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Compassion Focused Therapy (CFT) for Eating Disorders: An Interpretative Phenomenological Analysis of Patients' Experiences

and

Clinical Research Portfolio

Claire Beattie

BSc (First Class) Honours in Psychology

Submitted in partial fulfilment of the requirements for the degree of

Doctorate in Clinical Psychology

Institute of Health and Wellbeing

College of Medical, Veterinary and Life Sciences

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CHAPTER 1: SYSTEMATIC REVIEW

The Role of Identity in Eating Disorder Recovery: A Systematic Review

Word Count: 7,777

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Prepared in accordance with guidelines for submission to the European Eating Disorders Review (Appendix 1)

ABSTRACT

Background

Previous research has suggested that eating disorders can be characterised as disorders of the self and that disturbances in overall identity development is a core feature contributing to the formation and persistence of eating disorders. It is suggested that failure to establish numerous and diverse domains of self-definition in childhood and adolescence can contribute to an individual resorting to body weight as a viable source of defining the self. By turning to body weight as the source of self-definition, an individual is thereby able to compensate for the lack of clear identity and the associated emotional states, such as helplessness, that encompass disturbances in identity development. It is proposed that if the eating disorder is experienced as a part of the self, then this would have implications for a person's willingness or ability to consider engaging in treatment. It is therefore an important aspect to consider as difficulty "letting go" of the eating disorder identity may impede long-term recovery.

Purpose

This review sought to systematically examine and synthesise qualitative studies which focused on the role of identity in eating disorders and to consider the impact that this may have for long term recovery from an eating disorder.

Method

A systematic review of the literature was carried out between September 2016 and November 2016. No time period was specified for the search as to date there have been no systematic reviews conducted of this topic area. Six databases were searched – EMBASE,

ASSIA (Applied Social Sciences Index and Abstract), Medline, PsychInfo, Psychology & Behavioural Sciences and CINAHL. A total of 2,723 papers were identified for consideration for inclusion in the review. This was narrowed to 8 papers suitable for inclusion in the synthesis and a hand search of the reference lists was then conducted. This search yielded no further papers and therefore the synthesis included 8 papers. The 8 papers were then rated using an adapted version of Walsh & Downe's (2006) Adapted Quality Assessment Criteria for qualitative papers. The papers had predominantly focused on Anorexia Nervosa (AN).

Results

Six new super-ordinate themes were developed through meta-ethnography and synthesis of the eight studies: 1) Not knowing myself; 2) Relationship with AN; 3) Acknowledge negative consequences of AN; 4) Reluctance to relinquish the anorexic identity; 5) Consideration of a "new me"; 6) The path to recovery. A seventh theme, 'Focus on food for control', was not included in the final analysis as it was only suggested in three of the articles and themes were only included if they appeared in four or more of the papers.

Conclusions

The six themes identified and included in the final analysis could be characterised as stages through which an individual may progress; from developing the eating disorder, precipitated perhaps by a fragile sense of self, to the benefits of the anorexia, before the realisation of the negative consequences associated with the anorexia. An individual then engages in a battle when considering relinquishing the anorexic identity, before acknowledging a potential new self and thereafter the pathway to recovery. Identifying with the anorexia and

reluctance to relinquish the anorexic identity were themes that all eight papers reported and this is something that needs to be taken into consideration during therapeutic intervention.

Key Words: identity; eating disorders; qualitative

INTRODUCTION

There has been much research tasked with looking at the characterisation of recovery from mental illness (Andresen, Caputi & Oades, 2006; Kean, 2009; Scotti, 2009; Lampshire, 2012). One such characteristic is that an individual may be required to develop a new and enduring sense of self that doesn't include the mental illness (Slade, 2009). Empowering an individual who has a mental illness to develop a more positive identity is a challenging task for clinicians. Buck et al. (2013) identified four independent but related challenges associated with the recovery process that clinicians should be prepared to address. These are the discomfort elicited by the threat of loss or actual loss to a previous sense of identity; the loss of a previous way of making sense of the world; an awareness of the concrete losses an individual may have experienced, and being able to accept oneself as an ordinary person. Buck et al. (2013) presented a vignette of an individual in recovery to illustrate the four challenges that can arise during the recovery process.

The first challenge, discomfort elicited by the threat or actual loss to a previous sense of identity involves supporting an individual to face the discomfort and confusion that results when recovery requires a change of identity. The old identity may be primarily negative but this will still be viewed as less threatening than attempting to adopt a new, unknown view of oneself. The second challenge associated with identity change in recovery according to Buck et al (2013) is a loss of previous ways of making meaning of the world. The beliefs held by an individual when in the throes of mental illness may not hold true as recovery becomes more achievable. This can then lead to a state of confusion and anxiety and a desire to return to an old but predictable identity that does make sense of the world surrounding the individual. During challenge three, addressing concrete losses, an individual may become

aware as recovery progresses of the things that their mental illness has taken from them. For example, after years of perhaps being socially isolated during the illness, re-engaging socially and becoming aware that you have lost social skills can lead to feelings of worthlessness and isolation. In some cases of mental illness, there may also be a loss of symptoms which were perceived as pleasurable, such as the mania an individual with Bipolar Affective Disorder may experience. This loss needs to be mourned and may not be viewed as a loss that is deemed socially appropriate to acknowledge. However, it is nonetheless a loss for the individual and failing to address this may create a barrier to recovery. A strong illness identity has been shown to be associated with chronicity and lack of belief in the efficacy of treatment available (Holliday et al., 2005). The final challenge is empowering the individual to accept themselves as an ordinary individual. This involves supporting the person to acknowledge that they have agency over their life and also that they are no more or no less special than anyone else. This may be challenging for an individual who has perceived that their symptoms demonstrate a sign of strength. An example of this would be starvation in eating disorders. Studies have indicated that sufferers' view their ability to starve themselves as a skill which sets them apart from everyone else (Serpell et al., 1999).

Following on from this, previous research has suggested that eating disorders can be characterised as disorders of the self and that disturbances in overall identity development is a core feature contributing to the formation and persistence of eating disorders (Stein & Corte, 2007). It is suggested that failure to establish numerous and diverse domains of self-definition in childhood and adolescence can contribute to an individual resorting to body weight as a viable source of defining the self. By turning to body weight as the source of

self-definition, an individual is thereby able to compensate for the lack of clear identity and the associated emotional states, such as helplessness, that encompass disturbances in identity development. Weinreich, Doherty & Harris (1985) argue that Anorexia Nervosa may only become apparent after a person has engaged in a futile struggle to establish a sense of self and identity. Thinness and weight are then used in a misguided attempt for individuation.

Addressing the role of identity in eating disorders has implications for current therapeutic interventions which commonly target weight, attitudes to food and body image difficulties. Eating disorders are very complex and have the highest mortality rate across all psychiatric diagnoses (Franko et al., 2013). The recovery rate for eating disorders is low with estimates that less than half of those suffering from AN (Steinhausen, 2002) and BN (Poulsen et al., 2014) will actually recover. Bowlby et al. (2015) suggest that even those that do recover will go on to experience difficulties in physical, social and psychological functioning. Clinicians will often encounter patients who are resistant to, or refuse treatment even when their physical health is at serious risk. This can be confusing and frustrating for those involved in caring for someone who has an eating disorder. The eating disorder appears to be causing them significant levels of distress yet they are choosing to refuse treatment (Hope, Tan, Stewart & McMillan, 2013). As discussed previously, recovery from mental illness requires evaluation of the current sense of self and consideration that a new sense of self can be developed. Hope, Tan, Stewart & McMillan (2013) propose that if the anorexia nervosa is experienced as a part of the self, then this would have implications for a person's willingness or ability to consider engaging in treatment. It is therefore an important aspect to consider as difficulty "letting go" of the eating disorder identity may impede long-term recovery.

To date there has not been a systematic review conducted to evaluate the evidence thus far and therefore a review synthesizing the literature would be useful in conceptualising what we currently know and identifying the next steps required to further explore the concept of identity in eating disorders (Stein & Corte, 2007).

Purpose

This review will aim to systematically examine and synthesise qualitative studies which have sought to explore the role of identity in eating disorders and consider the impact that this may have for long-term recovery from an eating disorder.

METHOD

Search Strategy:

A systematic review of the literature was carried out between September 2016 and November 2016. No time period was specified for the search as to date there have been no systematic reviews conducted of this topic area. Six databases were searched – EMBASE, ASSIA (Applied Social Sciences Index and Abstract), Medline, PsychInfo, Psychology & Behavioural Sciences and CINAHL. The databases searched were chosen with guidance and approval from an NHS librarian. In addition, The European Eating Disorders Review Journal; International Journal of Eating Disorders and Eating Disorders: The Journal of Treatment and Prevention were hand searched using the key terms.

Search Terms:

The literature was systematically searched for articles which contained the key terms "Eating Disorder", "Identity" and "Qualitative". Alternative synonyms were derived from a review of the existing literature on Eating Disorders and Identity from Google Scholar, and

amalgamating the varying ways that the key terms could be classified. The key terms were then combined within their categories using the Boolean operator 'OR' and then the search terms combined using the Boolean operator 'AND'.

The following search terms were used:

1. (("eating*" OR "anorexi*" OR "bulimi*" OR "EDNOS" OR "pro an*") AND ("identity*" OR "personal identity" OR "function" OR "illness perception" OR "self concept" or "self*"))
2. ("experience*" OR "qualitative*" OR "phenomenological" OR "thematic analysis" OR "grounded theory" OR "narrative" OR "discourse analysis")
3. 1. AND 2.

All identified titles were then screened for relevance and included or excluded according to specific inclusion and exclusion criteria as detailed.

Inclusion Criteria:

- Employs a qualitative method
- Has a focus on identity
- Has a focus on eating disorders
- Peer-reviewed journal
- Published in English

Exclusion Criteria:

- Quantitative papers
- Focus is on something other than identity

- Focus does not consider recovery
- Mixed methods design
- Focus is disordered eating
- Population is children and adolescents

Procedure:

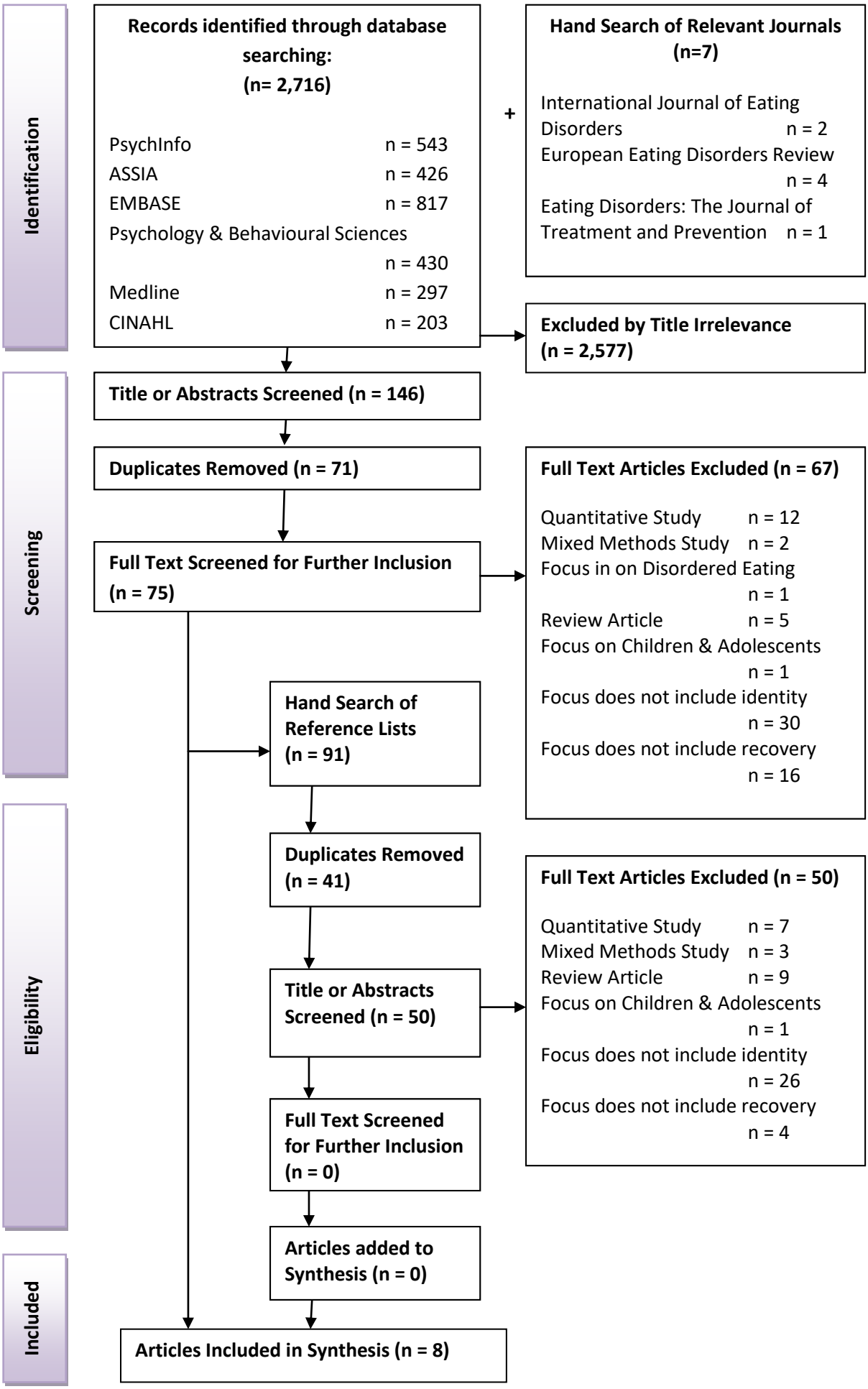
A total of 2,723 papers were identified for consideration for inclusion in the review (Figure 1). The first stage of the review process involved excluding those papers where the title was irrelevant. Following this, the abstracts were screened of the remaining papers and excluded on this basis before the remaining papers were subjected to a full text review. There were 8 papers included in the synthesis and a hand search of the reference lists was then conducted. This search yielded no further papers and therefore the synthesis included 8 papers. Details of every search were documented to provide a transparent record of the search process as outlined in Table 1.

TABLE 1. Electronic Search Strategy

Database	Search Terms/Fields	Results	Interface	Date Searched
PsychInfo	(("eating*" OR "anorexi*" OR "bulimi*" OR "EDNOS" OR "pro an*") AND ("identity*" OR "personal identity" OR "function" OR "illness perception" OR "self concept" OR "self*") AND ("experience*" OR "qualitative" OR "phenomenological" OR "thematic analysis" OR "grounded theory" OR "discourse analysis" OR "narrative")) LIMITS: Linked Full Text; Peer Reviewed; English Language; Adulthood (18+)	543	EBSCOHost	10th October 2016

Psychology & Behavioural Sciences Collection	Search Terms as Above LIMITS: Linked Full Text; Peer Reviewed; English Language	430	EBSCOHost	10th October 2016
ASSIA	Search Terms as Above LIMITS: English Language; Scholarly Journals	426	Proquest	11th October 2016
EMBASE	Search Terms as Above LIMITS: Full Text	826	OVID	11th October 2016
MEDLINE	Search Terms as Above LIMITS: English Language; Linked Full Text; All Adult (19+)	297	EBSCOHost	12th October 2016
CINAHL	Search Terms as Above LIMITS: English Language; Peer Reviewed; Linked Full Text; Age Groups “All Adult”	203	EBSCOHost	12th October 2016

Figure 1: PRISMA Flow Chart



Quality Appraisal:

Over recent decades, there has been a growing interest in better understanding an individual's experience in a variety of contexts (Walsh & Downe, 2006). This has particularly been the case in healthcare settings and NICE guidelines (2011) stipulate that patient experience is a key element in helping us develop therapies. Studies which focus on patient experience are largely phenomenological (i.e. the focus is on lived experience) and qualitative in nature. There are several approved tools for appraising quantitative literature in contrast to qualitative research where there has been debate over the reliability and validity of tools developed to date. Several authors have produced guiding principles for appraising the quality of qualitative research (Murphy et al., 1998; Sandelowski & Barroso 2002); however criticism of such frameworks has focused on the lengthy and time-consuming nature of using them in practice. Walsh & Downe (2006) carried out a comprehensive review of the current frameworks used to appraise qualitative literature and synthesised the information found to form a comprehensive checklist which could be more easily utilised in practice.

Walsh & Downe (2006) list eight stages: scope and purpose; design; sampling strategy; analysis; interpretation; reflexivity; ethical dimensions and relevance and transferability. Within the eight stages, there are 12 essential criteria. The quality rating of the papers included in this review were subject to assessment in accordance to an adapted version of Walsh & Downe's (2006) criteria for appraising qualitative literature (Appendix 2). In order to evaluate and compare quality, each study was allocated two points if the criterion was fully met; one point if the criterion is partially fulfilled and zero points if there is no evidence that the criterion was met. This provides a total potential score of 24 points. Studies were

rated as 'good' if they received a score of 18 or more (75%); 'acceptable' if they scored 12 or more (50%) or 'inadequate' if they scored 11 or less (under 50%). One hundred percent of the included papers were reviewed by an independent assessor (a Trainee Clinical Psychologist familiar with the rating strategy). The level of agreement was 87.5% indicating good inter-rater reliability. Two papers were scored differently but through discussion, the assessors were able to reach agreement about quality.

Out of the eight studies identified for the review, five were rated as good quality with a score of 18 or above out of 24. These papers met most of the criteria for good qualitative research as outlined by the adapted Walsh & Downe (2006) Adapted Quality Assessment Criteria. Three papers were rated as acceptable. The writer acknowledges that the criteria for the papers included may only demonstrate partial fulfilment due to the need to remove information to reduce the word count in order to meet requirements for publication. Table 2 provides qualitative and quantitative descriptions of the included studies and the quality rating awarded.

TABLE 2. Quality Appraisal of Papers

Author & Year	Number of Participants/ Gender	Diagnosis	Stage of Illness	Qualitative Methodology	Quality Rating
Lamoureux & Bottorff (2005)	9 Females	AN	Recovered	Grounded Theory	16/24 Acceptable
Jenkins & Ogden (2012)	15 Females	AN	Recovered or in recovery	Interpretative Phenomenological Analysis (IPA)	18/24 Good
Petterson, Thune-Larsen, Wynn & Rosenvinge (2013)	13 Females	AN or BN (numbers not specified)	Later process of recovery	Content Analysis	15/24 Acceptable

Higbed & Fox (2010)	13 Participants; Gender not specified	AN	Currently unwell	Grounded Theory	18/24 Good
Williams & Reid (2012)	14 Participants; 12 females, 2 male	AN-Restricting: 8; EDNOS: 6	Currently unwell	Interpretative Phenomenological Analysis (IPA)	18/24 Good
Bowlby, Anderson, Hall & Willingham (2015)	13 Females	AN-Restricting: 6; AN-Binge/Purge: 1; BN: 3; AN and BN: 3	Recovered	Moustakas' (1994) Modification and Adaptation of the Stevick-Colaizzi Keen Method	18/24 Good
Patching & Lawler (2009)	20 Females	AN: 6; BN: 2; AN and BN: 12	Recovered	Life History	18/24 Good
Weaver, Wuest & Ciliska (2005)	12 Females	AN	Recovered	Feminist Grounded Theory	17/24 Acceptable

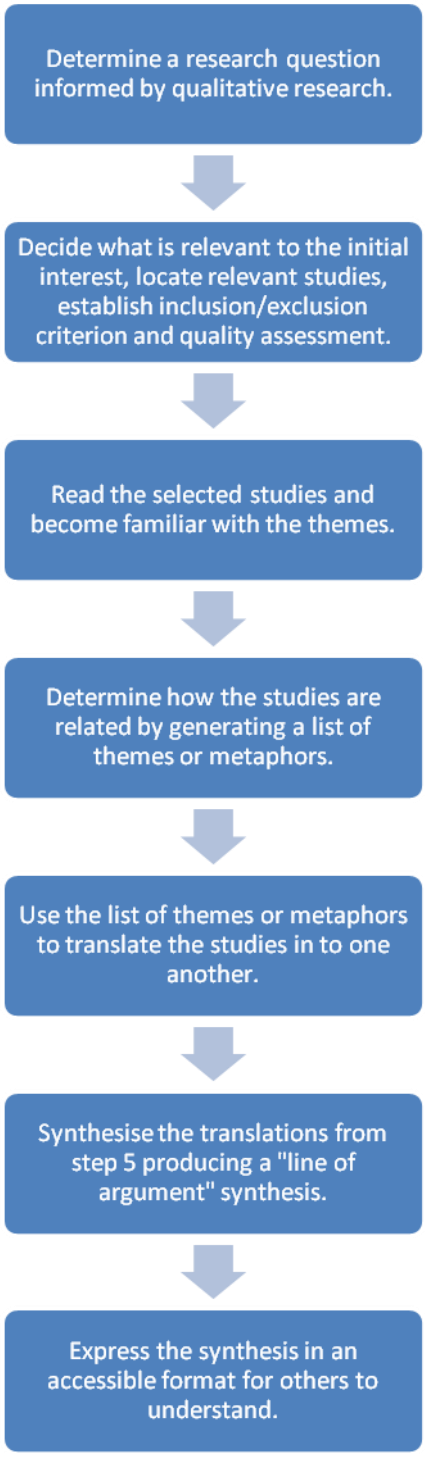
Method of Synthesis

There are a number of approaches which have been suggested for the synthesis of qualitative data, such as thematic synthesis, textual narrative synthesis, meta-ethnography and ecological triangulation (Barnett-Page & Thomas, 2009). Synthesising qualitative research raises a number of challenges. Explanatory context could be lost when multiple studies are combined. In addition there may be different philosophical assumptions underpinning studies such as those proposed by phenomenological and ethnographic approaches. Some have argued that individual studies produce unique and distinct views which can be lost when the research is accumulated to try to answer a specific question (Pope, Mays & Popay, 2007). Despite the caveats to synthesising qualitative literature, there are many benefits including further development of our theoretical or conceptual knowledge in a particular area. Interpretative methods for synthesis focus on re-interpreting

and re-analysing the information produced across a range of papers to form a whole which may lead to greater understanding of a topic.

Meta-ethnography was selected to synthesise published qualitative research exploring the role of identity in eating disorders. Meta-ethnography is an interpretative approach developed by Noblit and Hare (1988) originally used to combine the findings of ethnographic research conducted in education. There are three different methods of synthesis used in meta-ethnography: reciprocal translational analysis (RTA); refutational synthesis and lines-of-argument (LOA). Meta-ethnography is increasingly adopted for research syntheses in health care, particularly in relation to research which asks questions relating to patient experiences of illness and care.

FIGURE 2. Seven steps to meta-ethnography as adapted from Noblitt & Hare (1998)



Results

The themes presented by the authors in the eight included papers are detailed in Table 3. As per Major & Savin-Baden (2010), first order themes and codes were developed and then the themes were combined across the studies. Six new super-ordinate themes were developed through meta-ethnography and synthesis of the eight studies (Noblitt & Hare, 1988). The six super-ordinate themes are 1) Not knowing myself; 2) Relationship with AN; 3) Acknowledge negative consequences of AN; 4) Reluctance to relinquish the anorexic identity; 5) Consideration of a "new me"; 6) The path to recovery. A theme was included if it was suggested in four or more of the articles (50% or more). This means that six themes will be discussed in more detail whilst one theme, 'Focus on food for control' was also identified as a theme but was not included as it was only suggested in three of the articles. Each of the six super-ordinate themes will now be discussed in turn, with reference to quotations from participants in the original research studies.

TABLE 3. Original Themes from the Eight Articles

Article (Author & Year)	Themes
Weaver, Wuest & Ciliska (2005)	1) Perilous self-soothing 2) Not knowing myself 3) Losing myself to the anorexia nervosa obsession 4) Finding Me 5) Informed self-care 6) Celebrating myself

Lamoureux & Bottorff (2005)	1) Seeing the dangers 2) Inching out of anorexia 3) Tolerating exposure without anorexia 4) Gaining perspective by changing the anorexia mindset 5) Discovering and reclaiming self as "good enough"
Patching & Lawler (2009)	1) Control 2) Connectedness 3) Conflict
Higbed & Fox (2010)	1) Making sense of anorexia nervosa 2) The relationship between anorexia nervosa and the self 3) The recovery struggle 4) Coping with treatment
Williams & Reid (2012)	1) Relationship with anorexia nervosa 2) Striving for the perfect self 3) Controlling the self through the body 4) Battling the 'anorexic voice'
Jenkins & Ogden (2012)	1) Being anorexic 2) The process of change 3) Being recovered
Petterson, Thune-Larsen, Wynn & Rosenvinge (2013)	1) Realising negative consequences 2) Searching for alternative coping 3) Searching for normality and identity 4) Accepting the losses

Bowlby, Anderson, Hall & Willingham (2015)	1) Recovery is a nonlinear process 2) Recovery is comprehensive, including both external and internal components 3) Recovery involves the process of learning to understand and value the self 4) Recovery involves understanding that the eating disorder is separate from one's identity as a person 5) Recovery involves finding purpose and meaning in life 6) Recovery requires the development of healthy and meaningful relationships

TABLE 4. Seven Super-Ordinate Themes Identified

Theme Name	**Prevalence**
1) Not knowing myself	4 of 8 articles
2) Focus on food to control	3 of 8 articles
3) Relationship with AN	7 of 8 articles
4) Acknowledge negative consequences of AN	7 of 8 articles
5) Reluctance to relinquish the anorexic identity	8 of 8 articles
6) Consideration of a "new me"	7 of 8 articles
7) The Path to Recovery	7 of 8 articles

A Description of the Six Super-Ordinate Themes

Not Knowing Myself

Four of the eight articles discussed the notion of 'not knowing oneself' as a significant factor in the onset of anorexia nervosa. Prior to the onset of Anorexia Nervosa, participants reported feeling *"out of control"*, *"unhappy"* or *"under pressure to perform"* which was exacerbated by their low self-esteem. Anorexia Nervosa had become a vehicle of control for coping either with the stresses and frustrations of everyday life or early trauma (Jenkins & Ogden, 2012).

Participants described how life experiences prior to the onset of their eating disorder resulted in a need to change their identity or exert some control over their life:

"Not sure why, but one day I realised I had some form of control over food"

The method of changing identity through the body was something that all participants in Williams & Reid's (2012) study recognised.

Not knowing oneself often results from prioritising relationships with others at the expense to the relationship with the self. One participant summed it up as *"restricting all your needs: spiritual, personality, nurturing. You live for everybody else"*. There is a sense of uncertainty about "*who I am, what I want, and where I fit in"* (Weaver, Wuest & Ciliska, 2005).

Patching & Lawler (2009) suggest that a lack of control and connectedness, and relationships fraught with conflict in childhood and adolescence inhibits an individual's ability to develop a strong sense of self. Often individuals purported that they had a sense of 'being different' and that *"...maybe if I was thin then I'd feel like I belonged..."*

Overall there was a sense that failing to develop a strong sense of self, be it due to stressful experiences growing up, left an individual vulnerable to developing an eating disorder as a way of exerting some control and influence over their own life and creating an alternative identity.

Relationship with AN

The relationship with the eating disorder is predominantly viewed as positive in the early stages. The eating disorder is often personified via the use of names such as "Ed" for Eating Disorder; "Ana" for Anorexia or "Mia" for Bulimia (Bowlby, Anderson, Hall & Willingham (2015), indicating an affiliation with the eating disorder.

The eating disorder has been described as a beneficial "*life jacket" and "coping strategy".* Some have even described the eating disorder as their "*best friend"* (Pettersen, Thune-Larsen, Wynn & Rosenvinge, 2013).

There is a sense that the eating disorder enables the individual to 'survive' unpleasant experiences:

"*When it all began I adored it. I needed it in my life and saw it as the only way I would survive".* (p. 804)

The person could often rely on the eating disorder during the most difficult times of their life (Williams & Reid, 2012).

As well as being something that could be relied on, the eating disorder also had positive psychological effects initially:

"I felt that if I could control what went in and out and how much exercise I did then I could control other things in my life" (Patching & Lawler, 2009, p.16)

Participants in Higbed and Fox's (2010) study struggled to acknowledge their eating disorder as a mental illness:

"*So I don't know, I don't really see it as a mental health thing because I think that would be too strong"* (p. 313)

Others recognised that their eating disorder elicited love and attention from others and were able to identify that there were secondary gains to having an eating disorder:

"I've had more love and attention off my family and I'm so frightened of it I got fully better then love would go... and attention" (p. 315)

The eating disorder becomes an exclusive focus in the individual's life and often individuals' report feeling as though they were two different people; the "*anorexic me"* and the "*normal me"*. The normal part is characterised as rational and the anorexic part as irrational. The anorexic part is reported to be frequently dominated by the "*anorexic voice"* (Jenkins & Ogden, 2012).

Acknowledge the Negative Consequences of AN

Eventually the reality of the eating disorder begins to take its toll and the negative consequences associated with it became apparent and real:

"It was quite shocking as well to see the damage the starvation and restriction can have and how this affects not only your body but also your thought processes..." (Jenkins & Ogden, 2012, p.27).

"It was no life"; "It was a kind of hell – I lost many years"; "I didn't live" (Pettersen, Thune-Larsen, Wynn & Rosenvinge, 2013, p.94).

"The only thing I can say is that Ana saved my life when I couldn't cope, but is now killing me... and I know it, but can't stop it" (William & Reid, 2012, p.805).

"*I felt like the disease had so much control of my life. It had taken over and I felt even more out of control than before I got sick"* (Patching & Lawler, 2009, p.16).

"I was almost 30, and I thought, 'I am not going to go through the next 30 years of my life like this... I won't live through it" (Lamoureux & Bottorff, 2005, p.175).

Consideration of a "New Me"

This theme was characterised by the realisation that the individual had 'lost' their personality to the eating disorder. At this stage, the individual begins to consider that one's identity as a person is separate to that of the eating disorder. As a result there is an acknowledgement that other components of themselves could define them:

"*So it sort of, even though I didn't realise it, it did strip me sort of my personality and everything. I feel like I'm more, more me now"* Higbed & Fox (2010).

"*Begin to take tiny, tiny baby steps"* to begin the process of forming an identity separate from anorexia (Lamoureux & Bottorff, 2005, p.175).

The women use "*soul searching"* to determine "*who am I?"; "what do I want?" and "where do I want to go?"* (Weaver Wuest & Ciliska, 2005, p.195).

Reluctance to Relinquish the Anorexic Identity

All eight papers made reference to the difficulty of relinquishing the anorexic identity to pursue recovery:

"It's sort of my identity, this illness, as I've discovered over years, this is who I am, this is all I know" (p. 317)

"I can see how that it sometimes is quite hard to let go of something that's been such a big part of your life, that fulfils you, fills you with a different sort of emptiness" (p. 318)

"It's very much a part of me, sort of my identity. And by losing that, it sort of exposes me to... I don't know what. And it scares me to actually let go of it completely" (p. 318)

Higbed & Fox (2010)

There is a fear that life will potentially become more difficult without the anorexia there as the individuals' identity and that success in life is dictated by the eating disorder:

"AN was my way of feeling successful and different from other people, suddenly I felt huge... if you build your whole life about controlling what goes in your mouth and making sure that you don't put on weight, it's [weight gain] horrible, horrible" (p. e29)

Giving up the AN identity is viewed as a *"huge risk because I was convinced I couldn't be anything else"* (p. e29)

Jenkins & Ogden (2012)

"I think giving up the identification with the eating disorder is something people really struggle with. It is giving up the fantasy of special-ness. Who am I if not eating disordered? What makes me special and how do I get attention?" (p. 7)

"I felt for a long time that the door was closed but that I could unlock it if I really needed to. It was something I held on to" (p. 7)

Bowlby, Anderson, Hall & Willingham (2015)

For some, there was an importance of learning alternative strategies before they felt able to say a 'final goodbye' to the eating disorder. As one participant noted, "*I had to cut the rope to what had been my life jacket for ten years, but I couldn't do that before I had learnt to swim"*

(Pettersen, Thune-Larsen, Wynn & Rosenvinge, 2013, p.94)

Others could recognise that the disorder played both a functional and dysfunctional role at the same time:

"*I still have my eating disorder because I know what to expect from it and it is something that I can rely on. I stay with my ED like an abused woman stays with her abuser. It is truly a love-hate relationship that I cannot escape"* (Williams & Reid, 2012, p.805)

"It was more comfortable even though it was torturous, there was some kind of comfort in knowing how to restrict my diet" (p. 175)

"I was moving into territory that was unknown... an identity... that was unknown" (p. 175)

There were three factors that contributed to the women's vulnerability and made it difficult to inch away from anorexia: the control and power they perceived the anorexia to offer; the way their identity was interwoven with the eating disorder and the notion that they themselves were just "*not good enough"*.

Lamoureux & Bottorff (2005)

The Path to Recovery

There was a mixture of responses to the notion of recovery from an eating disorder. Whilst some saw it as an opportunity to develop an alternative identity, others remained pessimistic of the likelihood of recovery. For all, recovery was viewed as a lengthy and challenging process.

"I have a new identity, I am a student, a friend, I have a social life and I know that people I know now don't see me as anorexic. I might have a history of that but they see me as other things first" (Jenkins & Ogden (2012, p.e29).

"To me, I think, having experienced this, I mean I don't think you ever really get rid of it, I think it's something that's always going to be with you, but I think you do learn how to control it, and over power it and become stronger than it" (Higbed & Fox, 2010, p.318).

Participants described having to learn to differentiate between "Ed", the voice of the eating disorder, and their true authentic self. There was a sense of searching for purpose and meaning in life that no longer centred on the eating disorder (Bowlby, Anderson, Hall & Willingham, 2015). The recovery process also involved re-learning healthier ways to eat and view their body, and also, for some, to re-learn the informal rules of social interactions. It is

learning to get their needs met and not feel bad for it (Pettersen, Thune-Larsen, Wynn & Rosenvinge, 2013).

Discussion

This systematic review sought to examine and synthesise qualitative studies which focused on the role of identity in eating disorders and the potential impact that this may have for recovery. Six super-ordinate themes were identified: Not Knowing Myself; Relationship with AN; Acknowledge the Negative Consequences of AN; Reluctance to Relinquish the Anorexic Identity; Consideration of a "New Me" and The Path to Recovery.

The research suggested that the descent into AN is often precipitated by identity confusion and a desire to change oneself. Often the fragile sense of self results from low self-esteem; difficult life events and feeling out of control of one's life resulting in a desire to change. An individual may then exert control over food, weight and shape and over time, this becomes an expression of who they are and integral to their identity. Initially the relationship with the eating disorder is viewed as positive providing the individual with support to survive difficult times. It can also lead to feelings of specialness and provide a sense of power which, in turn, may reinforce the eating disorder behaviours and cognitions. The exclusive focus in the individual's life becomes the eating disorder and gradually, what has been described as the anorexic voice, continues to gather strength. The literature argues that this then leads to a crisis whereby the individual begins to acknowledge the reality of the eating disorder and the associated negative consequences and consider that the disease had gone from being protective to something that was becoming intolerable.

This then leads the individual to begin to consider what life might look like without the eating disorder. There is a realisation that perhaps the individual has lost themselves to the eating disorder and that the eating disorder no longer works for them but against them. Reluctance to relinquish the anorexic identity appears to be a challenging stage during recovery. Research has suggested that individuals' view giving up the eating disorder as a huge risk in case life without the eating disorder is worse than life with the eating disorder. There are also reports of fear of who the individual is if they give up the one thing that they feel is core to their identity. Often, the eating disorder can lead to feelings of specialness and a fear of this specialness disappearing is another factor to consider when letting go of the eating disorder. It is also often the one thing that the individual may have felt they were good at and removing this can leave the individual feeling very vulnerable and out of control.

The path to recovery is described as fraught with challenges and a potentially lengthy process. It involves searching for purpose in life that is no longer centred on the eating disorder. It involves having to re-learn how to eat appropriately and also re-engage socially with others as social relationships are often lost through the eating disorder. It is also learning to tolerate the distress that comes with letting go of something which has been an integral part of your identity.

Link to Previous Findings

Buck et al., (2013) made reference to four challenges clinicians need to be aware of during the recovery process; discomfort elicited by the threat of loss or actual loss to a previous sense of identity; the loss of a previous way of making sense of the world; awareness of the concrete losses an individual may have experienced and being able to accept oneself as an

ordinary person. According to Buck et al., (2013), it is essential that these challenges are met in order to support full recovery from mental illness. The research included in the synthesis all make reference to the distress caused when considering whether or not to relinquish the anorexic identity. Many of the participants spoke of losing their 'best friend', losses which may not often be acknowledged during therapeutic intervention. There was also discussion of the specialness associated with suffering from Anorexia Nervosa and an acknowledgement that part of the pathway to recovery involves being able to accept oneself as an ordinary person (Buck et al., 2013). The current studies support Buck et al's (2013) research with regards to the challenges clinicians need to face when supporting an individual to recover from an eating disorder.

Limitations

Although the search criterion for the systematic review was kept broad to include all eating disorders, the included titles focus specifically on Anorexia Nervosa. The literature is unclear about the role of identity in Bulimia Nervosa. Future research could look at the differences in the identity process between those who have Anorexia Nervosa and those who have Bulimia Nervosa.

In addition, as the included studies are qualitative, the author's own perceptions are used during the interpretation of themes which may well be an influential factor on outcomes. Several of the included studies lacked or failed to mention reflexivity, which increases the risk of interpretational bias.

Implications

As discussed previously, current treatments for eating disorders commonly focus on weight, attitudes to food and body image difficulties. The reviewed research has demonstrated a need to consider the role of identity during therapeutic interventions. An individual needs to be supported to grieve the loss of the eating disorder identity and to spend time considering what an alternative identity might look like. It is essential clinicians consider the egosyntonic nature of the disorder and acknowledge the power struggle that may ensue when asking an individual to give up the aspect of themselves that they are often very proud of. In addition, more research needs to be conducted to ascertain whether Anorexia Nervosa and Bulimia Nervosa present differently in terms of the role of identity and better understand how identity may fluctuate if an individual moves from Anorexia Nervosa to Bulimia Nervosa, and the implications this may have for an individual's wellbeing.

Conclusion

In conclusion, this review sought to understand the role of identity in eating disorders and the impact that this may have for recovery. There were six themes identified which could be characterised as stages through which an individual may progress; from developing the eating disorder, precipitated perhaps by a fragile sense of self, to the benefits of the anorexia, before the realisation of the negative consequences associated with the anorexia. An individual then engages in a battle when considering relinquishing the anorexic identity, before acknowledging a potential new self and thereafter the pathway to recovery. Identifying with the anorexia and reluctance to relinquish the anorexic identity were themes that all eight papers reported and this is something that needs to be taken into consideration during therapeutic intervention. We are, after all, asking an individual to give

up the one thing that has perhaps made them feel special, in control of their life, or is counted as their biggest achievement. It is therefore understandable that there will be grief associated with this process and that work needs to be done to help the individual move towards an alternative, healthy identity.

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CHAPTER 2: MAJOR RESEARCH PROJECT

Compassion Focused Therapy (CFT) for Eating Disorders: An Interpretative Phenomenological Analysis of Patients' Experiences

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Prepared in accordance with guidelines for submission to the European Eating Disorders Review (Appendix 1)

Plain English Summary

Background

Eating disorders are serious psychiatric conditions which can be very difficult to treat. The three most commonly defined diagnoses are Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Eating Disorder Not Otherwise Specified (EDNOS). There are a variety of therapies advocated for the treatment of eating disorders including Cognitive Behavioural Therapy (CBT). The overall recovery rate for eating disorders is low with AN having the highest mortality rate of all psychiatric disorders. Research suggests that less than half of those with AN and BN actually recover.

Compassion Focused Therapy (CFT) is a therapy which recognises there are three affect regulation systems: the threat detection and protection system; the drive, vitality and achievement system and the contentment and affiliative soothing system. It has been suggested that those with eating disorders often function in either the threat or drive system due to high levels of shame and self criticism with the self-soothing system most often underdeveloped. Research is now beginning to focus on the role self-compassion may have for the severity of eating psychopathology.

Aims & Questions

The aim of the current study was to explore the experience and meaning of compassion and self-compassion for individuals with eating disorders who completed a 12-week CFT group. This was achieved by interviewing individuals who expressed an interest in taking part at a time that suited them at the location where they receive treatment.

Methods

Potential participants who had just completed a 12 week CFT group were approached by a clinician known to them. Semi-structured interviews were conducted with seven individuals' who agreed to participate in the research.

Analysis

Six females and one male participated in the research. Each interview lasted between 30-60 minutes. The interviews were audio-recorded and afterwards transcribed verbatim. The data was then analysed using Interpretative Phenomenological Analysis (IPA) which is interested in learning about an individuals' experience.

Results

There were four main themes that arose from the research: blocks to compassion; compassion for the self versus compassion for others; compassion for the self versus compassion for the eating disorder and moving towards a future without the eating disorder.

Conclusions

The results helped us better understand what the experience of CFT was like for the seven individuals who took part. Avoidance of emotions had implications for developing the capacity for compassion. This was made more difficult by the idea of there being two types of compassion: one for the eating disorder and one for the self in recovery and further complicated by the participants' fear of letting go of the eating disorder part of their identity as they were fearful of who they might be without it. Overall, all of the participants'

reported feeling as though they had an increased awareness of their emotional experience after the group. The findings are important clinically because they demonstrate the need to focus on the types of compassion required for the eating disorder versus the self. The findings are also important because they highlight how we can support people to develop other aspects of their identity so they feel safer about beginning to let go of the eating disordered part of their identity.

Abstract

Background & Aims

Eating disorders are serious psychiatric conditions which can be resistant to different types of treatment. Cognitive Behavioural Therapy is recommended as the treatment of choice by the NICE guidelines but research has shown that it is only effective approximately 50% of the time. Therefore, more recent research has begun investigating alternative treatments, one of which is Compassion Focused Therapy (CFT) and the role self-compassion may have for eating psychopathology severity. The aim of the study is to explore the experience and meaning of Compassion Focused Therapy for individuals with eating disorders who have taken part in a 12-week group.

Methods

Seven participants were interviewed using a semi-structured interview. The participants had all completed a 12-week Compassion Focused Therapy (CFT) group. The interviews were transcribed and analysed using interpretative phenomenological analysis (IPA).

Results

Four Superordinate themes were identified during analysis; these are: blocks to compassion; compassion for self versus compassion for others; compassion for self versus compassion for the eating disorder and moving forwards. Each Superordinate theme comprised several subordinate themes.

Conclusion

The study explores the concept of the participants' experiences of two types of compassion: compassion for the self versus compassion for the eating disorder and the conflicting goals of the eating disorder versus what the self wants from recovery. The incompatible goals lead to difficulty transferring theory into practice due to the consequences this has for the eating disordered part of the individual's identity. Participants reported an overall increased awareness of emotional experience but there was recognition that recovery is a gradual process and there will be a continual need to apply the skills and techniques gained from the group throughout the recovery process.

Key Words: Compassion Focused Therapy; CFT; eating disorders; interpretative phenomenological analysis; IPA; patient experience

INTRODUCTION

Eating Disorders

Eating disorders are serious psychiatric conditions which can be resistant to different types of treatment. The three most commonly defined disorders in the Diagnostic and Statistical Manual 5th Edition (DSM-5) are Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Binge Eating Disorder (BED). The National Institute for Clinical Excellence (NICE) guidelines, updated in 2017, for eating disorders state the AN should be treated with a choice of psychological treatments including individual eating disordered focused cognitive behavioural therapy (CBT-ED); Maudsley Anorexia Nervosa Treatment for Adults (MANTRA) or Specialist Supportive Clinical Management (SSCM). If the three aforementioned treatments are deemed ineffective, the guidelines suggest eating disorder focused focal psychodynamic therapy (FPT). However, there is no one specialist treatment advocated for AN that is viewed as highly effective in tackling the persistent and chronic nature of AN (Kass et al., 2013). Individual eating disordered focused CBT (CBT-ED) is the NICE recommendation for treatment of moderate to severe BN and is well established as an effective and long-lasting treatment (Kass et al., 2013). However, research has shown that CBT is only effective in about 50% of cases (Byrne et al., 2011).

Overall, the recovery rate for eating disorders remains low with AN having the highest mortality rate out of all psychiatric disorders (Franko et al., 2013). Research has previously suggested that less than half of those suffering from AN (Steinhausen, 2002) and BN (Poulsen et al., 2014) will actually recover.

Role of Shame and Self-Criticism in Eating Disorders

Levels of shame and self-criticism are suggested to be high in those with eating disorders. More recent research is beginning to examine the role self-compassion may have for the severity of eating psychopathology. Ferreira et al., (2014) were interested in testing the moderating effect of self-compassion on the relationships between shame memories and eating psychopathology. The authors administered a variety of measures to a group of 34 individuals attending an eating disorders care unit as outpatients. The individuals had a mixture of diagnoses (AN =10; BN =15; Eating Disorder Not Otherwise Specified (EDNOS) = 9). The results showed that self-compassion was inversely and strongly associated with overall severity levels of eating psychopathology and that the positive dimension of self-compassion emerged as a significant predictor of eating psychopathology severity variance. This study demonstrated that self-compassion can have a buffering effect against shame memories on eating psychopathology severity and suggests that low levels of self-compassion may be a barrier to recovery. It's unclear from the paper as to whether any of the 34 participants had received previous treatment for their eating disorder, particularly of a compassion focused nature, which may have influenced the moderating effect of self-compassion on the relationships between shame memories and eating psychopathology. The authors also group all the diagnoses together and therefore it can't be distinguished whether a particular diagnosis demonstrated higher levels of shame memories and how this links to severity of eating psychopathology.

Kelly, Carter & Borairi (2014) conducted a study to determine whether reduction of shame early on in the therapy process would influence remission of eating disorder symptoms over time. They also sought to investigate whether early increases in self compassion facilitated

faster reductions of shame and eating disorder symptoms over the course of treatment. Ninety-seven participants were recruited to the study between September 2010 and August 2012. The sample comprised those with AN-Restriction (27.2%); AN-Binge/Purge (18.5%); BN (29.6%) and EDNOS (24.7%). The participants recruited comprised both inpatients (27.8%) and those who attended the day hospital (72.2%) at Toronto General Hospital.

Treatment was based on group therapy broadly underpinned by CBT; the authors acknowledge that self compassion with implicitly promoted across all groups but that there was no direct group intervention targeting self-compassion. The investigators administered the Eating Disorder Examination Questionnaire (EDE-Q); the Experiences of Shame Scale (ESS) and the Self-Compassion Scale-Short Form (SCS-SF) at time periods throughout treatment to monitor change.

Analysis revealed that the patients who experienced larger reductions in shame in the first few weeks of treatment showed faster decreases in their eating disorder symptoms in the following 12 weeks. Patients who also showed larger increases in self-compassion in the initial weeks of treatment showed faster decreases in shame over the 12 week duration, controlling for change in eating disorder symptoms in the early stages. The authors linked the changes in shame and self-compassion to the model of Compassion Focused Therapy and suggested this may be a useful model to consider when working with persistent eating disorder symptomatology. The paper didn't specify whether there were differences in the reduction of shame and increase in self-compassion between the different diagnoses and therefore the reader is left to draw their own conclusions about whether a certain diagnosis (e.g. BN) may be more or less likely to experience shifts in shame and self-compassion as a result of attendance at the group programme. In addition, it isn't clear whether the

participants had previous therapeutic input of a compassion focused intervention that may have influenced their understanding of the role of shame and self-compassion in the maintenance of their eating disordered behaviours.

Compassion Focused Therapy

Compassion Focused Therapy (CFT) is a biopsychosocial model derived from an evolutionary and neuroscience model of affect regulation that suggests that different affect regulation systems developed for different functions. Three affect regulation systems have been recognised: the threat detection and protection system; the drive, vitality and achievement system and the contentment and affiliative soothing system. The three systems are seen as mutually regulating (Goss & Allan, 2014). The threat system has evolved to focus attention on potential threats in an individuals' environment and is linked to the 'fight, flight, freeze' response. Early life events can impact on the sensitivity of the threat system which can lead to the development of maladaptive styles of coping in order to regulate the threat system (Gilbert, 2009).

The drive system motivates us to achieve our needs and goals, and is a complex system which can be viewed as a source of positive feelings. However, although this system can lead to feelings of pleasure and happiness, such emotions are contingent on us meeting our needs and goals. Therefore, the drive system is influenced by and influences our threat system which can lead to the development of negative emotions such as despair (Gilbert, 2009). The contentment and affiliative soothing system is associated with a sense of 'being'. It is based on attachment theory and research which demonstrates the regulating effect caregiving responses can have on an individuals' physiology. This system leads an individual to feel soothed and calmed.

CFT was developed in recognition that the negative affective component of a disorder often remains despite the individual being able to rationalise their problems cognitively. Researchers began to acknowledge that many disorders have high levels of shame and self-criticism associated with them and that, as a result, those individuals may struggle to feel relieved, reassured or safe (Gilbert, 2009). Self-criticism and shame are viewed by Gilbert (2009) as a transdiagnostic problem. The contentment and affiliative soothing system is seen as poorly accessible in people with high shame and self-criticism whilst the threat detection and protection system is often in drive. CFT therefore seeks to develop the contentment and affiliative soothing system via skills which influence affect regulation, whilst helping the individual to better understand the role of the threat and drive system and ways to regulate all three systems to promote optimal well-being.

Compassion Focused Therapy for Eating Disorders

In recent years, there has been an increased focus in the application of CFT to different clinical presentations including eating disorders. Eating disordered behaviours are suggested to function as an attempt to regulate the threat system via the drive system (Goss & Allan, 2010). In 2014, Gale et al., conducted a study evaluating the impact of incorporating CFT into a standard CBT programme for people with eating disorders. Using a repeated measures design, 139 patients attending the Coventry Eating Disorders Service took part in a 4 session group based psychoeducation programme before going on to participate in a 20-session group based recovery programme of CBT combined with CFT. Participants completed three measures (Eating Disorder Examination Questionnaire; the Stirling Eating Disorder Scale and the Clinical Outcomes in Routine Evaluation Outcome Measure) at five time points throughout the study. Ninety-nine participants were included in the analysis

(AN=19; BN=26; EDNOS=54) which found that CBT combined with CFT was an effective treatment particularly for those with BN, with 73% considered 'recovered' by the end of the programme. Twenty-one percent of those with AN were considered 'recovered' with another 37% making a significant improvement. For those with EDNOS, 30% were considered 'recovered' following treatment. This led the authors to conclude that CFT has potential benefits for those with eating disorders by impacting on the symptoms and psychopathology of the eating disorder. It is important to note that CFT in this study was delivered as an adjunct to CBT and therefore it is difficult to distinguish between the efficacies of both interventions in the improvement of eating disorder symptomatology. The authors stated that more research was required to investigate the use of CFT in eating disorders. In particular, understanding the patient's experience of CFT is crucial in developing the therapy and improving its suitability and applicability in the treatment of eating disorders. This highlighted gap in the literature influenced the development of the current study.

Justification for the Research

Compassion Focused Therapy is an evolving therapy with a growing evidence base across a number of different presentations including trauma (Lawrence & Lee, 2014); psychosis (Braehler et al., 2013); personality disorders (Lucre & Corten, 2013) and eating disorders (Gale, Gilbert, Read & Goss, 2014); however, there is not yet enough evidence for CFT to be recommended as a recognised treatment in the use of eating disorders according to NICE Guidelines (2017) and the Psychological Therapies Matrix (2015). Patient experience is a key element in therapy development according to NICE (2017) and therefore, given the potential benefits of CFT highlighted in earlier studies, it would be beneficial to consider

patient experience of CFT to contribute to the growing evidence base and help us better understand the suitability and applicability of CFT as part of the treatment for eating disorders.

Applications

It is anticipated that this research will contribute to the growing body of literature which is being developed looking at the efficacy of Compassion Focused Therapy as an adjunct to treatment as usual for those individuals who have an eating disorder. It is hoped the research will provide insight into the value and benefit of Compassion Focused Therapy and a greater understanding of the aspects that were perhaps less helpful. It is hoped this research will help better understand the role compassion may play in eating psychopathology for the individuals recruited into the study. Additionally, this study aims to understand the participants' experience of CFT in a group setting which may help shape how the group is delivered within the service in the future.

Aims and Hypotheses

The aim of the current study is to explore the experience and perceived benefits of Compassion Focused Therapy for individuals with eating disorders who have taken part in a 12-week group through the use of semi-structured interviews. An additional aim is to explore how CFT may have impacted upon an individual's perception of shame, self-criticism and self-directed hostility and which aspects of the CFT programme were helpful or less helpful.

METHODS

Ethical Approval

Ethical approval was sought and approved through NHS Greater Glasgow and Clyde's Research Ethics Committee (REC) and the Research and Development Department (R&D) as indicated in Appendix 3.

Design

The study used Interpretative Phenomenological Analysis (IPA). IPA is an idiographic approach which means it focuses on the individual and their experiences. In accordance with NICE (2017), patient experience is considered a key element of therapy development and thus IPA is a method by which the research reflexively interprets their experience. IPA is frequently used as a research method when studying eating disorders (Mulveen & Hepworth, 2006; Fox & Diab, 2015). Table 1 outlines the inclusion and exclusion criteria for the study.

Table 1: Inclusion and Exclusion Criteria

Inclusion	**Exclusion**
- Aged 18-65	- Non-English Speaking
- Patients within the Adult Eating Disorder Service (AEDS)	- History of a Learning Disability or Cognitive Impairment which may impede on the individual's ability to provide informed consent and sufficiently understand the purpose of the study
- Participated in the 12-week Compassion Focused Therapy Group	- Deemed too medically unstable by their keyworker to participate in the research
- Able to provide informed consent	

CFT Group

The CFT group was delivered in a group setting which comprised 12, two hour sessions with a brief break in the middle. The group facilitators were a Clinical Psychologist and Senior Eating Disorder Practitioner for the first group and two Senior Eating Disorder Practitioners for the second group. The facilitators had completed an Advanced Clinical Skills workshop for CFT and participated in Advanced CFT workshops run by Dr Ken Goss focused specifically on the application of CFT to eating disorders. This was the first time this group was delivered within the service and it was delivered as an adjunct to treatment as usual, which was primarily CBT.

Sample

Determining the required sample size in qualitative research requires consideration of five main factors. These are scope of the study; nature of the topic; quality of the data; study design and the use of shadowed data (Morse, 1994). Whilst these factors cannot definitively determine the required sample size, they can enable the researcher to justify the sample size selected. In IPA a large amount of data is generated for each participant. This means that fewer participants are required and it is recommended that studies recruit between 6 and 10 participants (Smith et al., 2009). It was hoped that between 6 and 8 patients would agree to take part. Two groups took place during the recruitment period. The first group ran from August 2016 to October 2016 whilst the second group ran from the March 2017 to the May 2017. The first group had six participants who completed the 12-week group whilst the second group had three participants who completed the group. Four people from group one agreed to take part (3 women, 1 man) and all three from the second group (all women) agreed to participate giving a total of seven participants.

Semi-Structured Interview Design

The interview schedule was developed by reviewing the literature to date which has looked at group CFT for eating disorders and identifying the recurring themes that arose. The questions were then developed in conjunction with a Clinical Psychologist working within the AEDS and who was responsible for developing the group materials and involved in running the first group. Several discussions took place to identify areas of interest and follow up questions based on the recommendations of past research. The interview schedule can be found in Appendix 4.

Recruitment

Patients were approached in the penultimate session of the CFT group by one of the group facilitators not involved in the research process. They were provided with an information pack which included the Participant Invitation Letter (Appendix 5); the Participant Information Sheet (Appendix 6) and the Participant Contact Details Sheet (Appendix 7). The patients were asked to return the Participant Contact Details Sheet to the final session if they were interested in taking part. They were reminded that they were under no obligation to participate in the research and that there was no consequences to their ongoing care if they chose not to participate. Participants were recruited from both of the CFT groups which ran during the recruitment period.

Procedure

When the researcher received the Participant Contact Details Sheet, contact was made with the patient through the communication method of their choice to arrange a suitable time for them to attend the AEDS base for an interview. The researcher then went through the

Participant Information Sheet again with the participant to ensure they understood the purpose of the study and what their participation would entail. Once the researcher and participant were satisfied that any questions had been answered, the researcher obtained written informed consent from the participant. The participant was reminded that they could stop the interview and withdraw from participation at any time during the interview process. The interviews were recorded on a Sony Digital Dictaphone. The interviews ranged from 28 to 54 minutes, with an average of 40 minutes. Excerpt from Interview 1 can be found in Appendix 9.

Data Analysis

As this study is qualitative, the interview transcripts gathered were analysed using Interpretative Phenomenological Analysis (IPA) and more specifically the guidance outlined by Smith, Flowers & Larkin (2009). The first stage of the analysis is line-by-line examination of the emergent themes from each individual transcript. The researchers then identified emerging themes from each individual transcript and made notes on this. This led to the development of a discourse between the principal investigator and the project supervisors to consider the emergent themes and begin to make meaning of the participants' experiences leading to the development of the researchers' interpretative account (Larkin, Watts & Clifton, 2006; Larkin & Thompson, 2012; Smith, 2017).

The next stage of analysis involved developing a framework which demonstrated the relationships between themes. The analysis of the material should be done in such a way that the process of developing the themes is transparent to the reader (Pietkiewicz & Smith, 2014). This should lead to the development of a full narrative guiding the reader through the process of the identification and interpretation of the themes. Throughout this process,

the researcher should be mindful of the influence of their own perception on the interpretation of the data (Smith, Flower & Larkin, 2009).

The researcher listened to each of the audio recordings once before beginning the transcription. Audio recordings were transcribed using Express Scribe and a foot pedal. All data was anonymised for any patient identifiable information and pseudonyms given to participants. The researcher then listened to the audio recording one final time to check the accuracy of the transcription. Once the data was transcribed the audio recording was deleted from the audio recorder and Express Scribe to protect participant confidentiality. The researcher then read and re-read each transcript several times in order to familiarise themselves with the interview. Following this, the researcher noted descriptive, linguistic and conceptual comments on the margins of each transcript and began to group initial themes together as per the recommendations of Smith, Flower & Larkin (2009). The themes were further explored to search for connections between them and the transcripts were compared for recurrent themes and to check for accuracy (Larkin & Thompson, 2012).

To increase the validity of the identified themes, the Chief Investigator of the project, who is experienced in the use of IPA, blind read two of the transcripts and made comments on emerging themes accordingly. The researcher and Chief Investigator then compared notes on emerging themes to check for levels of agreement and to discuss any differences. Both parties identified similar themes across both transcripts used though, as this is a subjective process, there was variation in the language used to conceptualise the themes.

Research Reflexivity

To increase the integrity and trustworthiness of qualitative research, it is argued that researchers should engage in reflexive analysis; that is, be self-aware of the influence that their own experiences can have during the collection and interpretation of the data (Finlay, 2002). The researcher maintained a reflexive diary throughout the collection and interpretation of the data to make transparent the process through which meaning of the data was made.

Results

Participants

In total seven participants consented to take part in the research (six females; 1 male). The mean age was 28.6 (range was 21 to 44). The numbers recruited were in line with recommendations of sample size for IPA outlined by Smith, Flower and Larkin (2009). The mean BMI in Group 1 at the start of the group was 19.25 (range was 14.49 to 24.26) and the mean BMI in Group 2 at the start of the group was 16.04 (range 15.81 to 16.2). The mean BMI of Group 1 at the end of the group was 19.55 (14.49 to 25.16) and the mean BMI of Group 2 at the end of the group was 16.30 (15.01 to 17.46). Three of the participants were inpatients at the start of the group whilst the other four were outpatients. All members of Group 2 had a diagnosis of Anorexia Nervosa whilst in Group 1, the diagnoses comprised Anorexia Nervosa, Bulimia Nervosa and Eating Disorder Not Otherwise Specified (EDNOS).

Superordinate and subordinate themes

Four Superordinate themes were identified during analysis; these are: compassion for self versus compassion for others; compassion for self versus compassion for the eating

disorder; blocks to compassion and moving forwards. Each Superordinate theme comprised several subordinate themes which are outlined in Table 2. The themes are outlined in detail in the next section and quotations from the participants are used to illustrate the themes in greater depth and ground the analysis in their lived experience.

Table 2. Superordinate and subordinate themes relating to patients' experiences of CFT for eating disorders.

Superordinate Themes	**Subordinate Themes**
Compassion for Self versus Compassion for Others	1) Undeserving of compassion 2) Difficulty receiving compassion 3) Compassion as something for others
Compassion for Self versus Compassion for the Eating Disorder	1) Two types of compassion 2) Fear of losing the eating disorder identity 3) Difficulty transferring theory into practice
Blocks to Compassion	1) Avoidance of emotional experience 2) Avoidance of home practice
Moving Towards a Future Without the Eating Disorder	1) Increased awareness of emotional experience 2) Taking a step back from emotions

COMPASSION FOR SELF VERSUS COMPASSION FOR OTHERS

Undeserving of Compassion

Five of the participants spoke of a real sense of being undeserving of compassion.

> *"... yeah, well, for, for me it was more that I'm a, you know, I think, I think I'm a bad person, therefore I don't deserve it..." (Michael, Line 20)*

> *"I suppose that is just one of the blocks... like feeling you... erm, like you don't deserve it..." (Layla, Line 102)*

However, for some, this sense of undeserving shifted over the duration of the group to a recognition that perhaps they were deserving of compassion like everyone else.

> *"I'm more accepting of other people reaching out with compassion for me because before, I kinda thought well I don't really deserve that like, I'd kinda shut it off" (Gemma, Line 111)*

Gemma demonstrates a shift in her belief, previously viewing herself as undeserving of compassion and moving towards a gradual acceptance of compassion from others.

Difficulty Receiving Compassion

Five of the participants spoke of the difficulty they had receiving compassion. This was partly related to the sense of being undeserving of compassion but compassion from others also elicited feelings of discomfort and left some of the participants uncertain how to respond when compassion was received.

> *"Ahh I feel bad saying this but I did usually feel quite uncomfortable, umm because I always tried to find the hidden meaning to it as well which is bad practice" (Jane, Line 193)*

> *"Yeah... yeah, I can't say that I necessarily like it" (Michael, Line 150)*

Compassion in the form of compliments was particularly difficult for some participants who were searching for the hidden meaning behind the comment.

> *"... my Mum's friend said I was looking well, but I did react in the same way that I would normally, but it didn't affect me in the same way, which was, it sounds weird,*

she was like you're looking really healthy and I was like, I don't know what to say, cause I've not gained" (Rosie, Line 196)

For Rosie, being told she was looking well which was intended as a compassionate compliment yielded feelings of discomfort due to Rosie's interpretation that this meant she had gained weight.

"I think I'm just more accepting of it... because before I'd probably just... be really dismissive and... the... I'd have an automatic response of... 'oh they're just saying that because of this...'" (Layla, Line 254)

Compliments were also difficult for some participants who appeared uncertain of the social etiquette when receiving a compliment.

"One of my big challenges has been to not repay a compliment with a compliment straight back... I guess I always viewed compliments as a kind of currency... you've got to repay it straight away or they'll be mad at you" (Jane, Line 184)

Jane's understanding of receiving a compliment was that they were mutually exchanged at the same time otherwise this may lead the person giving the compliment to be offended at this not being returned.

Compassion as Something for Others

Participants struggled both with feelings of being undeserving of compassion and also with difficulties in receiving compassion. Most identified compassion as something to be shown to other people and were ambiguous about applying this to themselves:

"... when they kinda ask you at first, what do you see compassion as, I would always think it's something that you give to other people" (Layla, Line 41)

"I thought it [compassion] was more just for other people" (Lizzie, Line 220)

"I always related compassion to opening it up to other people... I never really thought of compassion like as soon as I thought of compassion, I thought of someone else being upset or someone else needing your assistance rather than being compassionate to yourself" (Gemma, Line 101)

Of interest was the notion from one participant of compassion being a form of weakness.

"I must admit, one of my main focuses of compassion before was that it was, I guess it was a form, a weakness... that is something that I can't do" (Jane, Line 39)

Compassion is therefore viewed as something for others and potentially as a weakness. Most of the participants' struggled with the concept that compassion could be applied to the self and even if this was comprehendible, the feelings of being undeserving and subsequent guilt prevented participants' from being able to apply this to the self:

"I did become... I felt more like... ok to be like... spend time or... be compassionate or go and have a nap or whatever... and not feel guilty but... I think that just kinda went... and now I'm just... I just feel guilty all the time" (Lizzie, Line 158)

COMPASSION FOR THE SELF VERSUS COMPASSION FOR THE EATING DISORDER

One of the more interesting findings of the research relates to the Superordinate theme of compassion for the self versus compassion for the eating disorder. All seven participants spoke of the internal conflict of not being able to provide compassion for the self and for

the eating disorder as the two often have incompatible goals. This led to the concept of two types of compassion; the struggles of retaining the eating disorder as part of the identity and the impact both of these concepts have on an individuals' ability to transfer the theory learned from the group into practice.

Two Types of Compassion

Six of the participants made reference to the concept of two types of compassion and the idea that the compassion required for the self and recovery is quite different to the compassion that the eating disorder necessitates:

> *"... it's not as easy as I thought it maybe was to be compassionate towards myself because it's not letting myself do what I want or the eating disorder do what it wants, it's actually... because the compassionate thing to do is be firm with myself and to take care of myself so... and that means not doing the eating disorder behaviours that before I would have said were the soothing things..." (Lucy, Line 146)*

> *"... yeah cause it's like in the moment I could think what's actually the right thing to do here is kinda like there's almost two paths, paths, like... I could say on one hand being compassionate is being... almost like following rules and things like that and not, and kinda just keeping myself calm and not like... putting myself out there because I'm keeping myself safe but then... it could also be compassionate to do the right erm... thing for recovery I suppose" (Layla, Line 118)*

Layla's quote demonstrates the conflict associated with the concept of two types of compassion. Compassion can mean staying the same because that feels safe and doesn't necessitate challenging the eating disorder. It can also be compassionate to push yourself to

do what is right for your recovery, even if that means challenging the eating disorder and the anxiety associated with it.

> *"I don't know if it's so much more the compassion side of things or that it's I'm challenging my thoughts which I guess is compassionate, in some sense" (Rosie, Line 80)*

> *"... if you're wanting to progress you're going to have to push yourself to do things that scare you..." (Lizzie, Line 201)*

Both Lizzie and Rosie's quotes demonstrate how compassion can sometimes be about challenging yourself to do things that scare you, like following a meal plan or gaining weight in the name of recovery. This can be difficult though, because for many of the participants', the eating disorder was viewed as an integral component of their identity and compassion for recovery means challenging the very essence of the person they perceive themselves to be.

Fear of Losing the Eating Disorder Identity

Five of the participants spoke of the difficulties of applying compassion to the self because it challenged the eating disorder which they often felt very protective of. There was a real sense of anxiety about what it might mean to let go of that part of their identity because often it has been around for a long time and become comfortable for the individual, despite the distress it may also cause.

> *"I don't know what I would sort of do without it [the eating disorder] I suppose... because it's become such a big part of me..." (Layla, Line 105)*

"... because I've lived the way that I've lived for... such a long time and even though it's not a very pleasant place to be... well... people often stay in bad situations just because, yeah it's familiar, so while there, a possibility of... yeah, being able to be you know, different, it seems... achievable, it seems like a... yeah... there's a risk involved I guess" (Michael, Line 127)

Michael and Layla both make reference to the eating disorder forming a big part of how they see themselves. Michael's quote conveys the uncertainty of risking recovery by letting the eating disorder go and life potentially not being any better without it. He likens his relationship to the eating disorder to how others' might stay in a bad situation because to leave feels extremely frightening. Discussions in the wider group reflected that this was a fear that many of the participants' shared.

"... a lot of us admitted that we didn't want to give up the eating disorder" (Rosie, Line 305)

Others were able to recognise the function that the eating disorder might serve in being a communication tool to those closest to them:

"I think... fears of losing your eating disorder, because of, erm, like maybe, things that are maintaining it... I viewed a more transparent relationship with my Mum, so that was something that made it find it really hard for me to let go of it" (Gemma, Line 137)

For one participant, there was anger directed towards the group for the emphasis placed on recovery.

"It's always emphasised on getting rid of your eating disorder which makes some people quite reluctant, well... made me quite reluctant to want to listen... people used to always talk about the click and that one day something would just click in your head and... and to me... I'm not doing it then cause... I don't want that click... I want it to be my choice, and if I don't want to get rid of my.... like eating disorder then... I'll just have to live with it..." (Lizzie, Line 168)

Lizzie's quote communicates her choice over ownership of the eating disorder and anger towards others for the group emphasis on letting the eating disorder go and the subsequent loss of identity that will be experienced alongside this. She initially starts by generalising this as this belief of the group before specifying that it was actually her opinion that the group emphasis was on letting go of the eating disorder.

Difficulty Transferring Theory into Practice

Fear of letting go of the eating disorder identity and the conflicting types of compassion required for the eating disorder versus the self provides rationale for why the participants are perhaps having difficulty putting theory into practice. All seven participants reflected on the difficulties of putting into action the skills learned from the CFT group but recognised that there were shifts in their understanding of compassion and how to apply it:

"Erm... not really, that probably the harder bit... like I understand why I do it but it's not... as easy to just... when you're in the mindset, just to change..." (Lizzie, Line 47)

"I was saying earlier that I feel like my thinking's changed so it's, but I feel that it's kinda leapt ahead but the doing part still kinda... slowly plodding along... erm... so I need to try and apply it more to the practical side" (Lucy, Line 60)

Both Lucy and Lizzie's quotes illustrate that there has been a shift in their thinking but difficult remains following this through behaviourally.

> *"I think I've got the tools to work on that, like as myself like, to do it obviously over a, probably take years till it changes the way you think but, I think it has definitely developed my knowledge in terms of understanding... why what happened has happened" (Gemma, Line 13)*

Gemma's quote highlights that the process of change takes time and requires continuing to focus on and apply compassion into the future in order to be able to see the behavioural changes. Transferring theory into practice is also suggested to be influenced by the stage of change a person is at in their recovery pathway.

> *"I think it also comes from being ready to try and make the changes as well so... I'm more kinda... ready, like I would challenge... it doesn't mean I don't have falls; some days I go ahead with it [restricting eating] but I still try and cause I'm more aware of it now as well whereas before I had no idea, I was just doing it and that was that" (Rosie, Line 37)*

> *"I guess I don't exactly know the solution yet, I'm still working on that but I am recognising what's happened and that, in a way, makes it less of an unfamiliar, scary territory which does help" (Jane, Line 157)*

Rosie and Jane's quotes provide an example of the pathway of change perhaps shifting from an increased awareness towards tolerating the uncertainty of not having a solution, towards behavioural change. There is recognition that recovery will present challenges along the way

but the increased awareness is viewed as the first stage in transferring the theory into practice.

BLOCKS TO COMPASSION

The seven participants spoke of potential blocks to compassion comprising an avoidance of emotional experiences both prior to and during the group and an avoidance of home practice. Both subordinate themes provide a potential barrier to developing compassion for the self. Avoidance of emotional experience and avoidance of home practice both negatively impact on an individual's ability to embrace the concept of compassion.

Avoidance of Emotional Experience

The eating disorder can function as an attempt to avoid emotional experience through numbing and the participants who made reference to the avoidance of emotional experience spoke of how this desire to avoid and block out emotions often dated back prior to the development of the eating disorder:

> *"I'm just emotionally shut off... it's just like this thing I can't... I just can't do it for some reason" (Michael, Line 75)*

> *"...umm, I guess with an eating disorder in general, it's mostly about numbing... emotions and for me personally, I found that I am... quite... unaware sometimes and don't really give names to the emotion that I'm feeling" (Jane, Line 83).*

Avoided emotions may then manifest themselves as physical symptoms that the individual may not recognise as a manifestation of an emotion.

"... usually through kinda anxiety behaviour that I don't really recognise that that's what it's got to do with" (Rosie, Line 256)

Overall, the participants spoke of emotional avoidance as a strategy which enabled them to cope in difficult situations:

"... my kind of coping strategy number one in life is avoidance" (Michael, Line 36)

Avoidance of Home Practice

Avoidance of doing the home practice in between sessions appeared to link to the avoidance of emotional experience. To be able to engage and experience the home practice in a meaningful way an individual would have to be aware and willing to confront their emotional experience. As previously mentioned, there was a tendency for participants to be avoidant of their inner emotional experience which would then link to why there may be such an aversion to completing the home practice in between sessions. This is illustrated by the following quotes:

"From the get go I was like 'oh here we go', I don't want to get into any of this kinda stuff... I tried a few times but I didn't really think it helped" (Layla, Line 151)

"I'm not very good at that cause that involves thinking about your emotions so... sometimes I would do it like... give minutes before the group type of thing, before I'd left the house and stuff, I kinda would just shut it off, that type of thing, that would involve having to write down... anything about your emotions, I just... I guess it's avoidance cause it makes it real and you need to think about it and so I just wasn't very good at that type of thing" (Rosie, Line 126)

There appeared to be a shared resentment to the use of the phrase 'homework' due to the negative connotations that this had to early school days. It also appeared to create some anxiety as homework was interpreted by some participants as having a right or a wrong answer:

> *"I think it was something that I really struggled with initially, I think that was cause I was unaware of a lot of blocks that I had was, I'm a perfectionist so, I was kinda like, a fear of failure because I was like 'oh these aren't working" (Gemma, Line 74)*

> *"It was quite, the way they called it like homework and the way... like at the start I felt like 'oh I had to do it' and all that... and then I just start, stopped doing the, the breathing thing cause they kept on giving that us every week and I'm like I'm not filling it out just... for their satisfaction" (Lizzie, Line 146)*

Gemma was able to recognise that the home practice was difficult for her due to her own perfectionistic tendencies and a need to do everything 'right'. This created anxiety for her which in turn led to avoidance of the home practice initially.

MOVING TOWARDS A FUTURE WITHOUT THE EATING DISORDER

The final superordinate theme comprises two subordinate themes which suggest movement towards a future without the eating disorder. This in part comes from recognising the difficulty of transferring theory into practice and noticing the steps prior to that, for example increased overall awareness.

Increased Awareness of Emotional Experience

All seven participants spoke in length about the increased awareness they have of their emotional experience after partaking in the group.

> *"I definitely gained a lot a, a different insight to things erm, and a lot of skills to be more aware of understanding, not necessarily like completely changing my way of thoughts because it is quite hard to change it completely" (Gemma, Line 12)*

> *"... yeah I think probably the drive, threat and soothing system has changed how I deal with it... or at least I'm more aware of it, I'm not quite 100% dealing with it better" (Lucy, Line 175)*

Both Lucy and Gemma reflected that the skills learned from the group have been helpful in increasing the awareness they have of their emotional experience. For Lucy, recognising where her emotions fit in the three systems model has increased her understanding of when different situations shift her into the different systems.

> *"I think I've been able to kind of recognise that I'm doing it and just stop and kind of change the narrative a little bit and say... that's maybe not actually that fair and it's not actually, it's not fair being that critical with myself, I'm a human being..." (Michael, Line 95)*

> *"I was trying to be more... compassionate to myself whereas before, I guess I wouldn't have done so I don't know, that's the kind of skills, just trying to be kinder to myself and go, I'm not a bad person, it's not my fault I had this mental health issue" (Rosie, Line 48)*

Both Rosie and Michael's quotes illustrate an increase in compassion towards themselves when they notice that they are being quite critical. Being able to recognise themselves as someone who has a mental health issue or as a 'human being' represents a shift from their initial beliefs that they were undeserving of compassion.

Taking a Step Back from Emotions

Increased awareness of the emotional experience is, in part, possible by taking a step back from the emotional experience. Five of the participants' reflected on their newfound ability to not necessarily be reactive to difficult emotions.

> *"I do try... and be like more... I try not jump the gun as much... trying to like stop my emotions getting into like the peak" (Lizzie, Line 113)*

> *"I think... when you step back a bit, umm, which is good if something's happened that's got you into a bit of a disordered thinking cycle because then it can almost break that rush of emotion and it can make you focus on what you need to do at the time" (Jane, Line 112)*

Jane's quote indicates the benefit of being able to take a step back from overwhelming emotions in reducing the intensity of the emotion and allowing for more clarity to decide on the action that results from the emotion.

> *"... instead of letting things kinda just build up and really get to me and... that probably puts me in like, a really kinda like threat, like... don't' talk to me kinda zone, and I'm more like, right well it doesn't matter...I don't I suppose let it put me in that kinda zone so much" (Layla, Line 292)*

Layla's quote illustrates the use of tools learned through the CFT group to lessen the intensity of an emotion by being able to take a step back from that experience.

Discussion

The aim of this study was to explore the experience and perceived benefits of CFT for individuals with eating disorders who had partaken in a 12-week group as part of their treatment. The study used IPA and analysis revealed four superordinate themes: blocks to compassion; compassion for self versus compassion for others; compassion for self versus compassion for the eating disorder and moving towards a future without the eating disorder. The target number for recruitment was between six and eight participants with a total of seven recruited to the study.

The superordinate themes gave away to ten subordinate themes which identified different areas of interest with regards to the participants' individual experiences and the benefits of engaging in the CFT group. Avoidance of emotional experience appeared to be a precipitating and maintaining factor of several of the participants' eating disorders. This made it difficult to engage with the home practice tasks set between sessions as to do so required experiencing difficult, and preferably avoided, emotional experiences. Many of the participants saw compassion as something that was meant for other people and as something that they themselves were undeserving of. Part of the discomfort relating to being undeserving of compassion appears to relate to uncertainty with how to tolerate and respond to compassion received from others, with some participants searching for a hidden meaning behind the compassionate comment.

Throughout the group and with increased understanding developed the notion of there being two types of compassion: compassion required for the self and recovery, and

compassion for the eating disorder. The two are incompatible due to conflicting goals (for example, weight loss in the case of the eating disorder and weight restoration in the case of recovery). Compassion therefore at times means doing something that is challenging and may potentially cause distress, such as following the meal plan, because it is important to the individuals' overall recovery. Compassion for the eating disorder still remained quite strong. Many of the participants spoke about their fear of losing the eating disorder identity; of not knowing who they are if they don't have the eating disorder as part of them, and this appeared to influence how able they were to transfer theory into practice. All of the participants reported an increased awareness of their emotional experience and the ability to take a step back from overwhelming emotions but behaviourally showing themselves compassion was viewed as much more difficult. This is understandable as if the eating disorder is perceived to be a central part of an individual's identity, any activities that could potentially lessen this attachment will be viewed as threatening and thus avoided.

Link to previous findings

Several of the themes are consistent with previous published research literature which has looked at therapeutic interventions in relation to eating disorders. Perhaps most applicable to understanding the shifts that the participants have undergone throughout the twelve weeks is the literature which looks at motivation to change and what stage of change an individual is at (Hötzel, van Brachel, Schlossmacher & Vocks, 2013). The participants in the current study were at different stages of recovery and this may have had an impact on the skills and techniques they were able to gain throughout the group, with those further on in recovery more able to utilise the group to support ongoing recovery.

There is a large amount of research which looks at the relationship between alexithymia and eating disorders, particularly in anorexia nervosa (Westwood, Kerr-Gafney, Stahl & Tchanturia, 2017). This relates well to the subordinate theme of avoidance of emotional experience as the eating disorder often functions as a way to avoid difficult emotions. Together with avoidance of home practice which can arise due to an avoidance of emotional experience, both present blocks which prevent an individual from being able to demonstrate self-compassion.

Compassion for self versus compassion for other, and the three subordinate themes, map on to Gilbert, McEwan, Matos & Rivis (2011) developed measures of fear of compassion from others; compassion for others and compassion for the self. As outlined by Gilbert et al., (2011), fear of compassion for the self was related to fear of compassion from others. In the current study, difficulty receiving compassion from others was related to the notion of the individual viewing compassion as something for others and not something that they are deserving of receiving.

Eating disorders, in particular anorexia nervosa, have been viewed in the literature as ego-syntonic in nature, meaning the individual personally values the symptoms associated with the disorder (Fox, Larkin & Leung, 2011). In the current study, the concept of two types of compassion arose due to the conflict between compassion for the self versus compassion for the eating disorder. Most of the participants in the current study spoke of valuing the eating disorder part of their identity, and at times, expressed resentment that the group was encouraging letting go of that identity to move towards recovery. They were often torn between doing what felt compassionate for the eating disorder (e.g., skipping a meal) rather than showing compassion for themselves and complying with the goals of recovery. There

was a recognition that compassion sometimes meant doing things that caused distress and were difficult in order to progress with recovery but that this could be terrifying because it meant challenging the eating disorder.

Overall though, all of the participants described an increase in awareness of their emotional experience and several were able to take a step back from overwhelming emotions rather than reacting automatically. This is similar to the findings of Lawrence & Lee (2013) who conducted a study using IPA which explored participants' experience of CFT for trauma. They found that participants experienced a more positive outlook on life after participating in the group whilst recognising that there was still an ongoing struggle to manage their difficulties. In the current study, all the participants spoke of their increased awareness of their emotional experience but also highlighted this in the context of it being a gradual process to recover which wouldn't see their beliefs and behaviours change overnight.

Limitations

The relatively small sample size, although characteristic of IPA, limits the generalisability of the findings. A further limitation is the disproportionate male-to-female ratio recruited.

Future Research

The participants in the current study comprised a transdiagnostic sample which meant it was difficult to identify whether there were differences in the experience of those with anorexia nervosa versus those with bulimia nervosa in how beneficial CFT was in tackling eating disorder symptomatology. It would be interesting to establish whether those with anorexia nervosa were more invested in the eating disorder part of their identity. In addition, it would be helpful to correlate the qualitative data with quantitative data,

gathered via psychometric measures, to identify whether there were any significant changes in psychopathology from the start to the end of the group. This would allow us to better understand whether the increased awareness of emotional experience reported by participants was matched by improvement in scores using a psychometric tool.

Implications

This study adds to the current body of literature by addressing the role of patient experience in the delivery of a 12-week compassion focused therapy group. Of particular interest was the suggestion by six of the participants of the concept of two types of compassion: compassion for the eating disorder versus compassion for the self, and how this relates to maintenance of the eating disorder identity as a valued part of the self. It may be useful to consider clinically how we support patients to develop their understanding of what compassion for the eating disorder might actually look like and how this interferes with the compassion required for recovery. In addition, it highlights the importance of considering the role of the eating disorder identity and how you help the individual to build up other parts of themselves that are meaningful which may allow them to consider letting go of the eating disorder. The current study also demonstrates the value of understanding how maintenance of the eating disorder identity may limit an individual's ability to put theory into practice because of the ramifications this may have for the eating disordered part of the self.

Conclusion

This study highlights the experience of seven individuals with eating disorders who underwent a 12-week CFT group as part of their treatment. All of them found the group

beneficial in increasing overall awareness of their emotional experience and enabling them to learn to take a step back from overwhelming emotions. The study explored the concept of the participants' experiences of two types of compassion and the conflicting goals of the eating disorder versus what the self wants from recovery. The incompatible goals lead to difficulty transferring theory into practice due to the consequences this has for the eating disordered part of the individual's identity. The participants recognise that the skills and techniques learned from the CFT group require ongoing practice for them to be of value in their recovery. Several of the participants recognised that the recovery process and implementing change was likely to be a gradual process whilst others expressed frustration at this and a desire for there to be a 'quick fix'. Recommendations for future research are provided and the implications for clinical practice highlighted.

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Appendix 1

European Eating Disorders Review

© John Wiley & Sons Ltd and Eating Disorders Association

Edited By: Professor Fernando Fernandez-Aranda

Impact Factor: 2.912

ISI Journal Citation Reports © Ranking: 2015: 19/122 (Psychology Clinical)

Online ISSN: 1099-0968

Author Guidelines

Manuscript Submission

European Eating Disorders Review has now adopted ScholarOne Manuscripts, for online manuscript submission and peer review. The new system brings with it a whole host of benefits including:

- Quick and easy submission
- Administration centralised and reduced
- Significant decrease in peer review times

From now on all submissions to the journal must be submitted online at http://mc.manuscriptcentral.com/erv. Full instructions and support are available on the site and a user ID and password can be obtained on the first visit. If you require assistance then click the Get Help Now link which appears at the top right of every ScholarOne Manuscripts page. If you cannot submit online, please contact Maurine Balansag in the Editorial Office (EEDRedoffice@wiley.com).

Illustrations must be submitted in electronic format. Save each figure as a separate file, in **TIFF** or **EPS** format preferably, and include the source file. We favour dedicated illustration packages over tools such as Excel or Powerpoint. Grey shading (tints) are not acceptable. Lettering must be of a reasonable size that would still be clearly legible upon reduction, and consistent within each figure and set of figures. Supply artwork at the intended size for printing. The artwork must be sized to the text width of 7 cm (single column) or 15 cm (double column).

Manuscript style. All submissions, including book reviews, should be double-spaced and clearly legible.

The first page should contain the **title** of the paper, full names of all authors, the address where the work was carried out, and the full postal address including telephone, fax number and email to

whom correspondence and proofs should be sent. The name(s) of any **sponsor(s)** of the research contained in the paper, along with **grant number(s)** should also be included.

The second sheet should contain an **abstract** of up to 150 words. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work. Include up to five **keywords** that describe your paper for indexing purposes.

- **Research articles** reporting new research of relevance as set out in the aims and scope should not normally exceed 6000 words with no more than five tables or illustrations. They should conform to the conventional layout: title page, summary, introduction, materials and methods, results, discussion, acknowledgements and references. Each of these elements should start on a new page. Authors may not find it necessary to use all of these subdivisions, and they are listed here only as a guide.
- **Review articles** should offer a synthesis of current knowledge in a field where rapid or significant progress has been made. The text should ideally not exceed 7000 words, 50 references and 5 figures or tables.
- **Brief reports** should concisely present the essential findings of the author's work and be compromised of the following sections: Abstract, Introduction and Aims, Method, Results, Discussion, and References. Tables and/or figures should be kept to a minimum, in number and size, and only deal with key findings. In some cases authors may be asked to prepare a version of the manuscript with extra material to be included in the online version of the review (as supplementary files). Submissions in this category should not normally exceed 2500 words in length.

  Brief reports bring with them a whole host of benefits including: quick and easy submission, administration centralised and reduced and significant decrease in peer review times, first publication priority (this type of manuscript will be published in the next available issue of the journal).
- **Case Reports** The journal does not accept case reports for publication. Authors of case reports are encouraged to submit to the Wiley Open Access journal, Clinical Case Reports www.clinicalcasesjournal.com which aims to directly improve health outcomes by identifying and disseminating examples of best clinical practice.

Reference style . The APA system of citing sources indicates the author's last name and the date, in parentheses, within the text of the paper.

Appendix 2

Walsh & Downe (2006): Adaptation of Summary Criteria for Appraising Qualitative Research Studies

Authors: _____ Total Points Awarded: _____

Date: _____ Overall Quality Rating: _____

Paper: _____

Stages	Essential Criteria	Specific Prompts	Points Awarded - Criterion Fully Met (2 points) - Criteria Partially Met (1 point) - No Evidence Criterion has been Met (0 points)	Overall Quality Rating Possible Score of 24: - Good = 18 or more (75%) - Acceptable = 12 or more (50%) - Inadequate = 11 or less (under 50%)
Scope and Purpose	Clear statement of, and rationale for, research question/aims/purposes	• *Clarity of focus demonstrated* • *Explicit purpose given, such as descriptive/explanatory intent, theory building, hypothesis testing* • *Link between research and existing knowledge demonstrated*		
	Study thoroughly contextualized by existing literature	• *Evidence of systematic approach to literature review, location of literature to contextualise the findings, or both*		
Design	Method/design apparent, and consistent with research intent	• *Rationale given for use of qualitative design* • *Discussion of epistemological/ontological grounding* • *Rationale explored for specific qualitative method (e.g., ethnography, grounded theory, phenomenology)* • *Discussion of why particular method chosen is most appropriate/sensitive/relevant for research question/aims* • *Setting appropriate*		
	Data collection strategy apparent and appropriate	• *Were data collection methods appropriate for type of data required and for specific qualitative method?* • *Were they likely to capture the complexity/diversity of experience and illuminate context in sufficient detail?* • *Was triangulation of data sources used if appropriate?*		

Sampling Strategy	Sample and sampling method appropriate	• *Selection criteria detailed, and description of how sampling was undertaken* • *Justification for sampling strategy given* • *Thickness of description likely to be achieved from sampling* • *Any disparity between planned and actual sample explained*		
Analysis	Analytic approach appropriate	• *Approach made explicit (e.g., thematic distillation, constant comparative method, grounded theory)* • *Was it appropriate for the qualitative method chosen?* • *Was data managed by software package or by hand and why?* • *Discussion of how coding systems/conceptual frameworks evolved* • *How was context of data retained during analysis* • *Evidence that the subjective meanings of participants were portrayed* • *Evidence of more than one researcher involved in stages if appropriate to epistemological/theoretical stance* • *Did research participants have any involvement in analysis (e.g., member checking)* • *Evidence provided that data reached saturation or discussion/rationale if it did not* • *Evidence that deviant data was sought, or discussion/rationale if it was not*		
Interpretation	Context described and taken account of interpretation	• *Description of social/physical and interpersonal contexts of data collection* • *Evidence that researcher spent time 'dwelling with the data', interrogating it for competing/alternative explanations of phenomena*		
	Clear audit trail given	• *Sufficient discussion of research processes such that others can follow 'decision trail'*		
	Data used to support interpretation	• *Extensive use of field notes entries/verbatim interview quotes in discussion of findings* • *Clear exposition of how interpretation led to conclusions*		

Reflexivity	Researcher reflexivity demonstrated	• *Discussion of relationship between researcher and participants during fieldwork* • *Demonstration of researcher's influence on stages of research process* • *Evidence of self-awareness/insight* • *Documentation of effects of the research on researcher* • *Evidence of how problems/complications met were dealt with*		
Ethical Dimensions	Demonstration of sensitivity to ethical concerns	• *Ethical committee approval granted* • *Clear commitment to integrity, honesty, transparency equality and mutual respect in relationships with participants* • *Evidence of fair dealing with all research participants* • *Recording of dilemmas met and how resolved in relation to ethical issues* • *Documentation of how autonomy, consent, confidentiality, anonymity were managed*		
Relevance and Transferability	Relevance and transferability evident	• *Sufficient evidence for typicality specificity to be assessed* • *Analysis interwoven with existing theories and other relevant explanatory literature drawn from similar settings and studies* • *Discussion of how explanatory propositions/emergent theory may fit other contexts* • *Limitations/weaknesses of study clearly outlined* • *Clearly resonates with other knowledge and experience* • *Results/conclusions obviously supported by evidence* • *Interpretation plausible and 'makes sense'* • *Provides new insights and increases understanding* • *Significance for current policy and practice outlined* • *Assessment of value/empowerment for participants* • *Outlines further directions for investigation* • *Comment on whether aims/purposes of research were achieved*		

Appendix 3

Administrator: Mrs Elaine O'Neill
Telephone Number: 0141 232 1815
E-Mail: elaine.o'neill2@ggc.scot.nhs.uk
Website: www.nhsggc.org.uk/r&d

R&D Management Office
West Glasgow ACH
Dalnair Street
Glasgow G3 8SW

14 July 2016

Miss Claire Beattie
Trainee Clinical Psychologist
Mental Health & Wellbeing
Admin Building
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G12 0XH

NHS GG&C Board Approval

Dear Miss C Beattie,

Study Title:	**Compassion Focused Therapy (CFT) for Eating Disorders: An Interpretative Phenomenological Analysis of Patients Experience**
Principal Investigator:	**Miss Claire Beattie**
GG&C HB site	**Community Mental Health**
Sponsor	**NHS Greater Glasgow and Clyde**
R&D reference:	**GN16MH280**
REC reference:	**16/WS/0120**
Protocol no:	**V3; 23/05/16**

I am pleased to confirm that Greater Glasgow & Clyde Health Board is now able to grant **Approval** for the above study.

Conditions of Approval

1. **For Clinical Trials** as defined by the Medicines for Human Use Clinical Trial Regulations, 2004

   a. During the life span of the study GGHB requires the following information relating to this site
      i. Notification of any potential serious breaches.
      ii. Notification of any regulatory inspections.

It is your responsibility to ensure that all staff involved in the study at this site have the appropriate GCP training according to the GGHB GCP policy (www.nhsggc.org.uk/content/default.asp?pageref=1411), evidence of such

2. **For all studies** the following information is required during their lifespan.
   a. Recruitment Numbers on a monthly basis
   b. Any change of staff named on the original SSI form
   c. Any amendments – Substantial or Non Substantial
   d. Notification of Trial/study end including final recruitment figures
   e. Final Report & Copies of Publications/Abstracts

Please add this approval to your study file as this letter may be subject to audit and monitoring.

Your personal information will be held on a secure national web-based NHS database.

I wish you every success with this research study

Yours sincerely,

ENeill

Mrs Elaine O'Neill
Senior Research Administrator

Appendix 4

Version 2, 18/04/16

Compassion Focused Therapy (CFT) for Eating Disorders: An Interpretative Phenomenological Analysis of Patients Experiences

Questions for Semi-Structured Interview

Introductory part of the interview

1. Introducing myself
2. Introducing the study
3. Conversation to build rapport

Questions pertaining to the group

1. How did you find being in the CFT group?
2. Did you gain new knowledge from the group? (followed by 'can you tell me a little more about that?' if required)
3. Have you been putting the new knowledge you have gained into practice?
4. Did you gain new skills from the group? (Followed by 'can you tell me a little more about the skills you have gained?')
5. Are you using the new skills you've gained?
6. Has the new knowledge and skills you have gained affected the way you react to stressful situations?
7. Has the new knowledge and skills you have gained affected the way that you manage your emotions?
8. Have you noticed anything about yourself in the way you respond to stressful situations?
9. Did you gain anything from the compassion exercises you did throughout the group?
10. Do you continue to use any of the compassion exercises in your day-to-day life?
11. What was your experience of the expectation of home practice of the exercises?
12. Have you noticed any changes in your overall coping with stress?
13. Have you experienced any changes in the way you view yourself?
14. Have you experienced any changes in the way you respond to difficulties?
15. What is your understanding of compassion? Has this changed over the course of the group?
16. Have there been any changes in the way that you respond to compassion from others?
17. Are you aware of any changes in expressing kindness and compassion towards yourself?
18. Are you aware of how you act towards yourself during difficult times before completing the group?

19. Are you aware of how you act towards yourself during difficult times after completing the group?
20. Are you aware of how you feel towards yourself when things go wrong?
21. How do you experience your emotions?
22. Do you try to understand your emotions?
23. What was your favourite aspect of the group?
24. What was your least favourite aspect of the group?

Ending the interview

1. Thanking participant for their time and input
2. Answer any questions

PARTICIPANT INVITATION LETTER

Title of Study: Compassion Focused Therapy (CFT) for Eating Disorders: An Interpretative Phenomenological Analysis of Patients' Experiences

My name is Claire Beattie and I am a Trainee Clinical Psychologist studying at the University of Glasgow. This study is a part of my Doctorate Training in Clinical Psychology within the University of Glasgow. I am interested in hearing about your experiences of Compassion Focused Therapy for treatment of an eating disorder. I enclose an information sheet for you to read over.

If you think you might like to take part in the study, I will contact you to discuss and arrange a time for an interview. This interview would take place at Florence Street Resource Centre and involve a discussion of up to 60 minutes to find out about your experiences.

The interview will be recorded on a digital voice recorder to ensure that I gain a full understanding of your experiences. All information will be treated with the utmost confidentiality; however, if something is reported during the interview that indicates you are at risk to yourself or to others, then I have a duty of care to report this information to other appropriate health professionals. You will be able to take breaks during the recording if you wish. After recording, the interview will be transcribed word for word and any references to people or places will be anonymised. Once the transcript has been checked for accuracy and completeness, the recording will then be destroyed. It will not be possible to identify you from the transcript as it will be given a code for identification purposes. Information linking your name to the identification code will be stored separately in a secure location away from the rest of the data.

If you would like more information about the study, please do not hesitate to contact me by telephone on 07480215509 or by email at c.beattie.1@research.gla.ac.uk.

Yours sincerely,

Claire Beattie

Trainee Clinical Psychologist

Contact Details: Academic Department, First Floor, Admin Building
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow, G12 0XH
Email: c.beattie.1@research.gla.ac.uk

Supervised by:

Dr Kenneth Mullen
Senior University Teacher
University of Glasgow

Dr Caoimhe Patton
Principal Clinical Psychologist
Adult Eating Disorder Service

PARTICIPANT INFORMATION SHEET

Title of Study

Compassion Focused Therapy (CFT) for Eating Disorders: An Interpretative Phenomenological Analysis of Patients' Experiences

Introduction

My name is Claire Beattie and I am a Trainee Clinical Psychologist studying at the University of Glasgow. You have been given this information sheet because you are being invited to take part in my research project which will be submitted as part of my Doctorate in Clinical Psychology. The project is supervised by Dr Kenneth Mullen, Senior University Teacher, University of Glasgow and Dr Caoimhe Patton, Principal Clinical Psychologist, Adult Eating Disorder Service.

What is the purpose of this study?

I am interested in finding out about your experiences of attending a Compassion Focused Therapy group as part of your treatment for an eating disorder. In particular, I'd like to know more about what you found helpful from the group, and your experience of being in a Compassion Focused Therapy group.

Why have I been invited as a potential participant?

You have been given this information sheet because you have recently completed a 16-week Compassion Focused Therapy group as part of your treatment for an eating disorder.

Do I have to take part?

No, you do not have to take part in this study if you do not wish to. Participation in the study is entirely voluntary and your care and treatment will not be affected in any way should you choose not to participate. You are also free to withdraw from the study at any time without giving a reason. You may also request that the information you have provided is withdrawn from the study.

What will happen if I choose to take part?

If you decide to take part in the study, I will contact you to arrange a suitable time to meet with you. We will meet in a private clinic room at Florence Street Resource Centre and I will ask you to sign a consent form (version 2, 28/03/16), to confirm that you are happy to take part and understand what is being asked of you. The interview will last approximately 60 minutes. I will electronically record the interview to make sure that I have an accurate record of what we discussed.

Are there any risks or disadvantages to taking part in the study?

There are no direct risks involved in taking part in this study, although you may potentially find it distressing to talk about some of your experiences. You may take a break or stop the interview at any point if you choose to do so. If you need further support after the interview, this can be discussed and I can direct you to the Clinical Psychologist involved in the study to discuss any issues that the interview may have raised further.

Are there any benefits to taking part?

There are no direct benefits to you of taking part in this study. The findings from the study may potentially lead to new knowledge, which could then be used to help other people in a similar situation to you in the future.

Will my information remain confidential?

All information you provide as part of the study will remain confidential. The only people who will have access to this information will be the lead investigator (Claire Beattie), the academic supervisor (Dr Kenneth Mullen) and the field supervisor (Dr Caoimhe Patton). Representatives of the study sponsor, NHS Greater Glasgow & Clyde, may also have access to your information to ensure the study is being conducted properly.

Your information will be stored securely. Everything you say during the interview will be kept confidential unless any indication was given that you were a risk to yourself or to others. In this circumstance, I have a duty of care to break confidentiality but I would try to discuss this with you directly first.

What will happen to my information?

The results of the study will be written up as a report, which will be submitted as part of the lead researcher's Doctorate in Clinical Psychology. It is anticipated that the results will also be submitted for publication in a scientific journal and may be presented at conferences. Quotes from your interview may be used; however, any information which could identify you will be removed. You will also have the option to be notified when the report is available.

After your interview, the recording will be kept in a locked filing cabinet which only the researchers are able to access. After the interview has been transcribed word-for-word, it will be deleted from both the recording device and the computer it was uploaded to. The transcriptions will be kept securely stored on a password protected laptop.

Who has reviewed the study?

A member of staff from the University of Glasgow's Doctorate in Clinical Psychology programme has reviewed the study. Additionally, approval has been granted by the West of Scotland Research Ethics Committee and NHS Greater Glasgow and Clyde Research & Development.

What happens if something goes wrong?

If you would like to make a complaint about any aspect of the study, please contact Claire Beattie, Trainee Clinical Psychologist in the first instance. The NHS Greater Glasgow & Clyde Complaints Service is available for information and advice on procedures. They can be contacted by telephone on 0141 201 4500 or by email at complaints@ggc.scot.nhs.uk.

What do I do next?

If you have any further questions about the study or would like to discuss it further, please do not hesitate to email me on c.beattie.1@research.gla.ac.uk or telephone me on 07480215509.

If you decide you would like to take part, please complete the opt-in form and return it in the enclosed envelope to your final Compassion Focused Therapy group session or hand it in to reception at Florence Street Resource Centre. Once I have received this, I will contact you to arrange a suitable time to meet with you.

If you would like to speak to a research professional who is independent of the research study, you can contact Dr Sarah Wilson by email on sarah.wilson@glasgow.ac.uk or by telephone on 0141 211 3921.

If you do not wish to take part, you do not need to do anything further.

I would like to thank you for taking the time to read this information sheet.

Principal Investigator

Claire Beattie
Trainee Clinical Psychologist
Mental Health & Wellbeing
First Floor, Admin Building
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Academic Supervisor

Dr Kenneth Mullen
Associate Academic
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1055 Great Western Road
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Field Supervisor

Dr Caoimhe Patton
Principal Clinical Psychologist
Adult Eating Disorder Service
Florence Street Resource Centre
26 Florence Street
Glasgow
G5 0YX

CONTACT DETAILS

Title of Study: Compassion Focused Therapy (CFT) for Eating Disorders: An Interpretative Phenomenological Analysis of Patients' Experiences

Researcher: Claire Beattie**,** Trainee Clinical Psychologist

I am interested in finding out more about this study and consent for my details to be passed to the researcher who will then contact me.

My preferred means of contact is (*tick appropriate response)***:**

Post ☐

Email ☐

Telephone ☐

Please provide details of your preferred means of contact in the space below.

Address: _____

_____

Telephone Number: _____

Email Address: _____

If you wish to be contacted by telephone, are you happy for a message to be left on an answering machine (*tick appropriate response)*?

Yes ☐

No ☐

Participant Name: _____

Signature: _____

Date: _____

Appendix 8

Version 3, 09/07/16

PARTICIPANT CONSENT FORM

Title of Study: Compassion Focused Therapy (CFT) for Eating Disorders: An Interpretative Phenomenological Analysis of Patients' Experiences

Researcher: Claire Beattie, Trainee Clinical Psychologist

Contact Details: Academic Department, First Floor, Admin Building
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow, G12 0XH
Email: c.beattie.1@research.gla.ac.uk

Please write your initials in each box if you agree with the statement:

1. I confirm that I have read and understood the information sheet (Version 3, 07/07/16) for the above study. ☐

2. I confirm that I have had the chance to consider the information and that the researcher has answered any questions I have to my satisfaction. ☐

3. I understand that my participation is voluntary and that I am free to withdraw from the study at any point without having to give a reason, and with no consequences. ☐

4. I understand that I can ask for my data to be withdrawn from the research at any point. ☐

5. I understand that my information will remain confidential and that any information that could identify me will not be made publicly available. Representatives from NHS Greater Glasgow & Clyde may look at my information for audit purposes. ☐

6. I give permission for my interview with the researcher to be digitally recorded. ☐

7. I give permission for the researcher to use anonymised quotes from the interview in the write up of the research. ☐

8. I understand that the academic and clinical supervisors (Dr Kenneth Mullen and Dr Caoimhe Patton) will have access to the anonymised data gathered to ensure that the study is being conducted properly. ☐

9. I consent to being a participant in this study. ☐

Name of Participant	**Date**	**Signature**
_____	_____	_____

Name of Researcher	**Date**	**Signature**
_____	_____	_____

Lucy: Erm... I think the blocks to compassion [CB: ok] erm... I found that really useful cause I hadn't really thought about that before [CB: ok] like... like how the things that stop me well... kinda blur into what my blocks to being compassionate to myself are... so, I found that really useful em... and also the... the letter writing

CB: Ok...is that writing yourself a compassionate letter? [Lucy: yeah, yeah] ok

Lucy: that was really helpful that one so em... and the, the drive, threat and sooth, soothing system [pause], it sticks in my mind but I could never really... get my head [both laugh] round it, so is that a drive or is that a threat so... [CB: yeah, and quite often it can be a bit of both can't it] yeah, yeah so I could understand it but... sometimes when I had to write it for myself, I was like ummm, I'll just stick it in there [both laugh]

CB: So maybe difficult for your own experience to go, is this a, a threat thing or this a drive thing [Lucy: yeah]

Lucy: Yeah I think maybe if there had been more examples, I'd maybe have got my head round it more but I think we only used like one example [CB: ok] so maybe there wasn't enough [CB: yeah] for me to get my head round, maybe if I'd seen more examples, then I'd be like ah right ok this is this...

CB: Yeah it makes it a bit more difficult to conceptualise, yeah I can understand that... and the... the sort of skills and knowledge that you have gained, do you feel you've been putting them into practice since the groups finished?

Lucy: Yeah, erm [pause] I was saying earlier that I feel like my thinking's changed [CB: ok] so it's, but I feel that it's kinda leapt ahead but the doing part still [CB: ok] kinda... slowly plodding along... erm... so I need to try and apply it more to the practical side [CB: ok] but I would definitely say that I am still like benefiting from it and applying it even although the group's finished... I'm still like doing some of the exercises [CB: ok] and I'm still doing the... like the relaxation and meditation stuff as well

CB: That's been quite helpful? Which of the exercises have you found... the most kinda helpful to do at home?

Lucy: Erm... I'd say the blocks to compassion [CB: ok, that's been...] yeah, I've been doing it quite a lot and I've been doing the meditation but not necessarily the ones [CB: ok] from there [both laugh] and also others ones... em... that are already recorded and [CB: yeah, yeah] can use them so they're... I find them quite good as well [CB: that's been quite helpful] mhmm, yeah [CB: that sounds really good] yeah

Group Skills
- Blocks to compassion.
- Letter writing

Identifying perpetuating factors & how these link to recovery?

3 systems beneficial but difficult to grasp what is drive vs. what is threat.

Need for more examples.
Difficulty relating content to own situation?
Repetition of saying 'more than one example' & 'would've got my head round it'
Trying to convince herself or justify it to me.

Transferring theory into practice more difficult.
- continuing to use techniques - meditation & relaxation.

Quite good
- in a helpful sense?

CB: Erm... ok... do you think the... the skills and the knowledge that you've gained has had an impact on how you respond to stressful situations?

Lucy: Erm [pause] yeah, I think the, like the breathing exercises have been quite good [CB: ok] erm, just to kinda ground myself if I'm doing something that's... a bit more stressful than usual or I'm challenging myself with something then... I find sometimes that that helps [CB: ok] to sort of like calm me down a bit [CB: take a step away] yeah [CB: from it a little bit] yeah, and just even, by kind of thinking, is that the compassionate thing to do or is that the eating disorder thing to do, so... yeah... I think, erm, certainly catching myself sometimes [CB: that's really good], sort of thinking... wait a minute [CB: yeah] you know, is that the compassionate thing to do and then maybe extending that on to like, well would... like a friend do that [CB: yeah], you know if she felt like that would, would she take the same approach that you're taking now [CB: yeah] or I think like or... what would Jan say [Lucy laughs] you know like [CB: yeah, yep], she'd rap your knuckles for you [both laugh] so... is that the compassionate thing to do but definitely like catching myself sometimes and thinking well, wait a minute, the compassionate thing to do here would be to... [CB: yeah] so, you know and then going and doing it whereas, before I wouldn't have thought about doing that

CB: So it sounds like it's just, it's put that break in place [Lucy: yeah] almost hasn't it? [Lucy: yeah] that kinda, stop, wait, what's going on here [Lucy: yeah, yeah, yeah definitely] ok. Erm... do you think you've noticed anything else different about how you would respond to stressful situations?

Lucy: Erm [long pause], I think probably I'm less hard on myself... so,,, like before I would... probably beat myself up and criticise myself and tell myself to get a grip and pull my socks up [CB: yeah] and I just need a kick [Lucy laughs] up the back side, whereas... now, not all the time but sometimes I'm like [pause] more gentle [CB: ok] with myself, sort of, more accepting I suppose, like, ok I maybe didn't deal with that, that brilliantly but [pause] I try and understand why I didn't [CB: yeah] and... yeah... like I think, what I can do differently the next time and not just think that... I'm useless [Lucy laughs] or whatever so... not letting myself off but just being a bit more gentle with myself [CB: a bit kinder to yourself], yeah [CB: and that's something you've noticed since the groups] yeah, yeah [CB: sort of finished], yeah definitely, yeah

CB: Ok... and how about other emotions, do you feel that there's anything you've taken from the group to manage, you know, anxiety or... other types of emotions?

Use of breathing exercises as a grounding technique, in stressful situations

Separating compassion & the ED

Is that what a friend would.

Alternative means of justifying compassion for the self

Use of keyworker to justify when she's not being compassion

Remaining guilt about self compassion & what it means to be self compassionate?

Taking a step back from emotions

Recognising when not being compassionate & taking steps to rectify this. This is at odds with what she said about the doing part' being more difficult

More accepting & addressing relenting standards & being more gentle.

Appendix 10

Major Research Project Proposal

Compassion Focused Therapy (CFT) for Eating Disorders: An Interpretative Phenomenological Analysis of Patients Experiences

Date of Submission: 23rd May 2016

Version: 4

Word Count: 3,028

ABSTRACT

Background: Eating disorders are serious psychiatric conditions which can be resistant to different types of treatment. Cognitive Behavioural Therapy is recommended as the treatment of choice by the NICE guidelines but research has shown that it is only effective approximately 50% of the time. Therefore, more recent research has begun investigating alternative treatments, one of which is Compassion Focused Therapy (CFT) and the role self-compassion may have for eating psychopathology severity.

Aims: The aim of the study is to explore the experience and meaning of Compassion Focused Therapy for individuals with eating disorders who have taken part in a 12-week group.

Methods: Semi-structured interviews will be conducted. It is anticipated that between 6 and 8 participants will be recruited. Interpretative phenomenological analysis (IPA) will be used to analyse the interview transcripts.

Applications: It is hoped that this research will contribute to the growing body of literature which is being developed looking at the efficacy of Compassion Focused Therapy as an alternate treatment for those individuals who have an eating disorder. It is hoped the research will provide insight into the value and benefit of Compassion Focused Therapy and a greater understanding of the aspects that were perhaps less helpful.

INTRODUCTION

Eating disorders are serious psychiatric conditions which can be resistant to different types of treatment. The three most commonly defined disorders in the Diagnostic and Statistical Manual 5th Edition (DSM-5) are Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Binge Eating Disorder (BED). The National Institute for Clinical Excellence (NICE) guidelines produced in 2004 for eating disorders state the AN should be treated with a choice of psychological treatments including Cognitive Analytic Therapy (CAT), Cognitive Behavioural Therapy (CBT), Interpersonal Psychotherapy (IPT) and focal psychodynamic therapy. However, there is no one specialist treatment advocated for AN that is viewed as highly effective in tackling the persistent and chronic nature of AN (Kass et al., 2013). Cognitive Behavioural Therapy for Bulimia Nervosa (CBT-BN) and IPT are the NICE recommendations for treatment of moderate to severe BN and are well established as effective and long-lasting treatments (Kass et al., 2013). However, research has shown that CBT is only effective in about 50% of cases (Byrne et al., 2011).

Overall though, the recovery rate for eating disorders remains low with AN having the highest mortality rate out of all psychiatric disorders (Franko et al., 2013). Research has previously suggested that less than half of those suffering from AN (Steinhausen, 2002) and BN (Poulsen et al., 2014) will actually recover.

Compassion Focused Therapy (CFT) is derived from an evolutionary and neuroscience model of affect regulation that suggests that different affect regulation systems developed for different functions. Three affect regulation systems have been recognised: the threat detection and protection system; the drive, vitality and achievement system and the contentment and affiliative soothing system. The three systems are seen as mutually regulating (Goss & Allan, 2014). CFT was developed in recognition that the negative affective component of a disorder often remains despite the individual being able to rationalise their problems cognitively. Researchers began to acknowledge that many disorders have high levels of shame and self-criticism associated with them

and that, as a result, those individuals may struggle to feel relieved, reassured or safe (Gilbert, 2009). The contentment and affiliative soothing system is thought to have evolved with attachment systems and is seen as poorly accessible in people with high shame and self-criticism whilst the threat detection and protection system is often in drive.

Levels of shame and self-criticism are suggested to be high in those with eating disorders. Current research is beginning to examine the role self-compassion may have for the severity of eating psychopathology. Ferreira et al., (2014) were interested in testing the moderating effect of self-compassion on the relationships between shame memories and eating psychopathology. The authors administered a variety of measures to a group of 34 individuals attending an eating disorders care unit as outpatients. The individuals had a mixture of diagnoses (AN =10; BN =15; Eating Disorder Not Otherwise Specified (EDNOS) = 9). The results showed that self-compassion was inversely and strongly associated with overall severity levels of eating psychopathology and that the positive dimension of self-compassion emerged as a significant predictor of eating psychopathology severity variance. This study demonstrated that self-compassion can have a buffering effect against shame memories on eating psychopathology severity and suggests that low levels of self-compassion may be a barrier to recovery.

In 2014, Gale et al., conducted a study evaluating the impact of incorporating CFT into a standard CBT programme for people with eating disorders. Using a repeated measures design, 139 patients attending the Coventry Eating Disorders Service took part in a 4 session group based psychoeducation programme before going on to participate in a 20-session group based recovery programme of CBT combined with CFT. Participants completed three measures (Eating Disorder Examination Questionnaire; the Stirling Eating Disorder Scale and the Clinical Outcomes in Routine Evaluation Outcome Measure) at five time points throughout the study. Ninety-nine participants were included in the analysis (AN=19; BN=26; EDNOS=54) which found that CBT combined with CFT was an effective treatment particularly for those with BN, with 73% considered ‘recovered’ by the

end of the programme. Twenty-one percent of those with AN were considered 'recovered' with another 37% making a significant improvement. For those with EDNOS, 30% were considered 'recovered' following treatment. This led the authors to conclude that CFT has potential benefits for those with eating disorders by impacting on the symptoms and psychopathology of the eating disorder. The authors stated that more research was required to investigate the use of CFT in eating disorders further. In particular, understanding the patient's experience of CFT is crucial in developing the therapy and improving its suitability and applicability in the treatment of eating disorders. This highlighted gap in the literature led to the development of the current study.

AIMS AND HYPOTHESES

The aim of the current study is to explore the experience and perceived benefits of Compassion Focused Therapy for individuals with eating disorders who have taken part in a 12-week group through the use of semi-structured interviews. An additional aim is to explore how CFT may have impacted upon and individual's perception of shame, self-criticism and self-directed hostility and which aspects of the CFT programme were helpful or less helpful

PLAN OF INVESTIGATION

Participants: Participants will be patients attending NHS Greater Glasgow & Clyde's (NHS GG&C) Adult Eating Disorder Service (AEDS) who have a diagnosis of anorexia nervosa (AN), bulimia nervosa (BN) and unspecified feeding and eating disorder as per the Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-V, 2013). The eating disorder diagnosis will be confirmed by a professional deemed qualified within the AEDS. Patients seen within the AEDS are treated using a transdiagnostic approach and this study is therefore not distinguishing between individual diagnoses. It is recognised that patients can move between diagnoses during treatment and recovery (Fairburn, Cooper & Shafran, 2003). Participants will have undergone a 12-week CFT group in addition to treatment as usual prior to participating in the study. There are no additional criteria

for selection to the CFT group due to the limited number of patients seen within the AEDS. The CFT group will be delivered by a Clinical Psychologist and Nurse Therapist who have attended approved CFT workshops. It is estimated that approximately 6-8 participants will be required to reach data saturation. Starks & Trinidad, (2007) report that typical sample sizes for phenomenological studies range from 1-10 persons. This is feasible target for recruitment. It is anticipated that each group will have between 6 and 8 members and the group will run three times during the duration of data collection.

Inclusion and Exclusion Criteria: Participants will be aged between 18-65 and can be male or female. Participants must be able to provide informed consent and be patients within NHS GG&C's Adult Eating Disorder Service. Participants must also have took part in the 12-week CFT group in addition to treatment as usual. Participants will be excluded if they are non-English speaking or have a history of a learning disability or cognitive impairment which may impede on their ability to provide informed consent and to sufficiently understand the purpose of the study.

Recruitment Procedures: Participants will be approached by a member of the eating disorder service team who will be known to them and informed about the study being conducted via the Participant Information Sheet. If they agree, their details will be passed, on a contact form, to the researcher who will then contact them to organise a suitable time to conduct the semi-structured interview. Participants will be given an opportunity to ask questions about the study either prior to the interview or at the interview. Informed consent will be obtained prior to commencing the interview.

Design: The study will utilise a qualitative research design; more specifically, Interpretative Phenomenological Analysis. Semi-structured interviews will be carried out retrospectively once participants have completed a 12-week CFT programme in order to explore their experiences of the programme and their understanding of compassion and self-compassion. The recommendations of Smith et al., (2009) will be taken into consideration when preparing the schedule for the semi-

structured interview. These include not directly asking participants your research question; in-depth thought into the range of topic areas being covered; placing the topics in a logical sequence; considering how open questions can be phased appropriately and discussing the selected question with colleagues for input.

Research Procedures: Participants will complete a semi-structured interview lasting up to one hour with questions focused on their understanding of compassion and self-compassion; what they valued about the approach; the benefits they found and whether there are any areas they didn't find helpful. This will take place at Florence Street Resource Centre and the interview will be recorded using a digital recorder.

Data Analysis: As this study is qualitative, the interview transcripts gathered will be analysed using Interpretative Phenomenological Analysis (IPA). Qualitative approaches are concerned with understanding the participant's point of view. IPA is an idiographic approach, meaning it focuses on the individual and their experience. IPA is interested in the meanings participants ascribe to events and views participants as playing an active role in the construction of meaningfulness of their experiences. The interview is a dynamic process whereby the researcher has an active role in the process. The researcher is trying to understand the participants world and experience but this is reliant on and complicated by the researcher's own conceptions. This results in a double hermeneutic, or, in other words, a two-stage interpretation process (Smith & Osborne, 2008).

In accordance with NICE (2004), patient experience is considered a key element of therapy development, and given the current knowledge base of the use of CFT in eating disorders, the current study is aimed at better understanding the experiences of those who have taken part in a 12-week CFT group. Themes will be developed using an iterative process consistent with IPA methodology with each transcript subject to detailed analysis (Pauley & McPherson, 2010).

Justification of Sample Size: Determining the required sample size in qualitative research requires consideration of five main factors. These are scope of the study; nature of the topic; quality of the data; study design and the use of shadowed data (Morse, 2000). Whilst these factors cannot definitively determine the required sample size, they can enable the researcher to justify the sample size selected. In IPA a large amount of data is generated for each participant. This means that fewer participants are required and it is recommended that studies recruit between 6 and 10 participants (Smith et al., 2009).

Settings and Equipment: Interviews will take place at Florence Street Resource Centre, 26 Florence Street, Glasgow, G5 OYX. The interviews will be recorded using a digital voice recorder and transcribed using transcription software, both of which can be borrowed from the Doctorate of Clinical Psychology Course, University of Glasgow.

HEALTH AND SAFETY ISSUES

Participants' Safety Issues: It is possible that some participants may become distressed during the semi-structured interview as they are reflecting on their own experiences of CFT and this may evoke emotions about their illness and recovery. The interviews will be conducted by a Trainee Clinical Psychologist who will aim to contain any participant distress arising during the interviews. If necessary, the Trainee Clinical Psychologist can seek assistance and support from a clinician within the Adult Eating Disorder Service. The Trainee Clinical Psychologist will also advise the participant to discuss any issues that arise with their named key worker.

Researcher Safety Issues: It is possible that the researcher may experience some distress whilst listening to the participant's experiences. In the event that this occurs, the researcher, as a Trainee Clinical Psychologist, can seek support from both the academic and field supervisors and the university advisor who is responsible for providing pastoral support and guidance for the Trainee

Clinical Psychologists.

ETHICAL ISSUES

Ethical approval will be obtained through the local NHS Research and Development offices and NHS Research Ethics Committee (REC) prior to the study commencement. To ensure potential participants do not feel coerced into participating in the study they will be approached by a clinician known to them in the AEDS. The study will be explained clearly to the participant and informed consent obtained before the semi-structured interview takes place. It will be stressed to participants that participation is completely voluntary and that they are free to withdraw at any time without this impacting on the care they receive. In line with the BPS Code of Human Research Ethics (2010), participants will be informed that they can ask for the destruction of all or part of the data that they have contributed during the data gathering phase if they wish. Thereafter, participants will be informed that they consent to the inclusion of their data in the study. Permission will also be obtained from participants allowing the use of quotations from their interview transcript to be used during the write up of this research.

All data will be treated as confidential and the NHS Greater Glasgow & Clyde Code of Confidentiality and Data Protection will be adhered to. Only the participant consent forms will contain person identifiable information, as these require the participant's name and signature and these will be kept in a secure, locked location on NHS premises. Electronic data will be coded, password protected and stored on a private drive within an NHS Greater Glasgow & Clyde computer for 10 years as is stated in the University of Glasgow's Code of Good Practice in Research. Details of the coding system used will be kept separate to the electronic data and stored in a locked filing cabinet on University premises at Gartnavel Hospital. Data will only be accessible to the Principal Investigator, supervisors and representatives of the study sponsor, NHS Greater Glasgow & Clyde. It is possible that some participants may become distressed during the interview when asked to reflect on their own experiences of the CFT group and this may evoke emotions about their own eating disorder

recovery. This will be handled sensitively and any distress which arises will, in the first instance, be contained by the researcher who is a Trainee Clinical Psychologist. If concern about an individual persists, the researcher will seek further guidance and advice from individual's designated clinician or other clinicians within the Adult Eating Disorder Service as appropriate. The Trainee Clinical Psychologist will also encourage the individual to seek support from their named key worker within the AEDS.

The study will be written up as a scientific paper for publication in a relevant journal. The findings will also be presented at relevant conferences. In addition the study will be written up as part of the Principal Investigator's Doctorate in Clinical Psychology and the thesis will be available to access from the University of Glasgow upon successful admission. A brief copy of the findings will be provided to the service to give to patients who request to know the outcome of the study.

FINANCIAL ISSUES

The researcher will require funds for printing and photocopying. The digital voice recorder, transcription software and transcription pedal can all be borrowed from the Doctorate of Clinical Psychology Course, University of Glasgow therefore incurring no additional expense for the study. Further details are outlined on the Research Costs & Equipment Form found in the appendices.

TIMETABLE

September 2015	Outline to Mental Health & Wellbeing, University of Glasgow
November 2015	Draft Proposal to Mental Health & Wellbeing, University of Glasgow
December 2015	Final Proposal to Mental Health & Wellbeing, University of Glasgow

February 2016	Submission to Ethics
May 2016 – April 2017	Data Collection
March 2017 – May 2017	Analysis & Write Up
June 2017	Draft to Supervisors
July 2017	Thesis Submission

PRACTICAL APPLICATIONS

The qualitative data gathered from this study will contribute to the emerging research on Compassion Focused Therapy (CFT) for eating disorders. It is hoped this research will help better understand the role compassion may play in eating psychopathology for the individuals recruited into the study. Additionally, this study aims to understand the participants' experience of CFT in a group setting which may help shape how the group is run in the future.

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RESEARCH EQUIPMENT, CONSUMABLES AND EXPENSES

Trainee: Claire Beattie

Year of Course: **2nd Year** **Intake Year**: **2014**

Please refer to latest stationary costs list (available from student support team)

Item	**Details and Amount Required**	**Cost or Specify if to Request to Borrow from Department**
Stationary	3 Reams of Box of A4 Envelopes (250)	Subtotal: £9.01
Postage	N/A	Subtotal: N/A
Photocopying and Laser Printing (**includes cost of white paper**)	Photocopying and Laser Printing 500 sheets	Subtotal: £25.00
Equipment and Software	Digital Voice Recorder Transcription Software Transcription Pedal	To be borrowed from the Doctorate in Clinical Psychology programme Subtotal: N/A
Measures	N/A	Subtotal: N/A
Miscellaneous	N/A	Subtotal: N/A
Total		**£34.01**

For any request over £200 please provide further justification for all items that contribute to a high total cost estimate. Please also provide justification if costing for an honorarium:

Trainee Signature…… … Date……

Supervisor's Signature …….. Date ……