times greater than non-overweight adults.

The level of non-insulin dependant diabetes mellitus is nearly three times higher amongst overweight people despite evidence indicating this form of diabetes may be inherited. In fact losing weight appears to normalise the metabolic reactions of such a condition. The level of coronary heart disease is not directly linked to obesity itself with no clear evidence suggesting the onset of coronary heart disease with obesity although the medical profession and health educators continue to promote such a link. Both Boseley (1999) and the NIHCD (1985) report that the distribution of fat deposits around the body may provide a clearer link with coronary heart disease. Excess fat storage around the abdominal cavity may be a better indicator of possible coronary heart disease rather than the actual level of obesity. Individuals who store fat around the thigh or buttocks for example show less prevalence of coronary heart disease.

The link between obesity and carcinoma is stronger. The American Cancer Society Study cited in the NIHCD, (1985) paper carried out an epidemiological survey of over one million members of the population. Obese males, (regardless of other health risks such as smoking) had a higher mortality rate than non-obese males from cancer of the colon, rectum and prostate gland. Obese females had a higher mortality rate from cancer of the gall bladder, breast (amongst postmenopausal women), cervix, endometrium and ovaries. Obese women had an increased risk of getting endometrial cancer by over five times compared to non-obese women. The study merely presents such epidemiological statistics. It does not propose any endocrinal or metabolic causative factors for such cancers although the effects of

corticosteriods and the hormonal roles of the hypothalamus, pituitary and the adrenal cortex on the ovaries and breasts are affected by obesity to some degree. The prevalence of colon and rectal cancers amongst obese males may be attributed to diet particularly if high in carbohydrates and low in fibre.

The link between decreased life span and obesity is also quite strong (NIHCD (1985). The mortality rate is high amongst the obese under-fifties making younger people more at risk. As in coronary heart disease an important contributory factor appears to be the distribution of fat deposits rather than obesity itself. In general weight reduction programmes based purely on medical grounds indicate that the following diagnosis should be given priority; non insulin-dependant diabetes mellitus, a family history of diabetes mellitus, women with a history of diabetes associated with pregnancy, hypertension, hypertriglyceridemis, and hypercholesterolemia. Whilst the link is not as clear as the above list, a weight reduction programme is medically advised for coronary heart disease, gout (chronic recurrent arthritis of peripheral joints), chronic obstructive pulmonary disease and osteoarthritis in weight-bearing joints. These medical guidelines are outside the social, cultural and psychological effects of obesity. Research evidence is not yet clear but it is possible to make an assumption that the negative effects of obesity on a persons mental well-being may turn out to be one of the most widespread and damaging long term influences.

Summary

Like the eating disorders of anorexia nervosa and bulimia nervosa the debate continues about cause and effect. The biomedical model retains the most dominant quantitative data but still has no valid and reliable evidence clearly demonstrating a genetic, endocrinal or metabolic cause for obesity. Obesity as the NIHCD (1985) paper highlights, is clearly associated with hypertension, non insulin dependant diabetes mellitus and certain cancers yet the cause remains elusive and research continues in the areas of biological factors which lie behind the distribution of fat, energy regulation and genetic determinants.

Alongside the biomedical approach are epidemiological models which examine lifestyles and food habits and their correlation to well-being as well as studies of psychosocial factors such as the substitution of love and emotional need by food and the reasons for comfort eating; the loss of control over eating habits; and the effects of social exclusion and a persons own sense of being.

The underlying similarities with the other two disordered eating conditions can be demonstrated again here. Like anorexia nervosa and bulimia nervosa the condition of morbid obesity is chronic, debilitating and receives social disapproval. One could even argue that the public ignorance of anorexia and bulimia nervosa give the conditions a sense of mystery and an assumption that it is a real "disease" whilst obesity is perceived as a condition of the lazy and weak-willed. A gross and unfair simplification of all three conditions but one which confers on the obese a degree of mockery and loss of social status. Murphy's (1993) work indicates that the social ideal of body image pushed by

the media and the political, medical, diet and fashion industries have a negative effect on self-image in the obese. Whilst the person with bulimia nervosa is almost terrified of gaining weight (Dolan and Gitzinger, 1994), and the person experiencing anorexia nervosa is obsessed with food intake and control, the obese person has a continuous, lifelong battle to control the maintenance of weight itself and as Lacey (1998) comments the obese person has to make permanent lifestyle changes with minimum support and guidance. Lean states in Lacey's (1998) article that there is a need for a more comprehensive service including medical intervention, pharmaceutical interventions, alongside the help and guidance of dieticians, nutritionists, physiotherapists, and provision for psychological support. The high rate of failure amongst the chronic obese to maintain a reduction in weight leads to a poorer overall quality of living for many years, if not for the whole of the life span.

THERAPEUTIC INTERVENTIONS

The nomenclature of "Nervosa" in the diagnosis of both anorexia and bulimia indicates the medical viewpoint that both conditions have behavioural and psychological manifestations and are therefore best treated with a mixture of psychopharmaceutical and psychotherapeutic intervention. (Nervosa equating to a nervous disorder). The use of the word morbid in the diagnosis of obesity generally indicates that the individual is so overweight that the risk of acquiring a major health problem is high. Obesity as a medical condition is treated via pharmaceutical interventions for identified health problems (as in diabetes or hypertension) but the main focus of intervention is in encouraging a change of lifestyle by the individual in order to reduce weight.

Medically all three conditions are viewed from the stance that they are deviations from normal or healthy food intake and whilst there are a range of theories from the biomedical to the cultural regarding the causes of the conditions, the approaches to treatment interventions are broadly agreed. This may be due to the fact that the medical establishment hold a statutory duty to provide treatment interventions based on diagnosis and (except in a minority of independent practitioners) control the process of referrals as well as the use of resources, particularly finance. The debate surrounding eating disorders is therefore much more focused in the area of treatment interventions and centres on results criteria and successful achievements of specific interventions.

Bhanji and Mattingly (1988) summarised the complexity of basing interventions on results by noting that long-term results were difficult to measure because amongst other things, doctors were not consistent in their use of the diagnostic criteria. Not all used the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases and progress notes included terms such as "low" weight or "overweight", without referring to recognisable charts such as the Height-Weight ratio or Average Body Weight ratio. Follow up was poor and case studies were often inaccurate or incomplete.

Bhanji and Mattingley (1988) argue that to address such problems there should be a formal agreement amongst the whole medical establishment to use a standardised diagnostic criteria, focus and outcomes. Cases should be treated consecutively by the same person with independent corroboration of the results.

However the differences in treatment interventions make such an approach difficult, not least because of individual preferences and trends in psychotherapeutic fashion. In the same year as Bhanji and Mattingley published their book, Duker and Slade (1988) stated that gestalt therapy, psychodrama, encounter groups and assertive training do not work and they lacked conviction that any other psychotherapeutic intervention would be much better. They proposed an almost existentialist approach which concentrated on helping the individual to build a new self, supplanting the "fragmented sense of being" found in the anorectic condition. Their approach

had objectives (outcomes) which improved the individuals self-esteem and decision-making abilities leading to reflective exploration of the clients belief-systems.

Zerbe (1995) had similar objectives. Clients were facilitated to take greater personal responsibility and improve their self-analytical capacities and explore contradictions in the self. Zerbe, however, took an interesting psychoanalytical approach which incorporated feminist theories into the counter-transference process. She presented one successful case study of a client who had been unresponsive to "traditional treatment interventions" for many years and who presented with a diagnosis of anorexia nervosa and bulimic tendencies. (DSM IV, 1994 criteria in this case would be anorexia nervosa binge-eating/purging type.)

Connors (1996) takes as his therapeutic objectives the facilitating of the clients control of self-harming behaviours, the use of an open communications process and enabling the clients to explore and resolve underlying issues. His approach is broadly humanistic in contrast to the existentialist approach of Duker and Slade (1988). Connors also notes that art therapy can help individuals gain self-respect and a behavioural approach is useful provided the client controls the stages and sets his or her own goals. Whilst Bhanji and Mattingly (1988) agreed that pharmaceutical interventions such as major tranquillisers could be useful in anorexia nervosa, Connors states that caution should be exercised as the evidence of benefit is mixed and in some cases the use of drugs increases the individuals perception of loss of control. However

the use of cognitive approaches, particularly alternative imagery, distraction, re-orienting and displacement activities is viewed as therapeutic. Connors concludes that "different approaches work at different times with different people". Alongside the different therapeutic approaches lies differing underpinning theories. For instance Connors' humanism, Zerbe's psychoanalysis and feminism and Duker and Slade's existentialism share similar objectives, particularly empowering the client to control their own lives, yet they come from three different approaches and therapeutic theories. Furthermore underlying theories often conflict with practices. The interventions espoused by Ullman and Krasner (1975) would not receive much support today yet their book was an influential source of information in its time. In their section on "feeding problems" are case studies which involve compulsory hospitalisation, transfers from pleasant ward environments to bare rooms, the hospitalisation of a twelve year old girl to a psychiatric ward where she was treated with "various drugs and threats" (the treatment did not work) and aversion treatments on babies (one second electrical shocks to a nine month old baby and the squirting of lemon juice into the mouth of a six month old baby). All done in the name of behavioural aversion therapy. Of interest is Ullman and Krasners' implied rejection of Nemiah's (1950) psychoanalytical theories that anorexia nervosa was due to internal sexual conflict. (The forties and fifties being the period when psychoanalytical interventions were the fashion). In 1960 Gwynne-Jones cited the work of Beech (page 770) who attempted to demonstrate Nemiah's theory via a behavioural approach. Gwynne-Jones was writing in Eysencks influential

Handbook of Abnormal Psychology (1960) which paved the way for the popularity of the behavioural treatments.

Van der Hout and Merckelbach (1991) point out that by the end of the seventies "behaviour therapy went cognitive" due to the perceived narrowness of operant conditioning and aversion techniques for conceptualising and treating "abnormal behaviour". Behavioural interventions absorbed cognitive approaches and both behavioural and cognitive techniques are now used co-jointly in attempting to deal with eating disorders. (Notwithstanding the fact that Van den Hout and Merckelbach espouse the use of conditioned nausea when dealing with food aversions). The prominence of cognitive interventions is based on the important role given to the concepts of positive thinking, changing negative thought patterns, analysing consequences and advocating problem-solving approaches. Concepts which are enthusiastically practised (Beck, 1967; Beck and Freeman, 1990; and Ellis, 1985).

The cognitive-behavioural approach is currently the most dominant treatment intervention with the person-centred approach of Rogers (1967) often adopted in providing counselling support whilst psychoanalysis also remains popular (Garner, Fairburn and Davies 1987). The Mental Health Foundation (1999) imply the three main approaches are used when stating that the person with an eating disorder should not be judged but given love and respect as they begin the process of taking control of their lives through new ways of thinking and confidence building exercises. Grothaus (1998) identifies that medical treatment is "always warranted" in eating disorders as several complications

can be life-threatening. In cases of dehydration, renal problems, abnormal thyroid function or cardiac dysrhythmias, hospitalisation is strongly recommended. However the treatment programme is thereafter carried out on an out-patients or home visit basis. Grothaus lists the treatment approaches as psychoanalytical, cognitive-behavioural, group therapy, family therapy, support groups, education programmes, nutritional therapy and pharmacological therapy.

Garner, Garfinkel and Irvine (1986) proposed that a combination of cognitive restructuring therapy with nutritional planning achieved a balance of dealing with both the psychological and physiological problems caused by weight loss. Scheider et al (1987) proposed a cognitive-behavioural approach, which concentrated on self-efficacy programmes. Fairburn et al (1995) compared cognitive-behaviour therapy, behavioural therapy and interpersonal therapy and found that behavioural therapy was the poorest intervention. In pharmacological interventions the results are mixed. Anti-depressants are the drug of choice when dealing with bulimia nervosa (Grothaus, 1998). One advantage is its weight gaining effect yet as Glassceiling (1997) highlights there is still debate about the length of time treatment should be given and what guidelines are followed to indicate cessation of treatment. Furthermore the Harvard Mental Health Letter (1993) indicates that people with bulimia nervosa often do not follow treatment guidelines. Even when they do there is a high level of relapse once pharmacological treatment stops. The Harvard Mental Health Letter cites one study showing a third of patients who ceased taking the tricyclic antidepressant emiphramine (tofranil) relapsed within four

months. The Harvard Mental Health Letter supports the use of cognitive behavioural interventions as giving the best results whilst the use of exposure or desensitisation programmes are discouraged. The use of cognitive behavioural interventions in conjunction with group and individual therapy appears to give a result of up to two-thirds remission a year after treatment stops whilst one-third continue to exhibit "mild residual symptoms". The most difficult to treat are individuals with other mental health problems or other addictive behaviours.

Like the studies above Holyoake and Jenkins (1998) suggest that a strict behavioural approach does not work and they found cognitive behavioural interventions based on a humanistic (person-centred) approach gave better results whilst Zarb (1992) advocates cognitive-behavioural approaches when working with adolescents.

Bell (1999) points out that cognitive-behavioural therapy is the "gold standard" treatment for bulimia nervosa yet it is only effective for up to 50 percent of patients. Bell cites Fairburn et al's (1995) study and highlights the point that interpersonal therapy had the same outcome as cognitive-behavioural therapy after one year. Bells study (using cognitive analytic therapy) identified 149 problems amongst 30 clients with eating disorders (anorexia nervosa and bulimia nervosa using DSM IV, 1994). Bell concluded that individual psychotherapy is required by many individuals with eating disorders but in particular those diagnosed as anorexia nervosa and that

cognitive analytic therapy is a unique treatment which encompasses the best of cognitive-behavioural approaches and interpersonal therapy.

Kirschenbaum et al (1985) found that a behavioural programme aimed at 65 obese adults showed that after two years only 60 per cent of average weight loss had been maintained. The results are viewed as moderately favourable. Kirschenbaum et al were surprised to find that factors such as social pressure or therapeutic support were "relatively important contributors" to the behavioural programme and that weekly contact was important in maintaining weight loss. Therapists who were perceived by the clients as "democratic" were also more successful than "authoritarian" therapists. It appears that therapists who were perceived as democratic allowed the clients more choice and control and so were probably diluting the strictly behavioural approach with either person-centred and/or cognitive practices. The results support the widespread view that cognitive-behavioural therapies are currently the most effective interventions in eating disorders.

However treatment regimes cannot be underestimated in terms of rigour, longevity, complexity and patience. Grothaus (1998) makes a point of focusing on the morbidity and mortality rates amongst clients with eating disorders. In one study she cites Steinhausen et al (1991) who reports that the mortality rates found in clients with anorexia nervosa had fallen from ten per cent in the 1970s to 4.4 per cent in the 1980s. Yet up to 20 percent of the sample was expected to have a poor outcome, either dying or suffering the chronic effects of anorexia. A similar figure was presented by Patton (1988)

in the UK with mortality rates over a ten-year period being 3.3 percent in anorexia nervosa and 3.1 percent in bulimia nervosa. Grothaus (1998) in reviewing Pattons figures found that the most common cause of death was suicide and that two consistent factors were low weight at hospitalisation and repeated hospital treatments. The importance of regular, focused out-patient treatment cannot be underestimated. The central belief in current therapy that the client should be helped to control their eating disorders is easily sabotaged by the effects of the disorder itself. The Mental Health Act (1983) takes the issue of consent to treatment interventions at its most serious when confronting eating disorders. Under section 63 of the Act the consent of the patient is not required for medical treatment. It is given by, or under the supervision, of a responsible medical officer. In the case of persons with anorexia nervosa such treatment can be deemed behavioural treatment provided ethical and legal steps are taken to prevent degrading or inhumane interventions (Mental Health Act Guidance notes, Turner, 1996/7). In certain situations not only could the patient receive behavioural treatment without consent but also be force-fed. Force-feeding has to be demonstrated as a pre-requisite for the "treatment of the underlying mental disorder". The sensitivity required was summarised by Grothaus (1998) who noted that working with people experiencing eating disorders is both challenging and frustrating with unreliable outcomes and the continuous need to offer an eclectic therapeutic approach.

Whilst Grothaus was discussing the eating disorders of anorexia nervosa and bulimia nervosa her view supports those put forward by the Merck Manual

who as far back as nineteen seventy-seven suggested that obesity should be seen within a treatment framework which will last for life. The need for therapeutic support can be appreciated when the Manual states that it is "difficult for people to maintain their motivation when a rigid dietary regime seems to stretch endlessly into the future. Facing a task of this magnitude requires fortitude, dedication and motivation". Accompanying the major change in food intake is the need to increase activity. Murray and Pizzorno (1990) note that the sedentary habit of watching television is strongly linked to obesity. (There is increased intake of snack foods and a lowering of basal metabolic rate). Yet watching television is habitual and enjoyable to most people and changing viewing habits is difficult, more so when even to lose 500 calories a day requires a forty-five minute jog, a one hour tennis game or a brisk walk for one hour and fifteen minutes (Murray and Pizzorno, 1990). The Merck Manual (1977) noted that walking two and a half miles in under one hour consumes about 210 kilocalories. The obese person usually has to accumulate a loss of around 3,500 kilocalories per week. Reducing food intake and expending more energy is virtually the only therapeutic advice widely offered.

Murray and Pizzorno (1990) are not alone in stating that the stigma of obesity leads to low self-esteem, depression and comfort-eating behaviour yet there is little research into the effects of psychotherapeutic interventions. According to Murray and Pizzorno counselling is necessary to improve self-esteem (the type of counselling is not addressed) and then a change in eating behaviour "may" occur. They state that even the most perfect diet and exercise regime

will not work with a person with low self-esteem. What is interesting is the huge amount of information available regarding dieting and exercise for the obese yet there is so little information on psychotherapeutic interventions. This is in contrast to anorexia nervosa and bulimia nervosa where there is more information on psychotherapeutic interventions than on weight-gaining and weight maintaining diets. It could be assumed that the medical diagnosis of anorexia nervosa and bulimia nervosa as mental health conditions in the Diagnostic Statistical Manual IV (1994) provides a focus for mental health interventions.

It is also intriguing to note that bulimia nervosa is not found in the index of virtually every cognitive-behavioural textbook before the early seventies. After the early seventies it became a focus for psychotherapeutic interventions on a par with those used with individuals experiencing anorexia nervosa. If morbid obesity was given the same mental health diagnostic status it is probable that the balance of intervention would move more towards cognitive-behavioural and person-centred interventions. Currently expert clinicians and researchers accept that obesity is psychologically harmful yet appear to approve (by their silence alone) the stance that the individual is wholly responsible for reducing intake and being more active, a stance that would meet with disapproval if taken towards anorexia nervosa and bulimia nervosa. This is not to say that morbid obesity should be categorised as a mental health diagnosis. It is nevertheless an intriguing mental exercise when examining treatment possibilities.

Summary

In conclusion, the treatment of eating disorders can be sub-divided into the following. For anorexia nervosa cognitive-behavioural approaches with an emphasis on individual interpersonal therapies has the most success; for bulimia nervosa cognitive-behavioural approaches combined with both group and individual therapies appears the most effective interventions; for morbid obesity the emphasis is on individual motivation although person-centred counselling is indicated alongside the broadly behavioural emphasis on diet and exercise. In all eating disorders, medical interventions are necessary whenever physical complications arise. There is a trend to prescribe pharmacological interventions, mainly anti-depressants (Amphetamines have been prescribed in obesity in certain cases but it is not a widely supported intervention.) However authors such as Connors (1996) and Grothaus (1998) counsel caution whenever pharmacological intervention is required as results are mixed and in some cases contra-indicated. Psychoanalytical approaches are used with some clients experiencing anorexia nervosa or bulimia nervosa but the research results are not well documented and there are acknowledged difficulties in controlling variables.

Psychotherapeutic interventions follow trends and these can be seen over the last thirty years when examining interventions in eating disorders. The focus on psychoanalysis shifted in the late fifties and early sixties towards a rigid behavioural approach although both concentrated almost exclusively on anorexia nervosa with little mention of bulimia nervosa or obesity. The popularity of cognitive therapies in the mid-sixties meant that by the seventies

the interventions were a mixture of cognitive and behavioural therapies which concentrated on both anorexia nervosa and bulimia nervosa. The influence of the person-centred school has led in the last fifteen years to a more non-judgmental approach, less hospitalisation, more out-patient and home treatments, a drive to put the individual more in control of treatment regimes and to provide more choices on how and when treatment should be carried out. The Mental Health Act (1983) provides a statutory safety-net for medical intervention without consent.

Cognitive-behavioural therapies provide respite for up to two-thirds of individuals with bulimia nervosa, up to half of individuals with anorexia nervosa and up to a third of individuals with morbid obesity. Individual interpersonal therapy matches cognitive-behavioural figures in anorexia nervosa. Relapse rates are high for all three groups. Depression and low self esteem are shared amongst all individuals experiencing eating disorders. Suicide rate amongst bulimia nervosa appears to be around four percent whilst amongst anorexia nervosa it is around three per cent.

Despite nearly half a century of therapeutic interventions, eating disorders remain intractable and chronic conditions. Common positive themes appear to be therapies that provide a supporting environment, a sense of control, security when exploring the self, an emphasis on being in the present, positive reinforcements of alterations in both cognitive functioning and behaviour, control over the pace of therapeutic progress and the abilities of the therapist to remain consistent over a long period of time.

Such common themes are central to an existentialist approach to therapy, particularly those espoused by Yalom (1980). What existentialism provides is a more rigorous focus on these themes yet its therapeutic impact on the eating disorders has not been adequately recorded. The theoretical basis of existentialism is often interweaved with cognitive-behavioural approaches particularly when used in conjunction with interpersonal therapies but receives little acknowledgement. (For example the work of Connors (1996), Bell (1999) and Duker and Slade (1988) have recurrent existentialist themes.) Providing measurable outcomes of the merits of existentialism as a therapeutic approach towards eating disorders is the aim of this study.

EXISTENTIAL PSYCHOTHERAPY

Existential therapy grew out of three major sources and cannot therefore be traced to a particular individual or movement. The first source is the philosophical concepts espoused by Sören Kierkegaard (1944), Fredrich Nietzche (1997), Martin Heidegger (1962), John Paul Sartre (1943) and Albert Camus (1947) who in their various ways were concerned with the individuals awareness of Being and the Self's relationship with the world. The second source can be traced to the field of literature and the works of authors concerned with the sense of human existence. For example Corey (1991) cites Dostoyevski as an early existentialist influence whilst the Website Existential Resources (1998) offers Milton's Paradise Lost (1929) and Goethe's Faust (translated 1949/1959) as pre-existentialist writers. Both Camus and Sartre wrote novels and existentialists ideas are major themes for Sammuel Beckett and Harold Pinter. The third source lies in the interest shown by psychoanalysts and psychiatrists during the post-war years in the individuals perception of their own experiences. Freudian focus on narrative, symbolism and rhetoric led many psychotherapists to question psychoanalytical approaches at that time and the work of Heidegger (Trans 1962) and Sartre (1943) influenced such therapists to move away from the search for infant symbolic conflict and to concentrate instead on the meaning of existing in the present for their traumatised clients. Early influential European figures were Ludwig Binswanger (1975) and Medard Boss (1963) (both leaned heavily on psychoanalysis and Heidegger's phenomenological approach) and Victor Frankl (1963) (who was a student of Freuds and adopted many of Nietzches'

and Sartres' ideas). The work of Erich Fromn (1994) continues to be influential in both Europe and the United States of America but the major American figures are Rollo May (1953) and Irvin Yalom (1980). May pays frequent tributes to the work of Boss and Binswanger and bases his existentialist work on Heideggers' philosophy. Yalom however whilst assimilating Heidegger prefers to espouse Nietzche's and Sartres' philosophies and is less influenced by Binswanger and Boss.

Existentialists share a wariness for determinist thinking and are predominantly concerned with the sense of control and choice that individual's perceive they have in their daily life; with personal responsibility, with social inclusion, with love and with the sense of meaningful and authentic existence. Consequently concepts such as self-awareness, meaninglessness, isolation, guilt, regret and death are explored and findings published from the particular vantage point of the writer (Philosopher, or author, or therapist).

Such a panoramic view of the individual allows widespread inclusion of many theoretical, philosophical and creative minds whilst simultaneously disseminating different interpretations of existentialism, some of which misunderstand the central concerns of the existentialist, namely meaningness, love and purpose in the present time. For example the influence of Hegels dialecticism influenced existentialist thinking towards thesis and anti-thesis, hence the interest in opposing concepts for many writers. Fromm (1956) is interested in love for example and he makes comparison with emotional needs and desires and their effects on the non-attainment of love. Fromm (1974) also

wrote about freedom to give meaning to existence by exploring mans capacity to destroy. Camus (1947) wrote about the importance of self-awareness regarding love and reason by pointing out the irrationality of war. Yalom (1980) writes about hope, meaning and responsibility through a dialectical discussion on anxiety, isolation, meaninglessness and death. Sttettbacher (1991) concentrated on the importance of parental love by asking if parents are motivated to have children not by love and security in a relationship but by egotism alone.

This is an important point for the understanding of existentialism. The fact that concepts of hope, love, meaning and so on are provided through examples of how opposite concepts (despair, fear, superficiality) has an effect is a dialectical device for presentation and not an indication of the writers philosophy. Such a misunderstanding is easily made. Sproul (1999) for instance states that "existentialism tends to see man in a mood or an atmosphere of despair" and provides Sartre (1943) and Camus (1947) as examples of pessimism and individualism, missing the facts that both had fought for the French Resistance and secondly both saw humour in the contradictions of modern living. Camus made the point using an aphorism that death renders life meaningless but living is meaningful www.existentialists, 1998.

Yalom (1980) with more understanding suggests that (postwar European) existentialism emphasises human limitations and the tragedy of a human existence. This has to accept the anxiety of uncertainty, isolation and

apartness and that this emphasis was due to the personal experiences of war which the authors had survived. (As mentioned above Camus fought (as did Sartre) in the French Resistence but he had also lost his father Lucien who was killed in the Battle of Marne in the first World War). American existentialism is based on humanistic psychologists who emphasised interaction with others, the potential for self-realisation and the encouragement of self-awareness. This more optimistic approach has become the dominant model in modern existential therapy.

The work of post-modernist deconstructionists has also led to the misunderstanding of existentialist concepts. Foucalts' (1971 and 1978) and Kristevas' (1982 and 1991) work in semiotics and symbolism has existential strands but similar to Lacan's writings, (in Owen 1993) although influenced by Hegel, belong firmly in the tradition of modern psychoanalysis with its emphasis on discourse and narrative analysis (Wright, 1982; Kohut, 1978). Young (1988) was influenced by Freud, Marx and Darwin, yet displays existentialist concepts in his deep interest in human nature. There is further ambiguity when influential thinkers and popular therapists such as Maslow (1970) and Rogers (1967) are labelled humanistic when they work from an existentialist perspective. Rogers for instance takes a similar view to Laing (1967) by noting that a psychologically "free" person is "completely engaged in the process of being and becoming himself....is soundly and realistically social; he lives more completely in this moment, but learns that this is the soundest living for all time" (Rogers 1967 page 192). Laing's (1960) views on therapeutic interventions also involves existentialist concepts of Self and

Experience yet he is often labelled as anti-psychiatry, a term he did not use when referring to himself.

As a term "existentialism" has come to mean different things to different people and consequently has been criticised for lacking rigour and a singular focus.

Corey (1991) notes that because exitentialism in therapy is not based on a determinist structure it is viewed by critics as an anti-science fashion with poor use of operational concepts and testable hypothesis. Yet Heaton (1997) claims that one of the attractions for the therapists is precisely because existentialism is not a "psychological school of therapy founded by a charismatic leader who claims to have discovered some truth with profound therapeutic implications to humanity". (page 68). The philosophical basis of existential therapy accepts that the individuals experience is profoundly complex and cannot be reduced to simple theories, general rules and therapeutic techniques. Corey (1991) suggests that existential therapy can be viewed as an intellectual approach to therapeutic practice or a philosophy that a therapist may personally follow. (My underlining). The medical model of care cannot be assimilated into existential therapy because in existentialism the individual is not seen as sick but as unable to make a choice or to take control of the circumstances in their lives. These are recurrent themes in case studies involving eating disorders.

Yalom (1980) states that it is not techniques or a set of rules that is the focus of existentialist therapy but rather the focus is on helping the individual cope with and understand feelings of alienation, meaningless and isolation. May (1953) defined an existentialist approach as an attempt to understand the person by seeing the individual's experiences as those which are real to the person irrespective of objective attempts to provide the experience with a finite set of properties. In Kirkegaardian terms the beliefs of the individual may verge on superstition, or magic (as in addictive gambling, religious faith or obsessive compulsive disorders) and cannot be influenced by reason or rational thinking unless the individual wants to be influenced. The theories of science can be absorbed into existentialism thinking but because of its stress on individual perceptions, existentialism is too large to be absorbed into empiricism.

Cohn (1997) discusses Heidegger's reference to the human being as "Dasein"; (Being there) to suggest that the individual is existing in an empirical world which can be objectively measured and simultaneously existing in the sense made of that empirical world. Yalom (1980) adds that every individual constitutes their own world and any attempt to study human beings with a generalised measuring tool "as though they inhabited the same objective world is to introduce monumental error into ones' observations" (Page 23).

Meaning for the individual is never caused by events but is created by the individuals perception of events and whilst there will be shared experiences leading to similar meanings it is the uniqueness of the individuals perception

that is retained and explored by the existentialist therapist. For the clients with eating disorders there may be similarities of experience but their uniqueness leads to a deeper exploration of their own perception of the experience of eating. This may explain Bell's (1999) findings that a mixture of individual and group therapy is helpful to the client with bulimia nervosa.

Strasser and Strasser (1997) quote May (1983) as stating that the three main sources of existentialism; literature, psychology and philosophy, all try to analyse the human being as existing in a unique world which is shared by other human beings. Strasser and Strasser go on to state that phenomenological philosophy and existential philosophy are linked but they are not the same. For instance Husserl (1977) pointed out that phenomenology is concerned with the individuals subjective interpretation of experience and the relationship between the interpretation and the individuals approach to others as well as the relationship between interpretation and sense of being. The use of subjective investigation by the phenomenologist can lead to an understanding of such relationships.

Despite the philosophical differences, Strasser and Strasser (1997) state that as the existential therapist aims to analyse the individuals existence in the here-and-now then the use of a phenomenological investigation is the most appropriate tool during the assessment process. Cohn (1997) however suggests that Husserl's views on subjective awareness begins to create an imbalance between Heideggarian Dasein so that there is less weight given to the interaction between an individual in the world and more weight given to

the subjective sense of the world. The therapist and client are then both influenced by their past experiences which can become the difference between them and lead to a loss of focus on their interaction. This begins to drift away from existentialism which relies heavily on the simultaneous relationship between objective interaction and the interpretation of the interaction. Neither can exist without the other and neither can be considered more important than the other. As Cohn (1997) states more eloquently "interaction is inevitable and detachment impossible". This is important when considering the existentialist approach to eating disorders as the sense of numbness that individuals describe may be an attempt to detach themselves from the objective world. But that very sense of detachment is achieved through interaction with the world. (Overeating, bingeing or refusal to eat). There is a tension between the interaction required to reach detachment and the interaction of others who try to prevent the detachment. The therapists attempts to help the client reduce the tension between interaction and detachment by concentrating on the individuals sense of being, on the ability to choose and control behaviours which in turn allows the development of meaning, inclusion and purpose, with less self-harmful behaviours.

The concept of tension or anxiety is central to existential therapy. Kierkegaard (1944), Heidegger (1962), Sartre (1943), May (1961) and Yalom (1980) all give considerable importance to the role of anxiety or angst as a fundamental aspect of human existence. The anxiety discussed by phenomenologists and existentialists is not the psychological concept of fear or its physiological manifestations. The angst is the unsettled feeling

experienced by the individual who is aware of their self in the world. It is the realisation that consciousness of self is accompanied by the awareness of self's fragility in the objective world; the sense of finiteness and the end of self through ones death. Angst can therefore help the individual to find meaning and purpose in existence or drive the individual towards objectives in an attempt to detach themselves from feelings of Angst. This is only possible by the cessation of awareness of Self in the world. Van Deurzen-Smith (1988) suggests that anxiety can only be temporarily forgotten if the individual exists in "a mindless way", if the individual pretends that there is nothing that can be done about their lives, that they are as they are and therefore no point in choosing a different way of living. As soon as the world imposes choices on them the existential anxieties return. The drive to lessen anxieties in living which is experienced by the person with eating disorders is made more powerful by external factors and by individuals who are perceived as manipulating them to engage in a world with which they receive little hope or meaning. The individual experiencing anorexia nervosa, bulimia nervosa or morbid obesity is deeply immersed in their own Angst and highly sensitive to the objective world. A recurring theme amongst clients with eating disorders is their high level of awareness of others. One option to be relieved of their physical and emotional awareness is to be free to engage in activities which leads to numbness and detachment. At least for a short while. The price for such strength of will, stubbornness and repeated self-harming behaviour is social, physical and psychological damage to the Self.

Van Deurzen-Smith (1988) points out that for the therapeutic approach to be effective the therapist should be experienced and creative. This is not because an eclectic therapeutic approach using a variety of psychotherapeutic techniques would thereby be more readily available but precisely because the therapist is experienced enough to be confident in existentialism. The therapeutic structures proposed by cognitive-behavioural proponents is opposite to the existentialist structure. Van Deurzen-Smith suggests that the many psychotherapeutic approaches are reductionist in practice and lack philosophical rigour. In an attempt to be as professionally flexible as possible inexperienced therapists are offering as many therapeutic "techniques, tricks and gimmicks" as they learnt in their training and development. The fact that the techniques sometimes have differing ideological and philosophical principles is more harmful to the client. Van Deurzen-Smith takes the view that cognitive-behavioural practices achieves the best results when the client acknowledges the assumptions that individuals learn to think and behave in measurable patterns and therefore can relearn new patterns. Interpersonal counselling in turn achieves the best results if clients accept that expressing their feelings and being active in exploring such feelings is beneficial. This may explain the differing therapeutic results achieved when using cognitive-behavioural and interpersonal approaches in eating disorders. As Connors (1996), Hsu (1990), Bruch (1985) and Stein et al (1994) noted, there is often a background of dysfunctional family interaction with individuals experiencing eating disorders and the ability to express themselves emotionally is either underdeveloped or repressed. The existential anxieties raised in interpersonal therapy when feelings are expected to be expressed may be dealt with by

avoidance of the therapy itself. Garner et al (1986) and Fairburn et al (1989) both found that individuals with bulimia nervosa had a tendency to drop out of group therapy.

Van Deurzen-Smith (1988) also suggests that the eclectic approach can be confusing for the client. Allowing the client to divulge thoughts and feelings in an attempt to bolster self-determination on the one hand and then leading the direction of behaviours to be taken outside the therapy on the other are opposing principles. The person-centred view is that the expression of emotions assumes a "healing" process whereas the cognitive-behavioural view assumes that reason, rationality and control are the most appropriate means to develop maturation. Duerzen-Smith does not advocate that such therapeutic approaches are intrinsically wrong but that the inexperienced therapists who choose an eclectic approach may themselves lack the therapeutic skills to make eclecticism effective. The eclectic approach does work when the therapist is experienced and has the creative skills to balance the different approaches and principles so that the therapeutic practice is synthesised into a consistent and coherent pattern. The same point is made about the existential therapist. If the therapist is to be effective then philosophical issues regarding their own sense of Being, purpose and meaning need to be addressed. The existentialist therapist needs at all times to be aware of their own and the clients Dasein and Angst as they share, for a while, the same external world. However the interpretation of what is actually going on in therapy will be different for both the client and therapist.

The existential anxieties of the clients require reassurances by the therapeutic application of a consistent framework of reference regarding meaningness, choice, inclusion and self-hood. Van Deurzen-Smith identifies four goals for existential therapy; to encourage the client to become authentic, to help the client understand their own internal interpretations and value systems applied to the objective world; to build up confidence in the clients own interpretation of the world, and to explore with the client their priorities to give meaning, purpose and new directions for living. The consistency of the therapists own existential awareness is crucial if the four goals are to be achieved.

Strasser and Strasser (1997) advocate Van Deurzen-Smith's four goals and also suggest that clients should be helped to realise the limitations placed on them by the external world and to differentiate limitations imposed by their own interpretation of the world. Strasser and Strasser are interested in the limitations that time itself imposes on the therapeutic process and suggest that time should therefore be a practical tool for precipitating faster emotional responses from both the client and the therapist. Strasser and Strasser take the phenomenological view of Husserl (1977) that the therapists should attempt to suspend preconceived concepts of the therapeutic situation so that when an assessment is carried out with each new client the clients own world view of their own unique situation is gleaned first. The information gained is then compared with the therapists original first impressions and in this way the therapists own prejudices or bias can be internally explored. Spinelli (1989) following earlier phenomenologists called this bracketing. By further limiting the length of therapy the initial urge of many therapists to be seen as the

helping expert is suspended. They simply do not have the luxury of time to explore this issue and need to work on the immediate relationship with the client because the client is interpreting the Angst caused by the limitations of therapeutic time.

Strasser and Strasser base their existential approach on the work of Spinelli (who wrote the introduction to their book). In particular Spinelli's (1989) phenomenological view that true reality will always be beyond the grasp of humans because individuals construct meaning on the experience of reality and this in itself is constrained by the innate, organic capacity to develop meaning. Time can therefore be viewed differently at different times. Strasser and Strasser (1997) point out that, externally and objectively, time passes on a measurably fixed framework yet an individual with depression views time as passing very slowly whilst in another mood state time may pass very quickly. Restricting the number of therapeutic sessions to twelve sessions (with two follow-up sessions at six and twelve weeks) is an attempt to use the internal interpretation of time as a tool to awaken existential anxieties quickly through goal setting priorities. The restricted number of therapeutic sessions limit the chances of client dependancy and allows exploration of repressed or dissociated emotions which rise to the fore at a faster rate. This in turn enables the therapeutic sessions to focus on Van Deurzen-Smith's (1988) four therapeutic goals.

Van Deurzen-Smith believes that the first session is one of the most important therapeutic sessions and lends weight to the therapeutic process outlined by Strasser and Strasser. Van Deurzen-Smith states that it is in the first

assessment session that opportunities exist for the therapist to outline to the client the existentialist goals. In this session is raised the fact that existentialist therapy will not attempt to change or cure the presenting condition or even "make life any easier, although it may make it easier to live" (Existentialist Counselling in Practice, Page 38). During the first session there is also an opportunity to assess the clients demonstration of coping mechanisms in an anxiety-provoking situation. The way physical and psychological anxiety is presented in the first session may indicate the methods that the client chooses to deal with existential anxiety itself. Talking too quickly, rushing to put their views across, not talking at all, waiting for the therapist to lead the discussions are examples given by Van Deurzen-Smith as methods the individual uses when dealing with living itself.

Corey (1991) points out that the very fact that individuals are referred for therapy is because there is a discrepancy between coping with anxiety and existential angst. May (1981) reinforces the view that the therapist is not there to cure. Instead the therapist facilitates the fear-provoking process towards authenticity so that the essence of the awareness of their life leads to a different way of dealing with anxiety itself. This awareness of the freedom to choose and for taking responsibility for what they are like in life (or what they could become in life) gives a sense of purpose and meaning to existence which, whilst in itself anxiety-provoking, reduces the discrepancy between coping with anxiety and angst.

The anxieties induced by the therapeutic process is further reduced by the therapist being there with the client. Corey (1991) provides examples to indicate how therapists become so involved in the technique of therapy that they fail to engage in the clients anxieties of actually attending therapy itself. This distances the relationship between therapist and client because the therapist is not making an attempt to understand the clients internal interpretation of the therapeutic relationship. Van Deurzen-Smith (1988) stresses its professional boundaries but, like Yalom (1980), argues that the therapist must relate deeply with the client in order that the client can feel sufficiently confident in the relationship to engage in their problems and explore new ways of coping. The therapist can incorporate cognitive-behavioural techniques, psychoanalytical concepts or person-centred strategies but like Van Deurzen-Smith (1988), Corey (1991) does not believe existentialist therapy is eclectic in the sense that the eclectic therapist applies what works outside a philosophical vacuum. Corey states that there are three phases in existential counselling. The first phase explores the clients assumptions about the world and their sense of existence within it. The second phase encourages the client to examine the source of their internal value system and restructure existing interpretations of the relationship between the external world and their values. The final phase assists the clients to apply new interpretations of values and beliefs into practice by engaging with the external world. Techniques which help the clients gain self-awareness and responsibility for the outcomes of their own choices are therefore implemented in existentialist therapy.

Cohn (1997) dislikes the term assessment in existentialist therapy as it implies objectivity whereas the initial session should be free of previous bias and suggests that Spinelli's (1989) "bracketing" approach is more appropriate followed by evaluating the anxieties demonstrated by the client as well as examining what is shown in the session itself before finally avoiding the temptation to prioritise the clients presentations at the first session. The focus of all subsequent sessions should always be within the framework of Heideggerian relatedness with the client; in other words the therapist is conscious that both the therapist and client are sharing the same external world whilst retaining their subjective interpretations. This awareness is particularly arduous in group work where there are several people sharing of the same external existence (in terms of time, objects and environment) but with several different internal interpretations.

Another approach is advocated by Stettbacher (1991) who is concerned with primal feelings in the young and their effects on the development of loving relationships. He proposes four steps in therapy which develop the sense of Being and responsibility. The first step concentrates on what is being sensed or perceived by the client; the second step explores the meaning of feelings and their effects on the individual; whilst the third step encourages critical reflection in an attempt to understand the relationship between perceptions, feelings and reactions. The final step examines what Stettbacher calls demands and is concerned with almost Fromm-like differentiation between wants and needs, not wanting and not needing. The four steps can move forwards or backwards over many years. Stettbachers approach is a useful

method of therapy with clients who have chronic, long-term problems and who would not benefit from the time-limited therapies espoused in Strasser and Strasser's (1997) approach.

Duker and Slade (1988) are concerned with the sense of "limbo" and "nothingness" expressed by individuals experiencing eating disorders and also offer four phases in the therapeutic process. They argue that the sense of frustration and anxiety experienced by individuals diagnosed with anorexia nervosa or bulimia nervosa leads to a fragmentation of the sense of Self because the Self is constructed upon food and body control. Any attempt to reconstruct the sense of Being by the use of cognitive-behavioural approaches, assertive training, group therapy and so on will inevitably lead to a deeper sense of fragmentation because the sense of who they are in the world, without the control of food or the control over their bodies, lacks any valuable meaning.

Duker and Slade express little faith in such approaches unless they are within a philosophical framework and centre on philosophical goals. They argue that an eclectic approach aimed at enhancing the existing Self is unhelpful and suggest that the client should explore the possibilities of acquiring a new Self-hood. The first phase concentrates on helping the client to define the Self and to explore the steps the client takes towards choice and decision-making, whilst the second phase builds up the clients self-esteem. The third phase is critical, as it concentrates on the awareness of the present and the process of living in the here and now. The importance of this phase is based on the

reflective process when the opportunities for the development of the new Self can be held back by the existential anxieties of living with the responsibility of freedom. The final phase explores the clients new external subjective rules and belief systems. Duker and Slade go on to offer measurable outcomes of the process as an increase in Average Expected Body Weight and client feedback that the sense of "Nothingness" in their lives has diminished.

Like Van Deurzen-Smith (1988), Corey (1991), Yalom (1980) and May (1981) Duker and Slade point out that the change towards an existentialist awareness will not cure or make life any easier. Clients who begin to control their eating habits can be confronted with a sense of aloneness for instance and the sensation of being solitary in a shared world can lead to attempts to suppress such feelings by returning to past eating habits.

Hall (1999) gives a view of the processes that therapists may experience as they explore their own interpretation of existence within therapy. Hall explores the concept of Truth within the practice of counselling and everyday living and highlights the importance of finding time for reflection so that personal perceptions can be viewed with more clarity. Hall employs the use of the Four Noble Truths of Buddhism (suffering, the origin of suffering, the cessation of suffering and the path which led to the cessation of suffering) to illuminate his personal progress and whilst spiritual in content the work exemplifies the process of subjective interpretation. Hall notes for instance that therapists may practice therapy because of their own struggle with suffering. The practice of therapy provides both a deep source of knowledge

of suffering itself and the realisation that sharing the objective world with clients who have experienced worse suffering does not mitigate the sense of suffering felt by the therapist. Hall goes on to state that his personal sense of suffering "was the thoughts, fears and anxieties that went endlessly round in my head which constituted the source of suffering and <u>not</u> the events in themselves" (My underlining) (Page 308). This agrees with the observation of Yalom (1980) who stated that meaning is never caused by events but is created by the individual. Hall (1999) goes on to describe the part reflection plays when the therapist encourages clients to perceive that they are capable of change and even when they are in the state of suffering they are changing. This sense of change is important in therapy as like Cohn (1997), and Strasser and Strasser (1997), Hall notes that therapists quickly ascribe diagnostic labels on clients and he provides a view close to Spinelli (1989) that "bracketing" (putting aside preconceived labels and predictions about the client) is necessary to prevent change stagnating. Hall is particularly interesting with his views of "no self". These are very close to the Heideggerian Dasein (Being There) and according to Hall involves a spiritual process of reflection via such methods as meditation, chanting, yoga, and hypnosis. This is not to detach from the Self (the numbness/nothingness) but to provide clarity in seeing the Self. Hall also suggests that when there is interaction with a client to the extent that the therapist is totally concentrating on the clients issues and the clients own interpretation of experience there is an awareness of loss of Self; the "no-self". A state that May (1981) and Yalom (1980) believe is essential in existential therapy. And like Heidegger (1962), Kierkegaard (1944), Sartre (1943) and Camus (1947), Hall takes a European existentialist

view that the process of facilitating profound changes in the individual does not offer cure or happiness and that suffering is an important concept in itself. His views that suffering lies in the absence of the awareness of the here-and-now and that there is insight in understanding that all life is suffering, provides a framework with which to grasp the impact of Angst upon the practising therapist.

Yalom (1980), like Hall, believes that there are many methods of assessing inner conflict. Yalom talks of "deep reflection, dreams, nightmares, flashes of profound experience and insight" (Page 7) and that clients are "tormented by choice....." a therapist must catalyze a patient's will to act, and that the majority of patients are bedevilled by a lack of meaning in their lives" (Page 5). Yalom offers Bugentals (1963) view that Existentialism is anti-determinism and has its therapeutic focus on freedom, choice, purpose, values, responsibility and the dedication to appreciating the unique experiential world of the individual. (Bugental was then President of the American Association of Humanistic Psychology).

Yalom concentrates on four major ultimate existential concerns as the focus of therapy. These being death, freedom, isolation and meaningless. Death refers to the existential awareness of finiteness and the conflict which arises between the awareness of the inevitability of death and the desire to continue to Be. Freedom explores the anxieties caused by the internal confrontation between the individuals sense of "groundlessness" and the desire for rules and structure which would allow more control of the individuals own world and the actions

within it. Isolation explores the existentialist conflict arising from the awareness that Daseing means individuals share an objective world (and interacts with objects and others in the world) and simultaneously hold an absolutely unique perception of the world. This existential isolation prevents gratification of the desire to have contact with, and protection from, others in the shared world. Meaningless begins from the premise that all individuals construct their own meaning to life. Yalom suggests that all conflict arises from the tension between the yearning for structure and meaning in the objective universe that in itself has no meaning. The truth, if it externally exists, is distorted by each individuals subjective interpretation. Yalom proposes that strategies such as Rogers' (1969) humanistic approach to active listening, genuineness and sensitivity to the clients overall direction in life are influential in the process of therapy. Frankls (1969) logotherapy and engagement techniques are also useful, particularly when dealing with meaningless in the clients life. For Yalom ultimately the techniques are secondary to the fundamental engagement with the existential concerns of death, freedom, isolation and meaningless.

Malson (1998) offers an insight into the conflict that Yalom defines when discussing existential isolation in her interviews with women experiencing anorexia nervosa. Although Malson takes a feminist, post-structuralist view of anorexia nervosa, her study is of interest from an existential perspective. Malsons suggest that the sense of cartesian dualism is acutely experienced by women in her study. Taking Bruchs (1973) view that the poor self-image and low self-esteem leads to a "lack of sense of self" (Page 159) Malson argues

that anorexic practices are simultaneously a method of constructing self-identity and self-destruction. The body is separated from the mind. The sense of Self is disembodied from the body which is constructed as unruly, weak and threatening to the Self. Malson is not an existentialist and presents a discourse of Cartesian dualism to strengthen her main points. Nevertheless, she would be supported by existentialists such as Cohn (1997) and Van Deurzen-Smith (1988) in her presentation of dissociation expressed by women experiencing amenorrhea. Malson is particularly acute in highlighting the attempts by women engaged in anorectic behaviours to be "empty" and manipulate the self to be "identity-less". Whereas Hall (1999) views no-self as a positive process the attempts by individuals with eating disorders to detach themselves from engagement with the world is ultimately self-destructive. Hall would argue that over-involvement with the self results in a detachment from engagement with the world. Having an understanding of no-self in the Buddhist sense allows the world and other people to flood in. In anorexia nervosa there is not only existential isolation for the individual in the world but also a tension internally between the isolation of the mind in the body.

This is similar to Duker and Slades (1988) fragmentation theory for both anorexia nervosa and bulimia nervosa and could possibly be a source of tension between the sense of mind and body in the morbidly obese. Frömm (1974) for instance suggests that compulsive eating is not motivated by physiological hunger but by emotional "feeling of being depressed, anxious, "empty". (Page 113). The act of overeating is an attempt to escape from a depressed mood and a symbolic act to fill an "inner void". This view is

supported by Babiker and Arnold (1997) who suggest that extreme obesity should be viewed as self-harming behaviour and particularly for women as a form of rebellion against traditional feminine emotional responses. Babiker and Arnold also suggest that anorectic or bulimic behaviour may be strategies adopted by the individual to manipulate the body to be more socially acceptable. This is not a simplistic device to be liked but rooted in deep, complex feelings of unrelieved needs to be wanted and feel protected by others. This is similar to Yalom's (1980) existential isolation.

Like Malson (1998), Babiker and Arnold found that dissociation between mind and body occurs in self-harming behaviours. They argue that the individuals attack upon their own bodies demonstrates significant feeling towards the body as other. The person who "loathes and rejects their own body ..... seeing it as alien or other", is far more likely to feel willing, or even compelled, to injure or "punish" that body, or misuse it or treat it disrespectfully". (Page 68). Interestingly Babiker and Arnold also point out that whilst many individuals cope with traumatic experiences by numbing themselves, others regain sensations of "being alive real and present" through self-injury (Page 71). They also found that individuals gained a great deal of control when engaged in self-harming behaviours.

For Babiker and Arnold self-injurious behaviour are related to autonomy and control of "self"; to coping strategies, to self-destruction through sacrifice, to re-enactment, to interpersonal meanings and to the process of relationships.

Therapeutic interventions are primarily person-centred and appear to have a strong existentialist theme. For instance the "prejudices, beliefs and idealistic opinions of the therapist influence the outcome more strongly than the techniques applied" (page 29) is similar to the views of Cohn (1997), Strasser and Strasser (1997) and Yalom (1980). Babiker and Arnold also reject the concepts of illness and therapeutic interference and believe like May (1981) and Yalom (1980) and other existentialists that the foundation of the therapists work is "being there" for the benefit of the client.

Summary

In conclusion it appears that the experiences of individuals with eating disorders involve profound phenomenological and existential issues. The theories proposed within the philosophies of phenomenology and existentialism appear to support the empirical findings of clinicians and therapists working with individuals experiencing disorders. What has been lacking is its widespread use in therapeutic practice as a disciplined approach. Many therapists, (particularly person-centred therapists) hold a similar philosophical position or practice therapy with existential objectives without fully realising it. Some reject existentialism due to its many influences and too broad a base. Others reject existentialism because of its refusal to accept empirical reductionism. Yet the therapy is disciplined, focused and objective and can be applied in controlled settings.

The four concerns of Yalom (1980) and the opportunity to apply different therapeutic techniques within a formal underlying belief could be appropriate in engaging with individuals experiencing eating disorders. Yet the use of

existential therapy with its phenomenological philosophy has not been adequately evaluated as an intervention in eating disorders (although practising psychotherapists and clinicians such as Babiker and Arnold, 1997; Connors, 1996; and Grothaus 1998 apply certain existential themes).

The four concerns identified by Yalom (1980) are used for the thematic analysis of the impact of existentialist therapy within this study. The use of individual and group work concentrating on the three disorders labelled anorexia nervosa, bulimia nervosa and morbid obesity are also evaluated. The group work was based on time-limited therapy espoused by Strasser and Strasser (1997) in an attempt to evaluate whether clients were motivated by anxieties to present their concerns more readily than in the form of longer-term or maintenance therapy. Outcomes with all clients were measured in changes in Expected Average Body Weight, self-disclosure and external verification of progress towards Yaloms four concerns.

RESEARCH METHODOLOGY AND PROCEDURE

Introduction

An intriguing aspect of attempting to measure the effects of existential therapy is the existential insistence that an empirical reductionist approach does not fully acknowledge the interactive process. As each individual uniquely interprets their perception of the objective world it is not possible to measure that interpretation. The researcher in effect interprets the interpretation.

Strasser and Strasser (1997) and Cohn (1997) suggest that Husserls (1977) phenomenological approach does lend rigour to an existentialist approach in therapy. A common approach by virtually all the existential therapists is to present case studies, snap-shots of verbal interactions or discourse analysis to highlight a particular point (see for instance, Yalom, 1980; Van Deurzen-Smith, 1988; Strasser and Strasser, 1997; and Corey, 1991). It does seem possible therefore to implement an objective approach to collecting data.

However consideration has to be shown to the debate within psychotherapy and psychology on the reliability and validity of a method which is outside the logical positivist structures imposed by the traditional quantitative method. This debate is not centred on the desirability of using an existentialist approach but on the merits of a qualitative research method compared to the quantitative approach.

Craig (1996), writing in a special issue of Changes (the International Journal of Psychology and Psychotherapy) which discussed the tensions within qualitative research, stated that one of the strengths of the qualitative approach is its ability to provide data on the impact of certain interventions on a persons life. Analysis can be carried out on the effects for example of a particular therapeutic interventions on quality of life, both during and after the interventions. Qualitative research does challenge the more reductionist approach of positivist science although Craig acknowledges the problems presented to the orthodox approach when she discusses the inability of discourse analytical studies to be reproduced. The fact that the data is analysed from the personal perspective of the researcher and that the discourse can provide multiple perspectives provides scant comfort to the logical positivists. Yet the complex and rich data provided by such analysis allows some insight into how individuals perceive their self-hood and their interaction with the objective world and this is very useful for the existentialist researcher.

Warner (1996) continues Craigs' discussion by highlighting the accepted wisdom that quantitative data presents findings which can be reproduced, that the methodological approaches are reliable and are tested and re-tested for their validity until cause and effect are taken as objective truths. Warner argues that human behaviour and interaction is too unpredictable for logical positivism even when large numbers of people are analysed and the data subjected to statistical tests. The tension between researchers who hold the view that objectivity and facts can only be demonstrated by numerical reductionism and researchers who suggest that objectivity and facts can also

be demonstrated by verifiable interpretation of human experiences is a tension that cannot easily be resolved. Warner (1996) suggests that neither qualitative or quantitative approaches are value-free and that the tension may partly be due to the perspectives taken towards information gathering and dissemination. For example the logical positivist challenges the validity of subjective data collection and analysis often found in qualitative approaches whilst the subjective researcher challenges the interpretation of numerical analysis and the acceptance of its objective truth. Warner goes on to suggest that both camps have a point but neither side accepts the opposite argument. Only when one or both sides ceases to contradict the other and accept some of the criticism will this debate within science develop in a more constructive manner.

Jack and Clarke (1998) offer a useful response to Warner by noting how quantitative research relies on numerical data collected through a fixed positivist process related to causative relationships. Qualitative approaches however are not, (and this point appears to support Warners view that there needs to be a more constructive movement forward in the debate) opposing methodologies to logical positivism. Qualitative research is different because it focuses primarily on the individuals' or groups interpretations of their own lives. It is a process that allows an exploration of experiences, feelings and beliefs within an objective and focused framework. Whilst logical positivism has a fairly fixed research procedure with its hypothesis, manipulation of the independent variable, comparative control groups or baseline measurements and its manipulation of laboratory conditions in an orderly manner with the

aim of exploring causative relationships, the qualitative approach allows exploration via different routes. Clarke and Jack (1998) (in a separate article) concentrate on three popular routes, ethnography, ethnomethodology and phenomenology. The phenomenological route is the most appropriate for existential analysis due to its focus on the research participants own perception and interpretation of their being in and with the objective world. Whilst citing the views of several researchers Clarke and Jack provide an almost existential standpoint to the research process itself. For instance that the researcher actively attempts to gain understanding of the subjects viewpoints, that the researcher works closely with research subjects and that the researcher continuously reflects on their own interpretation of events and their effect on others. This is all carried out within a pre-planned procedure that provides a degree of objectivity to the research design. For instance the use of small groups is common because the data gathered from the research participants is rich and textured due to the data collection itself. In-depth interviews, focus group, diaries, case studies or close observation are the most appropriate because they allow the research subjects to elaborate on their subjective interpretation of experiences. Data analysis is thereafter appropriate to the data collection method.

For this study the data collection included semi-structured interviews and analysis is appropriately the grounded theory approach highlighting existential themes. Propositions and theoretical conclusions are reached following analysis of the data. Methodological issues which have been addressed include Clarke and Jacks' (1998) suggestion that reliability and validity can be

compromised when adopting such a qualitative approach. For reliability to be rigorous the data gathering and analysis has to be explicit enough to allow other researchers to undertake a similar study and importantly for readers to be made aware of how propositions and conclusions are reached. Whilst validity traditionally refers to the use of a method or tool which measures what it is suppose to measure, the existential focus on individual perception and sense of Being interacting with the world means that validity in this context is demonstrated by a logical, understandable explanation of the phenomena being studied. In this study the phenomena scrutinised is the effectiveness of existential therapy in altering the clients interpretations of their intractable eating disorders.

Data collection consists of case studies, interviews with clients and co-therapists, review reports, medical records, therapy records, post-therapy referrals, alterations in weight and changes in bingeing and/or purging frequency. Analysis adopts the grounded theory approach (Glaser and Strauss, 1967) and explores existential themes. Propositions are based on interpretations, patterns or connections, a method expounded by Seale and Barnard (1998). Carrying out a narrative analysis of over seventy-five hours of taped interviews was a daunting task and a certain degree of mental stamina was required to prevent the development of an early thematic framework which could cloud the interpretation given to transcripts heard later on in the process. Analysis using the approach of teasing out patterns after the tapes and transcriptions had been heard and read meant that when listening to the client tapes a certain amount of reliving the therapeutic process occurred. In

itself this was emotionally draining as feelings of pleasure at hearing the voices and reading the words of individuals with whom a close relationship had developed were tinged with both a sense of sadness and hope. Sadness that the cessation of the therapeutic relationship meant that we would probably not meet again and hope that their individual eating patterns now had a positive meaning within their interpretation of themselves and the external world.

Each discourse also has a unique rhythm and tone which reflects the speakers feelings and thought processes and their journey into self-exploration. These alter at different times in the therapeutic process and these different narrative events act as sign-posts towards the clients interpretation of the world. An element of fatigue therefore also lay in the concentration required in order not to miss such sign-posts and to ensure that the interpretation and propositions given to these areas were explicit and understandable to the external reader. A point supported by Clark and Jack (1998) which provides a degree of reliability and validity to qualitative research.

Research Method –Procedure

The research aim is to explore both the effects and the effectiveness of existential therapy in altering the individuals subjective interpretation of their self when they are deeply immersed in the experience of disordered eating. The grounded theory approach was chosen as the most appropriate research method because of its usefulness as a way to carry out interpretative analysis of emerging data. The analytical model is predominantly discourse analysis

and categorisation of transcription context are based on existential concepts and concerns.

Data collection included semi-structured interviews which are audio-taped and transcribed, case histories, therapeutic records, alterations in weight, alterations in the frequency of bingeing, purging and post-referral destinations and reports from co-therapists.

I carried out two therapeutic approaches; individual and group interventions. Clients diagnosed as experiencing anorexia nervosa were allocated group places alongside clients experiencing bulimia nervosa and morbid obesity. Other clients, again with any of the three eating disorders were seen individually.

The first step was to implement an Eating Disorder Clinic where existential therapy could be practiced. A proposal was submitted to one Mental Health Trust within the Region who kindly agreed to provide resources and a clinical area within a community based mental health centre. A mental health nurse therapist based in the centre was given responsibility for managing the therapeutic setting. All referrals were processed through the mental health centre and the policies, procedures and administration of the Trust were followed. Within the centre one room normally used for individual therapy was allocated to the research as was a larger group therapy room. These were pre-booked and were used for therapeutic interventions for one day every three weeks as the Eating Disorder Clinic. The Eating Disorder Clinic

Manager and existing support staff dealt with referral letters, medical records, correspondence and contact with clients and clinicians.

Whilst I carried out individual therapy alone the group setting included a co-therapist (the clinic manager who was completing her undergraduate programme in cognitive-behavioural therapy). Consequently she agreed to be interviewed twice and her transcription is included in the data analytical process.

Interview Schedule

To prevent bias all interviews were carried out by two interviewers using a semi-structured script. As the therapist and researcher I was not shown any interview transcripts, did not listen to any tapes and did not discuss the outcome of the interviews with co-therapists, clients or the two interviewers. Seventy-five hours of audio tapes and over sixty thousand words of transcripts were submitted for grounded theory analysis when the study was completed. The same procedure was carried out for other information. For instance only after the study was completed did a review of the medical notes, post-therapy destination and therapeutic progress notes take place. A formal report of the clinics work was submitted to the Mental Health Trust authorities three months after the study was completed.

The two interviewers were both Senior Lecturers from a separate School within the same University as myself. One interviewer holds a doctorate degree in phenomenological philosophy and the other holds a Masters degree

in psychoanalytical studies and is currently undertaking a doctoral thesis on therapeutic transference. Both have extensive experience in mental health care and therapeutic interventions.

Both interviewers organised the interviews separately from myself. Three clients within group sessions were interviewed twice, after two sessions of one-hour therapy and at the end of twelve one-hour sessions. Two clients seen on a one-to-one basis were interviewed three times; after two one-hour sessions, after six one-hour sessions and after nine and seventeen sessions respectively. Other clients were interviewed twice, after two sessions and thereafter between eight and twelve sessions. One client who was referred halfway through the study was interviewed twice to ascertain any short-term effects of existential therapy. One long-term client was interviewed twice during the research period.

A decision was also made to interview two past clients once only. Both clients had undergone existential therapy with myself and had not had any further therapy with me for two years and five years respectively. They acted to a certain degree as follow-on studies to ascertain what had happened since therapy. Finally the group co-therapist, who was also the Eating Disorders Clinic manager, and another therapist in the community mental health centre were interviewed twice on the same schedule as the group session. The views of one fellow therapist who saw existential therapy in action compared to the centre therapist who did not see existential therapy but had separate one-to-one sessions with a group session client was considered of interest.

The semi-structured script itself consisted of the following four questions which are designed to elucidate references to existential therapy and its major concerns.

Semi-structured script

Question 1

1a Is there any difference between the therapy experienced with Mike and the therapy you have experienced in the past?

Or

1b What have been your experiences of the therapy undertaken with Mike?

Question 2

Can you identify a specific experience in this therapy, describe it carefully and explain how it has affected your view of the world (of yourself, or of yourself in the world)?

Question 3

Before you came to see Mike what was it like to be (obese, anorexic etc)?

Question 4

How has this changed since undertaking therapy with Mike?

All interview data was stored by the interviewers until after the study was completed and the Eating Disorder Clinic formally transferred to the Mental Health NHS Trust authorities. The tapes and transcriptions were thereafter handed to myself for grounded theory analysis.

Prior to the completion of the study all clients were reviewed with the co-therapist and review letters advising post-therapy destination sent to all referral agents (GP's, Psychiatrists, etc). After the Eating Disorder Clinic had been formally transferred to Trust authorities an evaluation of therapeutic records and case notes was carried out and any information deemed of importance to the study was recorded in a separate record file and scrutinised after coding categorisation and axial analysis of transcription was completed.

Research Sample and Research Criteria

Therapeutic interventions continued with a number of clients during the study period but only a selection of clients were chosen for the research study. In order to confine the effects of existential therapy in a controlled environment a screening process was enacted for all clients referred to the Eating Disorder Clinic. Initial assessment interviews were carried out by the Eating Disorder Clinic manager and were based on an agreed selection criteria. Any client who met the criteria irrespective of any other concerns was invited to join the research study.

The selection criteria consisted of:

- Referral to the clinic via the clients GP, Psychiatrist or Mental Health clinicians
- Chronicity of condition. Identification as intractable by the referral agent
- A history of previous therapeutic support
- For clients identified as experiencing anorexia nervosa and bulimia nervosa a diagnostic criteria which met DSM IV (Diagnostic Statistical Manual, 1994)
- For clients with over-eating behaviours a classification of morbid obesity using Average Expected Body Weight.

Once a client met the above criteria and agreed to participate in the research study they were selected for group or individual therapy. The group sessions were closed and initially consisted of four individuals. One client left the

group after two sessions having gained employment which prevented attendance. Four other clients were allocated individual therapy either through a reluctance to experience group sessions or because the group sessions had commenced.

The selection criteria was very strict and therefore limited the number of clients who could be involved in the study. However the decision to concentrate on intractable, chronic conditions was deliberate. If existential interventions could be demonstrated to have some effect on the clients perception of the sense of Self when the client had experienced chronic periods with eating disorders then it may be a useful intervention in the clinical treatment itself. Another rationale lay in the issue of length of treatment. If clients had experience of past therapeutic interventions which had not worked they may be able to compare the existential intervention with other therapies and highlight differences or similarities. From an existential perspective the clients own interpretation of their different therapeutic experience gives an insight into a comparative model from a uniquely subjective interpretation. I was interested in whether shared concepts could be gained from their interpretations. This is an important point. The clients were, in many respects, "experts" in their condition. Therefore the obsessive nature of their disorder, the need for subterfuge, the constant monitoring of physical effects and the responses of other people, including the professional experts made them each a walking text. Whilst chronicity had wearied them they nevertheless held a great store of subjective perception and knowledge. I was curious to see whether these had shared viewpoints and whether they

matched the perceptions of the literature and clinicians engaged in treatment interventions.

The selection criteria stressed the long length of their experiences in order to acknowledge the known pattern of eating disorders. This being chronic, intractable, difficult to treat and complexed in its duration and effects on the individual. The clients in this study knew their condition intimately and had the experiences to evaluate its effects over a long period of time. I wondered what their stories collectively analysed could tell us about the eating disorders from their side of treatment.

After much thought a decision was taken to include morbidly obese conditions alongside the criteria of anorexia nervosa and bulimia nervosa. After all the Eating Disorder Clinic accepted clients who had problems with over-eating and high weight and my own experiences in therapeutic sessions with clients indicated that it was a chronic, intractable condition with health-threatening effects. Despite the extra problems with controlling the research method when extra potential categories are included it seemed to me the plight of the individual experiencing morbid obesity met the research aim of exploring the effectiveness of existential therapy in altering the individuals subjective interpretation of their Self when experiencing eating disorders. One client with a diagnosis of morbid obesity was therefore included in the study and three further clients experienced obsessive binge-eating and obesity. Two other clients were experiencing chronic bulimia nervosa and the remaining three,

including the two past clients, restricted their food input and experienced anorexia nervosa.

Ethical Consideration – Impact on Data Collection and Research Design

Permission to carry out the research was granted by the NHS Trust authorities following submission of objectives for the Eating Disorder Clinic and full CV and therapeutic interventions were carried out within the management system operating in the community based clinic. I had a co-therapist who was also the eating disorder clinic manager and I continued to have weekly supervision sessions from a therapeutic supervisor. Additionally my own professional code of practice was followed (United Kingdom Central Council 1992) as well as ethical guidelines for therapeutic interventions (Wing, 1991; Clarkson, 1995).

Nevertheless there were particular issues for this type of research which required consideration before the actual study commenced. These issues whilst pertinent to research design anyway preoccupied me because of the nature of the therapy and the clinical diagnosis of the clients.

Carrying out research on a sensitive subject such as eating disorders was made considerably more difficult by the research aim of gauging the responses of clients to a particular form of therapeutic interventions which was being carried out by myself. Several issues were identified as problematic before the study commenced. These included:

- The emotional and cognitive state of the participants. I did not know what effects the opportunity of further counselling after their long experiences would have on their desire to provide informed consent (Seale and Barnard, 1998). They may have wearied of therapy.

- The fact that I was the existential therapist working with clients and the study was examining the effects of this intervention. It was difficult to see where my role as therapist would not blur with that of researcher (McLeod, 1994).

- The physical effects of eating disorders on the clients. I was already familiar with the "numbness" often described by those experiencing eating disorders. There is also hypoglycaemic and hyperglycaemic effects, gastrointestinal effects, skeletomusclular effects, endocrinal effects and, often, anxiety, low mood, insomnia and general mental fatigue. I was concerned that no extra pressure was added by research activities.

- Confidentiality and anonymity. Audiotaped interviews may provide identification clues, discourse analysis may do the same thing. Medical and therapeutic notes may be accessed by people not involved in the research. Correspondence may inadvertently be reproduced revealing personal details. Sensitive material may leak into the public domain. I was well aware of the clandestine nature of eating disordered behaviour and the fear of exposure experienced by individuals who had long histories of presenting a public face.

- The voluntariness of subjects who were specifically referred to an eating disorder clinic (McLeod, 1994). Firstly how would it be possible to ensure the right to non-participation and secondly the right to terminate inclusion in the study in a manner which was both explicit and protected the confidentiality of others who had agreed to participate and were in the same group sessions.

- The prevention of digression in the therapeutic sessions from the clients concerns to the concerns I had with the study. How would I prevent myself from deliberately exploring research issues at the expense of exploring the issues which the client wanted to discuss.

- The rights of clients, co-therapists, centre staff and service managers to be adequately debriefed at the end of the study.

- The post-study referral system had to be rigorous enough to ensure where relevant, continuity of therapeutic service to clients.

- The dissemination of study findings to interested parties, especially the clients in the study and the importance of disseminating the study findings in a manner which was understandable to all parties. In other words prevent professional jargon and exclusive terminology.

Rather than have negative effects the above issues added interest to the research approach. I had been practising existential therapy since the mid

nineties and saw clients with eating disorders weekly. I had taught research studies and had supervised undergraduate and post-graduate dissertations for several years as well as carried out research in my own professional area. So I am familiar with methodological problems. But the issues above were intriguing and overcoming them whilst achieving the research aim was satisfyingly challenging and involved something I enjoyed; planning projects. I decided to take each issue in turn, and the following tactics were followed throughout the study period.

- <u>The emotional and cognitive state of the participation to provide informed consent</u>

All clients were, as mentioned earlier, assessed by the Eating Disorder Clinic manager/co-therapist to initially ascertain whether they met the selection criteria for the study. Clients who met the criteria were informed at the assessment session that a research study was being carried out during their period of therapy and that the study was investigating the therapeutic effects upon them personally. The effects would be elicited through a series of interviews, which would take place shortly after the therapy commenced and at the end of their therapeutic period. The interviews were to be carried out by researchers from a city university and would be confidential. Their written consent to take part and for their interview content to be examined by the research leader would be necessary and their confidentiality and anonymity would be maintained (see below).

The clients were requested to consider the above information for one week. If they agreed to participate then after contacting the Eating Disorder Clinic manager they were further requested to provide written confirmation. All clients agreed to participate in the study. Additional information was then sent to each client. The opportunity of meeting and discussing relevant issues of importance to clients with the interviewers were arranged. All clients were provided a twenty-minute preparatory session prior to the first interview. Clients were sent a reference sheet which included points for discussion in the preparatory session as well as a thank you letter and an approximate schedule for interview dates. The reference sheet incorporated guidelines covering confidentiality, anonymity and termination rights. Clients were also informed of their rights to be interviewed by either interviewer (one was a male, one a female) and that interview dates were negotiable. All the individuals approached agreed to participate in the study and appeared to be as curious about their experiences and therapeutic practice as I was. The perception I held that they may have become weary of therapy was not borne out in practice.

- <u>The blurring of the therapist and research role</u>

A decision was taken to form a research team consisting of myself, two interviewers and the eating disorder clinic manager and each team member allocated explicit responsibilities. These were:

As team leader I was responsible for ensuring the research study was carried out. Regular meetings were held between the research team to discuss

operational issues. (Visits to the clinic by the interviewers, private rooms to be arranged and so on.) In reality the EDC manager and the interviewers arranged such things without my involvement. I was to take no part in the data collection exercise or interview schedules. My primary task was to continue my normal therapeutic work and concentrate on the needs of clients. This was a major research stress-reducer. I could work with clients without worrying about data collection and data management. All interview content were taped and transcribed by the interviewers and it was agreed that neither the EDC manager or myself would discuss interviews or have access to the material until after the study was completed.

The EDC manager would be responsible for organising the clinical environment, resources and communication channels. As normal therapeutic practice I would complete referral acceptances, session records etc and would adhere to the community centres policies, procedures and organisational needs. The EDC manager also acted as my line manager.

As well as managing the EDC she also agreed to be a co-therapist in the group session, acted as a secondary therapist in all group sessions and completed therapeutic group records

The interviewers accepted the responsibility for data collection using the semi-structured interview technique. After a briefing session which outlined the aims of the research they collaborated on designing a semi-structured

interview schedule, organised schedules, audio-tape resources and security of data. As the therapist I was not privy to these arrangements and apart from meeting to ensure interviews were organised I had no part in the data collection period. At the end of the study all data was submitted to myself for grounded theory analysis.

The research was also submitted as doctorate study through an external (out of region) University of Nottingham. This ensured that the research process was scrutinised by my supervisor who was not involved in the research and who provided guidance regarding the design itself.

In effect the input from the research team members and my supervisor allowed me to concentrate on therapeutic interventions and cancelled out concerns about research issues encroaching into therapeutic sessions. The nature of existential therapy as Yalom (1980), Heaton (1997), Cohn (1997) and others have stressed is focused on the interpretation given to existential concerns such as love, being, inclusion, meaning and hope. Therapeutic sessions require concentration on what is being said, mental processing in order to provide an adequate response and the constant reflective awareness of the therapeutic intervention itself. Hall (1999) discusses this element of the therapeutic process and notes its effects on the therapist. Intrusive thoughts and digressing issues get in the way of concentrating on focusing on the client and their concerns. Placing such concerns within an existential framework were important elements of therapeutic work. I am grateful to my colleagues for taking on the burden of operational management and supervision for this

research study as they allowed me the freedom to continue existential therapy with clients.

- Physical effects of eating disorders and the extra burden of being research participants

The EDC manager, the two interviewers and the clients negotiated the most convenient periods to carry out the interviews and there were instances when clients were ill, had other commitments or simply forgot interview dates. Interviews were then rescheduled. However as nearly all the interviews were held during clinic days and the semi-structured technique of the interviews encouraged clients to tell their own stories there was no evidence of any additional stresses linked to the research design. As can be seen the interview consisted of open questions related to the clients own experiences and were not too dissimilar to therapeutic assessment sessions. There were no instances of self-reported or observed physical effects (either positive or negative) which could be attributed to the research design and no discernible effects on physical presentations linked to the clients disordered eating. There were effects which are attributed to the therapeutic interaction between myself and clients and these were revealed during interviews. The input from interviewers which separated my research and therapy roles was important in identifying such effects.

- Confidentiality and anonymity

All interviewees whether clients or co-therapists were given pseudonymus. Transcripts have all identifiable information blanked out. Although I believe the interviewees can identify themselves it would not be possible for individuals outside the research team or therapeutic staff to identify clients. The research team and clinical staff are subject to professional codes of conduct and are not permitted to discuss clients outside the therapeutic setting. Furthermore the two interviewers had no access to medical/therapeutic records and no details of client histories were revealed except by the clients themselves.

All therapeutic records were recorded in the medical notes, stored on clinical premises and subject to the clinics security procedures.

- The voluntariness of subjects

No client dropped out of the study. One client discontinued group therapy after two sessions and did not participate in the study as interviews had not taken place. Nevertheless the negotiations regarding interview appointments consistently reminded clients they could terminate their participation at any time whilst continuing their therapeutic sessions with myself. The fact that there was a clear distinction between data gathering and therapy reduced any anxieties on the part of both the client and myself.

Normal group session procedures were followed so in the first introductory session an agreement covering behaviour, trust, confidentiality and respect was discussed and agreed by all group members. The research study was never discussed in therapeutic sessions and group members arranged their time with the interviewers outside the group. This meant that individual group members including myself would not know who was involved in the study or who dropped out unless the individual disclosed this information.

- Contamination of therapeutic issues by research concerns

This had the potential to be a difficult area. The nature of processing data as study develops is an important element of the Grounded Theory approach. Yet I was emphatic that the individuals with whom I worked in exploring their experiences of eating disorders should have my full concentration. This was an important element of the Existentialist approach. I did not want to be preoccupied with open coding or axial categorisation whilst therapy was taking place. This was the catalyst which led to a research design incorporating separate data gathering and therapy activities. I would continue my normal therapeutic sessions and have no access to data or be involved in data gathering activities. Grounded theory analysis could still take place because the interviews and subsequent transcripts were chronologically carried out. Data consisted of sequential information. All data was securely stored by the interviewers until therapeutic sessions were completed but the study continued thereafter.

After the therapeutic sessions were completed I relinquished my role as therapist and only then was data handed over. This data included health records, referral correspondence, review reports, session records, interview audiotapes, transcripts and supervisory sessions. By working my way through this pile of information from the beginning I could process open codes, develop these into axial categories and explore their connections and patterns. I could also keep a seperate record of developing ideas and incorporate these into the propositions. The research design therefore prevented contamination of the therapeutic sessions with research concerns and upheld the principles of the grounded theory approach and existentialist therapy.

- <u>Debriefing sessions</u>

All those involved in the study were involved in debriefing sessions. Clients had individual and group sessions four months after therapy ceased. The sessions gave feedback on the study itself and discussions centred around the theoretical conclusions and their views on the findings.

Summary copies of the study were given to all participants. A workshop was held for co-therapists and service managers and a summary of the study findings discussed. A formal ritual of thanks and farewell took place although it could not adequately express my gratitude. A formal report was also submitted to senior Trust managers which incorporated a full review of the eating disorder clinic itself. The EDC was thereafter incorporated into the

mental health service and delivered by two experienced therapists employed by the Trust.

- Post-study referral

All clients referred to the eating disorder clinic were formally reviewed at the closure of the study and the following post-therapy recommendations were sent to referral agents and the EDC manager.

Client	Recommendation
Andrea	discharged and put in contact with self-help group
Beryl	referred to new Eating Disorder clinic
Chris	discharged
Dorothy	discharged – referred to marital therapist
Rachel	discharged
Fran	discharged and put in contact with self-help group
Gemma	discharged – referred to cognitive therapist for non-eating related therapy

- Dissemination of findings to study participants

Copies of the full completed study were given to all participants on request and all participants received a summary of the main findings. A summary was also sent to Trust authorities following the clinic review report. Co-therapists

and the health centre itself were given full copies and a series of workshops held for mental health staff and managers.

The two interviewers and the EDC manager/co-therapist received full copies of the dissertation and have permission to publish data which may impact on their own research activities. A series of seminars have been planned within the University focussing on the study conclusions and also on the research design and these will be delivered by the research team.

Therapeutic Interventions

Existentialism is not a haphazard philosophical approach to therapy but consists of utilising different techniques and interventions to explore what Yalom (1980) called existential concerns. These concerns centre around the individuals interpretation of their sense of Being and of being-in-the-world. Yalom in particular raises core concerns which I have applied to the subject of eating disorders. These include the individuals perception of control and choice in their lives; the meaning of being-in-the-world; their awareness of freedom in their lives and the interpretation which individuals give to social interaction and social inclusion. These appeared to be concerns that could be central to the existence of individuals experiencing eating disorders. Therapy concentrates either explicitly or implicitly on such concerns and drives the interaction and discussions taking place between therapist and client. The skill and experience of the therapist (Van Deurzen-Smith, 1988) to remain focused on existential concerns and prevent digression is also tempered continuously by the awareness of the therapeutic relationship. Attempts are made

throughout to pass power and authority back to the client. This has to be demonstrated in practice because increasing a sense of control is an existential objective.

Carrying out existential therapy with clients experiencing any of the three disordered eating diagnosis requires a major shift away from traditional approaches and can sometimes challenge existing mental health resources and interventions. The existential intervention in disordered eating does not try to change behavioural eating patterns but attempts to find out why there is engagement in disordered eating. And this exploration of cause is not to gain knowledge about disordered eating (although this occurs) but to allow the client to safely explore what disordered eating means to them as individuals. It is when clients gain insight into why they engage in disordered eating that they can begin changing their pattern of behaviour and thought process. In this technique the intervention is closer to addiction work than the more common interventions which are based on techniques used in obsessive-compulsive work.

Consequently whilst undergoing existential therapy at the Eating Disorder Clinic clients are not seen by nutritionists, dieticians, food psychologists or health promotion officials. The word "diet" is rarely uttered and clients are not instructed to carry out food related behaviours. The requirement that all clients are referred by General Practitioners, Psychiatrists or other Mental Health professions is to ensure there is always a professional approach to the health and wellbeing of clients. Clients who do not wish to eat (anorexic

behaviours) are observed and monitored continually as therapy progresses, clients who regularly purge (bulimic behaviour) are monitored but not exhorted to stop and the same applies to clients who over-eat or binge-eat or are grossly over-weight. They are not exhorted to commence a healthy eating programme such as diets. This aspect causes the most surprise to clients but is a deliberate and transparent approach which allows clients a sense of potential control of the therapeutic process. Behavioural interventions to alter present eating patterns are not therefore adopted as fundamental therapeutic principles. The objective of the existential interventions is to provide a safe environment within which clients can explore their sense of Selfhood and their relation with food and the objective world. Information about disordered eating and the negative physical and psychological effects are provided and discussed with clients when relevant. The majority of clients with chronic conditions have experience of these effects but do not always have awareness of the relation between eating/not eating and such effects. Referral by health care professionals allows fast and effective intervention to occur if such interventions are required. Every therapy session therefore commences with a general health assessment.

All clients in this study experienced intractable, chronic eating disorders. The selection criteria was chosen deliberately. If existential intervention had any impact on such individuals it may be an effective intervention alongside, or alternative to, the more common cognitive-behavioural intervention. On the other hand if existential intervention had no impact or was demonstrated to be less effective than the usual interventions then this could be more readily

shown when working with clients with long experience of therapy. Each client was approached in a similar and systematic way and experienced a similar therapeutic process. Even so each client brought their own unique interpretation to this process and no two interventions were entirely alike.

Van Deurzen-Smith (1988) discussed the eclectic techniques which therapists utilize to explore existential concerns and this approach is commonly adopted in my therapeutic intervention. However the nature of eating disorders and its effects on the individual does mean that there are distinct therapeutic phases which occur during the therapeutic relationship. These phases can be summarised as Assessment phase, Self-esteem phase, Self-assertion phase, Existential phase and Ending phase (see section 16 Open Coding). A particular interest of mine was the influence of time on these phases and whether Strasser and Strassers' (1997) ideas on time-limited therapy could be demonstrated when working with clients experiencing disordered eating patterns. Sessions were of a limited number within a fixed time period after which there was an evaluation and where relevant post-study referrals. The results were surprising.

Therapeutic work within the phases concentrated on developing an awareness of the sense of Self which could, within certain parameters, make choices about the relationship that could be taken within the individuals subjective inner world and also the interaction with the objective world. The parameters include what Heidegger (Mulhall, 1996) called "existentials" and what Cohn (1997) called "existential givens" which include circumstances and

experiences outside of the individuals control. For example where a person is born and raised, the effects of the environment, historical influences and so on.

The focus on why clients engage in disordered eating and what meaning this has for them is seen in the existentialist context as more important than encouraging changes in eating patterns. Changes may occur when the individuals understand their interpretation of disordered eating and its meaning within their lives.

The Assessment phase consists of a general physical and psychological assessment, history taking, defining ground rules, explaining the therapeutic process and informing the client that the focus is on understanding the meaning of disordered eating for them and not on implementing changes in eating patterns. As previously mentioned this is consistently observed to surprise clients, particularly if they have experienced previous therapeutic input and especially if they have had an admission as in-patients. The lack of input from eating/food/diet experts also surprises although clients can be referred to a nutritionist if they demonstrate a lack of knowledge about their eating patterns. Clients in this study had such a long history of disordered eating that they amassed a large store of food knowledge.

The Self-esteem phase concentrates on the clients sense of Self and self-image and utilises both cognitive and person-centred techniques to explore the connections between eating and their interpretation of the mind and body. Like Malson's (1998) findings the clients in this study with the diagnosis of

anorexia nervosa appeared to present a clear duality between their relationship with the mind on the one hand (their interpretation of the mind as their being) and the body on the other (their interpretation of the body as separate to their sense of being) whilst individuals who binged and purged were preoccupied with their body shape. Individuals who were obese regularly experienced feedback from other people and this impacted on their sense of social inclusion. Exploring the relationships clients have with their self-image, eating and interaction with others allows the client opportunities to reflect on the meaning of food in their lives and to identify possible causal links.

The Self-assertive phase incorporates cognitive-behavioural and client-centred techniques to encourage and reinforce decision-making strategies. The objectives are to create a safe environment which allows clients to practice hypothetical strategies for change; identify small but significant areas in their lives which the client may wish to change, support the client to implement change and help the process of change evaluation. The aim is to provide the client with a different locus of control. There is constant concentration required by the therapist to ensure that the objectives relate not only to the clients interpretations of the Selfs relationship with both the objective world and the internal subjective world but also the Selfs relationships with eating patterns.

When the client has demonstrated decision-making activities and appears less anxious when articulating views about their bodies and self-image the fourth Existential phase commences. In truth there is no clear demarcation line

between phases and clients often move between phases, sometimes act on two phases or move into the existential phase much quicker than originally anticipated. Nevertheless the phases provide a systematic approach to therapy and appear to provide a rational process for clients. For the therapist the existential concerns become the therapeutic focus irrespective of the techniques adopted and being more comfortable with the sense of Self seems a logical base from which to begin a shift in the clients locus of control (Yalom 1980). Practising and successfully achieving change appears to be a good base to begin to explore the sense of meaning, choice and control in the clients own life. This process also incorporates Duker and Slades (1990) views that the fragmented sense of Self experienced by individuals with eating disorders should not be put back together but rather a new sense of Self-hood arises out of reflection on the meaning of disordered eating in their lives. It also allows the Self to gain equity between cognitive and affective processing. As Connors (1996) points out when working with clients who have suffered abuse in early life there is often a dichotomy between the adults mental and emotional maturity. Clients often respond to interactive or anxiety-provoking situations with inappropriate behaviours and controlling food intake or deliberately over-indulging are emotional coping strategies. Allowing clients to explore the consequences of such strategies in a safe environment by initially having to confront their feelings about themselves and their bodies, then testing change strategies in real-life situations begins a process of control and responsibility.

The fourth phase utilises a Rogerian (1967) client-centred therapy, Bells' (1999) cognitive analytic therapy and Yaloms' (1980) existential therapy and concentrates on the clients interpretation of whether there is meaning to their life, their sense of Being-in-the-world (Heidegger's Dasein, 1962), the sense of control and choice in their lives (Yaloms locus of control and responsibility, 1980) its impact on their sense of Self and interaction with others (Fromm, 1956) and whether they have a sense of genuineness in their interpretation of being in the world (Heidegger, 1962).

This sense of genuineness continues to be a debatable concept for existentialists. Van Deurzen-Smith (1988) and Cohn (1997) both point out that it is used interchangeable with authenticity and can erroneously be defined as a value term. This view supports that of Heidegger's (1962) "falling" or inauthenticity which he discusses at length as a form of disengagement with the Self-in-the-world. This disengagement comprises a curiosity about the phenomenon in a person's life without reflecting on the selfs temporal time in existence. Avoiding the issue of the finite span of being in the world by constantly concentrating on for example what Fromm (1994) called the acquisition of material goods at the expense of self-knowledge creates an existential inauthenticity of living. Mulhall (1996) like Van Deurzen-Smith (1988) takes issue with those who take an interpretation of Heideggers concept of authenticity as value laden. Mulhall argues that the angst or anxieties raised by the awareness of the subjectivity of individual interpretation of the world and the encroaching moment of death can lead to a process of inauthenticity which may be required for authenticity to be fully

realised. Van Deurzen-Smith (1988) argues that authenticity and inauthenticity are processes which allow the existential self to have a relationship with the objective world. Genuiness or authenticity are concepts which refer to this dynamic process and not a static definition of the Self.

Sartre (1943) discusses the subjective interpretation of this process as "essence" and "ekstasis". Essence is defined as a persons past and it is unique to each individual. Because human living does not follow a predetermined pattern each individual develops their own essence or personal history. A sense of essence can be reached through temporal awareness (the individual has a past, present and future), reflection on the impact of the Selfs existence in the external world and the awareness that other individuals hold an unobservable interpretation of the Selfs existence whilst simultaneously the Self interprets the existence of others separate to the Self. Satre defined this as Ekstasis. Genuineness is the reflective process which explores the phenomena of essence, ekstasis and angst and the reason why it is given such prominence in the existential phase of therapeutic intervention.

For the client it is also one of the most painful and anxiety-provoking aspects of therapeutic work as the process of authenticity and search for genuineness means they cannot avoid facing existential angst and the meaning of their Self-in-the-world. In practice this creates a shift in their normal locus of control and exploration of other coping strategies apart from disordered eating. It is this phase which Duker and Slade (1988) suggested had a high failure and recidivist rate. The inability of other coping strategies and locus of control to

replace the feedback given by disordered eating coupled with lack of supportive reinforcement means it is easier to slip back into disordered eating patterns. This search for a meaningful replacement is sometimes expressed as a new found religious or spiritual interest and a belief in a supernatural support mechanism is often perceived as helpful to the client. The existential phase encourages an exploration of different coping mechanisms and respects the choice made by clients.

Therapy is finished when the Ending phase has been completed and the client is discharged. The ending phase evaluates the therapeutic process, identifies, and engages with, outstanding concerns and discusses present and future coping strategies. The temptation to continue therapeutic activity has to be resisted and the focus should remain on the clients relationship with their Self, the objective world and the interpretation given to eating patterns.

The same phases are followed in both individual and group therapy. Within groups the Assessment phase is longer as each client gives their own story in turn but the remaining phases are carried out as a group activity with the uniqueness of the individual contributing to the existential concerns for each phase.

The Grounded Theory Approach

Grounded Theory is attractive as a method from the existential perspective because of its emphasis on theory development as analysis progresses. Theory construction is an essential element of data analysis itself. Seale and Barnard

(1998) focus on the original proponents of Grounded Theory (Glaser and Strauss, 1967) and highlight Glaser and Strauss' distinction between two methodological procedures; constant comparison and theoretical sampling. Constant comparison involves identifying and clarifying concepts and connections during the period of data collection whilst theoretical sampling involves identifying what type of new data is required, identifying the area where that data may be found and then collecting the data. This research study has taken the constant comparison procedure and uses a series of stages as data analysis progresses.

The constant comparison approach is useful due to its adaptability as a tool for an existentialist approach which allows interpretations to arise as data is scrutinised. As Henwood and Pidgeon (1995) point out there are two meanings associated with Glaser and Strauss' (1967) original methodological approach. These being their ideas that theory is grounded in experience and contexts and that these theories emerge when data undergoes specific analytical processes which gives rigour and richness to data which otherwise looks subjective and poorly structured. This approach of being experience based and allowing systematic analysis is a method which permits the narrator to demonstrate their interpretation of the therapeutic process as it progresses. Henwood and Pidgeon (1995) state that qualitative data analysis using a grounded theory approach utilises both constant comparison and theoretical sampling and support Strauss and Corbin's (1990) guidance on grounded theory methodology. Initial data scrutiny generates low level categories which appear relevant overall and this stage is then followed by the identification of

patterns or connections between different categories. "Saturating" (Strauss and Corbin, 1990) the data again and constantly comparing content and abstract categories alongside theoretical sampling of new information allows the build up of emerging theories.

Seale and Barnard (1998) differentiate between the original constant comparison and theoretical sampling and go on to suggest that Strauss and Corbin (1990) elaborated on the process of abstract category relations by advocating an axial coding process which allows the researcher to carry out an intense analysis of each category in turn, comparing the relationships between categories and then forwarding propositions regarding such relationships before identifying emerging theories. Strauss and Corbin (1998), McLeod (1994) and Rennie (1990) acknowledge that axial coding can result in problems with identifying the most important phenomena and selecting categories which are less important. Strauss and Corbin (1990) are adamant that it is extremely difficult for example, to integrate two core categories into one single theory and the most appropriate approach is to choose one superior core category (indicating explicitly the rationale for such a choice) and subsume the other category within the chosen core category and then demonstrate their relationship within a single theory.

This is an important area for validity. As Henwood and Pidgeon (1995) identify, the attempt to acknowledge several layers of subjectivity, (and for the existentialist several subjective interpretation of experiences) creates difficulties with identifying the validity of the grounded theory approach.

They go on to state that validity in this area can be demonstrated if further issues, new questions or further research can arise from the theories presented at completion of data analysis. They also indicated that validity can also lie in whether the researcher is effective in persuading others in the field that the emerging theory is based on sound category coding and has some rigour.

This issue of persuasion supports Strauss and Corbin (1990) who emphasise the analytical, presentation and writing skills required in the grounded theory approach. Lincoln and Guba (1989) and Holloway and Wheeler (1996) offer the view that reliability and validity in qualitative research is further enhanced by credibility, dependability, transferability and confirmation of findings. For the existentialist researcher a further point to emphasise the validity of the method is the emphasis Strauss and Corbin (1990) put upon what they term theoretical sensitivity. They argue that the researcher is aware of preconceived assumptions and should be conscious of these factors as the process of analysis takes place. This point has already been discussed as a particular area which requires a careful approach. In this study the identifying of concepts and categories as each transcript is analysed does prevent, to some extent, preconceived assumptions or emerging ideas influencing the coding categorisation of transcripts analysed later.

The axial coding of categories and sub-categories and the approach of recording emerging ideas into a separate data file until all the concepts are coded also provides rigour to the existentialist approach. Ideas about textual content are analysed in turn and together with core categories begin the final

process of forwarding propositions and emerging theories. The theories are important validation elements in themselves. As Strauss and Corbin (1990) point out if the analysis of the data can explicitly demonstrate how a theory is reached then the theory itself provides a depth of quality to the research process.

Seale and Barnard (1998) continue this theme of quality by stating that in transcript analysis grounded theory is "a more rigorous type of qualitative analysis" (page 133). This rigour is identified in the coding categorisation, saturation, linking core categories and sub-categories and the development of theories. Seale and Barnard also support Henwood and Pidgeon's (1995) and Strauss and Corbin's (1990) views that the sheer rigour and time required for grounded theory analysis can make the approach daunting for inexperienced researchers. The processing of content, discourse, or themes into coding categories requires research knowledge about analytical models which are overlaid upon the grounded theory model. This layering is attractive from the perspective of existential interpretation of the objective world and again adds validity to the quality of the data analysis. Seale and Barnard (1998) suggest that validity and reliability can be further demonstrated if other possible sources of evidence can be assimilated into the presentation of theory. This study accordingly examines not only interview transcriptions and discourse analysis but also includes other sources of information such as review reports, medical records, alterations in body weight, frequencies of bingeing and/or self-induced purging, post-therapy referrals and the interpretations of co-therapists working in the clinical area.

In conclusion the grounded theory approach was adopted because it is sympathetic to the problems of methodology faced by an existential research design. Grounded Theory's insistence on analysing transcripts without pre-coding allows the narrator rather than the narrative to be important. The coding of concepts prior to categorising allows some defence against preconceived assumptions being applied to transcripts analysed subsequently and the return to original data to verify core categories can demonstrate interpretative processes. The filing of emerging ideas as a seperate record to coding categories provides rigour by discounting distracting data until axial categorisation is completed. The emerging ideas are then analysed, prior to presenting conclusions. The need to explicitly demonstrate credibility, dependability, conformability and the connecting principles leading to theory presentation allows the reader to apply their own perceptions and interpretations regarding reliability and validity. Of equal importance is the point that initial low level categorisation allows an analysis of data rich in content and with more breadth than would be possible with the pre-coded thematic approach.

Grounded Theory and Discourse Analysis

In this study discourse analysis was used to draw out the existential strands of the therapeutic process and some attention therefore needs to be taken to this form of analysis. McLeod and Balamoutsou (1996) for instance support the point made above that there are different types of narrative events which can be observed in the therapeutic process. These events can be categorised into frameworks which allow analysis of content, sequence, subjective

interpretation or linguistic patterns. McLeod and Balamoutsou give an overview of such frameworks citing the works of several authors including Luborsky et al (1992, 1994) and Rennie (1994). Analysing discourse via the content and structure of a client's story is a common approach. Luborsky et al (1992) suggest that stories can be placed into three elements; the storytellers goal or intention to convey a certain viewpoint; the response of others to the intentions; and the effects of such responses on the storytellers self. Luborsky et al also state that stories can be categorised into positive or negative outcomes and in a similar approach to existentialism suggest that stories change during the therapeutic process.

The difference between the existential approach and the discourse frameworks espoused by researchers such as Luborsky et al lies in the existentialist rejection of a positivist coding system which attempts to numerically connect patterns in discourse. This rejection is not adopted by existential researchers alone. McLeod and Balamoutsou (1996) also have difficulty with quantitative reductionist analysis and preference is shown to a framework espoused by Rennie (1994). This takes a humanistic approach to discourse analysis and accepts the viewpoint that subjective interpretation of events are socially constructed. Each individual narrative can therefore be interpreted differently by different readers. Existentialism goes further by pointing out that narratives from the storyteller are absorbed, interpreted and responded to by the therapist who by their response cause an interpretation and response within the narrator. The model of a narrator and interpreter is too one-sided for existentialist therapy. It is the interaction between interpretations that leads to

a narrative sequence and connective patterns. The contents of interviews in this study were analysed to evaluate the effects of the therapeutic process on the clients subjective meaning of their Self. Therefore the therapists' response to their stories and the existential focus of such responses are important conceptual categories.

Another interesting aspect of the humanistic analysis used by McLeod and Balamoutsou (1996) is their emphasis on the difference between Glaser and Strauss' grounded theory approach (1967). McLeod and Balamoutsou present a case narrative analysis of a fifty-minute single therapeutic session and stress their rejection of coding categories as an analytical model. Rather they adopt a person-centred whole narrative approach with an emphasis on interpretation by separate co-researchers with a view to either gaining a consensus of opinion or using differences in interpretation as a basis for generating deeper discussions of therapeutic perspectives. They suggest that this narrative approach differs from the grounded theory approach of Glaser and Strauss (1967) who advocated a textual analysis of thematic meanings or connections which arise from interpretative reading or listening. In other words a central tenet of Glaser and Strauss' view of acquiring new knowledge is to categorise thematic clusters as they appear and not to have identified themes prior to a research study.

McLeod and Balamoutsou recognise the difficulties of whole text analysis and in particular the dissemination of analysis which allows the reader to see how conclusions were reached. To overcome this difficulty they identified five

different narrative processes which provide the presentation format for their qualitative analysis. These narrative processes were reached after textual reading and do therefore appear similar to the grounded theory approach. McLeod and Balamoutsou's approach is appealing and presents an approach which is of interest to the existential researcher. Its main drawback lies in its emphasis on whole text analysis of single therapeutic sessions, which is not practical for studies of larger samples. Clients in this study experienced a number of sixty-minute therapeutic sessions on a one-to-one or group basis. Twenty-two interviews were carried out with clients and co-therapists by two interviewers resulting in seventy-five hours of tape, 62,918 words of transcription and after listening and reading a further forty hours of analysis to identify conclusions. Adding the hours of writing the results and disseminating the conclusions meant that the McLeod and Balamoutsou approach to narrative analysis was rejected.

Discourse analysis is an important methodology for the existential researcher and the social construct model adopted by McLeod and Balamoutsou has its supporters. Gillett (1995) pointed out the interpretation of discourse lies in the interpreters skill in understanding the social constructs and regulations within which an individual acts. For the observer to make sense of responses in certain situations there has to be an understanding of the meanings which stimulate such responses. Self-reports and narrative analysis are methods which allow a degree of understanding to take place. Nevertheless, as Gillett stresses, the narrator exists within many interpretations of the situation in which they find themselves and their stories are not isolated from other life

concerns. The narrator may be tired or sad, yet simultaneously will concentrate on a logical sequence to the narrative, respond to the interviewer, observe the environment in which all this takes place and also interpret their feelings towards the situation itself. As Yalom (1980) observed the narrative is also within emotional contexts such as anxiety or trust or hope. Gillett (1995) further states that the individual reaches conclusions which are tested and re-tested within the narrators own unique and complex interpretation. In effect there are many discourses occurring simultaneously; subjectively within the individual and explicitly shared with others.

Burman and Parker (1993) argue that social constructs do not arise in a subjective vacuum but are responses to collective interpretations of language, behaviour and shared objective experiences. They argue that the self cannot be studied outside of textual analysis and that narrative discourse provide a reproduction of the individuals self. Burman and Parker use the word "mind" which is here interpreted as meaning existential self hood. Whilst supporting discourse analysis as a more appropriate qualitative approach for research in social constructs they support the point made earlier that analysis is very labour intensive. This point is put forward to suggest by Burman and Parker that discourse analysis is more difficult than reductionist numerical analysis. They also state that like Gillett (1995) it is difficult to disentangle the different types of discourse at work.

The difference between the existential approach of viewing each individual as uniquely interpreting their own subjective reality and Burman and Parker's

social construct approach is best summed up by Gill's (1983) frustration that individual discourse analysis does not lead to an empirically based and generalised theory. For existentialists the individuals discourse does add to present theory and has importance for new knowledge. Furthermore the skill of the analyst in reproducing text and using language which allows the reader to understand how propositions were reached can easily be overlooked. The fact that the use of written interpretation can be influenced by the researchers own experience is accepted within existentialism but is seen as a methodological drawback in social construct theory. For both the existential and social construct researcher textual analysis is not value free and the writer must present findings in a manner that does not for example hint at hidden meanings. Analysis should acknowledge subjective interpretation within a focused goal. The goal should not be an ideological abstraction but one which recognises the subjective reality for the narrator no matter how banal or immaterial it appears to others. The textual analysis has to recognise the narrator and not the narration. This loss of the narrators voice for the sake of the reductionist approach was noted by Burman and Parker (1983) as not uncommon.

Fairclough (1995) takes the social construct theory further by suggesting textual analysis is the analysis of the use of language within a sociocultural practice. Taking Gillett's (1995) view of several discourse occurring simultaneously Fairclough suggests that textual analysis should be all-encompassing involving "phonological, grammatical, lexical (vocabulary) .... textual organisations in terms of exchange systems (the distribution of

speaking turns), structures of argumentation, and generic (activity type) structures" (Fairclough, 1995; page 7). Discourse analysis should also focus on both homogeneous and heterogeneous text and adopt a dialectical interpretation which takes account of the interface between individual interpretation of the text by the reader and the textual content itself. This approach by Fairclough is heavily influenced by sociocultural factors and in particular the relationship between language and power and he argues cogently for a more widespread understanding of language awareness and its use in different settings.

The issues of control and power are important for existentialists and Fairclough makes an important contribution here. As can be seen in the analysis of narratives within this study the use of power and control in an attempt to direct behaviour and attitudes towards a healthier eating pattern comprehensively fails. The existential discourse within therapy recognises the equality of subjective interpretation and language is important in conveying this point to clients. Control of progress is often taken by the client as Yalom (1980) noted and this is an area which is respected by the therapist and again conveyed through language (both verbal and non-verbal). This does not mean issues remain unchallenged. Existentialist therapy is constantly challenging to both therapist and client but the pace and speed of responses to challenges can be controlled by the client. However the use of Fairclough's model was not adopted as a method of analysis in this study due to its over-reliance on a reductionist framework and adoption of linguistic terms which may not readily be understood by a reader unschooled in a complexed, dialectical approach.

Nevertheless Fairclough's work has interesting aspects from an existential perspective, particularly the dialectical approach which Sartre (1990) and Camus (1947) adopted in a different context.

The different analytical frameworks mentioned above create several problems for existential analysis of narrative. As already discussed discourse analysis can take various forms from the quantitative reductionism (of Luborsky et al, 1992; to whole text analysis McLeod and Balamoutsou; 1996); or dialectical linguistic analysis (Fairclough's; 1995). Heenan (1996) even puts forward the view that in a psychotherapeutic setting discourse analysis and textual research may occur without firm guidelines or analytical frameworks and supports the social construct theory that multiple meanings, in psychodynamic terms, are constructed between client, therapist and sociocultural discourses. How the research is carried out or how texts are read can therefore be a matter of the researchers preference and experience.

Other researchers have also experienced analytical problems with narratives. Chinn (1996) suggested that discourses allow researchers to observe how individuals interpret and make sense of relationships. Chinn's work supports the points made earlier that different discourses occur simultaneously and was a consideration in her rejection of a pre-ordained coding system when she looked at motherhood and learning disabilities. Weil (1996) offers a reflective model of textual analysis and provides an interesting viewpoint that the internal discourses of the researcher can be presented in written form. These discourses can demonstrate a series of internal dialogues from different

perspectives, Weil calls these "multiple voices", and can be useful in presenting the interpretation of the researcher in the data collection process.

All the above approaches influenced to some degree the planning of the discourse analysis for this study. Yet each had drawbacks which made the grounded theory approach more attractive. Salm (1996) found herself in a similar position when she attempted to measure the impact which undertaking a counselling training course had on the lives of students. She was concerned that discourse analysis may emphasise the discourse process at the expense of content. Salm also raised some doubts about the lack of inter-rater reliability with the use of grounded theory and its emphasis on generating and naming categories as they arise. Similar concerns are raised by Glachan (1996) who provides a cogent summary of the different perspectives. Grounded theory for Glachan is concerned with discovering emerging theories whilst discourse analysis concentrates on the constructive and functional role of language. Both approaches acknowledge the interaction between researcher and subject and both acknowledge the importance of the personal interpretation of the researcher. Furthermore both grounded theory and discourse analysis can assimilate content analysis, a framework which quantifies verbal data (Pauli and Bray, 1996; Luborsky et al; 1992).

Dickerson (1996) and O'Callaghan (1996) writing different articles in the same issue of Counselling Psychology Review offer their interpretation of discourse analysis (Dickerson) and grounded theory (O'Callaghan). Their hesitancy can be demonstrated in the titles of their articles, Dickerson's

"Discourse analysis: a possible solution" and O'Callaghans "Grounded Theory: a potential methodology" (my underlining). Dickerson propounds the social construct theory approach as a rationale for the use of discourse analysis and stresses like Glachan (1996), the focus on language as a method of discovering the internal interpretations of interpersonal and sociocultural influences upon the individual. Dickerson points out that the textual detail could be lost in a grounded theory approach which may take a broad brush approach to narrative categorisations. O'Callaghan in turn points out that grounded theory is a continuous process which does not end when a particular area of research identifies emerging theories. These new propositions act as catalysts for further research and further knowledge acquisition in the particular area being explored.

For this study the use of an approach which clusters distinct conceptual units taken from interview transcripts and other data sources appears the more acceptable model of analysis. The continuous re-evaluation and reflection of conceptual categories allows the researcher to follow a series of transparent analytical steps which synthesise categories together into an emergent theory after identifying a series of conclusions. The facts that there are no pre-coded categories and that narrative analysis does not obscure the essential self-hood of the narrator also makes such an approach appealing to the existentialist researcher. Like discourse analysis, the grounded theory approach takes the view that knowledge interprets both the external and internal worlds for the individual.

O'Callaghan (1996) notes that knowledge itself is constructed to give meaning to existence and like discourse analysis it is accepted that narrative analysis cannot occur if language is isolated from mental processes. Both the researcher and subject influence the subjective and objective interpretation of each other. Strauss and Corbin (1990) point out a further similarity with discourse analysis by suggesting that the first stage of analysis of data lies in categorising and conceptualising narrative information into discrete units of meaning. This conceptualising often begins to differ from discourse analysis when they are categorised into as many different branches as possible. The researcher then narrows the categories into further conceptual categories which are less in number and combine concepts into meanings and themes.

Grounded Theory further allows meanings to be compared against different narratives so both individual analysis and group analysis can be developed. Constant note-taking to identify as many codings as possible in first stage analysis also prevents, to a certain degree, the emergence of pre-coded themes arising from reading transcripts which could influence later reading of further transcripts. When the second stage of gathering inter-connected meanings has been completed then inter-related themes can be identified and forwarded as emerging propositions and then theory. The conclusions and emerging theories are used as a basis for further research and knowledge generation.

DATA ANALYSIS

Process

This took the grounded theory approach (Strauss and Corbin, 1990) and open codes were listed as transcripts were read. Initial open coding was also carried out on correspondence and update reports to referral agents, case notes and evaluation reports. Second stage open codes narrowed the codes down to the codes not repeated and codes which were shared amongst the data. Due to the large volume of data a third stage open coding was required. The first open coding exercise identified six hundred and four codes, and the second stage identified three hundred and eighty-seven codes, which was still too large to categorize. The third stage identified one hundred and fourteen concepts of which eighty-six were shared amongst all the data and thirty-eight were separate single concepts.

Axial coding categorised the open codes into the following:

- Client history
- Negative effects of Eating Disorders
- Effects during phase I/II of therapeutic interventions
- Outcome effects
- Therapeutic principles and interventions
- The perceptions of the therapist

A separate file recorded developing perceptions, questions, points for clarification and issues of potential interest. These were fed into the theory generation during the proposition phase.

Open coding took forty hours of reading and re-reading of texts. It became clear some conceptual codes were identified on re-reading and it was only when the data was saturated (Strauss and Corbin, 1990) and I was comfortable that I could not identify any further codes that axial categorisation took place.

During open coding where single words had been difficult or inappropriate to adequately express a concept then a two word or a short sentence was used. For instance when a client described the effects of stopping bingeing behaviours these have been noted as "stopping bingeing leads to ……" and the self-reported symptoms are listed. If case notes, update reports or evaluation reports record direct quotes then these have been coded within speechmarks. The coding of the transcripts were carried out in chronological time order rather than client by client so first interviews were initially scrutinised, then all second interviews then third interviews. The same process occurred for the co-therapist and centre therapist transcripts and then coding of the two past clients was carried out.

The analysis of all data was carried out by hand and therefore required a structured process and careful sifting of the data. A decision not to use computer assisted programmes such as QSR NUD*IST (non-numerical unstructured data indexing, searching and theorising) was made on the

grounds that data saturation had to be sensitive yet prevent early thematic coding and there is always a temptation to store data in pre-named files. The importance of computerised analysis is not underestimated and given the choice, particularly regarding the size of the collected data, then a computer programme would be the first option. Programmes such as NUD*IST offer a flexible and interactive method of data analysis in qualitative research and experience indicates that data management is less arduous with computer assisted records. Yet the slow and methodical manual approach was felt to be important from both an existential and grounded theory approach. There was a subjective feeling of immersion in the data, of interpretation and re-interpretation as transcripts, referral letters, case notes and codes, were laid out together. Because the data was observable in a mass it was easier to see and remember where concepts or key phrases were repeated. The pace of coding allowed a slower reflection on emerging ideas and the axial categories emerged as self-formed rather than pre-coded.

Open Coding

The codes identified in the first stage of open coding were conceptual rather than thematic and the high number of concepts were gradually reduced by second stage and third stage identification of shared and separate concepts. For example lists of physical symptoms such as gastric problems, hypoglycemia and asthma identified in first stage open coding were eventually coded under physical problems in stage three. Similarly individual medication such as Prozac, Melleril and Trifluoperazine identified in stage one were finally coded under Neuroleptic medication in stage three. The number of

codes sub-sumed from stage one to two, and stage two to three were placed in brackets alongside the eventual concepts. The source of all codes are identified and the same sources were used throughout the open coding stages.

By the time axial categorisation occurred the data had been scrutinised to such a degree that familiarisation allowed patterns and connections to emerge from stage three open coding concepts. This familiarisation was not caused by just returning to texts, re-reading transcripts or rehearing tapes over and over again but also because each transcript and other data was analysed line by line and paragraph by paragraph. This was fairly simple to record as all written data were page and paragraph numbered and stored under source titles. So for example the chronicity of bulimia nervosa lasting twenty-three years can be identified as follows:

Source - first referral letter

Client - Andrea

Page - 1

Paragraph - 3

Another example would be the association between addictive behaviours and disordered eating behaviours which can be identified as:

Source - Client interview transcripts (1st interview)

Client - Rachel

Page - 2

Paragraph - 9, 11

Whole transcripts were always analysed and even the minutest detail scrutinised. Anything that could possibly be of relevance was recorded as a code in the earlier stages. What became a point of interest during axial categorisation was the number of codes from the various data sources which provided support to each other. The fact that connections and patterns recurred amongst different data gave qualitative reliability and internal validity to the analytical process.

Therapeutic practices followed a general system of Five Phases which incorporated existential concerns. As mentioned earlier some clients moved through the phases quite quickly whilst others spent longer in one phase and clients would often revisit past phases. The system allowed a certain rigour during transcript analysis as well as therapeutically managing the time spent with clients in actual sessions. (Strasser and Strasser 1997). The system also allowed the eclectic approach discussed by Van Deurzen-Smith (1988). The phases have been discussed in Section 12 (see pages 124 – 127) within the separate context of data analysis. The phases can best be summarised in table format.

(see pages 151,152 and 153)

THERAPEUTIC PHASES AND EXISTENTIAL FOCUS

PHASE	TITLE	INTERVENTIONS	EXISTENTIAL CONCERNS
1	Assessment Phase	• General health assessment • Current medication • Agreeing Groundrules • Explanation that there would be no input from nutritionists/food psychologists/dietician etc • Explanation of therapeutic objectives • Explanation that current eating habits can continue if they wish to do so • History taking • Identify current eating patterns	• Sense of control • Empowerment • Angst
2	Self-esteem Phase	• Explore concepts of Self-image and clients interpretations • Explore development of clients Self-image alongside eating patterns • Identify issues of importance or meaning related to eating and image of Self • Explore clients interpretation of Self • Explore clients interpretation of their interaction with others • Explore the role of eating in relation to interaction with others	• Meaning • Inclusion • Angst • Dasein
3	Self-assertive Phase	• Explore decision-making and assertive models • Explore clients decision-making strategies and identify possible causative factors • Identify impact of decisions on Self	• Sense of control • Empowerment • Inclusion • Choice • Angst • Meaning

PHASE	TITLE	INTERVENTIONS	EXISTENTIAL CONCERNS
		• Identify consequences of decisions on interaction with others and Self • Explore hypothetical scenarios in clients life which include decision-making outcomes • Evaluate effects on Self following hypothetical exercises • Identify one decision-making intervention in clients current life and agree time period to action decision-making activity • Evaluate outcome and consequences of decision-making activity • Identify further decision-making activity and monitor/evaluate reinforce positive consequences (support exploration of negative consequences) • Identify and action decisions regarding eating patterns	
4	Existential Phase	• Return to exploration of the interpretation of Self and Being-in-the-world (Dasein) • Explore the sense of Self in the context of eating patterns • Identify issues of concern regarding the sense of Self • Explore hypothetical coping strategies and their consequences to deal with identified concerns • Explore the sense of relationships with the objective world and other people • Identify issues of concern regarding the relationship with the world and others • Explore hypothetical coping strategies and their consequences to deal with identified concerns • Identify possible interventions to deal with issues of concern regarding Self and the relationship with others • Support implementation of interventions	Clients sense of Authenticity (Genuiness) of Being • Freedom • Dasein • Choice • Inclusion • Responsibility • Control • Meaning • Love • Hope

PHASE	TITLE	INTERVENTIONS	EXISTENTIAL CONCERNS
		• Explore consequences of the interventions on the interpretation of Self, others and the objective world • Explore the meaning of food to their relationship with the Self and the objective world • Identify the emotional nature of their relationship with food eating patterns • Identify possible changes to eating patterns and hypothetical consequences • Initiative/support graded and planned alterations to eating patterns • Explore effects of graded change and provide support if continuation is a decision by client	
5	Ending Phase	• Evaluation of the therapeutic time identifying any outstanding issues/concerns • Discuss future objectives and interaction with others • Discuss present coping mechanisms and locus of control • Farewell	• Empowerment • Control • Hope • Inclusion • Responsibility • Choice

Data analysis of interview texts clearly indicates the therapeutic phases which preoccupied clients at time of interview. For example in the Self-Esteem Phase the clients view of their sense of Self is often negative. Dorothy, who presented with problems with binge-eating and morbid obesity, states in her first interview shortly after therapy had commenced into phase two that she was "disgusted" with her body shape. (Interview 1 Paragraph 13) yet she was acutely aware that the therapeutic focus was on the meaning she gave to eating and the relationship such ascribed meaning had on her own self-perception.

"..... I mean now I hate food, its my big enemy. I'm not normal around it. I hate it, I just hate it. I just can't handle it and I think I'm becoming better at recognising that I was using the food to keep things in...." (Interview 1 Paragraph 14)

These explorations went further than just the clients sense of their Self in their everyday existence but also examined existential concerns. The angst felt by clients can be summarised by Dorothy when she stated;

"...in the past I thought I must have a death wish because why am I doing it? Why can't I stop it and not do it? (Long silence)" (Interview 1 Paragraph 16)

Saturation reading of, and listening to, the transcipts together with Case records and Review letters provided recognition of concepts relevant to therapeutic phases and supported the eventual formation of the axial categories. The system of phases in therapeutic practice also allowed

recognition of clients revisiting past phases when they had moved into subsequent phases and further self-exploration. For instance Chris, who presented with severe anorexia nervosa, used the Self-Esteem phase as almost a baseline comparison to measure her abilities to practice self-empowerment. (This was a focus during phase four; the Existential Phase).

"I actually go out now. I don't always have a main meal, perhaps a starter but its more than I used to do anyway…." (Interview 2 Paragraph 23)

"…..this is the first time that I've actually felt like a normal person." (Interview 2 Paragraph 27)

Analysing transcripts in chronological time order rather than client by client provided strong support that the five therapeutic phases were helpful in addressing the aims of the study. Both the effects and the effectiveness of Existential therapy with clients experiencing disordered eating appeared to be more readily measured when therapeutic practice itself was categorised in distinct phases. This approach to analysing the data also provided support to the work carried out by other existential therapists such as Van Deurzen-Smith's (1988) Four therapeutic goals; Corey's (1991) Three phases; Duker and Slade's (1988) Four phases and Yalom's (1980) Four concerns.

Axial Categorisation

This became the first opportunity to provide order to the final coding exercise and was made relatively easy by the patterns that had gradually been revealed

on re-reading the open concepts. The grounded theory principle that theories emerge from the data without pre-coding or thematic categorisation was supported by analysis of the final identified concepts. These could be grouped into distinct categories and the categories could be documented into a story form of beginning, middle and end. For example there were twenty-eight final codes which referred to Sartre's (1943) essence and had direct relevance to the history of clients. (The beginning of the clients story.) A further thirty-eight codes can be attributed to the negative effects of chronic eating disorders whilst sixty-seven concepts demonstrate the journey through the therapeutic experience itself and the eventual outcome. These were categorized under the headings of Phase I/II therapy and outcome effects. (The middle and end of the clients story.). The remaining codes demonstrate therapeutic principles, interventions and perceptions held by others of the therapist and were categorised under two headings; one on the therapy and one on the therapist. (The sub-plot of the clients story.)

Some concepts were relevant to more than one category and were therefore placed under different categories rather than form new sub-categories.

Conclusions

The six axial categories provided a framework which contained and demonstrated common recurring concepts and led to thematic relationships. In addition the analytical process now utilized the information kept in seperate records as the coding process commenced. These were mainly questions stimulated by textual analysis, notes of any observations made in passing

through codings and ideas not fully explored or clarified but kept for fear of loosing them. These were listed in a coherent form and supplemented the information held in axial categories. For example these additional notes refer to the point that different data sources support each other. Other interesting observations were also recorded. For instance that clients sometimes gave opposing perceptions of the therapist. This point would support the existential view that individuals provide their own unique interpretation of external phenomena. These additional records capturing points raised in the analytical process as it occurred also notes the sadness and poor health caused by chronic disordered eating and supports many of the concepts under axial categorisation.

The final stage of the analytical process integrated the axial categories and the records of ongoing reflection into an interpretative series of conclusions. These conclusions are submitted as existential engagement (Sartre, 1943) with the categories and reflective records even though the proponents of grounded theory such as Glaser and Corbin (1990) suggest that theory can be presented following axial categorisation. Sartre's (1943) engagement in this context refers to his view that the individual is always interacting with the world and engaging involves a deliberate action to be involved in or committed to choices based on the interpretation of being-in-the-world. Reflection in this context refers to the existential Ekstasis phase of the individual adopting an external point of view of him/herself. In other words to be objective in self-reflection.

The conclusions are based upon the subjective interpretation of the patterns that emerge from analysis of the categories and reflective records. One conclusion presents what is already known about disordered eating and is supported by published literature. Other conclusions offer new interpretations and demonstrate the deliberate choice to provide findings which attempt to reveal the effects of the data on objective self-reflection. Conclusions here offer a summary of the decisions reached following grounded theory open and closed coding and interpretative engagement with such data. The reader has some insight into my thought processes through the presentation of the final staging post reflected upon before theory presentation.

THEORY PRESENTATION

Following analysis of axial categories and other source material the following four conclusions were reached. They are summarised as follows before each in turn being presented in detail.

1. The experience of any of the three chronic intractable eating disorders causes a range of debilitating physical and mental illnesses. There is also a strong link between all three disordered eating behaviours and self-harming. Individuals experiencing anorexia nervosa engage an extremely strong will to desist from eating whilst bingeing and over-eating is an outward presentation of psychological outbursts. Many individuals adopt both anorexia and bulimic behaviours at intervals and the conditions are not always discrete entities.

2. Food intake appears to influence mood states in all three eating disorders. For instance a state of numbness characterised by an almost trance like condition appears to be a common experience for individuals with eating disorders. For the condition of morbid obesity there appears to be strong relationship between mood state and the level of sugar and carbohydrate intake.

The effects of food substance and intake on mood conditions lead to a behavioural pattern similar to addictive behaviour rather than the responses found in conditions such as obsessive/compulsive disorders.

The obsession with food can be likened to the addictive need for more experience of the numbness. This numbness can be gained either by binge-eating for a quick but short-lived effect (hence the need to binge approximately every three or four days) or by cessation of eating for a slower but longer-lasting effect. This attempt to gain a longer-lasting effect presents symptoms of depression such as low self-esteem, lethargy, poor cognitive function, sleep disturbances and feelings of sadness. Overeating and binge-eating raises mood and has an effect remarkably similar to anti-depressant medication, particularly those aimed at serotonin levels. Prior to the numbness there is a feeling of elation, comfort and security and it may be that the numbness is post-prandial overdose.

3. The possible addictive qualities of food substances would explain the consistently high level of physical discomfort associated with the cessation of chronic bingeing. Furthermore all clients reported an increase in negative symptoms when undertaking existential therapy. These symptoms are difficult to tolerate and a return to binging or cessation of food intake brings almost immediate relief and therefore causes a major obstacle to a return to healthier eating.

4. The existential approach had a positive effect on all clients in the study. The focus on increasing the clients locus of control appears to allow clients to positively change disordered eating patterns. This is in direct contrast to attempts by healthcare professionals to change disordered eating behaviour through a more directive approach. Clients perceive such approaches as

intrusive, unwelcome and a cause of resentment. The direct approach clashes with the clients own sense of control and success is based on treatment compliance rather than an internal change in the Self.

There is some self-reported data which indicates that clients do seek internal change and this can be demonstrated through their search for a creative or spiritual satisfaction in their lives. What is interesting is that as the clients own locus of control expands so does their willingness to engage in creative activities. When clients are steeped in self control they do not voluntarily engage in any activities which have a likelihood of not meeting their own exacting standards. This may be an important assessment criteria which measures the effects of treatment interventions. If it is working then the client demonstrates an increase self-efficacy by engaging in activities where there is an explicit sense of being active for activities sake and not to reach a high standard. Paradoxically the clients sense of control increases when involved in environments which are less controllable by them. It is this existential interpretation of their engagement with an objective world that begins to stop the practice of disengagement from the world and stop dualistic thinking about their bodies.

Each conclusion will now be considered in turn.

Conclusion One

Conclusion one is hardly surprising and offers no new insight into the disordered eating experience. The ICD-10 (1997) lists vomiting, purging, over-use of aperients/diuretics, and widespread endocrine disorders as typical diagnostic criterias for anorectic conditions whilst the work of Weiner and Katz (1983) highlight the hypothalamic-pituitary-adrenal axis disturbances and Mehler (1996) notes the high levels of premature osteoporosis in young women experiencing anorexia nervosa.

Hsu (1990) presented his views that individuals experiencing bulimic behaviours suffered severe upper and lower gastrointestinal problems and the DSM IV (1994) lists symptoms such as swollen salivary glands, poor dental conditions, ulcers and cardiac problems. The National Institute of Health Census Development (NIHCD, 1985) indicate the link between poor health and morbid obesity and list hypertension, non-insulin dependant diabetes mellitus, osteoarthritis and cancers as major problems. The clients in this study support past research findings. For example Andrea in her first interview states when discussing her bulimic pattern;

"I could imagine twenty, thirty years ago I could have picked up and my body would feel better for it whereas now I think, well I've probably done damage beyond" (page 7 paragraph 12)

and Dorothy discussing obesity and dieting; "last year I was diagnosed diabetic ..... I was being sent to a dietician. I was devastated, everyone

saying well you've got to do it now, its imperative that you do or you'll die" (first interview page 7 paragraph 15)

In the second interview the same client explains one doctors response as ".....because I've got the diabetes..... She just says you're going to die. When she put me on the medication she said I'm only going to give you these if you don't binge" (interview 2 page 1 paragraph 6)

On binge-eating, Rachel lists "a bad stomach and headaches ..... my eyes would get puffed up and I'd have diarrhoea that sort of thing" (interview 2 page 1 paragraph 7)

Later on discussing bingeing again she describes "feeling really ill and horrible" (page 2/3 paragraph 10)

This experience is shared by Fran who states that after over-eating "I can't think straight, really thirsty..... I just want to turn over and die, that's how it feels" (interview 1, page 7, paragraph 6)

Such statements are supported by first stage open codes taken from case notes and assessment records which contain a mixture of physical illnesses such as oesophageal spasms, dental problems, hypoglycaemia, hyperglycaemia (diabetes mellitus), asthma, muscular pains, insomnia and tiredness. Alongside the physical effects all clients experience a range of mental health problems. Such symptoms are well known in the literature and form the

diagnostic picture for medical intervention. The DSM(IV) (1994) for instance lists depression as a presenting feature in anorectic conditions and the word "nervosa" specify its inclusion as a mental health disorder. The ICD-10 (1994) states that a full diagnostic assessment for anorexia nervosa should include looking for depression and obsessive/compulsive traits.

Many authors highlight feelings of anger and sense of exclusion found in individuals with anorexia nervosa and the relationship with food. Malson (1998) discusses these feelings within the context of controlling food intake, Holmes (1985) found anger common in hospitalised patients and that hostile behaviour was expressed through a refusal to eat. Van Vark (1998) suggests that homosexual young men who hide their sexuality take out their frustration through bulimic behaviours. Bruch (1985) discusses the anxiety levels found amongst adolescents who desperately try to control their food intake and Grothaus (1998) suggests that children with anorectic behaviours have great difficulties in expressing anger externally.

One client in this study who had chronic mental health problems provides a good example to support such research. The medical records for Chris diagnosed as anorectic give the diagnosis of depression and note that frequent suicidal attempts whilst the review letter to the referral GP (Review letter 1) highlights the level of anger, poor self-esteem and frequent self-harming behaviour after six group sessions. Controlling the rising feeling of depression became an important therapeutic intervention when working with Chris and a mixture of confrontation and gentleness was required when examining

"essence" (her own past). The client was aware of this strategy as can be seen in the interview transcripts. Even in the first interviews she states that the therapeutic intervention is "much more direct"; and "....I like the direct questions....." (first interview, page 1 paragraph 2 and 7) and the strategy is again noticed at the end of the therapeutic process when she notes in response to a question about the differences between the existential approach and past therapy "yes he's got a different approach, more directive and he seems to get more out of me" (interview 2, page 1, paragraph 3) and further in the interviews the therapy is seen as "more confrontative" (page 1 paragraph 5). Later when replying to a question about her response to such confrontation Chris states "yes he seems to have a knack of bringing things from the past that I've not thought of but they are not all coming at once and causing depression or anything like normal, it's a little bit at a time seeping out which I've never experienced before, I find it much easier to cope with....." (interview 2, page 3 paragraph 20).

Jane, who also experienced chronic anorexia nervosa provides insights which support the Association of American Family Planning (1997) view that self-blame and low-mood is commonly brought on by the inability to reach the clients own standard of perfection. In talking about art therapy during past hospitalisation client Jane remembers the effects on her own self-esteem as;

"I hated it, I found it difficult, mainly because I don't think I'm very good at drawing. It was because I was very much a perfectionist and everything has to

be done really well. It was hard because I felt everything I was doing was awful" (Interview 1, Page 1, Paragraph 5).

Dealing with such repressed frustration and anger by encouraging external mood display was a therapeutic strategy and its outcome is seen during early therapeutic sessions when the client observed that the therapy was non-judgemental and therefore encouraged outpourings of repressed feelings.

"That's the biggest thing because it made it safe to ask for help, or to cry or to say that I was angry or whatever, or that I was really lost and stuff. That when I would talk about bingeing or self-harming or whatever ..... It was ok so that's what you did, there was no judgement either way". (Interview 1 Page 3 Paragraph 14).

Jane also discusses the sense of exclusion, repression and control experienced by long periods of controlling food intake. In response to a question about what her past life was like she notes:

"lonely, that would be the biggest word ..... Very lonely ..... my mum was the only person I could cry in front of and then I would probably leave the room you know. I mean I've got a really close friend that I live with now and I wouldn't have cried in front of her, I'd have said I'm going home. I never expressed myself in front of other people ....." (Interview 1 Page 4 Paragraph 21).

Continuing this theme even when attending self-help groups the sense of exclusion continued.

"Yeah it was lonely because there was nowhere to express myself. Like the real stuff that was hurting because I didn't see Dr S very often and I tried various eating disorder groups but I found them unuseful to me. I mean I'm not saying they're not useful but for me they weren't the place because I found it difficult with people all much thinner than me at that time was a big issue. Yeah so there was nobody that I would express myself to so I was really lonely ....." "So it was very lonely because I was never me" (Interview 1 Page 5 Paragraphs 22 and 23).

Poor self-esteem seems to be an integral element of eating disorders. As the additional source records indicate there are no happy individuals experiencing eating disorders. Cooper and Hunt (1998) found similar results and that poor levels of self-confidence was common in the diagnosis of both depression and bulimia nervosa. Phillips et al (1997) in a similar study suggests that the cognitive processes amongst women experiencing depression is similar to women experiencing bulimia nervosa. They also noted that high levels of self-perfection and dualistic thinking were not prominent amongst women diagnosed with bulimia nervosa. This last point is supported in this study. It appears that self-imposed unachievable personal target and dualistic thinking is more likely to be found amongst individuals experiencing anorexia nervosa. (See for instance the quote above from Jane).

Depression however is common in all the eating disorders and is well documented. Craighead and Agras (1991) and Williamson et al (1985) carried out studies which found a correlation between low mood and both obesity and bulimia nervosa. Cooper and Fairburn (1992) found a higher incidence of negative thinking amongst clients experiencing anorexia nervosa and as far back as nineteen seventy-three Bruch noted such associations. Cooper (1997) in a review of cognitive approaches to anorexia nervosa and bulimia nervosa found depression common in both conditions and Poulakis and Wertheim (1993) found depression amongst individuals experiencing bulimia nervosa. Fairburn (1985), and Garner and Bemis (1985) found cognitive disturbances and low mood in bulimia nervosa and anorexia nervosa respectively. The individuals in this study support such conclusion. The concepts "grief" and "sadness" and "low mood" recur frequently in first stage open coding alongside a series of negative mood and cognitive codes. These remain common under the axial categories. Anti-depressant medication is commonly prescribed and a range of negative self-references and behaviours are narrated by the interviewees. Self-harming and suicidal behaviours are not uncommon. Chris comments for instance that "…. I've always sort of self-harmed, overdosed and even the motorway bridge I've been there a few times ……." (Interview 2 Page 4 Paragraph 28).

Jane discussing the controlling element of eating notes that "….. I was still very controlled, restrictive in what I would eat but also bingeing a lot and self-harming ….." (Interview 1 Page 2 Paragraph 8).

Karen, who like Chris and Jane meet the DSM IV (1994) criteria for anorexia nervosa, notes that on initially trying to get therapeutic help: "..... I was so desperate. I had really strong suicidal thoughts ....." (Interview 1 Page 1 Paragraph 1) and depression is a constant companion and had been present for a long period prior to existential therapeutic intervention.

Fran who was diagnosed as morbidly obese shared a similar experience notes in passing a reference to a past in-patient treatment "..... after I took an overdose, I was in hospital for about three months" (Interview 1 Page 3 Paragraph 20) and the level of anger is vividly presented. On responding to her reaction to initial therapy with myself she states;

"Well when I told my story I wanted to tear Mike's eyes out because he's a man and I thought I want to tear his eyes out because he didn't apologise and he was rushing onto the next subject and that also I felt he didn't care".

Self-harming also continues during therapy and is related to these feelings of anger towards myself. In reply to the question that anger towards me is continuing she replies; "Yes, I started eating a lot and then I got really down and started to cut myself. Then I didn't want to eat. My mum made me sit down and eat proper meals even though I didn't want to. All I wanted to do was sleep and escape from everything. I was so tired. (Interview 1 Page 7 Paragraph 59).

Negative self-imaging is commonly found alongside the low mood. Beryl states when discussing her lack of confidence at work that;

"..... I'm not presenting quite as professional image as perhaps slimmer colleagues are. Because obviously for one thing they can dress nicer than I can and it can project a better image and they're also more energetic around the office and can do things a lot quicker than I can" (Interview 1 Page 3 Paragraph 17).

Dorothy and Rachel who were diagnosed as respectively morbid obesity and bulimic nervosa exhibit poor self-confidence and low motivation when discussing the effects of therapy midpoint through the self-assertive phase. "I just feel that I've been like this for so long I don't know what's normal, I don't know how to act normally, don't know how it feels anymore ....." (Dorothy Interview 1 Page 8 Paragraph 16).

and "..... before I came this morning I thought oh should I go but I've got to miss the next one. I was glad when I got here, it was just being lazy. Well I was supposed to be at college, I don't know. The internal sabotage or something" (Rachel Interview 1 Page 4 Paragraph 22).

Beryl diagnosed as morbidly obese also reports the self-blame and guilt related to controlling food intake, and early in therapy reports;

"I think one of the main problems was that before I started coming here I thought it was all my fault, that I ate when everybody else could stick to a diet and I felt pretty useless about that ....." (Interview 1 Page 6 Paragraph 28). In the second interview she states a more positive outlook;

"..... I've realised that my problems aren't entirely down to me being a weak person or having no will power ..... (Page 1 Paragraph 2).

The proposition that anorexia nervosa, bulimia nervosa and morbid obesity are conditions which in chronic forms lead to serious multi-pathological ill-health is supported in this study. The data also supports the published literature in this area. For all types of interventions these are considerable obstacles towards a healthier sense of well-being and for the existential therapist these are important principles when exploring the clients sense of Self. To believe that your body is caught in a web of food-related conditions is an unpleasant experience. To realise that your own action has contributed to further chronic problems can reinforce feelings of self-blame and guilt. Existential interventions in such situations not only work on changes in interpretation of being and the relationship with the objective world but also in promoting coping skills to deal effectively with post-eating disorder conditions.

Conclusion Two

The content of food that is taken does appear to influence mood states and individuals with chronic eating disorders appear to have developed a highly

sensitive response mechanisms to certain food substances. These responses are captured in transcripts. For instance after several sessions Beryl discusses the effects of certain products on her mood state:

" ..... when I first came to see Mike one of the first things he made me do was knock caffeine off and I've since stopped eating chocolate and I think partly on a physical level perhaps I've stabilised my eating patterns and I've no longer got these highs followed by lows where I would kill for a mars bar or a can of coke just to get you feeling normal again. I'm no longer on that sort of roller coaster ....." (Interview 2 Page 2 Paragraph 13).

It is interesting to note here that Beryl perceived the therapist as directing her to lower the level of caffeine whilst the therapist was concentrating on the principle of client self-direction. This mixed view of the therapist either being directive or non-directive was found in coding categories and sometimes clients expressed such opposite views in the interviews.

Later in the same interview Beryl responds to how much she has changed by stating;

" ..... I'm now sort of going out more as well. I think maybe it was because I'd not seen anyone to go out with for a few days and that maybe I was feeling a bit down and I'd get a lot of sweets and a load of crisps and cheer myself up and then I ate them and felt more miserable again" (Interview 2 Page 3 Paragraph 16).

"I'm drinking tons of water and trying to shift towards healthier foods and keeping away from fast foods, chocolate and all the rest of it". (Page 4 Paragraph 21).

"I no longer get as stressed and I'm not in that position to want to go and have a binge" (Paragraph 38).

Chris who experienced chronic anorexia nervosa shared a similar experience and often didn't eat because she experienced the effects of food on her ability to work.

"I ate as little as possible so I couldn't go out and have a meal because I could eat calories and that affected my work" (Interview 2 Page 2 Paragraph 17).

However when she did eat she noticed that the effect reduced guilt and the sense of "depression has gone" and "this is the first time that I've actually felt like a normal person" (Interview 2, Paragraph 23 and 27).

As the conclusion outlines a sense of fugue-like numbness is commonly experienced in eating disorders. Dorothy describes it as: "I was a bit numb ..... which is what food normally does for me" (Interview 1 Page 3 Paragraph 9).

In particular times of stress food was important in avoiding the stress stimulus itself. Dorothy had for nearly ten years "always seen food as a comfort" and had reached the stage where "you were holding everything at bay; it stopped

you thinking. You didn't have to do anything because you were eating. It was that. It stopped you from thinking and it made you feel numb and I suppose I saw it as a friend in a way but when you felt terrible it was like a friend who went behind your back and undermined you and then you were lost" (Interview 1 Page 4 Paragraph 11).

Again the actual content of what is eaten appears to be an important factor in their effects in mood. Dorothy ate in secret "sweets and chocolate" (Page 5 Paragraph 11).

There is a wonderful example of insight regarding the link between food and mood state when Dorothy discusses her anger later in the same interview. The focus was on her feelings towards her father who often negatively commented on her weight and the following narrative was recorded:

"I'm ashamed of the fact that I can't control this and I'm angry. Like when my dad says anything and I hate him and put him with the food. Stuff you while I'm stuffing me". (Interview 1, Page 8, Paragraph 16).

The numbness is important as both a dissassociative and avoidance state. In the final interview towards the end of therapeutic sessions Dorothy describes how emotional pain was previously controlled by bingeing and she had recently experienced;

"…….. this huge binge, massive, not just normally its like cruise eating. You top yourself up until you achieve a certain level of numbness and you have to top yourself up. ……. I was doing all of it to control the anger, the pain, the fear. I didn't want to feel any of that so that's what the food is to me and that realisation is horrifying ……. It worked. It's still there. It was physiological. I was numb for three days (Interview 3, Page 2, Paragraph 7).

"……. it was just like taking on anaesthetic when you don't want to feel. That's just how it was" (Paragraph 12).

Gemma who also experienced morbid obesity often used sweet foods to binge on and used "food as a weapon and as a barrier to keep the world away" (Interview 1, Page 13, Paragraph 26). Stressful situations were dealt with by immediately eating, often bread and cake. Sugar and carbohydrates also influenced Rachel to a great degree. She interpreted the effects as mood enhancing.

"I can go a couple of weeks eating sugar and I'm as high as a kite really and I don't care and its alright but there's an inevitable come down from it all and that's when I'm at my lowest" (Interview 1, Page 2, Paragraph 11).

Towards the end of therapy this interpretation became fixed as she recorded the effects of sugar on mood.

"I've identified that sugar is the main thing. It used to take over everything that I was doing and within a few days I couldn't even go out except as far as the shop and then I'd buy loads of biscuits and come back..... I just felt totally disconnected from everything. Paranoid, terrible low self-esteem, low self-worth and I didn't want to see anybody (Interview 1, Page 1. Paragraph 7).

In response to a direct question about her views on sugar intake Rachel who experience bulimia nervosa adds:

"..... I go to sleep because I'm overdosing on sugar ..... I was wondering why I still felt the need to binge and a lot of it was physical" (Interview 2, Page 3, Paragraph 13).

Fran who experienced morbid obesity relates her response to anger as "I eat and eat and eat. I can't stop it. If I haven't got food I'll go out and buy it" (Interview 1, Page, 7, Paragraph 58) and again sugar foodstuff is identified as effective;

"..... but when I'm on a low I tend to eat all the wrong things and stuff myself with donuts and sugary things" (Interview 2, Page 5, Paragraph 43).

Sugar or carbohydrate foodstuff were identified as the main binge preference because of its effects on mood. The clients knew this. Yet little has been written about such effects being deliberately pursued through particular food

products. Biomedical researchers such as Mehler (1996) may have missed this connection as they sought a distinct physiological cause for eating disorders. Margo's (1987) work may have provided a clue with the suggestion that there may be a genetic predisposition in relation to mood affecting hormones rather than anorexia nervosa. This point may be supported by the social research carried out by Stein et al (1994) and Hill and Franklin (1998) which noted the correlation between maternal influence on eating patterns. Grothaus (1998) also commented on the strained inter-family relationships often found in families with members experiencing anorexia nervosa.

Connors (1996) has proposed that both anorexia nervosa and bulimia nervosa may be linked to early childhood trauma which leads to a later sense of disconnection from others, low mood, anxiety and self-harming behaviours (included here are the eating disorders).

Nash (1997) presented a series of research findings which provide support for Connors' (1996) views on early trauma. Nash's article covers the anatomical and physiological changes in the new-born brain and give findings suggesting that early abuse damages the brain to the extent that the individual develops an above average sensitivity to later stressors. Infants who are emotionally deprived showed reduced activity in areas of the brain related to happiness. Adler (1999) summarises the effects of early abuse as a reduction in the size of the hippocampus. This area of the brain is generally thought to aid memory and recall and is very sensitive to stress induced chemicals whether the body's own or externally prescribed.

The Harvard Mental Health Letters (1992) openly states that individuals with bulimic behaviours are likely to be addicted to drugs or alcohol and suggests a 55% chance of genetic susceptibility to bulimia nervosa. The condition was also observed to occur alongside low serotonin levels and that the episodes of binge-eating decreased with the use of anti-depressant medication. Additionally one-third of women with bulimia nervosa also had drug and alcohol problems.

Malson (1998) frequently refers to her interviewees self-reported sense of numbness and found a high level of substance misuse amongst individuals exhibiting bulimic tendencies. A similar picture is found in morbid obesity. Amongst the views on morbid obesity Dolan's (1994) approach to the symbolic value of over-eating can be related to the search for love and affection, whilst the Medical Science Bulletin (1994) suggested that it is a problem related to a neurotransmitter disorder which affects satiation and the Bulletin refers to the raised levels of tryptophan in the brain. Tryptophan is a known amino-acid which influences serotonin levels. Tryptophan in turn can be raised by increasing insulin activity and insulin rises when there is an increased level of blood glucose. It is also well known that hyperglycaemia occurs with severe weight gain. As with Weiner and Katz' (1983) view that there are measurable hypothalamic-pituitary-adrenal axis disturbances found amongst individuals experiencing anorexia nervosa so the American Cancer Society study (cited in the National Institute of Health Consensus Development (1985) suggested that the hormones released via the

hypothalamus, pituitary and adrenal cortex are affected to some degree by obesity.

Despite the exploration of physiological pathways and the research confirming that clients do experience mental health problems due to chronic disordered eating there is little written which points towards an addictive-type disorder. This may be due to the predominance of cognitive-behavioural therapy in the psychological approaches towards eating disorders. This is an important point from the existential perspective as the sense of Self, of Being-in-the-world and of love, of Self and others, are core concerns in therapeutic interventions. Focusing therapy on depressed mood or obsessive behaviour with clients who are experiencing eating disorders may be too narrow a target.

It is understandable that cognitive-behavioural approaches are popular. Beck (1976) gave a good framework for cognitive therapy when he stressed that there are three levels of cognitive functioning. A surface level of interfering negative thoughts, a deeper level of responses based on assumptions and an even deeper schematic belief level. Becks schema is viewed as forming in childhood and is the basis of the individuals interaction with the world. The existentialist would propose that schema involves authenticity and inauthenticity and subjective interpretation. Becks model emphasises that specific cognitive therapy can change negative thinking and behaviour by raising the individual's awareness of interfering negative thoughts and their interpretations of their responses to such thoughts or assumptions. At the deep schematic level such therapy can teach individuals to reframe their self-

reference both internally and how they react with the objective world. The model is therefore very attractive to therapists working with individuals who experience depression, anxiety or obsessive thoughts; common presenting symptoms in eating disorders. (Williamson et al, 1985; Phillips et al, 1997; Cooper and Hunt, 1998).

Drake (2000) suggests that Fairburn (1981) was a leading influence in applying Becks model in the area of bulimia nervosa and this then spread to interventions in anorexia nervosa (Cooper and Fairburn, 1992; Mizes and Christiano, 1995; Cooper, 1997). Fairburn's original approach was based on his view that it is the individuals attitude taken towards body weight and shape that underlies bulimic behaviours. The individual's attitude to food itself was therefore not the prime interest in therapy. By 1989 Fairburn and Cooper were stressing that the focus of therapy should be on breaking the loop which reinforces bulimic behaviours. Drake (2000) notes that their interest in the clients sense of self-worth being dependant on the individuals perception of their weight and shape led to Fairburn and Cooper suggesting that there is a consuming desire by the client to be thin. This desire overwhelms the control of normal food intake and the client becomes preoccupied with weight gain leading to behaviours such as over-exercising, reducing food intake and purging.

The increasing sense of self-disgust in turn leads to poor self-esteem, low mood and anxiety which reinforces negative food-related behaviours.

Despite the occasional questioning of the cognitive-behavioural approach, (Williamson, 1985; Wilson et al, 1986; Hollon and Beck, 1994; Wilson, 1996; Bell, 1999 and Drake, 2000) the model remains the dominant theoretical and practical therapeutic intervention in eating disorders. As such the dominant focus is on the individuals self-worth and self-esteem. The emerging pattern of addiction may be missed as the therapeutic assessments and interventions assume symptoms indicating low mood, obsession with food and agitated behaviour are mental health problems due to the effects of disordered eating rather than the effects of substance craving or withdrawal effects. Such cognitive and affective symptoms are put within the context of substance misuse when dealing with conventional approaches to drug addiction. Coomber (1994) noted that there is repeated, consistent behaviour for further drug use if, amongst regular users, the body reaches tolerance due to its adaptation to absorbed chemicals. The individual searches to find increasing dosage in order to achieve former effects. For the parents of heroin users the Department of Health (1994) advised them that whilst withdrawal symptoms included physical effects the major symptom is psychological craving.

In this study clients made repeated references to the effects of food on mood as addiction. Beryl noted that:

"..... when I first came to see Mike one of the first things he made me do was knock caffeine off and I've since stopped eating chocolate and I think partly on a physical level perhaps I've stabilised my eating patterns and I've no longer got these highs followed by lows where I would kill for a mars bar or a

can of coke to get you feeling normal again. I'm no longer on that sort of roller coaster and partly, just sort of understanding made me stop and think about what I was eating as well" (Interview 2 Paragraph 13).

In response to a direct question that fast foods and chocolate were problems in maintaining a healthier food intake Beryl responds "Oh just everything that was bad for me I loved it; chocolate, chips" (Interview 2 Paragraph 22).

Andrea frequently explains how she perceives her bulimic pattern in addictive terms. For example in the first interview she describes the long duration as "….a bit like being an alcoholic I had to tell myself I had the problem ……." (Interview 1 Paragraph 7) and she goes on to state that in correspondence with a friend who smoked cigarettes that her bulimic behaviour was described as: "…. she said I'm addicted to it and it's the only way I can explain it is that its like an addiction, and nobody in the past has believed that and they've said it isn't addiction" (Paragraph 8). Later when discussing the effects of bulimia on household income Andrea states: "I feel bad wasting money on the problem I've got …… I mean when you're on benefits you're allowed to earn fifteen pounds a week and I mean I've done that and taken jobs that will give me a tenner and I've thought well that will feed my habit and I've done it and then I think god I've done this and I shouldn't have done. I mean you feel bad about doing that …… I'm fairly honest and so I think I shouldn't have done that, but then I can't see my kids without because of the habit I've got, so you're constantly battling with that …….. (Interview 1 Paragraph 11).

Andrea had experienced anorexic behaviour and had discussed symptoms with a young female openly talking about anorexia nervosa condition and the sudden urge to eat;

"..... one girl said you've got to do it and when you've done it you can relax and that was one thing that I could identify with. And yet you wouldn't think that doing that would help you to relax but it does. It's like you're craving it and when you do it the craving subsides" (Paragraph 14).

Even towards the end of the therapeutic process the client describes the unrelenting bingeing craving as "it is like a drug you need in someway" (Interview 3, Paragraph 12).

Fran clearly noted the effects of food and mood with references such as "when I'm down I start thinking about food and hit the sugar.....when I'm angry I eat and eat and I can't stop it. If I haven't got food I'll go out and buy it" (Interview 1, Paragraph 57 and 58).

Rachel had a history of substance misuse and is a member of Alcohol Anonymous and is very knowledgeable about addictive patterns. Yet she clearly interpreted her relationship with food in a similar way.

"It takes over my life and makes it totally unmanageable. It's, I mean I've been addicted to all sorts, drugs, alcohol and I suppose food has been the continuous one" (Interview 1 Paragraph 9). She continues with:

"I definitely regret it. ….. it's taken away my life really and stopped me doing things I would have liked to have done and it's just there all the time. It is my life really" (Paragraph 9).

When asked when is her mood the lowest Rachel replied:

"When I'm bingeing but its worn off. Because I have sugar addiction so I can go a couple of weeks eating sugar and I'm as high as a kite really and I don't care and it's alright but there's an inevitable come down from it all and that's when I'm at my lowest" (Interview 1 Paragraph 11).

In response to a later question asking how she felt talking in the group sessions (each client told their "story" in turn) she replied;

"….. it wasn't too bad cause at Alcoholics Anonymous I've already spoken, not about food but I suppose in a way its more difficult with food its more glamorous to be an alcoholic than to be an over-eater. But I'm coming to realise that it is as life threatening, or making my life unmanageable, it is as disabling. You just don't get arrested and it affects your moods worse so medically its more unmanageable. I can get oblivious from alcohol but not from food" (Interview 1 Paragraph 16).

In the second interview after several further group sessions Rachel was asked what life was like before commencing existential therapy. Her response once again is coached in a graphic addictive context.

"Out of control really. I've identified that sugar is the main thing. It used to take over everything that I was doing and within a few days I couldn't even go out except as far as the shop and then I'd buy loads of biscuits and come back. In front of my daughter giving her loads of biscuits instead of cooking proper meals. Physically its hard. A bad stomach and headaches and just get cravings, other food, but mainly sweet things and I'd go places I'd thought there would be food or I wouldn't go places I thought there would be food because I thought I'd get tempted. I would if I went out and did anything. I wanted to go home again, I found I had no self-confidence, my eyes would get puffed up and I've diarrhoea and that sort of thing. And slowly I just stopped doing anything. But the mental things were probably the worst. I just felt totally disconnected from everything. Paranoid, terrible low self-esteem, low self worth and I didn't want to see anybody" (Interview 2, Paragraph 7).

The next question asked if things had changed since her attendance in existential group therapy and the addiction theme continues:

"..... since I've identified sugar as the main thing I've not eaten the same. Well I do over-eat sometimes but all the physical effects have gone" (Interview 2, Paragraph 8).

Rachel also appeared to have stopped the habit of going out only to buy biscuits. She noted that "I go out and do more things, whereas before I'd just go to places because I thought there were cakes and biscuits and stuff my face

with them. I remember once at AA I was sat next to a big plate of biscuits and I ate the lot, I couldn't stop. So no I do things because it feels right to do it rather than because foods there. If there's no food there I choose to go, rather than because there's food there. And I will consider doing things rather than not do anything whereas when I'm bingeing I won't do anything ..... I'm more confident. And also my emotional life, although its painful, is a lot better because its usually just numb" (Interview 2 Paragraph 10).

The need to achieve this numbness remained quite strong during this phase of therapy. This was especially apparent when engaging in relationships. Rachel had recently met a man and the relationship was developing to a more serious level. On recounting her first visit with him outside of her home town she noted her need to avoid this encounter and that her past pattern was to binge until numbness was reached. However;

". ..... this time I made myself go even though I was wrecked and I was bingeing and suddenly instead of it being an advantage and letting me off the hook and things it was a disadvantage because I was having to do the same thing but I was feeling really ill and horrible and I think even though I still binge or could binge I mean I take things a day at a time or even five minutes at a time. But part of it is realising that it's a disadvantage" (Interview 2, Paragraph 10).

The numbness appears to be most easily achieved through sugar intake but unfortunately such cravings once answered become uncontrollable. The experience of existential therapy helped Rachel to explore this area in detail and some pattern between sugar intake and mood state was noticeable. This was always interpreted in the context of addiction.

Like other clients who see craving, uncontrollable bingeing followed by the numbness, the client did not present this pattern within the context of obsession or depression. For instance in a response to a direct question about sugar addiction and how long she had been aware of this pattern Rachel replies:

"I think I have known it but not definitely. I have gone and eaten sugar and didn't really realise that I had to stay away from it all. I thought that after a few weeks I could have some, like the odd twix or something, thinking it could be months before I could stop again". (Interview 1 Paragraph 11).

The effects of the therapy was also interpreted within an addictive context. In reply to a question about what areas in her life had changed since commencement of existential therapy she noted.

"We get a lot of physiological explanations.....the physical side of things was helpful and that with the sugar thing .....why I go to sleep because I'm overdosing on sugar. Because I was beginning to feel emotionally a lot better

and I was wondering why I still felt the need to binge and a lot of it was physical" (Interview 2 Paragraph 13).

The physicality of food and the relationship with intake and mood were common presentations for all the clients even when there was only a dim awareness of such connections. Gemma noted for instance that;

"…. I got to the stage where I really was very desperate about talking. I knew I'd got something wrong and it was to do with eating and I knew it was something up there. It wasn't physical. It was emotional because I could lose weight but when my mind clicked I was losing weight it was like a switch, I ballooned, I just went a stone heavier than when I started" (Interview 2 Paragraph 9).

This comment was made in response to a question about the reason for attending existential therapy and the client continued the discussion with allusions to food cravings, and a similar drive to go out for food as Rachel;

"…… I didn't want to know how much I'm losing or how much I've lost …… And then I come to the week where they tell you what you've lost. I could feel the switch go in my head. I couldn't stop. It doesn't matter how much I've tried I couldn't stop it and I binged and binged for six weeks and I put on more in six weeks than I lost in three months…… I had to learn to control what I ate but now I'm more aware of what's needed and what's not. It came to me out of a compulsion to eat everything in sight. Where as now I

say well, I don't need that or it doesn't bother me. Two years ago if you'd have had a piece of chocolate cake in front of you and a small piece in front of me I'd have been livid. I couldn't have gone into a coffee shop and just had a coffee. I'd have had to have a coffee and a cake and I can do that now and it doesn't bother me. I'd have off-days ..... I know I'm doing it and I let it go and in twenty-four to forty-eight hours I can eat everything" (Interview 2 Paragraph 10).

Gemma was very aware of the effects of eating and mood states and would often engage in bingeing in response to her emotions. This was explored in therapy;

"Food was all I thought about, what I could eat. The feeling of guilt learning the difference between emotional hunger and physical hunger was hard because it produces the same kind of reaction, learning the difference between being angry. If I was angry I ate, if I was happy I ate. If you asked what I wanted to do to celebrate I would eat" (Interview 2 Paragraph 16).

This need to have a ready supply meant that the appearance of obsessive/compulsive traits could be easily observed. Yet the client appeared to see that such compulsions were behavioural manifestations of the drive to ensure cravings could easily be satisfied and she often referred to such behaviour within addictive parameters.

"..... physically you can be grown up and if you don't emotionally mature and sort things out then you will always have a problem or whether you become an alcoholic or whatever ..... Everything else can go to pot as long as your emotionally stable. If you're not ..... you haven't got a cat in hells chance of anything working over a long period of time ..... always being on a diet and I didn't want to diet for the rest of my life ..... because I could have gone from being a compulsive over-eater to an anorexic very easily. Food was all I thought about. I planned my day around where the food was going to be and where I was going to eat" (Interview 2 Paragraph 15).

Later in the interview, in response to a question asking her if she had any ideas on why existential therapy worked the context is again put in addictive terms;

"I just know it worked. I knew I'd got an eating problem ..... I didn't know how eating problems worked, I'd read a few books and that's how I worked out that I had an eating problem. I did a questionnaire and if you got ten out of twenty you had it and I got nineteen and I thought, oops it makes perfect sense. My sister read it and it didn't make sense to her but she's not got an eating problem ..... I got onto Mike ..... I just assumed he would tackle the eating, I didn't think he would tackle everything else. He looked most at the emotions and I think because he goes after a specific that makes it a much better therapy than just general. Alcoholics need to see therapists who know about alcohol" (Interview 2, Paragraph 19).

During the therapeutic process itself such observations were often explored with clients and recorded in formal assessment and referral letters. For example the second review report sent to the referral GP after seven sessions with Andrea it is recorded that the client "states that the eating pattern is addictive" (Letter 2 Paragraph 3) and that as the therapist I noted that "there does appear to be a conditioning process involving a complex interaction between a glycogen rush and physical relaxation which is artificially maintained" (Andrea, letter 2 paragraph 5).

After six sessions a review report regarding Chris who was diagnosed with anorexia nervosa shared a similar pattern recorded "she continues to have a very low food intake and describes what appears to be hypoglycaemic episodes alleviated by taking glucose syrup" (Chris, letter 1, paragraph 3). Whilst low mood and anxiety were often observed in clients this was not always the case. In some contradiction to the theoretical premise that bulimic behaviour has depressive traits the initial assessment of Gemma states

"I found no demonstration of underlying depression or anxiety" (Letter 1, Paragraph 4).

However eight months later a further review noted "I feel fairly certain that many issues she identifies as anxiety-provoking are a mixture of her projection of anxiety (that she has to, at some stage, face her unhealthy eating habits) and the fact that she lacks the will to tackle her eating habits. By the lack of will I

mean that she is overcome by the thoughts which surround a healthy-eating plan which are, in the main, negative" (Letter 2, Paragraph 5).

It was apparent by this stage of therapy that symptoms of anxiety and low mood were precipitated by thoughts of changing her eating pattern and due to the over-eating itself (which remained a comfort behaviour). Six further months of intensive existential focus on her eating habits led to the next review which records;

"she believes that her coping skills have increased greatly during this period. Her anxiety attacks have ceased and her previous low mood rose in May of this year" (Letter 3, Paragraph 2).

This pattern of progress was common in all clients and the research data presents a picture of low mood and anxiety rising and being most prevalent when it was time to change eating patterns. The common symptomatic presentation found in clinical work may therefore be due to the clients interpretation of their environment as one which is there to produce a result, a change in their eating habits. Perhaps like individuals viewed as substance misusers admitted to a clinic to prevent further abuse interventions are seen as the period to stop current habits. Continuing a disordered eating pattern is depressing but changing the pattern is even more depressing and anxiety provoking.

The three stages of open coding the research data reveal this prevalence of food and mood interaction and its hold on clients as therapy progressed

irrespective of the clinical diagnosis and serve as a reminder of their underlying similarities in all three conditions. Case note codings stage one reveal "anorexia nervosa", "grief" and "hypoglycaemia", (Chris). "Bingeing", "sadness, "high fat and high sugar food stuff" (Beryl). "Bingeing", "carbohydrate foods", "grief", "sadness" (Dorothy). "Bingeing", "grief" (Rachel and Fran). First interview transcription analysis shows "addictive link", "feed by habit", "addiction" (Andrea). "Comfort in food", "physiological need to eat", "numbness", "hate food – my big enemy" (Dorothy). "Client relates to addiction", "life governed by food"; "binge-eats on sugar products" (Rachel). "Bingeing", "hit the sugar" (Fran).

By the third stage of open coding the following codes were repeatedly found in all transcript data; (number repeated in transcripts are in brackets). Physical problems (20); history of negative past therapies (13), bingeing (25), low mood (24), anger (16), guilt (11) withdrawal effects from bingeing (18) feelings of exclusion (17), addictive link (13), increase in symptoms when therapy commenced (26).

The Additional Source Records also note the repetition of addiction noting "Addictive behaviours" alongside "depression" and "obsessions". These Records which contain emerging thoughts as data analysis progressed also note "the relationship between mood and sugar/fat/ carbohydrate", "the high level of addictive behaviours" "bingeing seems to be "letting go"; "the high level of numbness"; "Prozac-like effects. It is literally comfort eating"; "the severity of physical discomfort experienced when bingeing ceases (coded as

withdrawal effects)", "sugar? – what's in this? – "is it addiction?" "physiological effects of glucose/carbohydrate/fats?" "letting go – ref bingeing – is this related to Heideggers inauthenticity – "falling"; "spiritual aspect of numbness – is it asceticism?", "is over-eating related to serotonin and is this comfort eating?", "is eating disorders addictive?". Such thoughts were recorded as saturation reading occurred and grounded theory codings took place and were kept in a separate file and not scrutinised until axial categories were identified. As has been mentioned earlier different data sources supported the contents within each other and the Additional Source Records were found to contain emerging observations which succinctly coded data, which was also found amongst various data sources. The axial categories for example contain similar observations.

In the final axial category of client history can be found the codes "fat/sugar/carbohydrate food link" and "addictive behaviours". Whilst the axial category of the negative effects of eating disorders show "high fat foodstuff"; "high sugar foodstuff"; "high carbohydrate foodstuff"; "addictive behaviours"; "substance abuse (alcohol, drugs, laxatives)" and "numbness". In the axial category recording the effects on the clients during Phase I/II therapy there is an increase in virtually all negative symptoms including "increased bingeing (sugar/fat/carbohydrate foodstuff)"; "negative weight gain"; "negative weight loss"; "increased laxative use"; "withdrawal effects"; "increased numbness"; "restricted food intake (negative)"; and "increase in existing symptoms". Alongside these addictive traits are the commonly noted obsession with food, low mood and anxiety.

Existentialism is concerned with the Self and the interaction with the objective world and the interpretation given to such interactions. It is therefore interesting to find an addictive context for the clients relationship with food (whether they have an increased or decreased intake) and its effects on the attainment of numbness. Cohn (1997) cites Medard Boss' view on Heideggerian Dasein as being aware of "objects and people who are with the individual in a shared world and not just having awareness of the subjective Self". Interaction (engagement) with what is perceived in the world raises awareness of the Self. A refusal to interact (disengagement) can lead to anxiety when faced with the unfamiliar in the world as well as a lowered awareness of Self. This may be what is being observed in the numbness experienced by individuals in this study. It is a mechanism (suspicion lies in a physiological interaction between glucose, the enzyme tryptophan and the dynamics of the hypothalamus-pituitary-adrenal axis) which allows the Self to disengage from the world. Bulimic behaviour appears to cause a fast but short-lived disengagement whilst severely reducing food intake causes a slower but longer-lasting disengagement. Perhaps as the condition diagnosed as mania is perceived to have similar roots to depression so the effects of bulimia has similar physiological roots to that found in anorexic behaviours. One is over-dosing whilst the other is severely reducing what is the normal physiological reaction brought about by a "balanced" diet. Repeated episodes causes a conditioned response which disengages the individual from all the anxieties found when interacting with people and the objective world. What may begin as a desire to stay within the subjective Self however seems to quickly disintegrate into loss of control of the disengagement process as

addictive craving takes hold of the physiological mechanisms. Further disengagement may only be found in a reduction in interaction with the body itself; the dualism described by Malson (1998) and the fragmentation described by Duker and Slade (1988).

The failure to support the internal subjective environment is close to Descartes early thoughts on the distinction between mind and body. Cottingham (1997) interprets Descartes views on dualism as the individual inferring that "essence consists solely in the fact I am a thinking being. It is true I may have .....a body that is very closely joined to me. But nevertheless, on the one hand I have a clear and distinct idea of myself, in so far as I am simply a thinking, non-extended thing; and on the other hand I have a distinct idea of body, in so far as this is simply an extended, non-thinking thing. And accordingly it is certain that I am really distinct from my body and can exist without it". (Cottingham, 1997; p32). Within a discourse on existentialism it should be noted that Descartes essence relates to the conscious awareness of Self as a thinking being. This is quite different to Sartres' (1943) definition of essence which is concerned with a persons past. Descartes dualism seems to be a trap into which fall the individual with eating disorders. There is a gradual reduction in Dasein existence which is driven by raised or lowered food intake. The individual is isolated from the world but in control of the inner environment for a while. Unfortunately the body is not separate from the Self in its physiological environment. The essence which Descartes discusses cannot survive without bodily sustenance and it is a real source of frustration and anxiety for the individual when the body fails to support the process of

disengagement from the objective world. In extreme cases the physiological deterioration continues as the individual strives even more to control food intake and maintain a subjective awareness of Self. Eventually the state of numbness is reached and brings with it the relief from the anxieties and tensions of controlling the inner environment.

Full disengagement from the world and the Self can thereafter be accessed through continuous very low food intake, continuous very high food intake or periodic bingeing. But, like other forms of substance misuse, the body soon tolerates the dosage of food intake and further effort is required to reach the numbness. Within a relatively short time the common physical and psychological ailments of eating disorders are demonstrated and continuing disordered eating leads to the well-researched and observed chronic illnesses.

Cottingham (1997) shows that Descartes often used hunger and thirst as examples of the mind and body interacting. In later thoughts on the subject of the sense of the awareness of Self he (Descartes) stated that such awareness was based on the joint interaction between the mind and body and the interpretation given to sensory input. These include emotions as well as the five senses. Descartes moved towards thinking that there is an intimacy between the mind and the body that creates the state of humanness and the sense of essence although he never explicitly gave up the idea that the mind may be separate. For the individual with eating disorders the separation of mind from body becomes a major struggle as it is via the body that the initial isolation from the external world is processed. The physiological mechanism however can only be controlled for a short while before the body rejects any

attempts to reverse the process. This will be discussed in more detail later but the continuing drive to achieving numbness has existential aspects which may be of importance.

Yalom (1980) discussed existential isolation as experiences which reveal the inner nothingness at the core of being and demonstrate the Heidegerian viewpoint that the external world is a lonely and unsympathetic place. Yalom describes the feelings of dread when the individual realises that their interpretation of the world as one of familiarity and comfort can be quickly proved wrong. The objective world is one where uncontrollable change occurs and existence takes place in a state of flux. The immersion in the objective world through roles, status or materialistic wealth can be attempts to avoid such dread. Life itself causes so many dynamic reactions and interactions that it may be possible to avoid confrontation with the knowledge of the individuals aloneness. Yalom (1980) cites Kierkegaard and Heidegger to support his view that immersion in the world cannot always guarantee escape from the ultimate dread of all; that knowing there is nothing, and no being that can help the individual when facing their aloneness and that the core of aloneness is itself nothing. (Nothing is the word used by Sartre, 1943; Yalom, 1980; Heidegger cited by Mulhall, 1996).

Fromm (1956) suggests that this knowledge of aloneness and separation in a world which cannot be controlled is the source of all anxiety. The awareness of being seperate can cause so much anxiety that an individual can choose to make repeated attempts to interact with others or choose to withdraw from

others. Cohn (1997) goes so far as to state making no choice is a choice. Irrespective of the choices made there is always anxiety because the outcomes of such choices cannot be guaranteed. Hence the drive to control or manipulate others in an attempt to influence outcomes.

The individual with an eating disorder does interact with others in the world yet attempts to hide their pattern of eating. It is a secret activity which may be revealed through interaction with others and so one choice to reduce such anxieties is to reduce the opportunities to interact, to become lonely even when in company. Control appears easier because what is being manipulated is the relationship between the subjective Self and the objective world. However further anxieties are instilled as the isolation from others offers a glimpse of Yaloms (1980) dread and the interpretation of Self as based on No Thing and furthermore their control of others is loosened. Fromm (1956) suggests that in such situations the world can invade the inner Self in a surprise move because the Self is not watchful. Anxiety and depression occur periodically as the Self strives to control the inner Self without experiencing the dread of isolation and strives to maintain the intake of food without interference from others. It is not surprising if the state of trance-like non-consciousness is a relief.

Van Deurzen-Smith (1988) provides a good example when she discusses how absurd is the drive to organise life by pretending that living is safe and reality controllable. She notes that it is often the individuals who try the hardest to interpret life as predictable and secure who are most often reminded of their

limited coping mechanisms. Van Deurzen-Smith presents her example as the experience found in withdrawal effects after drug use. The false sense of peace is at the cost of increased anxieties later when the individual attempts to cease taking the substances. This is in effect the cost of escape from lifes anxieties. It is short-lived and it is much harder to engage authentically with the world afterwards.

The existential viewpoint is that engagement with the world with all its inherent anxieties is a form of freedom (Van Deurzen-Smith, 1988; Yalom, 1980; Sartre, 1943; Heidegger cited in Mulhall, 1996). Withdrawal is a form of inauthentic existence. The temporary sanctuary of numbness is not authentic existence because in such a state there is no internal debate or interpretation of Self occurring. Sartres' essence (1943), the individuals past, occurs in the dimension of time which physically ages the individual and his premise that essence occurs as a person lives and therefore makes his or her present time is still maintained even during periods of non-consciousness. The individuals return to conscious awareness means their time in limbo is still relevant and the world is still existing even though the individual strives not to interact with the world. The attainment of a state of numbness is a temporary state of non-awareness not an escape. It is a form of non-authentic living. Yet as discussed earlier the difference between authenticity and inauthenticity can be viewed as a process which can lead to a more constructive form of living.

Both Yaloms' (1980) approach and Mulhalls' (1996) view of Heidegger suggest that the anxieties of awareness can lead to a more authentic sense of

aliveness and that existential isolation can be a basis for a more interactive relationship with the world. Mulhall (1996) suggests that Heideggerian authenticity means acting on the knowledge that existence is not due to fate and life is not destined to a set pattern. An individual has a life to lead and, importantly can lead their own lives. The experience of inauthentic living, avoiding the responsibility to live their own lives (Van Deurzen-Smith 1988) can however articulate the sense of authenticity. Mulhall (1996) suggests that this articulation could be helped by a third party who engages in a dialogue with the Self and encourages reflection on the Self as a separate, self-responsible being who can influence their own life. Mulhall puts the third party in the context of an internal dialogue not far from Sartres' (1943) reflection wherein consciousness is a process of examining the Self.

Van Deurzen-Smith (1988) suggests that the existential therapists can support and encourage such a dialogue by helping clients to gain insight into their own intentions. This insight gives an increasing range of decision-making strategies allowing the individual to have some control over living. Van Deurzen-Smith translates authenticity in such a context as "being true to oneself" (page 48). She goes on to say that signs of authentic living are motivation, enthusiasm to do what is worth doing, increased vitality and enjoyment in living. Signs which are absent in the life of the individual experiencing eating disorders. Authentic living is an awareness of the reality of the world and a process which recognises the limitations both of the Self and the situations found in life. Experiences of pain, loss and unfilled

ambition whilst remaining true to the decisions made about self-direction are therefore aspects of authentic existence.

Horrocks (2000) interprets Heideggerian Dasein as the individuals lived experience and engagement with the world. Whilst not discussing authenticity Horrocks provides the view that the individual applies practical engagement with the objective world to demonstrate Being-in-the-world and rejecting individualism, subjectivity and objectivity. Being is the living experience of the present and the acceptance of existential givens. (Where a person was born, the circumstances of ones early life, the role of parents). Like Van Deurzen-Smith (1988) Cohn (1997) suggests that this living in the present means acknowledging how the past influences the present life and accepting separation and the pain of loss as authentic experiences.

Yalom (1980) states that facing and understanding the isolation of the Self allows the individual to be more loving towards others. The experience of the individuals sense of apartness raises awareness of the separation of others and recognition that others lead a life within their own self-constructed world. Understanding the aloneness of others can also provide insight into the present life of the Self. Yet the individual experiencing eating disorders often isolates themselves in the very practices which is their present everyday existence. The locus of control over their daily living becomes ever narrower and in effect they exist with the pattern of eating controlling them. Not only is it difficult to help give what Van Deuzen-Smith (1988) calls sign-posts on the road towards an authentic existence it is also difficult for the therapist to

understand that the isolation and loneliness of the Self enmeshed in the experience of disordered eating has passed beyond the point to even motivate the individual towards therapeutic interaction. The presentation of anxiety and depression becomes even stronger as therapy progresses. Both Yalom (1980) and Van Deurzen-Smith (1988) comment on the increased anxieties demonstrated by clients exploring and reflecting on the Self and existence.

The phases of therapy in this study were deliberately adopted to take account of such factors. Early sessions concentrated on building up the awareness of Self through reinforcement of positive self-image and interaction with others (self esteem phase). Only when the clients demonstrated through self-reporting that their self-esteem was stronger did the focus of therapy move on to expanding the locus of control. (Self-assertive phase). The existential focus on authenticity began when the client demonstrated successful outcomes in decision-making exercises. Whilst an increase in negative mental health symptoms was expected during phase II and III of the therapeutic process what was unexpected was the level of physical discomfort associated with the reduction in binge-eating and the negative effects this had on the individuals efficacy.

Conclusion Three

This conclusion supports the addictive quality of disordered eating. Mention has already been made of withdrawal effects and these were persistently raised by clients and often encountered during grounded theory coding. Despite showing what would normally be considered signs of more control over their

eating habits clients often displayed negative symptoms which slowed the process considerably. Gemma experienced the expected heightening of symptoms when her symptoms of depression worsened. However when she started to reduce her bingeing she reported;

"…. I don't binge as much, I don't overeat as much. After saying that I've put on a stone since seeing Mike but that's due to bad depression that I had just after Christmas and I'm back on medication…….. I find doing the counselling extremely hard, most people think it's easy, its not. It's one of the hardest things I've done in my life. I find it very scary. It gives me nightmares. I can tell how good the sessions are going by how I'm eating and how the nightmares are. If everything is ticking along then I know I'm not doing any work ……." (Interview 1 Paragraph 22).

By the time the second interview took place there were no negative symptoms reported yet for a long period all attempts by Gemma to stop bingeing brought a return to insomnia and, if she did sleep, persistent nightmares.

Rachel also reported a rise in depressive symptoms but additionally noticed the connection with food intake. Asked when is her depression lowest she responded;

"When I'm bingeing but its worn off. 'Cause I have sugar addiction so I can go a couple of weeks eating sugar and I'm as high as a kite really and I don't care and it's alright but there's an inevitable come down from it all and that

when I'm at my lowest. But also if I decide to stop eating sugar then for the first few weeks I have depression then. There's a shot term or longer fluctuation" (Interview 1, Paragraph 11).

In the second interview she remembers what life was like prior to attending therapy sessions. The constant visits to the shops for biscuits and sweet things and the physical symptoms of puffed up eyes and diarrhoea. However the change in such eating habits was difficult. She noted that:

"I've identified sugar as the main thing. I've not eaten the same; well I do overeat sometimes but all the physical effects have gone .... Emotionally I'm really shaky at the minute. So I'm trying to cling on to it. I've been trying to stick to three meals a day and the group, and I'm trying to see it as a long process instead of dieting again which is what I'd normally do and just face all the feelings that come up with it. It's been really painful I think and I've struggled with it ..... (Interview 2 Paragraph 8).

Later in the interview she repeats herself in a different context;

"I'm more confident and also my emotional life although its painful is a lot better because usually its just numb. My good emotions are numbed as well as my bad ones really ..... I'm sort of in a relationship now and struggling but I've started it since my eating in these last few months and it is painful and I'm struggling just a bit from insecurities and jealousy and all sorts of things where I would just normally eat and ditch the relationship and eat and eat.

You see I never raised, a big thing that came up for me was how much of an excuse I used not to do things really and it was binge .....it was a way I could cop out from doing anything. It wasn't really the eating it was to do with more emotions and stuff. Things that I was frightened of I would use it as a way to cop out ....." (Interview 2 Paragraph 10). When stress increased so did the reliance on bingeing as avoidance but even when she was stronger the pattern remained. "I was beginning to feel emotionally a lot better and I was wondering why I still felt the need to binge and a lot of it was physical" (Interview 2 Paragraph 13).

It is difficult to ignore the physical persistence to continue disordered eating even as there is a growing awareness and experience of an increased locus of control. Yalom (1980) suggests that there is a period in the therapeutic process wherein the client straddles "the fence between living and not living" (Page 201) and this may be the period when the physical effects of anxiety replicate the craving to eat for Rachel. Fromm (1974) puts forward a similar view that what he called compulsive eating is driven by psychological and not physiological hunger. Feelings of anxiety, depression or existential isolation fuel the psychological hunger. Fromm was well aware of the view that overeating was caused by depression and inadvertently passes comment on the physiological effects of food intake when he noted that eating fills an inner emptiness and temporarily displaces the feelings of depression. The inner emptiness and isolation cannot be faced unless there is a centre to the Self which is strong enough to accept present existence and take a certain control over circumstances. Disordered eating is a maladaptive attempt to fill the

inner emptiness rather than accept the angst of existence. The individuals sense of efficacy over food intake (a diet regime for example) is quite good until the physiological processes wrench control from them and eating thereafter is dysfunctional.

Yet there is hope in such a narrow locus of control because the awareness of inauthentic existence helps the client towards authenticity, of being true to themselves. The release from the state of numbness is one of the most important steps because the numb condition prevents the development of the Self. The closest definition to such an experience is that which Sartre (1943) calls non-conscious. This is different to psychoanalytical subconscious or physiological unconscious. Like a baby in the womb the individual in the numbness reacts to external stimuli but is not aware of Self in the sense of awareness of the existence of Being-for-itself and Being-for-others. The individual exists but is neither aware or unaware of living. Wrestling with authenticity and inauthenticity wearies clients in existential therapy and the numbness provides rest and relief periods. The continuing physical cravings and discomfort when the process towards numbness is changed reinforced depression and anxiety and pulls the client towards the not living described by Yalom (1980).

The process of control to loss of control and then back to control over food intake is described by Beryl (who was first interviewed after only 2 sessions). She observed that "I think I came aware that my weight was a problem back at primary school because I do remember going on my first diet when I was ten"

(Interview 1 Paragraph 19). Nineteen years later she was referred to the eating disorder clinic by her GP because she had not been able to follow a diet regime for a considerable period of time. When it was pointed out that she had been strong to continue to manage for so long she responded;

"whenever I went to the doctors before, even if it wasn't about my weight……. it was always, you know, eat less and get more exercise. It was a case of go away and do that so that's what you've got to do. I think the older generation of doctors have now left our practice and we've got younger doctors who've got newer approaches" (Interview 1, Paragraph 21).

Attendance at the Eating Disorder Clinic provided an environment for the client to reflect on what she expected from existential therapy; "I want to go away with at least some idea of why I can't stick to diets" (Interview 1 Paragraph 22). The locus of control did alter after only a few sessions she explained;

"I think one of the main problems was that before I started coming here I thought it was all my fault. That I ate when everybody else could stick to a diet and I felt pretty useless about that, but Mike's explained certain facts to me that I take away with me and I think well its not entirely my fault – this has happened and that has happened" (Interview 1 Paragraph 28).

Beryl went on to say that the issue of sugar addiction was raised in her first therapeutic session (assessment phase) and she remembered that

"Mike told me basically that when I went on a diet I would have these overwhelming urges to have something with sugar in to give my body a boost. And I didn't realise that it was my body saying I must have sugar. I thought it was me that had no willpower and that I was just a bit weak……it was a big relief really. I stopped blaming myself as much and it increased my self-confidence really. I stopped giving myself a hard time" (Interview 1 Paragraphs 29 and 30). Like Rachel and Gemma as Beryl's therapy progressed the pattern of physical discomfort and psychological stress was again observed. She replies to a question to expand on her increased self-confidence and motivation with;

"…. I've realised that my problems aren't entirely down to me being a weak person or having no will power, there have been some physical problems which have got in the way of me attaining my goals which I wasn't aware of before so having an understanding of those has helped me really" (Interview 2 Paragraph 2).

The physical problems occurred when there was a change towards more fruit and vegetables in her diet and a reduction in coffee and chocolate "…… I did have some quite severe headaches that lasted a week and diarrhoea and things like that" (Interview 2 Paragraph 13). As therapy progressed a growing resistance to cravings was also noticeable and supported Van Deurzen-Smith's (1988) observation that authenticity is following decisions made about living and taking responsibility about life; "…… I think before I tried to diet and I

suddenly had a craving for some chocolate I'd probably end up eating chocolate because I'd talked myself into a frame of mind where I'd be thinking what's the point, I've got so much weight to lose. I've been here a million times before, don't put myself through the misery, just have the chocolate and be done with it. But now I think, yes its worth resisting because I do feel confident that I'm going to get where I want to be and obviously that means making steps towards what I'm eating now……I'm drinking tons of water and trying to shift towards healthier foods and keeping away from fast foods, chocolate and all the rest of it" (Interview 2 Paragraphs 20 and 21).

In reply to whether changing her eating pattern was a struggle she noted;

"I have to be more organised……. it takes a bit of planning to take a lunch box to work thats full of health food. Before it was the convenience of being able to run out at lunch time and grab a mars bar but now I'm more organised and I get myself sorted then I think that's half the battle really" (Interview 2 Paragraph 24).

Nevertheless the struggle was ongoing. In response to whether she could decide between an example of chips and baked potato her response was "I'm not quite that good yet" (Interview 2 Paragraph 25). As with other clients the withdrawal effects created an unpleasant experience;

"….. I gave up the caffeine and I had this horrendous headache….." (Interview 2 Paragraph 26).

The craving for chocolates and caffeine was placated by "drinking lots of water, ….. fruit and low fat bars" (Interview 2 Paragraphs 29-31) but the struggle between what Yalom (1980) referred to as existing between living and not living continued for some time. In response to the question on whether Beryl would return to past habits in a crisis or when experiencing depression she replied;

"No I don't think I would 'cause I had a bad time a few weeks back and I did think if I'm not careful here all my hard work is going to waste but….. just sort of knowing that was a possible pit fall approaching me helped me not to fall back into my old ways really" (Interview 2 Paragraph 33).

Chris who experienced anorexia nervosa, indicated her struggle to move towards authentic living by stating that she began to eat more when in therapy. She began the process of "bringing everything out. You're not as disgusted" (Interview 1 Paragraph 18). As she took more responsibility for her lifestyle she found that "……. I didn't eat but now I do try and eat even though it may be an apple or yoghurt" but "I still want to be really thin but I am trying" (Interview 1 Paragraph 20 and 21). Several sessions later her efficacy had improved:

"It must be working 'cause I actually avoid the scales now and I used to weight myself and that at first. I used to weigh myself every day and now I don't get on them" (Interview 2 Paragraph 7).

"Well I know I'm putting weight back on again. I feel that but by not actually seeing it doesn't seem to trigger. Well I'm not eating anymore again. And I'm managing to eat.....I actually go out. I don't always have a main meal, perhaps a starter, but its more that I used to be able to do anyway and I eat in an evening now, not a lot but better. I don't feel quite as guilty now" (Interview 2 Paragraphs 8 and 23).

An increase in food intake seemed to influence her mood state.

"..... the depression has gone and the manic phase is going.....I've not got the moodiness and I've got more patience" (Interview 2 Paragraphs 24 and 42).

The increase in decision-making was aptly demonstrated in her process towards self-responsibility when she ceased taking a major tranquilizer. She had been on such medication for "eleven years and about three weeks ago I actually stopped taking Melleril 'cause I didn't want to any more and have had no knock on effect. In fact I feel more awake" (Interview 2 Paragraph 31).

Such a change, as her diet and food intake improved, appears to lend some support to Laings (1960) view regarding what he termed the Embodied Self. Laing argued that the embodied person feels more alive, real and worthy when the body itself is experienced as alive, real and worthy. Such a sense of being in the body provides an awareness of personal continuity in time and all the

physiological change that will occur as the body ages. The unembodied state is found in individuals who experience a mental detachment from the physical body. Laing was concerned with the experience of schizophrenia but also noted that stress or perceived anxieties can give a sense of unembodiness. The embodied and unembodied Self have no existential values such as those found in authenticity and inauthenticity and care should be taken when reading Laing that such confusion does not arise. The awareness of Self in either state influences the engagement with the world and influences how that is implemented. Laing posits a view which supports Descartes (Cottingham, 1997) argument that the sense of Self as in the body or detached from the body has no physiological objectivity but rather this sense of Self is engaged in collaboration with physiological processes. What is important is the way an individual engages and interrelates with people and objects in the world and that this engagement can be carried out whether the Self is embodied or unembodied. Through existential reflection Chris appeared to shift from an unembodied sense of Self towards an embodied sense of Self and as the numbness was overcome a sense of being more alive and real became more apparent. In her struggle to regain control of her eating she proceeded through an experience which Laing (1960) called the self-body dualism. An awareness of the state of being in embodiment or unembodiment in different time frames and situations.

Sartre (1943) observed a similar existential phenomena in his discussion on the body and he suggests that Being-for-itself is both wholly the body and wholly consciousness but they are not reducible into one or the other. He goes

on to say that Being-for-others is a physical encounter, there is no mental processing which can unite one person to another. Sartre states there is "no psychic phenomenon" (page 305) yet he insists the body is wholly psychic in the sense people make sense of mutual interaction with others through physical perceptions. This may be the experience of the client after severe fasting and whose perception of the Self is influenced both by anorexia and the achievement or temporary disengagement through numbness. The process towards attaining this state takes the individual from the embodied to the unembodied sense of Self. The process away from numbness appears to take the individual from complete disengagement, to the unembodied sense, to the Self-body dualism and then to embodiment. Interaction with others is increased through the use of the body in familial and socially shared behaviours and reinforces the sense of being-for-itself because of the engagement in being-for-others.

In this way Yalom's (1980) point that the awareness of the aloneness of Self and experiencing the nothingness at the core of Self allows an improved understanding of the aloneness of others and more understanding of the interaction of others to self. For example Chris noticed as she became more in control of her food intake that she was more aware of others in group sessions. On talking about one group discussion she found that questions were aimed at everyone in the group;

"..... he doesn't just aim at one of us, at first its one of us and then its someone else. It gives you a chance to reflect then on what's being said and they are

very similar things at the moment" (Interview 2 Paragraph 14). In reply to the question of whether she was no longer feeling alone in her struggle with eating she replied "yes, at last" (Interview 2 Paragraph 15). In a later discussion on her returning sense of health she was asked what she believed was the main catalyst for change;

"I can't find a reason at all. I've already been through that and I can't find any reason other than this group that's been any different" (Interview 2 Paragraph 32).

".... Its very friendly. If you've got something to say that sounds stupid you've got a lot of support there (Interview 2 Paragraph 34).

"It helps us to understand and get some insight into everything" (Interview 2 Paragraph 45).

Chris' eating improved alongside her growing reflection and insight into her past life. What Sartre (1943) called facticity, (the givens of her life) was gradually being accepted and there was a release from the guilt and anxieties expressed about her traumatic childhood. Chris began to display the authentic characteristics described by Van Deurzen-Smith (1988) when she broke away from her perception of her past (her essence) as one in which she colluded. The innocence of childhood was not a narrative she could give yet she altered her perception towards her faciticty so she could narrate that she was nevertheless an innocent child. Chris altered her abilities to respond to the

world away from the positions Cohn (1997) called manic, and depressive. ("there is nothing I can't do" and "there is nothing I can do" Cohn, 1997; page 124).

Yalom (1980) repeatedly stresses a point also made by Van Deurzen-Smith (1988); existential therapy can provide insight into the Selfs sense of Being but not necessarily provide a happier condition. Dorothy in her first interview highlighted the frustration of her bulimic pattern increasing as therapy progressed. After three sessions she felt that;

"...nobody give a stuff and its too late anyways. I don't know, I do feel like its been too long. I started so long ago I feel like its too late .....I feel as if I'm not going anywhere. I don't. I've talked about certain things but mostly about my husband but I feel at the end of the day its not about him .....the fact that I've got problems with my husband is a side issue.." (Interview 1 Paragraph 18).

Yet the sense of isolation and loneliness in her marriage was also apparent. "The loneliness is frightening ....." and ".....if others don't make me feel loved I feel terrible. You can't make people love you ..... you can't" (Interview 1 Paragraphs 19 and 20).

However therapy couldn't progress because of her weariness "I'm just tired, I'm too tired and I don't want to fight anymore" (Interview 1 Paragraph 24) and some time was spent in phase II on building up self-esteem. As had been

found in other clients as the bingeing decreased the physical symptoms worsened "…. I probably eat much less than I used to but because of my diabetes whatever I do eat has such a huge impact on that. That's what makes me panic and I'm not controlling it and I can't get to grips with my eating and I do binge but its nowhere near as much as my olden days and still my sugar is out of control and that panics me because I think its going to be too late. It's just too late" (Interview 2 Paragraph 3).

The focus of therapy continued to be painful;

"I like seeing Mike. I like seeing him. It just painful when I see him. When I come out I'm exhausted. I feel guilty because all I've done is talk about me and I feel terrible because I suppose what the main thing that he had done is let me feel things. He doesn't tell me off for the feelings that I have and I spend my whole life hiding what I feel and so its quite hard to come here and know that within five minutes he's going to know that I'm not okay ……" (Interview 2 Paragraph 9).

The focus on her relationship with her husband in therapeutic sessions would quickly reactivate the addictive craving to binge and this physical manifestation of her sense of isolation and what Fromm (1974) termed emptiness would sabotage further exploration. Discussing her growing self-assertion towards her husband she noticed that;

"..... I might want to talk to him about something, knowing that I can't because he's not interested and then at times when I'm feeling okay I think, well stuff you. At other times when I'm not feeling okay I could go into this downward spiral and I'm just dying for him to get out of the house and then I would be straight at the cupboard. So I would say there's still a tendency to go to food" (Interview 2 Paragraph 22).

As her anxieties and her depression increased her blood glucose level stayed high but a growing realization that her marital relationship was a contributory factor was now more openly discussed;

".... that recognition ..... it is a pattern that's repeating itself and that you did react that way because of what had happened, or not necessarily because of what had happened ....." (Interview 2 Paragraph 30).

But the physicality of craving also continued; "..... there are times I really feel I'm not going to make it. That its too late and sometimes I can still feel that it's just ..... peaks and troughs and I get really upset about it.....it's a behaviour that I've done for absolutely years that its easy to slip back into and I've always thought the food is there and that's the thing that only ever is. Other people aren't there ....." (Interview 2 Paragraph 36).

Therapy was difficult because of the grief of isolation, the physical illnesses experienced and lack of togetherness in the martial relationship. All the clients' attempts to disengage failed because engagement with her husband

was what she needed. Fromm (1994) discussed love in the context of greed. Not greed in the gross physical selfishness of depriving others of goods but in the existential sense of the person who lacks self-love. This lack of love is a source of frustration and anxiety and can stimulate compulsive eating. Dorothy demonstrated this behaviour because her perception of her own facticity made her see herself as unlovable and unattractive. Yalom (1980) mentions the same greed in the context of love and suggested that the experience of the contact between Self and others requires discourse; either verbally or non-verbally. The mutuality of expression towards each other was absent in Dorothy's relationship although communication existed on a more superficial level. The intimacy of love based on desire (to want to know each other) was as badly damaged but the thought of a dependence-based need for love was also upsetting. Fromm (1956) discussed the elements of love as those which allow for integrity, individualism, respect, concern and knowledge of both Self and the other or others. Fromm pursues his argument by suggesting that whilst existential isolation is a given and separateness is a condition of living the potential to share and cope with the anxieties of life is enhanced most through mature love. Like Sartres' (1943) being-for-itself and being-for-others and Descartes view of the separateness of the mind and body existing in each other, Fromm (1956) noted that love is a process that allows two to be one yet always remain two.

Yalom (1980) acknowledges Fromms influence on his own view that love may be the best response to the anxieties of existence and therefore love requires reciprocity. The client Dorothy was aware of this point. Her longing

for mature love from her husband and her frustration at not receiving such love reinforced her bingeing behaviour. Unlike other clients the need to gain numbness was not to gain relief from the battle for control of eating but more to punish and harm herself for her perceived weakness for wanting love.

Towards the end of the therapeutic process this paradox became a focus for the client and it was clear that the physiological effects of bingeing were still potent;

"I think I've achieved a lot with Mike. A lot of self awareness that I haven't experienced before. I don't know why that is. I mean I think he concentrates on me and my relationships..... but he kinda always asks well where do you see yourself and what do you want which was a bit of a shock to me" (Interview 3 Paragraph 6).

"Mike doesn't really talk about that (behavioural stuff). Every now and again he'll say, well how is the eating going but its not really about the eating its always about other things. I feel I've progressed more with Mike than I've ever done before and I just think, sometimes I feel my backs up against the wall because I've got nowhere to run off and hide now. I know I've got to (this sounds a bit glib) but to feel the pain. I know that I control it which I thought I would never say. I said it to Mike the last time I was here. I had this huge binge, massive not just; normally like cruise eating. You top yourself up until you achieve a certain level of numbness and you have to top yourself up. But I had this massive, massive binge because somebody had upset me, and it

was anger. It was everything and I knew I wanted to do was to that fridge and eat until I was numb and it would work. I knew it would work and I hadn't done that for such a long time I didn't used to think about it. I thought I was out of control but this time I knew that it wasn't that and I was in control of that and I was doing all of it to control the anger, the pain, the fear. I didn't want to feel any of that so that's what the food is to me and that realization is horrifying in the sense that presumably the solution is that you've got to feel the pain. I want to run away from that and that's what I've always done and …. I could choose it, choose to eat this way …. But this was so dramatic and it worked. It's still there. It was physiological. I was numb for three days" (Interview 3 Paragraph 7).

"I don't feel anything. It's like being anaesthetised …. I went to the fridge and emptied the contents of it ……I knew that I was in control of that…. and I just slept and the next day I couldn't even go to the airport…. because I would have been dangerous in the car 'cause I'd eaten so much ….." (Interview 3 Paragraphs 8, 9 and 10).

The need for numbness was overwhelming and related to the relationship with her husband. The inauthenticity of the relationship became a constant source of anxiety for her sense of Self and full disengagement allowed a temporary relief from her subjective internal dialogue. But like other clients the motivation to face her concerns was harder due to the relief provided by bingeing. On asked if the "massive binge" was an isolated incident she replied;

"It was a one-off in the intensity of it. After that I just thought, God this has got to stop. I cannot keep running away from all these things. It was just like taking an anaesthetic when you don't want to feel. That's just how it was and I thought I've got to feel the pain but I don't' know how to do that. I've not had a major binge like that before but I have, I think, binged little tiny binges or cruise eat until the foods nothing in your stomach. You know its all rotten inside and that's 'cause I'm just so insecure and fear so many things" (Interview 3 Paragraph 12).

These fears were based on relationships and the final sessions concentrated on her interaction with others and objects in the external world;

"When Mike came he concentrated on my husband and my primary relationships but if it wasn't my husband it would be someone else, its all of relationships, it could be an event, it could be something about my credit card … and in all of those I would go for food ….." (Interview 3 Paragraph 13).

The final review letter to her GP records that Dorothy was managing her dieting intake and would not benefit from further work on disordered eating; she controlled the eating even if it was "tiny little binges". She was discharged form the clinic and referred to a relationship counselling service with the observation that the bingeing revolved around choices to be made regarding her marriage. These were identified as whether to continue to exist in the dysfunctional relationship; to try and change the dynamics of the

relationship in an attempt to find mature love or to cease the relationship by separation.

The client had reached a different perspective to her eating and gained insight into the connection between her efficacy and avoidance behaviour and she was now better prepared to change her engagement strategies with others. Yet such insight did not bring happiness and her present life, although different was still painful. Strasser and Strasser (1997) provide a similar example in a case study which related to a girl bingeing and suggested that bingeing was related to hostility and anger towards herself because of fear of failure. When not bingeing the client sought out and dated men in, for her, a doomed search for a meaningful relationship. Like Dorothy in this study even when insight was gained the bingeing still occasionally happened and presented itself to Strasser and Strasser as a compulsive behaviour. The escape from anxieties which bingeing offers physiologically does appear to become an ingrained habit. Therapy is then required when the bingeing controls the individual. But occasional bingeing during periods of stress appears to be a controlling mechanism which for a short, temporary, period brings relief and may continue even after therapeutic sessions. This was demonstrated by Andrea who responded if her bulimic habit had altered since experiencing existential therapy;

"Its not really any different now than to when I first met him even though I've said what I have in that I'm coping with my life a lot better because I think when you've got it, you've got it .... I'm still bulimic ..... you can still feel

very negative about a lot of things, it's just a challenge every day .... Its just in general getting up and facing each day when you know you've got that in the background all the time" (Interview 3 Paragraph 9).

Andrea had experienced bulimic episodes for twenty-six years and the habit was almost an aspect of her sense of Self and Being-for-itself. Sartres' (1943) facticity was an important element for the client for despite the givens of her birth and early life the essence of most of her life was composed of bulimic experiences. She wrestled constantly with what Sartre (1943) termed bad faith because Andrea was aware that the response of others to her bulimic pattern would be negative and so she interacted in a way she knew in the Being-for-itself and Being-for-others was not genuine.

" .... I think it must have affected my personality as a whole and I think what would I have been like without this eating disorder its bound to have been different. Its like living two people .... you've got the person that you cope with on your own but not really anyone that anybody can know about, and then you've got the person that everybody thinks you are and I feel really false, 'cause I've got ..... valued friends and I feel I'm constantly living a lie to them 'cause they don't really know me. Everyone seems to view me oh that happy young lass who doesn't want a fella and copes on her own and .... Everything's hunky dory. But they don't know when you go in, shut your door what your private life is .... there's many a time I want to go out and shout out, look I've got this, they'll either like me or not like me .... but people aren't educated to understand these things .... so it's easier for me to

.... pretend its not there .... I don't feel anyone really knows me because of it and its like there's a person that wants to be there and be liked, but they can't be there" (Interview 1 Paragraph 9).

Yet being genuine to her Self was acceptance of a bulimic life which she perceived as the Being-for-itself and like Laings' (1961) self-body dualism was a state she could adopt in response to anxiety-provoking situations. In everydayness (Horrocks, 2000) Andrea was in an embodied state and highly aware of physiological sensory input but virtually every evening she disengaged from the world and self by attaining the numbness or if that was not achieved then the state of unembodiedment through bingeing; ".... I was just on a pattern, it was every night just once and I followed that for weeks" (Interview 1 paragraph 12). As with all the clients with eating disorders the perception of Self and efficacy was gained from experience.

Yolton's (1961) edition of John Lockes work (1706) on human understanding presents a similar approach. Locke suggested that thought involves awareness, discernment, comparison, memory, will and abstraction which receive input from the physiological senses but importantly are derived from experience. The awareness of thinking of Self for individuals with eating disorders can be reinforced by what Locke viewed as the source of ideas. Thoughts which are derived from sensory observations and thoughts which are constructed from such observations.

Whilst Locke cannot be viewed as a phenomenologist or an existentialist (his own essence was in the givens of a monotheist society and his work is wrapped in the influence of 17th century Christian society) he nevertheless posited the idea that was close to existential angst. When he discussed pleasure and pain he observed that "..... the chief, if not only, spur to human industry and action is uneasiness" (Yolton, 1961; p190). Similarly on motivation and volition he argued that behaviour and attitudes will remain in the same state if the individual is satisfied with such a state. Like Yalom (1980) Locke suggested that the action to change is based on uneasiness (anxiety) and the desire to lessen unease even if the solution is unknown. The sense of being lost whilst searching for a solution can sometimes be relieved when the idea of hope and goodness is provided from outside the Self. (Similar to Van Deurzen-Smith's (1988) therapeutic sign-posts).

The motivation to change eating behaviours is often paradoxical for the individual with long experience of eating disorders. There is unease when interaction with others and the objective world is attempted and unease when the fight to regain control of physiological cravings is attempted. Disengagement does not work and does not allay unease. The experience of numbness (non-consciousness) provides relief from both battles and is extremely hard to change. But the relief is gained at cost to physical and mental wellbeing which in itself then causes anxiety. Eventually there is overwhelming depression and dread as the glimpse of the nothingness at the core of Self becomes clearer and the route of escape from existential isolation

is lost. Locke suggests that such despair precipitates unease (anxiety) or pain and the inability to change (Indolency).

This despair was observed in the sessions with Andrea who expressed her fears as the bingeing increased;

"... I don't know why but I've gone absolutely to pot and I'm at screaming point and I felt on a downer, you can't understand why its changed and why it is.....I got worse" (Interview 1 Paragraph 12).

The physiological effects were problematic as the craving to binge continued. These became worse as the tension for control continued;

".... I used to try and keep busy to avoid the food. Now .....there's no food about and I'm worse and I have been worse than I've been in a long time yet a lot of the pressure has been lifted off me....routine had changed and its got worse .....it starts going downhill....like you've done it twice today..... I'm going to do it loads tomorrow and cause its constantly there..... you'll perhaps do it two or three times and its really difficult to get back to doing it just the once....." (Interview 2 Paragraph 7).

"..... I don't feel any pressure, this is what surprises me now, why has it gone worse just recently. The only thing I can think is that the routine changed....you daren't eat in case you go overboard and you know you are going to do it again" (Interview 2 Paragraph 11).

Like Dorothy and the case study presented by Strasser and Strasser (1997) the bulimic behaviour continued during periods of stress but the meaning given to the behaviour had changed.

Yalom (1980) states that such existential meaning is related to creative activity, experience and attitude towards suffering. Therapeutic interaction with Andrea began towards the final session to explore the positive effects of nearly a life-times bulimic behaviour. For instance on reflecting on her essence (past) and the facticity of bulimia she noted;

"I can think back to when I was young, fifteen, sixteen, I started but I was making myself sick at seven, so (silence) I got to the point where I thought it was to do with when I was small .....then some have tried to put it down to my mum and dads divorce.....I wish I could have seen somebody a lot earlier when I was younger. But it probably wouldn't have been eating then it would have been something else" (Interview 2 Paragraph 11).

Taking Lockes (1706) view that her sense of identify was immersed in the experience of bulimia and that Sartres' (1943) sense of bad faith was painful to her perception of integrity and furthermore that the craving was physiologically distressing the therapeutic focus was on increasing the locus of control and reframing her perception of her past into a more meaningful frame. Yalom (1980) and Sartre (1943) argue that responsibility for ones life is an aspect of existential freedom and that the individual is wholly responsible for the actions or inactions in ones life; whilst Heidegger's Dasein means that

the awareness of the Self existing both in-the-world and simultaneously interpreting what is in-the-world indicates a responsibility as Being-for-itself.

Yalom (1980) goes on to suggest that responsibility for Self cannot be practised without action (which he calls willing). For change to occur there must first be an assumption of responsibility and a commitment to action. Yet this is one of the hardest aspect of change for clients with eating disorders. The step towards knowing what should be done is much easier than the leap into doing. Yalom's existential therapy is based on change and the therapist should encourage action. This means that a focus should be made to help clients realise that not only is the individual responsible for the perception of their situation but also that the individual is the only person who can change the perception or the situation. Andrea viewed her past, and its facticity as almost entirely negative and that help would be found in others. On past therapies she comments;

"When I went to the doctor that's what I said, that I needed someone to talk to because it is such an isolating thing" (Interview 2 Paragraph 1).

"the other ones have always within a couple of weeks said right we'll give you think, try this and come back……you're expected to be better or something and you're not…… I know that you expect a miracle cure when you go to the doctors…… but their methods were wrong…." (Interview 2 Paragraph 2).

However there was evidence of a growing awareness for action and responsibility and this became the prerequisite for reframing to occur;

"..... I haven't got better with eating .....but I seem to be able to control how I live around it better ....." (Interview 2 Paragraph 3).

".....whatever I've done with Mike I can be totally honest and say, well I've only done five days that's all and he'd say fine; as with the others its more, couldn't you have tried this..... (Interview 2 Paragraph 5).

As more and more decisions in her life were taken the issue of her bulimic past was explored with a different perception of meaning. This was apparent to the client;

"The one thing he keeps repeating is ..... how you're a capable person and .....you're living your life 'cause I wasn't before, not before I saw Mike.....he focuses on what I can do and what I have done and it seems the questions, well why have you still got that eating? The only thing is, I do think about why I've still got it when everything else seems to fall into place, but maybe I wouldn't have thought that a few years ago because it was mainly depression and my eating, whereas now I'm doing a lot more and he makes out I'm a good capable person who's achieved a lot. So why is the eating still there, it's the only thing he repeats a lot and I think about that. But the only think I can say to that is its like if you don't do it its like you get withdrawal symptoms. Its like being on a drug but you can't live without food, and yeah I

question it now 'cause I think alright why is it still there when everything else is going right..... I don't know if it will ever go away one day but I don't really feel that it will" (Interview 2 Paragraph 6).

"My pattern of life has changed..... I used to feel right suicidal.....and used to think I was going to die anyway but now I see things that I want to do and I don't really want to die even though the eating is still there.....now I'm being more positive....." (Interview 2 Paragraph 16).

".....it's helping me live with my life but its not stopping me eating its hard to have bulimia....but so much else is positive now that if it is going to stop it will stop because the positive side of my life is coming into being" (Interview 2 Paragraph 17).

Towards the end of the therapeutic sessions this sense of meaning was much stronger yet withdrawal symptoms continued;

".... I've got a lot better in myself....you continually carry round feelings of depression which is always there.....its constantly there" (Interview 3 Paragraph 8).

".....it affects you in your day to day routine changes.....nobody before has ever agreed I get withdrawal symptoms .....it is like a drug you need in someway and.....whatever I've said he's never dismissed, he's prepared to see your point of view" (Interview 3 Paragraph 12).

This acceptance of her perception of her bulimia was important because it gave credence to her growing locus of control. The pattern of her daily life became more understandable and the physiological cravings were viewed with a different perspective. The second evaluation review noted that this pattern had been identified;

"There is still some indication of low mood and the bulimic pattern continues to be fixed. Andrea states that the eating pattern is "addictive" and when she attempts to stop bingeing and vomiting she becomes irritable and is unable to sleep. I suspect that her bulimic habit overrides her emotional state and at times ie she feels pressure, she cries, and then she feels better or she feels pressure, she binges/vomits and then feels better.

The next sessions will concentrate on this area and the habit (bulimic ritual) of her day. This takes the form of:

- working hard all day
- rest for half an hour in the evening
- binge eats for one and half hours
- vomits/purge
- feels very tired and retires to bed

There does appear to be a conditioning process involving a complex interaction between a glycogen rush and physical relaxation which is artificially maintained" (Andrea Review Letter 2 Paragraph 3/4/5)

The final review noted, six months later;

"Andrea had her final therapeutic session on (date). In the preceding week she had not been sick at all and reported that physically she felt very well. She continues to slowly gain weight (self report) and now feels she has strategies in place to refrain from vomiting on a daily basis;

A discernable pattern related to her vomiting is when her high level of control of daily living is disrupted. She therefore finds it difficult to relax as loss of control leads to increased episodes of vomiting;

It will continue to be a matter of time before the vomiting occurs infrequently but Andrea does not require therapeutic intervention within the clinic. Her level of insight into her eating patterns and her ability to plan evasive tactics coupled with her weight gain and sense of control means that therapeutic interventions would now only be on a maintenance level" (Andrea Review Letter 3 Paragraph 1/2/3).

The client was thereafter discharged. Her final interview captures her self-confidence but also the continuing influence of her long experience of bulimia;

"..... I suppose I've had it that long its changed a lot anyway, maybe it would have been different if I'd seen him from the start but I get the

impression that he think I'm quite controlled in the sense that its there and its going to be there, and so I can lead some sort of life with it whereas before it just sort of ruled me a lot" (Interview 3 Paragraph 2).

The reliance on others was fading and the awareness of Yaloms (1980) point that only she could action change was also apparent;

"..... I mean, nothing against Mike, but in the past I've received so little support and what I've experienced in the past hasn't always been that positive.... I've adapted myself more. It's myself that's really motivated me to be different 'cause I'm convinced it won't ever stop. I'm convinced of that" (Interview 3 Paragraph 3).

"..... it's to make the best of the situation as it is..... I'm completely more relaxed....." (Interview 3 Paragraph 4).

".....its like he constantly reinforces the fact that you're doing this and doing that, all the positive aspects, maybe why is there an eating problem? Because I feel so in control now that's something I question myself. He always seems surprised the life I live considering I've got this in the background and its made me alert myself to the fact that because its been a lot of years. I am now trying to focus on more positive aspects of my life.....he seems (or this is the impression I get) that I cope very well because I've got this as well and that makes you feel better because that's not the kind of information you get from other people. They may praise you for

what you're doing but they don't know that you're coping with this as well" (Interview 3 Paragraph 5).

The theme of addiction is also demonstrated in her approach to controlling her intake

"….every day you get up there's food there. It's not like drinking or smoking but with food the temptations there. In my case with binge eating. You either do it or you don't and if you don't you starve yourself and go the other way" (Interview 3 Paragraph 6).

"……..you can still feel very negative……. it's a challenge every day" (Interview 3 Paragraph 9).

Despite the daily challenges her perception of the bulimia was nevertheless reframed into a more positive focus;

"….. I do crazy things when I'm eating and not eating but I've learnt to accept that I'm not going to get up one day and it'll be gone. I know that its there and he admires the fact of everything you do and when you sit and look it, yet I do quite a lot where other people who are unwell can't do. But for all of this I'm not doing too bad really" (Interview 3 Paragraph 11).

It seemed that when Andrea was engaged fully in bulimia nervosa she achieved numbness to escape from the pressures of the knowledge that she

was being false to her Self and to others. The progress made through existential therapy appears to support Van Deurzen-Smiths (1988) view that inauthenticiy and authenticity are not fixed states and that the awareness of inauthentic living gives a good comparative measure to the perception of authenticity. Bulimia remained a fixed aspect of Andrea's sense of Being but episodes of bingeing were understandable to her and she took existential responsibility and action to increase efficacy and locus of control. This reduced the bingeing to a more manageable aspect of her life but it did not "cure" her. Nevertheless the reliance on health resources was heavily reduced, she had learnt much more appropriate coping mechanisms and her presentation of a dualistic Self to the world (Sartre's, 1943 bad faith) was internally resolved. Andrea was discharged from the eating disorder clinic.

Unlike Andrea, Dorothy's bulimic episodes were at times deliberate self harming and similar presenting behaviour were experienced by Fran. After only a few sessions Dorothy was cutting herself and in her first interview she was reporting a lot of pain and trouble in her life. The familiar pattern of getting the client to identify the control and responsibility that they may have over their lives and the feelings of anxieties which such existential focus brings was also experienced by Fran. Like Dorothy the sense of emptiness and the desire for love was distressing;

"It's been hard to diet and getting down when I put weight on. And feeling scared about losing weight, wanting to be fat because I was afraid. N (a co-therapist Fran was seeing at this time) says you can have a boyfriend whether

you're thin or fat or whatever and I'm getting used to that sort of idea but I've not had a relationship or anything. I've always been too scared and I've never wanted to be touched. I'm beginning to think about boys now.... but I'm still scared about being touched by men. I still feel dirty" (Interview 1 Paragraph 51).

Fran had suffered two separate acts of severe sexual violence and these incidents had understandably affected her perceptions of men and relationships. Yet the tension to overcome this fear of a relationship was almost unbearable. In her first interview she maintains a theme of wanting to tear my eyes out because I was a man. All my postures, gestures or verbal content were perceived and interpreted as having negative male traits. Her sense of anger at her past and those that had violated her were generalised and transferred to all men. Yet like Sartre's (1943) bad faith Fran knew not all men were like that and she had fond and loving memories of a kindly father. To prevent the weakening of her resolve and to punish her lack of will she turned to self-harming behaviours.

Malson (1998) discusses the elements of self-punishment and self-destruction found in her case studies when the women felt "bad" and that this copying mechanism led to the numbness "obliterating all thoughts and feelings" (page 168). Malson argues that self-destruction is the coping mechanisms but neither Dorothy or Fran wanted to die, rather as Cohn (1997) describes, their relation to their Being-for-itself and Being-in-the world was damaged and dasein interpretation given a negative perception. Fromm (1994) suggested

that some individuals seek to escape existential anxieties in a "crippled way" (page 70) and therefore still seeks an answer to their unease. Like Yalom (1980) Fromm advocates individual responsibility and activity and recognises the amount of perseverance and motivation required to change. Without the individual taking decisions about living in a way that creates a more positive outcome in life for the Self then freedom will not be experienced. Yet to change is wearisome. Van Deurzen-Smith (1988) recognised this and suggested that the existential therapist should help clients to translate negativity into a clearer understanding of what is missing in their solution to life.

Fran had placed herself through influence of past events into the position where self-harm prevented her from exploring what she was curious about; whether men could provide mature love. It was not to destroy her Self that made her bingeing increase as these areas were tentatively examined but rather the behaviour was to stop further examination. Her symptoms initially worsened;

"On some days I don't eat and on some days I really binge but its not been as bad..... I get very tired after the group and I don't understand why I get tired after the group" (Interview 1 Paragraphs 55 and 65).

The focus continued on the positive aspects of male behaviour and another group members reinforced such a perception by their own narratives regarding positive relationships. This increased Fran's anxieties as the awareness that

the responsibility for action became hers alone. This began to affect her dreams;

"Well I've been bingeing at night. I've not been bingeing through the day time. I've managed to stop doing that but I've been having really vivid dreams at night and they're been weird and they seem so real they do and I've been getting really high and then I've been getting anxious. Really anxious and really low and I've been nearly passing out with being anxious" (Interview 2 Paragraph 5).

The growing awareness of her sexuality was expressed at this phase of therapy as "I feel like I've grown up more, as if I'm a twelve year old and I've become an eighteen year old, that's how I feel……" (Interview 2 Paragraph 6).

Like Duker and Slades (1988) observation it was almost like the fragmented sense of Self had to be shed and a new sense of Being-for-itself grown. The symbolism for Fran becoming child-like and then creating a Heideggerian internal dialogue (Mulhall, 1996) which raised new sign-post towards a more positive sense of self allowed her to rebuild a new interpretation of Self (Duker and Slade, 1988). Frans friends had observed this symbolic metamorphis in progress;

"Noticed I'm more better in myself. They think I'm getting really high and then really anxious. I'm really anxious at the moment, I don't know why that

is, whether it's the newness of it. I don't know what it is" (Interview 2 Paragraph 25).

As with the other clients the sense of change was verbalised but in these stages of therapy the realisation that they were the change agent, willing action, had not yet occurred. And like the other women, any abrupt change led to a return to maladaptive eating;

"..... On holiday I hardly ate anything 'cause it was so hot, so I changed my eating habits and when I got back I started bingeing again" (Interview 2 Paragraph 29).

What was interesting was the pattern that could be discernable in the internal dialogue that was taking place on the topic of her sexuality. Fran's past experience with men had been of dramatic extremes between a loving, tolerant father and acts of extreme violence from two other men. These constituted the sum total of her emotional engagement and both extremes created an internal tension. Love and affection in what Fromm (1956) called mature love was seen in an asexual context for Fran whilst physical and psychological sensations of sexual desire were extremely anxiety-provoking due to her past experiences. Her Sartreian essence was influencing her present approach to her interaction with the world and others. But it was not a successful strategy. Like the women that Malson (1998) discussed, it was not acts of self-harm to destroy the Self that motivated Fran. It appeared instead that bingeing and

weight gain were forms of control which both kept men away and reminded her Self that eroticism was not to be explored.

In the initial review letter it was noted that in view of her past assaults "she cannot bear to be physically touched and will become agitated and aggressive if men approach her in any way seen as invasive" (Letter 1 Paragraph 2). Fran had other activities which helped her control her adult desires. She presented her interpretation of the world and her self in the world through art and poetry and the meaning she gave to her creative output appeared to have a more positive effect on her sense of Self. In one interview she was asked to describe her feelings about a particular painting she had completed:

"I've got meaning to it and the feeling I was feeling……." "…….. I feel like I'm flying round the world (laughs). I feel like I can cook. I can do everything, I'm a super person. I don't want to usually eat. Its good for my diet that day. I don't tend to eat all the wrong things but when I'm on a low I tend to eat all the wrong things then, and stuff myself with donuts and sugary things" (Interview 2 Paragraph 42/43).

As the existential focus on her perception of men and the possibilities of interaction with men continued her creative output began to increase and led to increasing feelings of well being. On being asked if she was getting more "highs" than before, she replied;

"Yeah and then my head feels like its spinning, feels like I can do everything and write all the things I want to write and I can't and it gets so frustrating. And I'm thinking I can do this and that and I can't. But I can usually achieve better when I'm high 'cause I usually feel lethargic and tired but when I get high I don't feel that. I feel as though I've got loads of energy and everything" (Interview 2 Paragraph 44).

Fran received great pleasure from these self-expressive activities and was increasingly more confident in her exploration of her Self and her perception of the world. It was therefore very important for the therapy itself to support this growing efficacy and her widening locus of control. This did mean that Fran was encouraged to see herself as the agent of change and that change necessarily caused anxiety and bingeing.

Laing (1967) recognised this aspect of the therapeutic relationship and discussed the authenticity which may be possible in the therapeutic process. He argued that whilst existential therapists have different theoretical approaches to the therapeutic process the core remains the engagement with the other person. This focuses on disentangling the differing interpretations between the therapist and client which prevents the shared perception of the clients alienation. Laing (1967) was more descriptive when he defined psychotherapy as "....the paring away of all that stands between us, the props, masks, roles, lies, defences, anxieties, projections and interjections in short, all the carry-overs from the past....that we use by habit and collusion, wittingly or unwittingly, as our currency for relationships" (page 39).

A similar view was taken by Fran when asked what had the existential group therapy provided for her self-exploration. She stated "I don't feel as dead and empty inside. Its as if it's a parcel and I'm unwrapping different layers and when I get to the bits that's not so nice he's helping me unwrap it slowly..... I don't feel as sore inside" (Interview 2 Paragraph 46 and 47).

Like other clients this experience of paring away layers of interaction with the Self and the objective world appear to support Duker and Slades' (1988) assertions that eating disorders cause a fragmentation of the Self. Fran appeared more motivated to define a new Self rather than attempt to rebuild a fragmented sense of the know Self. Her exploration and testing of the new Self and her relationship with food continued and in the final review letter it is recorded (by the co-therapist) that she is aware of her own control mechanisms; "not only has she been able to openly talk about her fears surrounding relationships but she has also started to contemplate the possibility of entering an intimate relationship at some point in the future. Her initial fears that losing weight may attract men are far less intense and she is beginning to see that she wants to lose weight for herself and that her fears have been preventing this" (Review Letter 2 Paragraph 2).

"Though (her) eating is yet to stabilise she now has periods where she doesn't feel the need to binge and she feels she will continue to build on this progress despite the group having ended. She is certainly more positive about her future and her ability to attain her goals, whether these be weight related or

not" (Review letter 2 Paragraph 4). Shortly after this point she was discharged from the eating disorder clinic.

All the clients who underwent therapy reflected on a negative period in their lives which required a lot of motivation and stamina to continue therapy. The coding stages taken in the Grounded Theory methodology record many instances of increased negative symptoms as existential therapy progressed. The final axial coding lists thirty-six concepts and captures the extreme discomfort experienced by the clients as they stripped away the layers of constricting self-protection with which they had enveloped the Self. The axial codes record within the thirty-six identified symptoms; an increase in bingeing (particularly on fat/carbohydrates foodstuff); increased weight gain amongst obese clients; weight loss amongst clients with anorexic behaviours, increased use of neuroleptic medication, increased anxiety, increased obsession with food intake and weight, a rising incidence of numbness and poor physical health. The perception of Self is particularly affected with increased poor self-image, poor self-assertion, poor self-esteem, poor self-awareness, low mood and a more rigid locus of control.

The only known alleviation of such symptoms (which occur very quickly after attempts to change eating patterns) is a return to either bingeing or extreme food rejection. These physical and psychological discomforts appeared to be controlled by food intake and the body's reaction to glucose levels. Clients appeared to have conditioned their bodies to respond to a form of self-medication through foodstuff. The return to a cessation of eating in the

anorexic pattern reduced physical discomfort whilst bingeing gave physical comfort and drowsiness. The craving for numbness and the discomfort experienced by clients as they attempted to return to less extreme eating patterns were major obstacles in the process towards a new sense of Self. These symptoms usually prevented the adoption of a broader locus of control and efficacy in the choice of new eating patterns.

Conclusion Four

Directing client behaviour or their cognitive approach to food were therefore linked to poorer response rate to therapy. Only by facilitating the process towards an altered perception of their Self as both the mind and body did clients find the strength to resist the negative physical effects. Overcoming what Descartes saw as dualistic thinking of the body as Other to Self (Cottingham, 1997) and accepting the view put forward by Locke (Yolton, 1961)) that the body allows the sensations of the external world and is important in experiencing the world did change then occur. Sartre (1943) described the somatic body as psychic, meaning the body allows individuals to experience and interact with others. Clients with disordered eating patterns in this study began to learn again what they had experienced in the past; that their Self was both mind and body, separate but equal in the Cartesian essence of their identity. The experience of chronic and unhealthy eating habits had helped them to continuously seek escape from their interaction with their subjective internal Self. The numbness gave them temporary refuge from anxieties and sadness but also reinforced the sense of dualistic experience. The Self was separated from mind and body, paradoxically residing in neither

but simultaneously in both. Malson (1998) was familiar with this dualism whilst Connors (1996) found the cessation of emotional maturation was common in individuals who self-harmed after suffering childhood abuse. They physically developed but experienced chronic, debilitating post-trauma symptoms which prevented the sensation of a whole Self.

For the clients in this study experiencing again the input from the somatic senses which had been corrupted by poor eating (as self-medication to reach the numbness) provided a sense of internalisation of their Being and a feeling of more control and efficacy in their relationship with the objective world. Although the anxieties of living did not cease, the sense of Heideggerian Dasein (Being there) did increase.

Laing (1967) noted that existential therapy offers no security, only an awareness of the separateness of the Self from others and the knowledge of Heidegger's dread. To reach this awareness an individual must overcome their sense of alienation, both from the body and the objective world and, if necessary, learn to reconstitute the Self. This point has been discussed in more detail and specifically in relation to eating disorders by Duker and Slade (1988). They argue that the dualistic sense of Self is influenced by the perception given to the body and food. The sense of loss experienced when control of eating and food intake is taken away from the individual leads to frustration and resentment which only increases anxiety and low mood. Like the experiences of clients in this study the absence of a rigid internal locus of control provided no meaning to the sense of Being and when traditional

cognitive-behavioural interventions were implemented the value given to Being itself was reduced. Fragmentation of the Self was therefore produced.

This sense of fragmentation was presented in some of interviews for this study. Jane who experienced anorexic behaviour for example states:

"Yeah its just like putting a mask on.....when you're in its all doom and gloom when I'm going out its where's the wardrobe. OK, we'll put on the nurse now, or friend, or daughter and I had separate identities with people I knew. There was no consistency really..... I would let different things out according to my interpretation of their expectations of me. So it was very lonely because I was never me" (Interview 1 Paragraph 23).

Gemma who experienced morbid obesity also had awareness of a different number of Self; "I had to break things down, and let things trickle in because if I don't I put up walls and barriers and a lot of different me's inside and I have to tackle each one before I can get them to be the complete person (Interview 2 Paragraph 24).

Duker and Slade (1988) suggest that therapeutic interventions should concentrate on the facilitation of a new sense of Self through a series of phases. This requires the client to initially define their perception of self and their efficacy in taking action based on their decision-making. The second phase builds up self-esteem to prepare for an existential phase of awareness of time and existing in the present. Duker and Slade suggest that this phase is

often the most problematic as clients experience the anxieties associated with responsibility and sense of freedom.

This third phase is very similar to the phase in this study wherein clients experience the physical and psychological effects which I conceptualise as withdrawal effects. The sense of meaningless as the eating habits change can lead to the adoption of their addictive habits. Rachel who experienced bulimia nervosa for example began to smoke cigarettes (after a long period of not smoking) when she reduced her bingeing;

".....it's the self-hate I usually get and..... I'm feeling a bit wobbly at the minute but it's early days. I always seem to switch to something else like I've had the odd cigarette in the last few days but hopefully I'll be able to stop that. I've only had a couple. Its when I get too stressed I feel like having one" (Interview 2 Paragraph 12).

Duker and Slade (1988) add that an improved locus of control can reinforce the experience of loneliness and aloness. The awareness of what Yalom (1988) discussed as Heideggerrian dread, the awareness of Nothingness, can lead to a return to the very eating habits from which they are trying to escape. The experience of numbness is very quickly reinstated as a preferable control mechanism. This anxiety provoked by self-direction is demonstrated by Fran who was asked if her friends had observed any changes in her since the commencement of existential therapy; "noticed I'm more better in myself. They think I'm getting really high and then really anxious. I'm really anxious

at the moment. I don't know why that is, whether it's the newness of it. I don't know what it is" (Interview 2 Paragraph 25).

Like Laings' (1967) approach to removing layers of experience, Fran also demonstrates the sense of a new Self emerging from the debris of Duker and Slades (1988) fragmented Self;

"Yeah I don't feel as dead and empty inside. Its as if it's a parcel and I'm unwrapping different layers.... (Interview 2 Paragraph 46).

Hillary the co-therapist in the group sessions observed alterations in clients who began to take control of their own lives. Discussing one lady who had a long history of bingeing she noted:

"I suppose one lady did. That's how she used to view herself as being a binge eater. It changed that she was a person that had a problem with binge eating and now she's sort of changed to well, this is who I am" (Interview 2 paragraph 26).

In individual therapy the same process was being observed by the clients themselves. Andrea, for example stated ".... I do feel its different, he seems to accept the fact of what I am" (Interview 3 Paragraph 10).

These statements of their growing awareness of self-identification (what I am; who I am) were explored within existential concerns of love, freedom, choice,

responsibility and genuineness and often altered from statements of what I am, who I am to existential questions of what am I? Who am I? Throughout the therapeutic phases, particularly phases I/II which had the highest incidence of withdrawal symptoms, there was a need to support the clients as the new Self began to experience the paradox of freedom and aloneness. Yalom (1980) discusses this issue of existential isolation at some length and writes about the responsibility for self-direction that humans can take as they become aware of the fact that they, alone, carry the burden of life's choices. Fromm (1956) goes further and suggests that this awareness of isolation and separateness from the world and others in the world creates the source of all anxieties and can give rise to an overwhelming sense of helplessness. It is in this context that attempts at suppressing such feelings often lead to a return to disordered eating patterns.

It was important to maintain a calm source of support for the clients as they wrestled with the growing awareness of isolation in the world. The frustration (from the therapeutic perspective) experienced when clients suffered negative symptoms required this calmness as it was already suspected that attempts at external control of their eating habits made clients resentful. Clients had to be alone in their awareness of isolation and separateness. Some comfort was drawn from Yalom's (1980) statement that existential isolation leads to growth and development.

Yalom argued that this awareness of Being as separate, causes a growth in autonomous action, self-reliance and independent living. Yalom's approach

supports Fromm's (1941) view that the developmental growth towards independence requires the awareness of existential isolation and it is this separateness that allows the individual to perceive the world as a place where they can make choices about their life. Not being separate but seeing the Self as part of another prevented autonomous living.

Sartre (1943) and Yalom (1980) both point out that this separateness from the objective world is also separateness from others and therefore affects interpersonal relationships. In this study as eating patterns altered so did the relationships with other people, but even more fundamental was the altered relationship within the internal Self. A degree of sensitivity and sometimes challenge was needed to prepare the client to face the awareness of interpersonal isolation. This led the therapeutic relationship to often be intense as dependence was explored. Yalom (1980) suggests that the fear of isolation may be a driving force behind transference in interpersonal relationships. Laing (1967) also states that transference and counter-transference may be a currency in some relationships. For the clients in this study there was the danger that the emerging sense of a new Self may adopt the therapeutic process itself as a defence against the fear of isolation. The therapist and co-therapist also had to be perceived as separate and isolated, so that the awareness of the existential aloneness of both therapist and client could lead to a more equal interpersonal relationship. Hence the decision to explicitly limit therapy to a fixed number of sessions.

Strasser and Strasser (1997) argued that structuring the limits of existential therapeutic sessions allowed more focus on change. For individuals with chronic eating disorders this seemed an appropriate focus. The efficacy of their daily existence and the limited locus of control required change. Reframing perceptions of Self and then supporting change during periods of discomfort were explicit in the existential therapy. Raising the awareness of the otherness, the separateness, of the therapist was done when clients appeared to need less support and were beginning to overcome the withdrawal effects. Both Strasser and Strasser (1997) and Laing (1967) raise this issue of therapeutic structure. They conclude that in the existential approach the generalisation of therapeutic principles to every therapeutic incident is impossible and these conclusions were supported in this study. Whether in individual sessions or in group sessions it was apparent that expanding locus of control and reframing the perceptions of Self occurred at different speeds with different clients. Some appeared to quickly move through the phases of existential therapy, others more slowly, and sometimes clients revisited phases already completed. Inevitably some clients therefore had a higher number of sessions than others.

Cohn (1997) provides a similar picture when he discusses the assessment phase. He suggests that there can be no assessment as such as it is only as therapy progresses and there is interaction that issues of alienation are disclosed by clients. Like Laing (1967) and Yalom (1980) Cohn suggests that it is the interaction in the time and space of the sessions that gives context to the therapeutic effect.

The sessions therefore required concentration. Some clients were more anxious then others, some suffered worse negative symptoms, some revisited past phases or reengaged in negative eating, some refused to accept the separateness of themselves from the therapist for long periods. All this was within the context of a refusal to direct clients eating habits, food content and coping mechanisms.

Yalom (1980) provided some direction for therapeutic interaction in such situations. He suggested that there should be a sensation by the therapist of the "other" and that the therapist should facilitate reciprocity so that the client experiences the separate otherness of the therapist. This requires the practices of listening closely to each other, giving up stereotypical assumptions of what should happen and responding to the issues raised by both client and therapist. The therapist objective should also focus on a need-less relationship of decreasing dependency on each other. The difficulty is in overcoming the anxieties precipitated by the awareness of isolation. Such anxieties can be perceived as more manageable through inauthentic relationships. The opportunity to engage in a more needy and conditional relationship can be found in the therapeutic relationship. Yalom (1980) suggests that the therapist should therefore explore with the client the perception of their relationship with others and whether there were loving relationships based on need. In this study such relationships were viewed as internal and concentrated on the love clients had for Self and whether the love, care and responsibility of the Self were conditional on the subjective perception of how and who they were.

In the beginning of the therapeutic process it was therefore important to let the client know that there would be little external control and direction by the therapists which was food related. Clients demonstrated their awareness of this point during interviews. Andrea, who had a long history of bulimia nervosa, for example stated shortly after the commencement of therapy that past therapy was unhelpful and she was initially reluctant to experience existential therapy.

"Um, the doctor at [ ], he suggested some sort of therapy. I said I didn't feel as though I wanted to be wasting anyone's time as I had in the past and it hadn't helped (Interview 1 Paragraph 2).

She quickly noticed the different approach; "Rather than dictate. No, perhaps that's a bit strong. Rather than them tell you try this, try that, all I can really say is that I've noticed he's asked things, but he's let me just talk and there's been no suggestion try this, try that. Its been more me saying what I want to say, but in the past they tried to form a programme of something to follow and for me its been things that haven't worked.....they've given you a programme and that's supposed to help you (Interview 1 Paragraph 4).

The therapies experienced in their past were nearly always seen as unhelpful. The external control by others often left a poor impression. Andrea continued discussing her past therapy as:

"It was more trying to get me into a pattern of more regular eating and although it was nice to come and be counselled by somebody...and you felt good about it, but when I thought about it and since I suppose, the programme they were giving you was saying try and eat this in a day. That hadn't even started to combat the problem. So they were giving you a programme to follow, of eating, but the problem was you couldn't eat, you couldn't follow a programme until you'd started dealing with the problem. So looking back now although I thought, well, I can't knock it till I try it, I couldn't. I tried and I just couldn't do it and I felt like I was failing myself a lot because I couldn't do what I thought should help me..... I was being told to do something that I wasn't even at a stage I could have coped..... I wanted to talk about it rather than be told, do that" (Interview 1 Paragraph 4).

This external directing caused frustration for Andrea because she perceived her long experience of eating disorders gave her more insight into the condition than the knowledge held by the therapist;

".....no disrespect to any of the others that I've seen but I feel...there's not a lot known about it and they're still searching in the dark, they're given you a programme and that's supposed to help you" (Interview 1 Paragraph 3).

"..... I just need support more than someone to say do this, do that. I felt under pressure with that.....the other ones have always.....said, right, well we'll give you this, try this and try that.....I'm not being awful (but)...unless you've had it I think it's such a new subject..... I felt that I

was educating them on it rather than them helping me 'cause I so couldn't get through somehow. That what they were doing didn't help. It just added pressure really. It was hard work.....their methods were wrong, they didn't do me any good" (Interview 2 paragraphs 1 and 2).

Other clients also noticed the different approach in existential therapy. Fran who experienced morbid obesity responded that in comparison to her other therapeutic sessions: "Yes it is different. It's a bit fast for me but I managed to tell him today it was a bit fast for me. We seem to go more in depth into things".....It makes you think about your eating and what you're doing with your body" (Interview 1 Paragraphs 9 and 10).

Gemma, like Andrea, was not enthusiastic about past therapies and was aware of the difference in the existential approach;

".....I've been for hypnotherapy which.....didn't do a lot of good..... I've been to the hospital to see a counsellor and she was pretty pathetic. She just said, well start talking. Well that's no good if nobody asks you questions..... Mike asked questions.... asked general questions rather than trying to get to the point...sometimes I find it hard but its only usually after I've gone I've realised its actually sort of brought it through the back door. Now whether that's because of experience, (I do realise that some people can't go through the front door,) I don't know. I'd say it took me about four months before I could really start talking up, but yes, I've found it interesting" (Interview 1 Paragraph 1).

Gemma's long history of therapeutic intervention and her own reading on psychotherapy itself made her wary of inauthentic interaction. Early sessions were often spent in trying to raise her awareness that she had the control to lead the direction of the sessions, and during this period Gemma's view of the therapy and therapist veered to and fro between directive and non-directive;

"I do a lot of thinking……. Mike's very non-confrontational with things, um, doesn't push it. In some ways that's very good for me. In other ways it isn't cause I'd go round the houses for evermore. It depends what I'm talking about and it depends what kind of mood I'm in when I get there. I've found he can make me very wound up and other times one hour seems like its two years long and it depends how close to the truth it gets" (Interview 1 Paragraph 2).

"… if he went in straight away with size nine boots my walls would go up and he'd get absolutely nowhere. Um it works sometimes, it doesn't always. Sometimes I do need pushing and he can actually be quite persistent sometimes, but I think he tailors it to the individual……. I've been to other counsellors and they just let you get on with whatever you want to say and don't tie it up and I find he sometimes ties it up into things….everybody else had wanted to talk about my weight and I'd got a fair way to understanding that my weight wasn't a problem, the problems went years and years back. Now we're going to start looking at my weight and I've had some sorting out to do first and he can be quite insistent at bringing things back to the point that

he wants...sometimes he's subtle about it. Not always, sometimes I go away and I'm thinking he'll not stop talking about it. He just goes a different way round which is good 'cause it means I don't have time to put the barriers up..... I've seen one, two, three, four different counsellors before.....and never really opened up to any of them and I saw (the other counsellor) for nine months and I probably hadn't told her as much as I told Mike in the first hour of meeting him. But then again he asked me specific questions, he was looking for something specific where other counsellors have just said, oh what do you want to talk about. Well for some people that's fine but for me that's no good 'cause I don't know where to start" (Interview 1 Paragraph 4).

This memory of the anxieties released by being encouraged to be more autonomous about the direction of therapy was still apparent after several sessions. She was also comparing this approach to past therapies. In her second interview Gemma recalls the focus on her perception of Self and food;

"(he) was more specific, he was looking for something where as others expected me to talk. Mike asked me questions and I thought, oh gosh where do I start.....He wanted specific things, I didn't know that at the time but he did.....well I think I knew I'd got something wrong, I knew there was some blockage. I'd been seeing the other counsellor for quite a while and had counselling before..... I tend to deal with Mike more with what's gone on, and why, and to cope with it now. Its better, I knew I had an eating problem... I tried all sorts,.....the eating disorder clinic at (the hospital) and ..... I tried the dietician and it didn't work (it actually made me more paranoid). I knew

what to eat and what not to eat. That wasn't the problem. So Mike had a framework in mind so I found that very helpful" (Interview 2 Paragraph 1, 3 and 6).

Cohns (1997) observation that an assessment session is not appropriate to existentialism was supported here. His view that it is the direction of interpersonal relationship in therapy that precipitates disclosure of alienation issues is borne out by Gemma continuing;

".....the one up at the hospital, she was also useless, no questions, no direction. I was meant to talk about what was wrong, well you can't always put into words what's wrong. What you say isn't always what's going on and you've got to be able to pick out and she couldn't do that at all. I went for three months and got nowhere. In fact I stopped going because she was so bloody useless, she made me feel worse. S (a co-therapsit) was much better, it got me talking and I spent a year just getting to know her and it being very general on the surface; took me a long time to open up....we got a family session but the woman running the sessions wasn't strong enough.....we had about six sessions then nothing...just starting to talk (Interview 2 Paragraph 7).

The assessment phase was however very useful in this study to give explicit reassurances to clients that they could control sessions (the groundrules) and that it would be the focus of psychotherapy that would be facilitated by the therapist. Hence the explanation that they could continue their present eating

habit if that was their wish. Knowing that they could still control their own eating pattern during therapy paradoxically gave the first glimmer that they may also be autonomous in changing the pattern. This approach also lessened the anxieties surrounding their perception of a controlling therapist and eased the route towards reflecting on the Self. This was noted by Chris who experienced anorexia nervosa who differed from Gemma in her perception of autonomy as she preferred the approach which allowed her to lead; "…..its much more direct and a lot easier to get into, within fifteen to twenty minutes I'm into the session" Chris went on to describe the early sessions as "it gets down to business and the underlying issues…. I feel more comfortable doing it that way….he's more open about it…..I like the direct questions…..the way the questions are asked make me think (and there is) time to go away and think about it……it doesn't happen straight away, it may come up weeks later" (Interview 1 Paragraphs 4 and 14).

Yalom (1980) acknowledges that the existential approach is not passive and that the psychotherapist engages with the client in facing the anxieties of seperateness. This means that existentialism is not an open-ended developmental therapy but one which wrestles with answers given in reply to questions about the existence of the Self in the everydayness of living (Horrocks, 2000). Cohn (1997), Strasser and Strasser (1997) and Laing (1967) hold similar views to Yalom's on this subject. In this study the therapeutic facilitation of the awareness of Self as an autonomous individual who could control eating patterns was immediately reinforced in the dialogue and discourse held in the early sessions. Chris could not recall how many sessions

she had attended by the time of the second interview but she retained a vivid impression of the existential approach compared to her past therapies;

"……he's got a different approach, more directive and he seems to get more out of me…….he doesn't like not quite ask you questions. He'll look at you and say what makes you say that, he puts you there and you've got to respond. I find it a lot better than when [ ] does it 'cause he seems to be reflecting it back" (Interview 2 Paragraphs 3 and 4).

This reflection process was not passive but an active attempt to reframe the paradigm which held clients in a negative perception that the eating patterns controlled their daily living. Reframing was demonstrated by Chris when she recalled;

"Its more confrontative. Yes, um, I found it a bit of a challenge to begin with but now I've got used to it I do prefer it" (Interview 2 Paragraph 2).

Clients had a long history of different therapies and therapists prior to existential psychotherapy. In total twenty-nine approaches or individuals had been attempted and recorded in the medical records. These ranged from different professionals (psychiatrists, psychologists, community psychiatric nurses, dieticians, hypnotherapists, social workers, nutritionists, mental health nurses, person-centred counsellors and cognitive therapists) to multiple sessions of up to four years. Yet clients were consistent in their views that attempts by others, (rather than themselves) to direct the progress of eating

habits were unsuccessful. Jane with a long history of anorectic behaviours for example, repeats the views already discussed earlier when describing past therapy, and the approaches used in treatment;

"I was admitted three times to the (Hospital).....there was cognitive stuff and we did quite a lot of stuff on body image in terms of looking at ourselves. Art therapy we did quite a lot of.....it was lots of cognitive work but also we used to do stuff like when we ate we had to have an hours rest after each meal so we sat with the nurse for an hour.....the psychiatrist was always looking at what was going on and how we were feeling and stuff" (Interview 1 Paragraph 2 to 5).

The search by Jane to replace the numbness when eating habits altered were, like Rachel, replaced by other negative behaviours. This had been a pattern even in past therapies; "I was still seeing Doctor (L) .....and I was doing alright with my eating... I was getting along....and thats when I started self-harming as well but it wasn't often then" (Interview 2 Paragraph 11).

This behaviour became quite secretive and was hidden from the caring professionals because in hospital; "you see different people all the time and you don't get the chance to build up that kind of relationship with people... I didn't like to cry in front of anyone and I didn't like to tell. I was very closed and I found it very hard to talk about what was happening" (Interview 1 Paragraph 12 and 13).

This sense of existential isolation and seperateness from others made Jane outwardly compliant but she suppressed her emotions when she was around others. The duality of her mind and body, (Duker and Slades', fragmentation 1988;) often created a sense of being lost in both the world and herself. She did not self-harm to destroy the Self but to try and gain a similar temporary reprieve from her sadness as she had found in anorectic behaviour. She was for several years alienated from others because she was afraid of their disapproval and the tendency to prescribe treatment interventions. Accepting the point that existential psychotherapy would not attempt to alter her behaviours regarding food and self-harm and that she could choose when, or if, she wanted change brought relief;

"It was the first time I ever felt really supported and really accepted. He was the first person that I'd ever started displaying any emotion to .....it felt safe to cry or whatever.....it made it safe to ask for help, or to cry or to say that I was angry.....or that I was really lost and when I would talk about bingeing or self-harming .....it was like most people...if I've binged or cut, they'd have a reaction like, oh it'll be alright or, what an awful thing to do to yourself but with Mike there was nothing like that. It was, ok so that's what you did. There was no judgement either way and he made it feel ok that I was doing it, not that's it's a good thing.....but that it wasn't a bad thing to be doing and maybe this is how I was coping.....one of the things I .....do is beat myself up for doing those things so then you go and binge.....and you create a cycle and I suppose that helped me to stop doing that and to go, ok this is where I'm at and maybe I don't like it but this is really where I'm at,

and if I don't do this I don't know what I'll do, so this is ok…..he's like that, whatever it is, its ok. I could just be any way that I was and it would be ok, as that person….that was the first time I'd experienced that" (Interview 1 Paragraph 13 to 16).

This sense of being lost and reacting negatively to their present coping mechanisms was shared by Karen who had been diagnosed as anorectic and who had real problems in being seen or heard by carers. Despite several requests to her General Practitioner to be referred to a therapist "they weren't receiving the message that I really did need to see someone; I was in a situation where I was very low…….. I had really strong suicidal thoughts" (Interview 1 Paragraph 1). Karen was different to Fran or Rachel in her behaviour towards her body and mind in that attempts at self-harm were genuine attempts to destroy her Being. Life was seen as meaningless. Yalom (1980) suggests that suicidal attempts can be traced to the individuals awareness that they are not loved by others and in certain situations they themselves cannot give love to others. Karen needed the engagement with others to fight off the overpowering feeling of isolation and loneliness and lack of love in her everydayness. The existential intervention in what was on first referral a crisis for Karen was the need to fully engage with Karen so that she would experience an interpersonal relationship which responded to her sense of isolation. Her suicidal intentions were viewed as an attempt to finally escape the pain that the awareness of seperateness gave her. Yalom (1980), Fromm (1994) and Hall (1999) refer to the intensity of such encounters as caused by being fully with the client to the degree of almost meditative

concentration Karen observed and recalled the environment in which the first session took place much clearer than I did;

"... I was coming in feeling depressed and....there's no office...so we just went wherever and so we just went in a room, sat down and someone came through and I think I was sat at one side of a desk and he was at the other and it wasn't an easy physical environment to counsel in on the first occasion, and even when someone walked through Mike didn't stop...it was a positive communication and he empathised a bit and I felt more positive then and I had more confidence communicating" (Interview 1 Paragraph 3).

Yalom (1980) constantly repeats his view that existential psychotherapy can help an individual to reach a point where they can make free choices. He also like Laing (1967), Van Deurzen-Smith (1988), Fromm (1994) and Cohn (1997) stresses that it is the therapeutic encounter and the relationship gained in such encounters that helps the client. Karen's first session was important for her because she could share her thoughts on loneliness. Having someone to listen meant that she was still separate but not lonely in that uncomfortable room. She could still choose to take her own life but the meaning and purpose she found in the intensity of the encounter gave her a little strength to continue further sessions. The content of the session was focused on her feelings of depression and isolation but as Yalom (1980) noted, the real catalyst which reframed her sense of Being in the world was the relationship itself.

When clients perceived the therapeutic relationship as shallow or perceive the therapist as disengaged they find progress towards understanding of their self difficult. Karen perceived her general practitioner as someone who was unaware of her existence despite directing her treatment. Gemma noted "in some ways they don't care, they can't care, it's a job" (Interview 2 Paragraph 7) whilst Dorothy, who had several past experiences of therapy described her interpretation of such sessions with the existential approach as; "I had some therapy eighteen months ago. It started off, it was the usual type of therapy. It started off all about food and then various things happened and then that it all went out of the window.....it had been targeted towards the food, I'd used it more or less to sort of, well, I wasn't telling her about other things.....so all the behavioural stuff went out of the window" (Interview 1 Paragraph 1 to 3).

".... I went to see the cognitive behaviourist therapist. I saw one privately.... I was waiting to be seen for about nine months....the therapist I saw when I was working I didn't trust I liked her but I felt I could have told her anything, I could have lied to her and she wouldn't have known. With Mike, I trust him to tell things to.....his approach is different, he's more in your face....he's more participative in his approach...he doesn't let you ramble on and on.....more interactive with you than someone who just sits still and doesn't say anything, doesn't ask questions. I like that" (Interview 1 Paragraph 4 to 7).

Yalom (1980) makes the point that it is not the therapeutic technique that is the core of successful therapy and repeats his view that irrespective of

technique it is the relations between client and therapist that is more important. This study supports this view as cognitive-behavioural approaches, analytical approaches, and person-centred approaches were adopted as interventionist tools. The variable that made such techniques appear different to the same techniques experienced in the past was the clients perception that the relationship underpinning such interventions was perceived as meaningful to them. Meaning and purpose were based on the approach that, despite reluctance on their part at times, they chose the speed and direction of progress. They controlled the pace of therapeutic treatment. When there was too much tension and anxieties in their life they could utilise the therapist as the support network until they regained the strength to continue. The focus remained constant and explored existential concerns such as love, responsibility, choice, meaning and freedom irrespective of the speed or direction taken by the clients.

Atherley (1992) noted a similar response by clients in her study on anorexia nervosa and she castigates the orthodox behavioural approach by presenting several case interviews where clients resented this intervention. She also found that hospitalisation was not an effective intervention and concluded that psychotherapy had the most positive evaluation. These therapies were viewed as more appropriate because they worked on the emotional and cognitive aspects of anorexia nervosa rather than the physiological and behavioural aspects. A decade later her findings that interventions which were in any way perceived as over-directive were resented by clients is replicated in this study.

Atherley (1992) concluded that an eclectic approach utilising different therapeutic techniques were deemed to be appropriate.

One difference with Atherley's findings is her view that clients in her study who had experienced repeated in-hospital treatments found a less directive approach more difficult than a directive therapy. The clients in this study who had in-patient experience had the same difficulty as all the clients who had past experience of directive therapy (as out-patients) in the initial phase of existential therapy but appeared just as open to a less prescriptive approach.

Atherley's (1992) other findings are replicated in this study, particularly her view that principles of the therapeutic relationship were the most important indicator of treatment outcome. She notes that the individual with eating disorders has an authentic inner Self which is suppressed underneath an inauthentic Self and she is almost existential when she describes the clients craving for the real and not false Self to be loved. Whilst not referring to existential sources but reviewing the findings of researchers and clinicians involved in eating disorders Atherley (1992) summarised the most effective therapeutic principles as, amongst several she mentions, unconditional acceptance, tolerance, genuiness, warmth, friendship, calmness and personal responsibility, all existential concerns.

Cohn (1997) proposes that existential psychotherapy should concern itself with client choice and work on three aims; the removal of the symptoms, a change in the internal psychic mechanism and the assimilation into the psyche

of an unaccepted or unacceptable aspect of a persons life whilst Strasser and Strasser (1997) propose that using psychotherapeutic principles or existential concerns facilitates a more authentic existence. Fromm (1994) agrees with this approach and like Cohn, differentiates between Freudian psychoanalysis and existentialism by stressing that the genuineness of the therapeutic relationship cannot be reduced to transference or counter-transference principles. Fromm goes on to state that therapeutic techniques should involve complete concentration by the listener, the ability to be able to experience the other and to reach out to the other with an understanding love which also ignores the fear of losing oneself. Fromm also suggests that directness is more appropriate than small talk. This point has already been described in earlier client transcripts.

Van Deurzen-Smith (1988) explicitly espouses the existential emphasis away from the prescriptive and medical orientated model by stating that existential counselling focuses on reflection, on attitudes towards living and on building the personal efficacy of living. Existentialism is not about cure but about how individuals cope with the condition with which they find themselves. Like the clients in this study the individuals presented by Van-Deurzen-Smith moved through various mood states as therapy progressed and she noted that anxiety was a common experience and demonstrated the process towards a growing autonomy and readiness to confront issues of living. Laing (1959) also argued that anxiety is a manifestation of the participation in the objective world and provides a means of acknowledging autonomous action, whilst Yalom (1980)

discusses the embracement of past suffering as a meaningful and authentic act enveloped in anxiety.

Facilitating the clients as they experienced anxious feelings was important when the therapeutic focus was on their locus of control. Expanding the responsibility for their own action and reframing their perception of Self were positively viewed by the clients, a point Yalom (1980) found when presenting case studies on intervention with individuals who were addicted to drugs and alcohol. Like Fromm (1994), Yalom urges directiveness in therapy to activate change and recognises a similar phenomena to Duker and Slade (1988) when he notes that the presenting personality may fragment as change occurs. In this study the axial coding category "Outcome Effects" (appendix iv D) lists thirty positive concepts at termination of existential therapy. These ranged from cessation of bingeing, improved physical well-being, positive weight gain or weight loss, increased self-awareness and altered interpretation of Self and the objective world. The coding categories also identify the therapeutic principles and the clients perception of the therapist and these encapsulate the approaches espoused by existential therapists. These are codes taken from interview transcripts so it is apparent that clients were aware of the interventions adopted and their effects on their efficacy and autonomy.

Existential psychotherapy had a positive effect on all clients who underwent therapy and can best be summarised in their own words in their final interviews. For instance Dorothy who was diagnosed as morbidly obese observed that;

"He's not trying to control us……it's just having an understanding and not judging. Listening, caring (maybe that's the question of why you do it).....some people are not with you, thinking about your problem there, just going through the motions, I never think that……whatever you say he'll never forget…. I mean…..things are hard, but that; what do you want, its what do you mean, what do I want (whispers)… I think it's about me being more assertive, it's not a long term objective but its like in this situation what do I want to happen….when he comes into this room his attention is here…." (Interview 3 Paragraphs 39-49).

Andrea who had a long history of bulimic behaviours ended her sessions by noting "…..because I feel so in control now ……..he always seems surprised the life I live considering I've got this in the background and its made me be alert myself to the fact that because its been a lot of years, I am now trying to focus on the more positive aspects of my life but I mean he seems….that I cope very well because I've got this as well. And that makes you feel better because that's not the kind of information you get from other people. They may praise you for what you're doing but they don't know that you're coping with this as well" (Interview 3 Paragraph 5).

Yalom's (1980) and Van Deurzen-Smith's (1988) views that cure is not the goal, only change, is supported by Andrea who continued; "……he's following a different pathway…whereas others have tried to change you, with this its not something where……in a few weeks go out and change. It just

won't change. They've got to accept you for what you are" (Interview 3 Paragraph 6).

Fromm's (1994) suggestion that both parties should actively listen during the therapeutic process was practised by Andrea; "It's not really any different now… I'm copying with my life a lot better…its just a challenge every day….its not just the same as before. I do feel its different…I feel more easy to say something…its easier to talk in lots of ways…you might not have got any further or you've not going to stop it, or get a miracle cure you feel…..accepted for what is going on….he was listening to me as much as I was listening to him…..whatever I've said he's never dismissed, he's prepared to see your point of view….there's progress on his side from where I've got….it's really knowing that somebody has gone that step further….." (Interview 3 Paragraphs 9 to 13).

Gemma diagnosed as morbidly obese, who had difficulties in deciding whether the therapist should, or should not, control the sessions at the beginning of therapy described her view at the end; "I just know it worked… I just assumed he would tackle the eating, I didn't think he would tackle everything else… I'm slowly beginning to accept what I am and who I am, but that's been a long time coming…. I thought I knew me fairly well but I found I didn't" (Interview 2 Paragraphs 20 and 21).

Rachel who experienced bulimia nervosa reached a similar conclusion to Andrea. Rachel had reached one existential objective by facing some

unacceptable aspects of her life (Cohn, 1997). She was now beginning to express her feelings and gaining much improved coping mechanisms. She observed that "its made me more open about it and I've been able to talk about it whereas I was really ashamed about it....its really helped me to be able to talk about it with people that understand....some of the questions that he asks I've never really thought about because it was totally out of control. I didn't know where to start in dealing with it really.....my friends have said that I look better and less troubled and I feel different, more in control" (Interview 3 Paragraphs 15 and 16).

Beryl who experienced morbid obesity had also begun to reframe her perception of Self and had fairly quickly began to socially interact with others as her confidence and locus of control improved. Yalom (1980) preferred the term improved responsibility for autonomous action rather than locus of control and Beryl did appear to present a picture of autonomy when describing the effects of existential therapy;

"I've realised that my problems aren't entirely down to me being a weak person or having no will power....just being able to talk through....how I felt other people viewed me before and now I don't read as much into things anymore. Before I think I was over-analysing everything everybody said and coming to a wrong conclusion, a negative conclusion, and I don't think I do that so much anymore either.....I think its helped me communicate with people a lot more, I'm beginning to make more friends than I have before and I'm reaching out to people more and I'm confident in what I'm saying. And

when they're talking back to me I'm not thinking, oh they don't want to be talking to me. I'm more confident with people" (Interview 2 Paragraph 3 and 4).

Beryl had relinquished her perception of Self as inadequate and adopted Duker and Slades' (1988) position that she should rebuild a new Self with all its attendant anxieties; "I now feel I can have a pretty good stab at it (being on my own) and yes there are going to be problems but I can cope with it… I'm looking at things differently really (Interview 2 Paragraphs 6 and 8). Previously however her condition was described as "Quite distressing really. I think I was generally quite unhappy at the time and quite withdrawn. It wasn't very nice at all, it was quite distressing" (Interview 2 Paragraph 10).

Her new confidence reframed her views on bingeing too; "…..the main problem as to why I came here originally, the fact that I couldn't stick to these diets and I just had these major bingeing sessions, I no longer have those. I mean I still probably eat more than other people but I don't have these sessions where I stuff my face and then spend hours feeling guilty. That's not happening" (Interview 2 Paragraph 12).

Cohn (1997) and Yalom (1980) both recognised that autonomous living meant being aware of, and preventing, potential pitfalls in everydayness and the threat of returning to past poor eating habits remained a constant threat to clients. However once they had discovered that withdrawal effects could be overcome and that feelings of anxiety may be due to what Fran called the

"newness" of the non-fragmented Self (Duker and Slade 1988) then this threat became one which could be prepared against. Beryl responded firmly when asked if she would go back to past eating habits if in a crisis;

"No, I don't I think I would cause I had a bad time a few weeks back and I though , if I'm not careful.....all my hard work is going to go to waste but, um, just sort of knowing that was a possible pitfall approaching me helped me not to fall back into my old ways really....and I think that's why when these situations arise I no longer get stressed and I'm not in the position to want to go and have a binge really" (Interview 2 Paragraph 33 and 38).

Beryl's last comments demonstrated that her impression of past therapies had not been forgotten and were compared unfavourably with existential interventions. "....going back to the early sessions with the mental health nurse, I think they were helpful but they were just a little bit too general and I come (here) and things are more specific and I really go away and think, oh yes, and he gets me thinking about things and I change the way I think about things as well" (Interview 2 Paragraph 44).

Chris who was diagnosed as anorexic had also undergone a radical shift in her perception and had progressed to the stage where she "actually felt like a normal person" (Interview 2 Paragraph 27) and viewed the existential focus of therapy as instrumental in her improved physical and psychological well-being. "It helps us to understand and get some insight into

everything.....it's a pity it can't be here all the time. I think it would help a lot of people".

Jane who also had a history of chronic anorexia nervosa also had a positive outcome despite having a long history of containing her feelings. She experienced severe transference as therapy progressed and this manifested itself in the neediness for others to recognise her Self. She had never experienced the emotions released when revealing inner feelings and thoughts to another. These began to overwhelm her and she began to see the therapeutic relationship as one which was the only loving interaction she could experience (Fromm 1994). "...it feels quite embarrassing to say, but its not really. I think it's quite a normal thing. But that I became quite attached to Mike is how I'll say it and I suppose it stands out that he was so ok about that....because I'd felt this happening but hadn't said anything. But it came to a point where because of that I couldn't express stuff to him..." (Interview 1 Paragraph 18).

Despite the common experience of managing transference in therapy, dealing with these feelings was much more difficult with Jane. Any attempt to deal with such emotions using therapeutic references (these feelings are normal, they are often due to such and such, and so on) would put the therapist in control of the process. Ignoring these feelings may have led to Jane suppressing her emotions again. A decision was taken to explore such feelings in relation to her new emerging Self and the response of the therapist to the reactions given by Jane when engaged in these discussions (Yalom, 1980; Cohn, (1997).

This approach reinforced Jane's perception of her Self as having the confidence to interact and generalise such feelings in other situations whilst also allowing her to retain control of the therapeutic process. Two years later she recalled the experience;

"I felt it was important to speak to him which was quite hard, but again it just wasn't an issue. It was, ok, well this has happened, what are we going to do about it kinda thing; or how is it going to be? Do you want to still see me? And its just really accepting of it and he just talks about things as being ok, I don't know how else to say it.... I mean we talked about, like transference and stuff like that and what I wanted from my life in other places. But I was getting it there and he asked how will I get it in other places and what do I want from him, and what do I want from the relationship with him and that its not appropriate. Well not that it's not appropriate, he never said that. But it made me aware that I have these feelings and I want these things, but that this isn't really the appropriate place to get it, and that was never what he said but that was what I sort of realised. Do you know what I mean, because that's the first time I have felt safe with somebody and be able to express myself, and to be me, and be who I am. Yeah I suppose its quite natural to become attached to the person who provides you with the space to do that cause it helped me look at and really widened how to get that in other areas of my life" (Interview 1 Paragraphs 19 and 20).

"....he set the limits in a really kind way. Because I suppose part of the stuff for me was how physically unattractive you are and I suppose one of my fears

about saying what was going on was that he'd look at me and go, ugh! You're horrible! How could you! But there was never any rejection. It was never going to happen and those limits were set really well. But I never felt rejected. So to deal with it in that sort of way, my sense of Self, while it was getting stronger, was still very fragile. And it would have been very easy for someone just to say the wrong thing and for me to feel very rejected by that and I never got that, even though really I was. He did it very well" (Interview 1 Paragraph 31).

The emerging sense of who she was and her new sense of control and efficacy was strengthened by the way existential therapy examined transference and counter-transference in this stage of the therapeutic process. It allowed Jane to overcome the effects recorded by Connors (1996) as results of childhood trauma and practice a developmental maturation of her emotional responses in a safe environment. Her progress continued and lends support to Duker and Slades' (1988) view that it is more beneficial if the individual experiencing eating disorders builds a new Self and discards the fragmented Self held in place during the period of the eating disorder. Jane believed she had changed and discovered the strength of autonomy in separateness discussed by Yalom (1980) and Fromm (1956). On being asked the reason she replied;

"I think it's a combination of things, it's like steps. You do different things at different times so like when I first started getting treatment at the (Hospital) that was what I needed because it was not too deep. They told you what to do and I didn't have to take any responsibility for stuff. So that was three years

and then Mike for two years. So I suppose seeing Mike was as the start of me discovering myself and what I really thought and what was important, um, and starting to express the real me. And it was very liberating to be with someone and just be yourself when that's something I very rarely did, and I suppose it kind of got me curious to go a bit deeper and discover a bit more and it also gave me the confidence that I was ok and that I was strong and I could do what I wanted….then I went travelling and see that was the biggest thing that changed me. Because I'm out on my own and I've got to depend on me so you become strong. Its not that I've not been strong but I think I was scared of showing my strength. But when you're on your own you've got to be strong and show it because you meet people who've never met you before so they've no prior expectation. So you can be whoever you wanted to be which for me was me. But you could go and put on any act you wanted to and nobody would know any different….." (Interview 1 Paragraph 26).

Like the other clients Jane had reframed her steely determination to control her diet into a more positive outlet and found a wider and deeper locus of control in environments she could least control (Yaloms, 1980; responsibility of autonomous action). The sense of self-direction which she found by controlling the therapeutic process was deepened by her recollection of earlier therapy;

"(Existential Therapy) was the first step to going further….without wanting to sound too clichéd it was the first step on the path to self-discovery you know….no one knows what would have happened if I'd not seen Mike but

what I got from the (hospital) I can't image me having gone away. So I don't think I would have gone if I'd not started (existential therapy) 'cause I don't think I would have had the confidence that I could do it and it was ok to do it (Interview 1 Paragraph 29).

Like the seperateness discussed by Strasser and Strasser (1997), Yalom (1980) and Fromm (1994) Jane realised that both herself and the therapist were isolated beings but the therapist was capable of providing support if she needed to have help. This knowledge was paradoxically empowering to her; ".....it's nice to know if you ever did need something he would be there. A kind of safety net. As long as you know there will be somebody, you don't need them" (Interview 1 Paragraph 30).

Years later this continuation of being there for her in times of stress developed into a professional friendship as our work in eating disorders and addictive behaviours occasionally crossed paths. Like other individuals in this study who overcome eating disorders Jane also found personal reflection and comfort in spirituality and creative outlets.

Karen was another client from the past and was contacted to participate in this study after therapy had ceased. She had a long history of anorectic behaviour. For her the most significant aspect of existential psychotherapy was hope and regaining a degree of control over her sense of Being;

"…..when I was distraught he'd let me just cry through it and sit there…he was able to communicate back to me so I wasn't feeling negative about myself all the time which gave me hope…..the way he didn't go on saying you should or you shouldn't….he didn't make a big thing of it" (Interview 1 Paragraph 6).

Like Gemma, who was diagnosed as morbidly obese, Karen had initial difficulty in taking the control of therapeutic progress and in reframing her locus of control but when she did feel she could choose the way she wanted to deal with her eating and self-harming she did so with a big decision;

"I mean I was still using laxatives at the time and I disclosed that to him and because we had such a trusting relationship he said to me, oh I bet you can't give up, not as a threat, just in conversation, and I said I bet I could, and I stopped using them" (Interview 1 Paragraph 8).

Strasser and Strassers' (1997) and Cohn's (1997) point that the assessment phase is not material was borne out by Karen. The therapeutic relationship was quickly established as she first appeared presenting as a very distressed and deeply hurt person immersed in the loneliness of isolation. She had stared hard at the nothingness at the core of her being and was overwhelmed by the aloneness described by Heidegger cited in Mulhall (1996), Fromm (1956), Yalom (1980) and Laing (1967). She was genuinely suicidal and the only communication to her sense of Self was the perception she herself could give to the interpersonal relationship in therapy. She had experienced severe

trauma and loss in her life and knew the dread which Heidegger often discussed. The exhausting concentration required in therapy with her was genuine because she expressed her isolation so dramatically yet she could not see the strength she displayed in carrying such pain for so long. The assessment centred on her sense of communicating and the response given by both herself and the therapist. She appears to have been aware of this; "….as well as communicating he was able to assess and communicate back to me…it was an immediate like empathy…." (Interview 1 Paragraph 6).

Karen had not experienced this approach before and responded to the question to whether this was a change to previous therapy with;

"Yes, just by the way a person communicated on such a level with me….the same wave length yes, and even with all my medical history and everything, that was nothing. He just took me as he found me and he didn't know anything about me and he trusted that….. the person that can communicate back to you that's neutral, there was no judgements or anything" (Interview 1 Paragraph 9 to 12).

Karen's growing confidence in the ability to convey her distress and be aware of the aloneness of others gradually weakened her suicidal drive although she did not find happiness;

"I've become more aware of myself. The depression is something that will always be there just under the surface but….the counselling and the contacts

that are made now for myself has given me hope....." (Interview 1 Paragraph 20).

Karen's increasing sense of hope however did increase her perception of humour. In response to a question about being challenged she noticed a less confrontational approach than had Chris or Gemma;

"Yes I was less conscious of him challenging. I think perhaps...he did challenge but I wasn't even aware he was doing it. He did it with a sense of humour and I'd do it back with a sense of humour...I suppose that (bit with the laxatives) was a challenge in a subtle way and it worked" (Interview 1 Paragraphs 22 and 23).

Again in support of Cohns (1997) assertion regarding the assessment phase, Karen only revealed what she wanted when she wanted. However this was acceptable because it reinforced her sense of control over the pace of therapy; "....there was one thing that was really difficult that I told him after about three or four session" (Interview 1 Paragraph 28).

Like Jane, a long period after therapy was completed she recalled a clear difference in her life before existential psychotherapy and had come to terms with what Cohn (1997) called unacceptable aspects of her past;

"There's a huge difference. I can come out and say things that I couldn't and discuss things and communicate about things in the past, so I can do that now and I couldn't.....it was gentle for me. It was challenging in small ways that

I wasn't aware of and just assisting me at opening up to say more and then to work on what you've said. It was always positive input. If there was anything negative there he never said so. I never went away with anything negative" (Interview 1 Paragraph 30 to 32).

Her first impression (which is blank to me) remained vivid and became a basis for a later friendship. Yalom (1980) and Fromm (1994) note that such friendship lies in the knowledge and guidance which can be provided by those who have experienced trauma to those who care enough to help;

"He listened with interest. I remember when I first saw him he just remained interested" (Interview 1 Paragraph 33). Karen remains a friend.

The existential approach was new to both therapists interviewed for this study. Natalie a qualified cognitive behavioural therapist, was the co-therapist in the group work and immediately observed the focus on existential concerns;

".....he focused on the here and now really....its more about the future and the possibilities available and how they can move forward from there. And also its about.....how they feel about themselves, what their relationship is with themselves rather than other people and getting them to look at why, just the choices they've made and why they've made them. Where they are in their life and how they got there. Self-awareness really, how they've got to where they are and the choices that they've made, very much about developing insight" (Interview 1 Paragraph 1).

"I suppose the main difference is……more focus on the client and about what they want. He talks to them a lot about having control over their life. He turns everything back on them whereas I suppose the way I've practiced, and others that I've worked with, they tend to see us more as the specialists and he turns that round so they don't see him that way... Um... He makes them question the control they have and the responsibility they have" (Interview 2 Paragraph 1).

Hilary, a person-centred therapist was a fellow therapist in the Centre but did not work as a co-therapist. She observed changes in her clients who attended existential group therapy. Interestingly, for one client Hilary also observed withdrawal effects. She was however, unclear about the focus of existentialism;

"….Fran was ready for a shunt in some direction and the group has certainly done that, now what element of the group I'm not sure (but)…..much more so than the other group which she joined….initially there was quite a bit of trauma….her symptoms increased so she became more anxious, she was having panic attacks, her mood dropped…..to a point where she was quite low and quite sad and there was……increases of self harm behaviour….and that happened quite quickly as the group began" (Interview 1 Paragraph 3 and 4).

Hilary had also observed quite dramatic transference from Fran towards myself as a male therapist which has been discussed earlier. Hilary was interviewed twice but even in the first interview she captures the attempts

being made to apply existential concerns. For instance the emphasis on time given by Strasser and Strasser (1997);

"....she's looking at the future an awful lot.... I think she's slowly becoming very aware of the time and the future.....the sense I've got of it is that there is a cognitive element to it but with more emphasis on focusing on to the future and motivating, and decisions....that's the gist of it" (Interview 1 Paragraphs 11 and 14). Hilary also has a hint of the focus on moving the control of the therapeutic pace back to the client;

"...she said its good to be in a group where she can talk a different language. She can't do that at the hospital and she does get a kick out of being treated as a mature, thinking, intelligent adult...and I think something which is important, is respect" (Interview 1 Paragraph 15).

Natalie, who observed the group therapy first hand was very clear about its focus;

"....quite challenging, quite questioning, um, quite confrontative so that when they talk about their life and how it is he'll ask them why they behave in a certain way or why they keep on behaving in a certain way. Like, a lot of people who self-harm, why do they carry on, what purpose does it serve, how its got to where it is now but also why they keep doing that... and you can tell that its really a question that they haven't considered before; and getting them to think about things and how they really are....its quite stimulating for

them.....and they can look quite surprised because its quite direct....you can tell that they come back and they have been questioning themselves more. You can see that progression" (Interview 2 Paragraph 2 and 3).

Natalie was also conscious of Strasser and Strasser's (1997) emphasis on temporal time as well as Yaloms' (1980) emphasis on autonomous responsibility (increased locus of control) and Duker and Slades' (1988) reframing the new Self;

"...The focus (is) on the person and the possibilities...looking at where they're up to now but more about where they're going. It is very positive....even being in therapy is very positive and this is the start of your growth, its like where do you want to be. Looking at the choices and saying to the people, you have control...its putting responsibility onto people and that you have choices and you have to accept the choices that they make....people...take responsibility now, and then go away and keep making choices in their life" (Interview 1 Paragraph 6).

Natalie also noted a difference between the personality of the therapist and the therapy itself; "I feel it's quite a positive model. I think he's a very positive person but I ....think that the philosophy from which he works (focuses) people growing from now into the future....part of it is his personality.... but...I've worked with other people that are good at their jobs but the reactions different ....yeah, I think it's the philosophy from which he works from" (Interview 1 Paragraph 10).

The emphasis on allowing the client to control progress had an effect on Natalie's own therapeutic practice;

"I would say that in the work with my individual clients now I do look much more at the person and trying to put the responsibility back to them and saying yes, that's in the past, that's whats happened and how can we move on somewhere" (Interview 1 Paragraph 14).

Towards the completion of therapy both therapists observed marked alterations in the clients. Hilary observed that one client was "certainly more mature....I think that the emphasis on looking at life in a broader way has made a difference" (Interview 2 paragraphs 5 and 6) whilst Natalie observed that the therapy appeared to work by commenting "it certainly seems to have done yeah. We've nearly finished the group now but they've come along so far. Its amazing really" (Interview 2 Paragraph 5).

Hilary recognised the influence of Carl Rogers (1967) on the respect given to clients and the adoption of person-centred techniques when they were felt to be relevant "I could say that Carl Rogers and phenomenology/existentialism shake hands coming from the different backgrounds...when the client arrives she'll say I've done this and this is because this...so I think she's beginning to explore environments and how she reacts to them...there are changes...(its) not a million miles from how I work" (Interview 2 Paragraphs 9, 14 and 23).

Hilary was also conscious of the less directive approach and its effects on the client;

"She's far more aware of what life will be like without the services…I (thought) she'd be with us forever, she'd get freaked by the thought of what would be out there….and quite regressed by it. Now she's has a much more mature outlook towards what her future will be…." (Interview 1 Paragraph 5).

"….I think a lot of the talk about ….what she would like…is coming more from her. I think in the past she's been told what she should be doing but…its coming far more from herself than being pushed by consultants" (Interview 2 Paragraph 8).

The decreasing influence of direct external control was also described by Natalie; "…. I would say the …people in the group feel like they are more in control. And you can see, like they used to talk about doctor such, and such said this, or the CPN said that. But they're not. They come in saying I think this and I feel that. This is what I can see and just the moods and ways in improved relationships. They're exploring areas they haven't looked at before…." (Interview 2 Paragraph 6).

Yet the phases of therapy were being followed despite the control of the pace and speed taken by the clients. Strasser and Strasser's (1997) position that explicitly limiting time and the number of sessions does assist clients to focus on their own deep issues is supported by this study. Natalie observed the

clients engaging with phase four and five (which I have termed the Existential and Ending phase) of therapy;

"People come in…I've assessed them all…and the problems food and that's what they talk about…they're still quite focused on food….straight away it was like, we'll scrap that and say, well why is food so important and what's actually happening in your life. In some aspects remove food from the picture and talk about everything else and thats what we've done. Its only now that we've got to the end of the session that they've brought food back in and its about finishing off" (Interview 2 Paragraph 2).

Natalie observed positive alternations in the client towards this ending phase; "….two of them have reported that their eating habits have changed a lot. One of them is not so sure but yeah, they're not talking about it as a problem….the ones that weren't eating are eating and the ones that have been bingeing are eating normally….they can make choices and they are in control so their view of the world has to change" (Interview 2 Paragraph 22 and 24).

"…some of them would have received a lot of stigma from other people so if they see themselves as a fat person its because that's what they are receiving from other people. But from a sense of self-esteem they can say for themselves, well it doesn't matter what the world thinks. But yes, they can relate with others and take that on board, but also they've got enough sense of themselves" (Interview 2 Paragraph 40).

"...the one that had anorexia has put weight on and is looking at keeping it on. The one that was binge eating isn't anymore, she's got a stable eating plan and feels confident about continuing. The other lady who was over-eating does so far less but there's other things, she was self-harming in other ways and they've stopped.... it seems to have come from their attitude. That's changed" (Interview 2 Paragraph 31).

Existential psychotherapy appears to be an effective intervention in disordered eating. I believe there is sufficient data emerging from the grounded theory approach to support the philosophy put forward by existentialist therapists such as Fromm (1994), Yalom (1980), Cohn (1997), Van Deurzen-Smith (1988) and Strasser and Strasser (1997). The changes observed by the clients and my fellow therapists could be traced to the therapeutic focus on authentic living. Clients confronted their own aloneness and began to find meaning in their own Dasein (Being there) and everydayness (Horrocks, 2000). They experienced the anxiety of existential isolation and took responsibility for autonomous choices.

Yalom (1980) cites Heidegger as providing a good description of the existential isolation faced and overcome by clients who underwent therapy in this study. According to Yalom (1980) Heidegger was fond of making puns and wordplay with "nothing" and quotes; "Of what is man afraid?" "Of nothing" (Yalom, 1980; page 360). Laing's (1967) writing perhaps captures the experiences of the new Self (Duker and Slade, 1988) as it looked at Heideggerian dread and chose the freedom to engage in, and with, the world;

"There is nothing to be afraid of

Nothing.

Exactly.

The life I am trying to grasp is

The me that is trying to grasp it!

Laing, 1967; p156 "*The Bird of Paradise*"

Summary

The use of the grounded theory approach and Glazer and Strauss' (1967) belief that emerging issues lead to new and different investigations in a field of knowledge is well suited to existential research. There is no end point, each knowledge acquisition leads to another. For me the more I have learnt the more I have realised how much more there is to learn on the subject of disordered eating. Grounded theory, like existentialism, seeks patterns, connections, links. The data collection and analysis in this study does indicate new connections and patterns which differ from traditional approaches and provides both interest for further research and further clinical approaches.

Two new areas present themselves for the researcher and clinician. The potentially addictive properties produced in the hypothalamic-pituitary-adrenal axis when glucose levels alter in extreme measures, and the potential for a different clinical approach which allows the client to control their eating habits and pace their therapy. These two areas are found in all three disordered eating conditions.

Saturation reading of a wide variety of data, then open and closed codings followed by axial categorisation indicate a strong possibility that eating disorders have an addictive element. The obsession about food which characterises eating disorders may not be due to an obsessive-compulsive neurotic syndrome but the behaviours associated with planning, or continuing, the experience of numbness. In extreme forms, and also in chronic cases, the numbness causes poor memory, concentration and motivation. These may be genuine physiological alternations due to glucose levels and enzyme effects. Observations and interviews suggest that bingeing precipitates a sudden but temporary state of numbness with hang-over like symptoms the following day. Bingeing has to be repeated approximately twice weekly to continue and replace the shortness of impact.

Severe reduction in food intake precipitates a slower but much longer-lasting state of numbness although physical tolerance (the body's attempt to regain homeostasis) means that in time more weight loss is required to maintain the numbness.

Support for an addictive element is provided by the fact that any attempt to alter a fixed pattern, either bingeing or intake, creates severe physiological and psychological discomfort. These include night-sweats, loose stools, aching limbs, headaches, anxiety attacks and bouts of severe low mood. A return to either bingeing or reduced intake almost immediately stops such discomfort. The individual appears to be trapped between the discomfort of change and the guilt of failing to change. After a while the motivation to even try gets weaker.

Despite extensive literature reviews no connection has been made between residivicism and the withdrawal effects recorded in this study. The biomedical approach appears to be looking for endocrine or genetic precipitators (Mehler, 1996; Margo, 1987), rather than the biomedical response to modern foodstuff whilst psychosocial research look for a familial, sociocultural or mental health source (Bruch, 1985; Malson, 1998; Woolf, 1990; Hill and Franklin, 1998). The reason why individuals engage in disordered eating is beyond the scope of this study. The shared background issues can be seen in the axial category "Client History" which indicates unhappy childhoods and early traumas. This study however does present a case for further research into addictive patterns which may cause the continuation of chronic eating disorders. In this sense the principles of grounded theory in discovering new emerging theories are supported.

For the therapist and clinician what is very clear is the successful adoption by clients of control of the pace of therapy. The clients were out-patients and care must be taken to ensure that a full risk assessment is carried out prior to the commencement of this approach to therapy but it appears clear that clients deeply resent external controls regarding their eating patterns. Allowing clients the choice of whether to continue their eating pattern during therapy is a significant breakthrough in treatment attendance and outcome rates. All the clients could provide examples where their compliance in treatment programmes never addressed their real concerns. The work of Atherley (1992) was supported in this area and raises doubts about whether past researchers measure success using a medical model and not the clients own

measurement. Cohn's (1997) assertion that clients will reveal their concerns based on their perception of the therapeutic relationship itself was supported repeatedly by clients in interviews.

The sense of dualistic thinking (Malson, 1988), made worse by poor self-esteem and physical ill-health, suggest the traditional cognitive-behavioural-therapy approach advocated by Fairburn (1984) and Garner and Garfinkel (1997) has its limits. The emphasis on low mood and body image is only partly successful because it appears to focus on only part of the picture. The further emphasis on obsessive-compulsive traits also misses the wider view. Bell (1999) was closer with her interpersonal analytical model which began to focus on the clients sense of loneliness and alienation from themselves. Self harming behaviours are rarely aimed at Self-destruction and when the client is ready they will often reveal self harming to be a narrow locus of control to prevent an act or thought rather than suicide. This is the reason clients give for its habitual patterns.

Again in the spirit of grounded theory it is proposed that further research should be taken to ascertain the outcomes when cognitive-behavioural approaches in eating disorders focus on addictive rather than compulsive behaviours. This research should be in all three disordered eating behaviours.

The existential concerns of meaning, responsibility and freedom appear to be appropriate therapeutic concerns in the field of eating disorders. Utilising the eclective techniques espoused by Van Deurzen-Smith (1988) within a fixed

time and number of sessions advocated by Strasser and Strasser (1997) and following the phases developed for this study allowed a constant emphasis on existential concerns. The theories propounded in particular by Fromm (1997) and Yalom (1980) guided the psychotherapeutic principles, whilst to a lesser extent the work of Laing (1967) provided some light in the areas of transference. Cohns' (1997) view that existentialism allows clients the chance to face the unaccepted or unacceptable in their lives was supported in this study.

What Yalom (1980) termed autonomous responsibility is often referred to as locus of control in mainstream psychology. All the clients irrespective of their diagnosis achieved a significant improvement in their locus of control and efficacy and this is demonstrated in interview transcripts, review letters and discharge rates from the clinic. The increase in control and freedom is due to more than working with self-esteem and self-assertion. Cognitive-behavioural supporters may argue that therapy was at deep schema level (Fairburn, 1984) and person-centred supporters may put forward the view that genuineness, non-judgemental and non-directive principles were being practised (Rogers, 1967).

It is nevertheless a new theory which has arisen from this study. Van Deurzen-Smith (1988) discussed the applicability of techniques in the practice of existential psychotherapy and the use of cognitive-behavioural approaches was used when relevant, and so was person-centred counselling and analytical therapy (Bell, 1999). What is important is the interpersonal relationship and

the constant attention to existential concerns which go beyond self-esteem and self-assertion. Exploring and reflecting on their very existence, their Dasien and the choices that they, alone, make in their everydayness (Horrocks, 2000) altered and reframed their perception of Self. Realising their isolation gave authenticity to their core of Being and tracking the route taken to the present allowed the clients to perceive their essence and the patterns and connections between their Self and eating habits (Sartre, 1943).

This new theory of eating disorders proposes that individuals exist beyond Cartesian mind/body dualism (Mulhall, 1996) in a state of temporary numbness to escape the feelings induced when external agents try to change their eating habits or to escape the inauthenticiy involved in interaction with others. This numbness is found in all three disordered eating behvaiours.

This is the reason that Duker and Slades' (1988) exposition on the fragmented Self is supported in this study. The sample is small but the case studies are rich in depth and detail and tracking the therapeutic progress between two and five years indicates clients reframe their self-identity into a new Self, shedding the constant and exhausting need to present different personalities to different people. The new Self is reinforced by the control that they hold over the pace and content of therapeutic sessions. This is very difficult to implement and there is often resistance to empowerment. There is therefore a need to prevent the sessions drifting and a time scale and number of sessions were pre-arranged (Strasser and Strasser, 1997). This did seem to have some success in bringing issues of alienation to the surface whilst continuing to let the client

control what will be revealed. This often means the therapist must be silent even when patterns are observed to the therapist but not to the client. The therapist must also adopt a watchful silence as clients experience the anxieties and physical discomfort of change.

Yaloms' (1980) view that autonomy and the freedom to choose arises from the awareness of separateness were important elements in the construction of the new Self. Clients began to realise that they alone faced the nothing except when they chose to look away from the awareness of their own isolation. They resented outside interference yet cried for help. When they discovered that only they could help themselves, (or not), did real locus of control expand and efficacy increase. Freedom was distressing, but less so than the frustration of hiding their experiences and undergoing therapy after therapy. In many ways the anxieties of interpersonal interaction together with the disappointment that their physical body could not be healthily maintained precipitated the drive towards numbness. This made what was left of their lives be extremely and rigidly controlled as the individuals sense of Self began to fragment. Existential freedom allowed clients to avoid rebuilding the fragments and instead, make the choice to be a new Self. This new Self is relevant to all three disordered eating patterns; anorexia nervosa, bulimia nervosa and morbid obesity.

This theory has emerged from the grounded theory methodology. But it is the testament of the clients, fellow therapists and treatment outcomes that provides the basis for this theory. It will I believe precipitate three responses;

further research into the physiological aspects of the numbness and withdrawal effects experienced by individuals with all three eating disorders; a change in the dominant psychotherapeutic approach which will give clinicians the opportunity to hand over control of the pace and content of therapeutic sessions to the client (and importantly, adopt appropriate risk assessments which will empower clients to continue their eating habits during therapy) and, finally, create an environment in which the existential approach can be debated, researched and taught in health, social and educational environments.

POSTSCRIPT

Eight months after the final therapeutic sessions a follow-up exercise was carried out to find out how the clients were engaging with their everydayness (Horrocks, 2000). The following information was gained;

Andrea (original diagnosis bulimia nervosa) – has completed a college course and seeking employment based on her qualification. Bingeing episodes largely reduced. Indicates willingness to lead bulimia nervosa support groups. Remains convinced the condition is life long and ever present.

Beryl (original diagnosis morbid obesity/binge eating) – enjoying the freedom and responsibility of living alone in her own home. Remains very vigilant regarding foodstuff and continues her healthy eating regime. Bingeing ceased and she has indicated that she may refuse the offer of a referral to the new Eating Disorder clinic but may accept referral to a person-centred counsellor. Has found new employment with better pay and conditions. Relationship with parents remains problematic.

Chris (original diagnosis anorexia nervosa) – weight gain has been maintained. Ceased to take major tranquilizers. Family relationships much improved. Endocrinal improvements, has become pregnant. Continues to produce creative sculptures and paintings.

Dorothy (original diagnosis morbid obesity/binge eating) Weight loss maintained, blood sugar levels balanced. Bingeing much reduced. More self-assertive within the family. Has commenced undergraduate programme in Psychology.

Rachel (original diagnosis bulimia nervosa) – bingeing sessions ceased. Has made plans to be married and move abroad. The newly married couple will carry out missionary work for the Church. Has found a deep spiritual relationship with God.

Fran (original diagnosis morbid obesity/binge eating) – continues to produce poems and paintings. Has completed a college course. Very open about her intentions to gain a relationship with a man and discussed her sexuality with her long-term therapist. Has been discharged from therapy.

Gemma (original diagnosis morbid obesity/binge eating) – has moved to another area. Last contact indicates continuing to binge-eat and her weight fluctuates as her mood alters. Relationship with the family has improved. Discharged from therapy.

Jane (original diagnosis anorexia nervosa) – has had two serious relationships. Continues to travel. Has qualifications in complementary therapies. Considering joining a commune. Has found a deep spiritual meaning in non-materialistic existence. No symptoms of anorexia nervosa.

Karen (original diagnosis anorexia nervosa) – shares a home of quiet solitude with a friend. Remains very sensitive to the moods and behaviours of other people. Depression has eased. Eating improved as has her overall physical wellbeing. Spends her time reading and being alone in the countryside. No symptoms of anorexia nervosa.

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DIGESTIVE PROCESS

The normal digestive process for the human is based on the need for the body cells to receive energy supplies for their own functional usage and to produce energy through the combination of food and oxygen. Food cannot be utilised by the body in its normal edible form. The process of digestion breaks down food into acceptable elements for the body to build new cells and tissues, repair damaged cells and tissues and provide the energy for the human being to live. Digestion is a fundamental physiological activity shared in common amongst all living creatures. Disruption to the digestive process is usually due to extrinsic factors such as illness, disease, lack of availability of food supply, wear and tear of tissues or organs and so on.

However in the eating disorders of anorexia nervosa, bulimia nervosa and morbid obesity there is severe disruption to the digestive process either through conscious effort or a loss of conscious control of normal eating habits. It is helpful when studying such eating disorders to have a working knowledge of the normal digestive process in order to understand the effects of process disruptions.

Physiologically digestion commences once foodstuff is inserted into the mouth. The physical sensations include texture, level of softness and hardness, size and taste. Taste is the most sophisticated of these sensations. The tongue's taste buds distinguish sweet, sour, bitter, and salty tastes. This is an important consideration

in eating habits as the pleasurable experience of eating is enhanced by the range of tastes which the human mouth can sense. In abnormal eating habits such as binge-eating the role of the taste buds appear to be secondary to feeling the stomach become distended when full. (About three pints of food or liquid). This allows the individuals to eat whatever is available irrespective of its taste pleasure. This may affect the production of saliva, which (with the aid of the teeth) breaks food down into a mushy compound for ease of swallowing and commences the process of digestion itself via the production of the enzyme ptyalin. Ptyalin acts on starch altering it to soluble sugar. Ptyalin is alkaline and by itself is relatively harmless in the mouth. However the sugars produced by its action are extremely attractive to bacteria. These bacterias break down the teeth in conjunction with acids which wear away tooth enamel. All the eating disorders therefore have an undesirable effect on teeth. The person with anorexia nervosa will not have the diet required to keep teeth healthy (milk, fresh fruit, and vegetables). The person with bulimia nervosa will introduce hydrochloric acids to the mouth through frequent vomiting whilst the individual who binge eats will introduce too many compounds for the digestive process to deal with in an adequate manner.

Eating disorders also prevent full digestion of food compounds during the soluble state. The soluble state is a physiological requisite for the process of diffusion to occur (the breakdown of food into elements required by the body into liquids that can pass through cell membranes). Digestion begins during chewing and then

continues for the next thirty feet through the alimentary canal. The first phase of the alimentary system is the oesophagus which assists food into the stomach via peristaltic movements (muscular contractions of the oesophageal wall). Food is prevented from returning back from the stomach by the cardiac sphincter (a ring of muscle at the end of the oesophagus and the top of the stomach). When the stomach is full, or if the stomach or throat is irritated then the cardiac sphincter will open causing vomiting. The habit of bulimia means the cardiac sphincter is opened consciously (generally through the action of abdominal contractions) whilst binge-eating overloads the stomachs capacity. Vomiting as well as decreasing the amount of food which can be digested also increases the volume of hydrochloric acid from the stomach to the throat and mouth, altering the chemical state of saliva and breaking down teeth enamel.

The stomach continues to break down any remaining food compounds through the action of hydrochloric acid and the production of the enzyme pepsin (from gastric glands). Pepsin commences the digestion of proteins.

After protein digestion the food compounds are passed into twenty feet of the small intestine through the pyloric sphincter. It is within the small intestine that the remainder of the foodstuff is digested and where blood absorbs soluble compounds and transports them throughout the body. Various enzymes from the small intestine work alongside enzymes from the pancreas and bile from the liver to digest starches, sugars, proteins and fats. The small intestine produces erepsin

to finish the digestion of proteins (which were initially broken down by pepsin in the stomach). The enzymes maltase and sucrose complete starch and sugar digestion.

The pancreatic fluids contain tyrosine which continues to digest proteins, amylase which digests starches and lipase which digests fats. Bile from the gall bladder emulsifies fats. The body absorbs the end products. Through the digestive process proteins become soluble amino acids, starches become soluble sugars and fats become soluble fatty acids and glycerine.

The inner lining of the small intestine consist of villi (tiny organs for the absorption of soluble products) which are supplied with blood and lymph vessels surrounded by a thin membrane. Through the process of diffusion proteins and sugars pass into the blood vessels through the membrane and are thereafter carried to other body cells. Fats are absorbed into the lacteal (lymph vessels) and are transported into large vessels.

As the blood transports sugars through the liver the liver cells remove some soluble sugar and alters the compound into glycogen which is stored for use as bodily fuel. Other cells in the body absorb the compounds required by altering the soluble solution into protoplasm or combine it with oxygen to produce energy. Whilst individuals with eating disorders can do little with the absorption process taking place in the small intestine attempts can be made to disrupt the process.

The experience of anorexia nervosa and bulimia nervosa can influence individuals to decrease food intake, or induce vomiting which can prevent the normal digestive process working. Another method is to expend more energy than is stored by the body. Taking less food whilst over-exercising means body cells work harder at combining food with oxygen (less on protoplasm) whilst the liver uses up glycogen to replace the reduction in soluble sugars.

The small intestine is aided in the absorption of solubles through the membrane of the villi by its peristaltic action. Any foodstuff that is not digested is pushed into the large intestine with normal solid wastes. A considerable amount of water is absorbed through the large intestine wall and the remaining waste products becomes semi-solid instigating defaecation. The use of laxatives can therefore be an important method of disrupting normal digestion. Aperients such as magnesium sulphate (Epsom salts) act by retaining fluid in the large intestine causing a high amount of loose stools. Others such as senna, cascara and castor oil stimulate peristaltic movement in the small intestine. Dioctyl decreases surface tension of soluble products preventing absorption and allowing more water to remain in waste matter whilst the over-use of lubricants such as liquid paraffin interferes with absorption of fats.

The individual experiencing morbid obesity carries out little intervention to stop the digestive process itself. Whilst the person with anorexia nervosa is obsessed with controlling the whole digestive process and the person with bulimic habits

attempts to prevent sugar and fat absorption the obese individual over-eats starch and fat foodstuff and expends less energy than stored by the body.

The normal results of digestion mean that bodily fat is spread unevenly throughout the body, with females having a higher proportion of adipose tissues than males due to the action of oestrogen, (which increase the amount of fat deposits). Testosterone reduces subcutaneous fat.

Anorexia nervosa as a condition influences this uneven spread in women by interfering with pituitary gonadotrophin secretion and a decrease in oestrogen output which reduces the body's ability to retain lipids. Lipids, besides acting as a major source of bodily fuel are also solvents for vitamins and help maintain lipoproteins (which assist the maintenance of cell walls). Lipids also provide a layer under subcutaneous tissue and are therefore important in conserving body heat and provide some protection against impact injuries. Shivering and feeling cold is a common complaint for individuals with anorexia nervosa.

The obese person however has more fat than is normal and despite not being active in disrupting the digestion process frequently instigates a hyperglycaemic state. (Too much glucose in the blood). The human body requires regular refueling and the amount of fuel depends on the energy being expended. As mentioned earlier the liver cells store soluble sugars by altering this compound into glycogen. The general level of blood sugars is controlled by the hormone

insulin which is secreted by the pancreas. Insulin reduces the level of glucose in the blood by either causing the liver to store it as glycogen or by increasing its uptake by bodily cells. Insulin also stimulates the enzyme lipoprotein lipase which activates fat-storing cells to take up triglycerides (fat molecules).

Often in overeating there is failure of insulin to control the metabolism of fat. This produces too much free fatty acids and ketones from sites of fat storage. (Ketone in particular is poisonous to the human body causing drowsiness and in extreme cases coma). Liver glycogen, fat and proteins break down to produce glucose which is not metabolised into body cells. This in turn causes excess glucose in the blood which rises above the renal threshold (the normal level at which the kidneys retain blood sugars). The body attempts to rid itself of the excess glucose through urine but the osmotic effect of high blood sugars means that more water and sodium chloride is also excreted. The loss of water and sodium chloride causes electrolyte imbalances leading to excessive thirsts, polydypsia (excessive drinking of water), polyuria (excessive urination) and dehydration. The high levels of ketones disrupt the functions of the heart, brain and kidneys causing various symptoms such as nausea, abdominal pain, cramps, headaches and drowsiness. If chronic the condition is diagnosed as diabetes mellitus and is frequently found in morbidly obese individuals.

The person with anorexia nervosa may have the opposite condition, hypoglycaemia (too little blood sugars). Over-excitement (overactivity) is a

common symptom as is a rapid pulse, sweating, tingling or numbness in the extremities and in extreme cases convulsions. The cause is the body's use of its storage capacity converting glycogen into glucose and quickly running out of reserves due to inadequate refueling.

Appendix II

CHRONICITY AND PREVIOUS THERAPEUTIC INTERVENTIONS

CLIENT	PRESENTING PROBLEM	LENGTH OF TIME WITH PROBLEM	PAST THERAPY
Andrea	Bulimia	26 years	Rogerian 2 years twice = 4 years Seen 2 psychiatrist Seen 3 psychologist
Beryl	Morbid Obesity	10 years	Seen 1 Psychologist
Chris	Anorexia Nervosa	15 years	Sees Psychiatrist every 3 months Art therapist every 2 weeks CPN Community dietician "Many years" Therapy
Dorothy	Binge-eating/Morbid Obesity	11 years	CPN 2 years
Rachel	Binge-eating	20 years	Past Psychiatric treatment
Fran	Binge eating/Morbid Obesity	15 years	Sees Psychiatrist Sees Rogerian therapist Therapy since 1995
Gemma	Binge eating/Morbid Obesity	15 years	Sees Psychiatrist since 1994 Hypnotherapy Private counsellor x 5 sessions History of not completing therapy Assertive training 1997 Cognitive-behavioural therapy 1997 Dietician 1998 Physiotherapist 1998 Relaxation classes 1998
Jane	Anorexia Nervosa	7 years	Psychiatrist In-hospital treatment x 3 Person-centred counsellor
Karen	Restricted eating/Anorexia Nervosa	20 years	Psychiatrist Analytical counsellor Social Worker

THERPEUTIC SESSIONS AND INTERVIEW SCHEDULE

CLIENT	NUMBER OF HOURLY THERAPEUTIC SESSION	INTERVIEWED	WHEN	TOTAL NUMBER OF HOURS TAPED	TOTAL NUMBER OF WORDS TRANSCRIBED
Andrea	9	3	At 2/6/9 weeks		
Beryl	9	2	At 2/9 weeks		
Chris	12	2	At 2/12 weeks		
Dorothy	17	3	At 2/6/17 weeks		
Rachel	8	2	At 2/9 weeks		
Fran	11	2	At 2/12 weeks		
Gemma	30	2	At 2/17 weeks		
Jane	Past client (20 sessions)	1	2 years after therapy		
Karen	Past client (20 sessions)	1	5 years after therapy		
Co-therapist Natalie	N/A	2	At 2/12 weeks		
Centre Therapist Hilary	N/A	2	At 2/12 weeks		
	136 hours therapy	**22 interviews**	**N/A**	**TOTAL 75 HOURS**	**62,514**

APPENDIX IV

AXIAL CATEGORIES

AXIAL CODING CATEGORIES	NUMBER OF CODES
• CLIENT HISTORY	28
• NEGATIVE EFFECTS OF EATING DISORDERS (CHRONICITY)	38
• EFFECTS DURING PHASE I/II THERAPY	36
• OUTCOME EFFECTS	30
• THERAPEUTIC PRINCIPLES AND INTERVENTIONS •	28
• PERCEPTIONS OF THERAPIST	19
TOTAL	**179**

APPENDIX IV(A)

AXIAL CODING CATEGORY – CLIENT HISTORY

DSM IV Bulimia Nervosa }
DSM IV Anorexia Nervosa } Chronicity
Morbid Obesity }

History of physical abuse

History of (negative) Therapeutic Interventions

Fat/sugar/carbohydrates food link

History of sexual abuse

History of laxative abuse

Unhappy adult relationship

Self-harming

Self-absorbed

Emotional immaturity

Poor self awareness

Poor self-image

Poor self esteem

Poor self assertion

History of low mood/depression

History of neuroleptic medication

Unhappy childhood

Feelings of exclusion

"Addictive" behaviours

Obsession with food and weight

Duality

APPENDIX IV (B)

AXIAL CODING CATEGORY – NEGATIVE EFFECTS OF EATING DISORDERS

DSM IV Bulimia Nervosa

DSM IV Anorexia Nervosa

Morbid Obesity

Physical Problems (Chronicity)

Neuroleptic medication

Grief

History of negative therapeutic interventions

Bingeing

High fat foodstuff

High sugar foodstuff

High carbohydrate foodstuff

Sadness

Low mood

Self harming

Laxative abuse

Anger

Vomiting

Spiritual search

Guilt

Poor self reflection

Poor concentration

Self absorbed

Emotional immaturity

Poor self-awareness

Feelings of exclusion

Anxiety

Numbness

Poor self-image

Obsessive about food

Obsessive about weight

Poor self-assertion

Poor self-confidence

Poor self-esteem

Addictive behaviours

Substance abuse (alcohol/drugs/laxatives)

Duality

Poor motivation

Low creative output

APPENDIX IV (C)

AXIAL CODING CATEGORY-EFFECTS DURING PHASE I/II THERAPY

Increase in neuroleptic medication

Increase in bingeing (sugar/fat/carbohydrate foodstuff)

Weight gain (negative)

Weight loss (negative)

Anger

Increased laxative use (negative)

Increase in vomiting

Increased "Spiritual" unrest

Guilt

"Withdrawal effects"

Increase self-harming

Increased self-absorption

Familial sabotage

Anxiety

Feelings of exclusion

Avoidance of eating problem

Obsessed with food

Obsessed with weight

Negative transference on to therapist

Increased numbness

Negative thinking

Grief

Restricted food intake (negative)

Poor self-image

Poor self-assertion

Poor concentration

Poor self-reflection

Low self-esteem

Duality

Poor self-awareness

Fixed locus of control

Low mood

Sadness

Poor physical health

Increase in existing symptoms

Hopeful

APPENDIX IV (D)

AXIAL CODING CATEGORY – OUTCOME EFFECTS

Cessation of bingeing

Cessation of daily vomiting

Improved physical well-being

Positive weight gain

Positive weight loss

Improved locus of control

Increased self-awareness

Increased self-assertion

Increased decision-making

Healthier eating pattern

Cessation of anorectic behaviours

Cessation of self-harm

Increased creativity

Improved mood state (raised mood)

Relaxed

Improved self-image

Improved self-esteem

Reductions in bingeing

Increased self-confidence

Improved inclusion

More trusting of men

Less self-absorbed

Increased emotional maturity

Less numbness

Cessation of daily weighing

Altered interpretation of Self

Altered interpretation of objective world

Improved motivation

Improved creativity

Hope

APPENDIX IV (E)

AXIAL CODING CATEGORY – THERAPEUTIC PRINCIPLES AND INTERVENTIONS

Non-directive therapy

"Sensitive-touch" therapy

Non-judgmental

Motivating therapy

Therapeutic trust

Therapy "easier to get into"

Directive therapy

Food-specific therapy

Positive therapy

Reflection-on-therapy

Reflection-in-therapy

Client focussed

In-depth therapy

Transference to therapist (positive)

Focus on self-awareness (client and therapist)

Hope

Altered interpretation of objective world

Altered interpretation of Self

Present-focused

Focus on choice

Focus on responsibility

Focus on locus of control

Focus on future

Focus on motivation

Focus on client respect

Focus on positive thinking

Equality of therapeutic relationship

Catalyst therapy

APPENDIX IV (F)

AXIAL CODING CATEGORY – PERCEPTIONS OF THERAPIST

Non-judgmental

Identifies with eating disorders

Understanding

Objective

Trusting

Interactive

Client-focused

"Has framework in his mind"

Calm

Genuine

Inclusive

Confrontational

Accepting

Persistent

Challenging

Caring

Self-reflecting

Directive

Respectful