EATING DISORDERS AND BODY IMAGE DISTURBANCE AMONG MALES AND FEMALES: FROM THE PERSPECTIVE OF SIX THERAPISTS WITH DIFFERENT THERAPEUTIC ORIENTATION

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Abstract

Objectives. Nowadays, a culture of slimness and flawless outward appearance has been cultivated and individuals are constantly exposed to images of slender females and overly slim, muscular males. The percentage of individuals, both males and females, who struggle with Body Image Disturbance (BID) and therefore Eating Disorders (ED) has grown spectacularly. Although studies about eating disorders are affluent, research exploring counseling clients with body image disturbance and eating disorders is limited. This qualitative study provides a unique perspective of the therapeutic world by enlightening experiences of therapists with different therapeutic orientation when working with clients, both males and females, throughout the disordered eating spectrum.
Material and methods. Six experienced therapists from 4 psychotherapeutic orientations (Cognitive-Behavioral Therapy, Person-Centered Therapy, Family/Systemic Therapy and Integrative Therapy) participated in semi-structured interviews which were analyzed through Interpretative Phenomenological Analysis.
Results. Interviews provided rich and detailed data highlighting the greater percentage of female cases and problems in the family system as the main underlying factor responsible for eating disorders in both genders. Thought diary, role playing, family involvement and mirror exposure were some of the interventions found to be utilized while differences in the client's response to therapy were attributed to personalities and individual characteristics. Bafflement, responsibility, anxiety and anger were the prevailing emotions that therapists presented.
Conclusions. Findings depict the complexity of the disorder and the corresponding emotional complexity of the therapeutic work with this specific clientele while they present an internal aspect of the therapeutic world. Independently of their psychotherapeutic orientation, therapists adapt their therapeutic plan on each individual employing interventions from other orientations and forming a flexible and integrative approach. Integration and flexibility are essential for a holistic and comprehensive intervention which can address challenges and benefit both clients and therapists.

Keywords: body image disturbance (BID), eating disorders (ED), therapeutic orientation, integration.

Introduction

Eating Disorders (ED) are compound mental disorders typified by maladjusted eating practices and severe affliction about body weight (Bryant-Waugh, 2000). Waller and Barnes (2002) defined body image disturbance (BID) as a misperception of actual body image (BI), an internal body shape and size. Conventional wisdom claims that BID/ED dominates the female population, but recent community studies suggest that a prodigious 26% of teen boys are unpleased with their

appearance (Neumark-Sztainer et al., 2002). Studies focused on the deployment of healthy familial borders suggested that over-involved, rigid and perfectionist families favor the development of BID/ED (Monacis et al., 2017). Teenagers feel unable to meet their parents' expectations and mold their own identity. Thus, they endeavor to obtain independence and autonomy by overruling their bodies (Park and Bernard, 2006).

Throughout the years, research has identified four fundamental therapeutic waves in the clinical treatment of BID and ED. The cognitive-behavioural approach (CBT) is widely accepted as the most efficient and principal treatment since it directly targets emotions, maladaptive behaviours and dysfunctional thoughts that conduce to a negative BI (Ogden, 2010). In spite of the promising outcomes, CBT presents undeniable limitations. Researchers claim that it may inadvertently supplant the emotional exploration and perpetuate the intellectualization of the disorder (Ogden, 2010). Further the person-centered approach (PCT), a non-directive approach which emphasizes on the therapist-client relationship where both coefficients collaborate with trust, empathy and acceptance (Teyber and McClure, 2011). Instead of being solution focused, therapists guide the therapeutic process with great flexibility and without interfering with the client's self-discovery process. However, PCT has the tendency to be more supportive and less challenging. Thus, cognitive distortions are not challenged but rather they are amplified and concealed feelings are not surfaced favoring the secretive nature of BID/ED (Bryant-Waugh, 2000).

Additionally, the family-based approach (FBT) which acknowledges family as a unit of a larger system where impacts among members take place. Beside the structured therapeutic plan, its core difficulty is the family engagement, hence relationships remain unexplored and the causing factors are perpetuated (Jones-Smith, 2012). Lastly, the integrative therapy which intends to merge the strong components of the existing approaches. In recent years, the need for a creative approach which integrates concepts from multiple modalities that can respond to the complexities of the disorder is imperative. There is a variety of psychotherapeutic orientations but studies found that early life experiences and family issues shape theoretical orientation development, since therapists choose the approach that they are mostly sensitized to due to family origins issues (Bitar, Bean and Bermudez, 2007).

Working within ED community can be rewarding and challenging. During sessions, therapists have declared experiencing an emotional roller coaster which derives from the demanding management of both the disorder and the psychological co-morbidities often accompanied. Therapists have confessed that therapeutic work with these clients may entail risks, such as emotional burnout, physical fatigue, stress-related problems, compromised immunity, depression, and suicidal ideation (Strober et al., 2007). According to this research, the most vulnerable therapists are those who tend to empathize with their clients and show an enormous level of understanding.

Although BID and ED are widely studied, research about therapists' experience is scarce and considerable difficulties were encountered sourcing related literature which ultimately provided an avenue for this study. The primary objective is to explore the experiences of therapists, who have been trained in different psychotherapeutic approaches, when working with BID or ED clients. In attempting to analyze their experiences and their therapeutic work, the utilized interventions, their effectiveness and the client's subsequent behavioral responses will be explored. In this study, it is hypothesized that each approach has effective interventions but the integration of them can provide a more complete and efficient premise. Also, many studies do not report gender differences in the outcome of psychological treatment (Bachelor et al., 2007). Thus, the present study aims to make separations on gender hypothesizing that both gender and personality are factors affecting the therapeutic outcome. Finally, the study attempts to explore untouchable aspects of various therapeutic approaches from an inside point of view in order to benefit both clients and therapists.

Material and methods

The main objective was to explore the experiences of therapists from four psychotherapeutic approaches (Cognitive-Behavioural, Person-Centered, Family/Systemic, Integrative) and collect profitable but manageable data that can answer the research question. The sample had to meet three primary criterions: certification on one of the selected approaches, at least five years of professional experience and clinical experience with BID or ED clients, either males or females. Based on the objective of the study and the characteristics of the population needed, purposive sample seemed an appropriate method. The first participant was approached by the opportunity way of contact; other three therapists were approached by referral from the first participant and the rest of them by the snowballing method. Thus, a total of six therapists (two representatives of each psychotherapeutic approach) was gathered. Further, the concept of semi-structured interviews fitted appropriately with the project's purpose and was adopted for the data collection. Interviews took place at each participant's office as it was mutually agreed. The interview setting needed to be quiet, accommodating and physically comfortable for participants. Each participant was interviewed once between forty minutes and one hour and none of the interviews was disrupted.

At the end of the interview process, transcription produced descriptive qualitative data based on which a thematic analysis initiated. The analyzing process consisted of four stages and was grounded on the IPA framework (Smith and Osborn, 2003). The first stage started with constant reading and rereading of the transcribed files in order to become familiar with the content and look for emerging themes. The categories created were then reviewed so that possible connections and fusions among the themes could be achieved. After regular checks, the themes were clustered into those which could be grouped together (subthemes) and those which remained in a category alone (superordinate themes). Finally, the reorganized framework of themes from the previous stage composed the analysis segment where every theme had to be illustrated verbatim by the original, transcribed interviews.

Results

The themes emerged from the analyzing process are presented in the following table:

Table 1. Superordinate Themes and Subthemes

Themes		Participants
Theme 1. Therapists' Motive for Training	a. Teacher's Influence	3
	b. Approaches Structure	2
	c. Randomly	1
Theme 2. General Experience with BID/ED Clients	a. Mostly Females	6
	b. Family Irregularities	6
	c. Secrecy	2
	d. Co-morbidity	5
	e. Acceptance and Understanding	2
Theme 3. Interventions	a. Thought Diary	5
	b. Diet Diary	2
	c. Family Involvement	4
	d. Photo/Mirror Exposure	2
	e. Art	3
	d. Distractions	2
	f. Role-playing	1
	g. Discussion	4
	h. Other Professionals	2
	i. Thought Challenge	1
	j. Therapeutic Relationship	1
	k. Observation	1

Themes		Participants
Theme 4. Differences at Responses	a. Personality	3
	b. Gender	3
Theme 5. Therapists' Feelings	a. Bafflement	6
	b. Responsibility	6
	c. Anxiety	2
	d. Anger	2
	e. Empathy	1
	f. Personal Limits	2
	g. Burn out	2
	h. Relief	1
Theme 6. Therapists' Opinion about Integrative Therapy	a. Meaningless	2
	b. Mandatory	6
	c. Effective	6

Theme 1

Based on the interviews, it was evident that teacher's influence during training and the approach's structure are the two main motives that lead therapists to choose their therapeutic approach. However, two participants claimed that randomly chose their approach.

"*All these things personalized at the face of a very good teacher… I met the appropriate person that mesmerized and attracted me*".

"*I could say that I started my training at CBT randomly and in the process of my training I started to fall in love with it*".

Theme 2

All participants spoke about their general experiences when working with ED/BID clients and highlighted the fact that the majority of their cases are female clients whereas males constitute a scarce percentage. The sample unanimously reported that problems inside the family system are the underlying factors responsible for ED in both genders.

"*Family relationships play an important role in eating disorders… either in a form of a strict control with relates to anorexia or in a form of a non-existent control that relates to bulimia and constitutes the feeling of freedom*".

Also, two participants acknowledged that BID/ED clients are characterized by secrecy and seek for acceptance and understanding:

"*People who suffer from ED especially the first period desire to keep it a secret… Also, I have noticed that issues such as ED, still are a taboo issue in small cities*".

"*Someone that can understand him…someone on whom they can rely on… You work as his antio-anxiolytic*".

Most of the participants reported that ED usually co-exist with other disorders such as anxiety, depression and phobias. When interplay between ED and other disorders exists, most participants reported to address initially ED and then the rest of the symptoms:

"*So many disorders… Yes… it's like a cluster… It's a puzzle that composes an image and every piece of it warns for something else… I have to work with this symptom, with the behaviour that has been established and not with anxiety*".

Theme 3

Regarding the interventions used, thought and diet diaries were considered primary interventions with the thought diary mentioned as one of the most effective:

"*In that case we made a thought diary and we identified cognitions so that she can check if her cognitions impact the way she behaves and ultimately if they are helpful or not… This helped her understand some of her distorted cognitions about food*".

It was crucial for four of the participants to get the clients' family involved and ask for

their assistance. Therapists request their physical appearance but if they are not willing to attend, they use other alternatives for their involvement in the therapeutic process:

"*I strongly believe that change happens inside the family… so I usually do circular questions even if the family is not here… For example I place the family imaginary inside the room… The parental cooperation after a period of time was crucial*".

Two participants attempted the photo/mirror exposure but both of them highlighted the negative impact:

"*On spot I can say that the mirror exposure and photo exposure was useless… high level of anxiety, distorted body image... I can say that I regretted using it… I thought that it will help but on the contrary, it deteriorated her thought process.*"

Working safely with the simultaneous help of other professionals such as a nutritionist, was highlighted as an essential element while behavioral experiments in a form of a distraction, role-playing, challenging thoughts through discussions and incorporating art such as drawing and playing were mentioned too:

"*I also asked for a dietitian's help… I could see that as long as she was losing weight… she would feed her anorexia. When she remained steady at her weight, it was easier to work and make her acknowledge a few things*".

"*There was a time that she didn't want to talk… she felt pressure and I asked her to imprint everything on the paper… draw… feelings, people, thoughts*".

The establishment of a therapeutic relationship and the importance of observing, becoming aware of what cues the body is giving, were noted by participants as important steps of acknowledging how the disorder operates:

"*My primary goal was to establish a trustworthy relationship. Because I could tell that if she didn't trust… we wouldn't be able to do anything*".

Theme 4

Differences in responses were attributed to personalities and individual characteristics with no reference to gender by three participants. However, the rest of the sample mentioned due to gender constructions, for instance females seem more responsive, expressive and willing to talk whereas males are negative in doing tasks and opening up emotionally, thus they have lower pace of development.

"*Women seem to be more responsive or consistent to the interventions. This is the impression that I have. Men are negative in doing homework*".

It was, also, mentioned that therapists feel the compulsion to be careful with their words and their interpretations with male clients and that the lack of emotional connection with them is apparent:

"*In my sessions with him I feel that I have to be very careful with what I say… In their speech you can identify phrases such as 'as you have said previously or compared to what you said in our last session*".

"*I feel that it is very difficult to get connected with the male*".

Theme 5

Throughout interviews, the commutation of emotions and the personal difficulties that therapists face were evident. Bafflement, responsibility and anxiety were the main emotions reported by all participants.

"*Huge bafflement… I started questioning my abilities as a therapist…'Why this doesn't work? I've tried it again'…'Am I doing something wrong?*"

In a number of occasions, the internal conflicts presenting during the therapeutic relationship through feelings of anger and empathy were demonstrated.

"*She couldn't change her thoughts… rigid thoughts… I'd feel anger sometimes because she couldn't understand the obvious… angry with her resistance*".

"*From the day that I became a mother, my emotions changed… I take the place of this mother and*

this child respectively… I try harder to help".

A personal and professional need for limits unfolded by two participants to describe the intricacy of their work while difficulties that lie when working with ED clients such as pressure and influences on personal or professional functionality, were highlighted in the following emotions, relief and burnout:

"*The weight of responsibility was so heavy for me… I chose to never have ED cases again. People have called me but I referred them to the public clinic*".

"*There were times that I felt that this was impacting on my life, on my work… I don't know if I can call it a burnout*".

"*I cannot hide the fact that I felt relief. It was like a huge weight on my shoulder that left*".

Theme 6

Therapists were familiar with integration and the conviction that integrative therapy should not be separated from the rest of the approaches was reported by two participants:

"*I don't think that this approach must have a different name, a different existence… it's good to be trained at a specific approach when you attempt to use interventions. Every therapist should have a basis*".

Integrative therapy was an essential and effective part of their work not only with ED clients but with all of their cases in a multi-faced and client-orientated form:

"*It is mandatory… to combine different approaches for a more affective outcome… It brings quicker results when you work with it*".

It is crucial for therapists to have multiple alternatives which they can utilize through the guidance of their supervisor:

"*I have more alternatives… if an intervention doesn't work… I don't feel that I may… lose the battle… I feel safe*".

Discussions

Within therapy, therapeutic orientation provides a framework and it is evident that when therapists are asked to explain their therapeutic work, they tend to refer to their orientation (Lyddon and Bradford, 1995). Teachers during training years and the approach's structure were found to be the main factors influencing the choice of approach. Thus far, research indicates that not mere exposure to certain theoretical orientations contributes to the selection of a therapeutic approach, but rather the interaction of two main types of factors, the external-professional (training) and the internal-personal factors (personality) (Buckman and Baker, 2010). Low levels of openness to experience, emotional expression, consciousness, optimism and commitment to logicality and objectivity were found to typify CBT therapists whereas humanistic therapists were more open (Poznanski and McLennan, 2003).

Interviews confirmed that the majority of the cases are about females whereas males either seek for male therapists or deal with BID/ED with lower frequency. Although males are physically larger than females, they are commonly more content with their bodies (Lawler and Nixon, 2011). Moreover, family functioning was unanimously found to be the underlying factor responsible for developing BID/ED in both genders confirming that not only genetics, personality traits and cognitive deficits are responsible for BID/ED. Also, BID/ED clients were found to present co-morbidity such as anxiety, depression and phobias. The initial treatment level and the interventions that therapists pursue are determined by the severity of ED and any co-occurring disorders. The majority of the sample employs diet journals to record daily consumption and thought diary to reframe and restructure dysfunctional cognitions at the heart of the attitudinal component. Key finding of the research was that thought diary is considered an effective CBT technique whereas food journal was negatively mentioned. Unlike with this, literature supports that food journals provide insight into the bigger picture and are pertinent to monitor changes and progress (Dubord,

2011). Also, interviews emphasized on the negative repercussions mirror/photo exposure had on clients' behaviors. In clinical trials, mirror/photo exposure was shown to reduce distress, negative thoughts, body dissatisfaction and, in few trials, it even improved unhealthy eating behavior (Griffen, Naumann and Hildebrandt, 2018). Though mirror exposure appears to be effective in some groups of patients (e.g. those with ED), its efficacy remains to be proven in other groups.

Further, family involvement was found to be an important asset in ED treatment. Parents are regarded fatal informants in the initial assessment, particularly since clinical cases tend to minimize and deny the symptoms (Couturier and Van Blyderveen, 2012). Within therapists' accounts, the implementation of art therapy in a form of drawing or playing had positive impacts in relaxing clients and facilitating their emotional expression. This may be explained by the fact that art therapy encourages individuals to freely enunciate emotions through art, rather than demonstrating a 'perfect' image (Hindmarch, 2000).

Simultaneously, participants have come to see the role of therapist and that of other experts such as nutritionists as extremely unlike but yet supplementary, and both critical to a felicitous remission. In line with this, research has shown that an inclusive team of professionals can address the multi-faceted and varying entanglements such as medical complexities involved while offering an effective and integrated treatment (Setnick, 2007). Additionally, role-playing, thought challenge and behavioral experiments were found to alter emotional state.   Apart from the interventions used, therapeutic alliance with a client-therapist feedback was remarkably mentioned for the therapeutic effectiveness. Considering that the dropout rates for ED patients are remarkably high and that ED are principally disorders of connection, the healing energy within the success of any treatment methodology occurs within the context of the therapeutic relationship.

This study notably suggests that both gender and personality traits can implicate diverse aspects of therapy which are relevant to precognition, interventions, therapeutic alliance, motivation and devotion confirming the initial hypothesis. Past studies found that client's symptomatology, motivational level and competence in forming interpersonal relationships can have a decisive impact on the therapeutic process (Bachelor et al., 2007). Limited research confirms that males are less likely to seek professional help and that they are less responsive due to the fact that they seek solution-focused help, hence they are not attracted by the emotion-focused treatments that are being offered. It has, also, been observed that clients have alterative starting points ('ports of entry') which impact their desire to talk and their interaction with their therapist. Correspondingly, male therapists who treat male clients may consent with the masculine norm of avoiding topics that can be emotional whereas female therapists may unconsciously label them as less emotionally devoted or sophisticated (Bunnell, 2016).

Furthermore, bafflement, anger and high levels of anxiety and responsibility were found to be the most prevalent feelings throughout treatment. Consistent with literature, therapists, with males more likely than females, express feelings of bafflement and inefficiency when treating BID/ED clients. After clinical interviews, therapists reported feelings of disengagement, helplessness and overwhelming criticism towards patients with a diagnosis of Cluster B (dramatic), whereas a more patronizing side surfaced towards patients with Cluster C (anxious) diagnosis (Betan et al., 2005). The accumulated negative experiences with them may reinforce their reluctance, especially from male therapists, to treat this specific clientele and may have contributed to the observed shortage of therapists treating these disorders (Thompson-Brenner and Westen, 2005). Research signalize that the percentage of male therapists who express reluctance to treat BID/ED clients is significantly higher (Satir et al., 2009). Intense discussions about BI issues, overprotective mothering and experiences of sexual abuse can often make male therapists feel intrusive. Apart from reluctance, literature supports that therapists, more particularly males, experience higher levels of anger and frustration when treating ED clients due to the high morbidity and the medical complications that often occur. Also, males feel more open to endorse this aggression and channel it usefully in the session whereas female therapists feel guilty and perceive

their aggression as a blemish in their self-control (Eagly, Wood and Diekman, 2000).

Additionally, burnout with crucial influences in therapists' personal lives and professional productiveness was identified. This is consistent with previous studies that have found strong counter-transferential responses, alterations in their eating patterns or self-image and decline in productivity (DeLucia-Waack, 1999; Satir et al., 2009). However, empathy and anger were other two emotions found to be linked with therapists' emotions. Literature notes that empathy and potential similarities in therapists, especially early-career female professionals, can lead either to identification or over-identification. On the one hand, identification may profit the therapeutic alliance whilst over-identification may impoverish the therapeutic process since therapists act overly nurturing towards clients, are condescending and obviate collision (DeLucia-Waack, 1999).

A strong point of this study is that all therapists' upmost purpose is to offer an individualized therapeutic plan that can fit the client's needs. Commonly, therapists decide to be trained at one theoretical approach and during practice they reform a flexible and integrative model. However, an increasing number of therapists deny labeling themselves with a single approach and prefer to identify themselves as integrative or eclectic (Feixas and Botella, 2004). In a recent survey, the proportion of therapists that practice only one theoretical approach in their sessions was only 15%, whereas the median number of approaches found to be used was four (Tasca et al., 2015). When conceptual and practical weaknesses of their approach arise, they are in need of complementary directions. There is a growing agreement that a single therapeutic approach is inadequate to treat all patients and respond to all problems.

Despite the novel findings reported in the study, certain limitations should be acknowledged. Most notably, the small sample size inevitably restricts the findings and does not allow generalizations to the larger population. However, IPA studies suggest a small sample size and while sample size is important, the depth of data is significant too and the quality of data collected considered being rich and fertile for interpretations. Additionally, the majority of the participants had a small number of male cases or even none, creating an imbalance in the study's findings among the information gathered for female and male clients. Nonetheless, this fact along with the existing literature was managed as a significant data that could explain behaviors and provide details about male population. Apart from sample size, the qualitative methodology, the exploration of participants' work and its effectiveness may enclose risks due to the fact that qualitative research is grounded on personal perspectives hence the rigidity of the information collected is difficult to be proven.

Conclusions

Research findings demonstrated a number of coefficients that could be beneficial for therapists and other professionals that work with this specific clientele. A unique insight into the therapeutic world and ED is offered as this research presents factual experiences. The nature and the etiology of the disorder along with other parameters that coexist are displayed in combination with the measures taken to limit the unhelpful behaviors and the feelings engaged. Despite the fact that it brings further knowledge to counseling and therapeutic field, current programs training therapists or offering professional services to individuals with BID/ED could enhance or modify their practice. In parallel, therapists who also work with these clients could be helped and incorporate methods that may reinforce the process of change. Further, this research could also be helpful for individuals who struggle with these disorders and might not have been diagnosed within any ED category. Most of the literature about ED focuses on the ethical rules and the effectiveness of each approach without giving information about how these approaches are applied whereas this study made an exertion to enrich the existing literature by providing realistic information. Hence, clients have the potential to get familiar with each approach, the way that it is applied and choose which suits their personality.

Acknowledgements

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