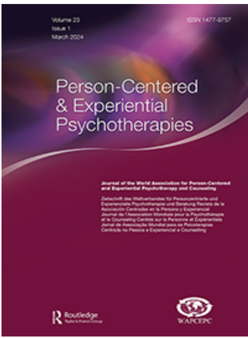

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A pilot qualitative study of a person-centered approach to eating distress in women

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ABSTRACT
Person-centered experiential (PCE) psychotherapists work with the phenomenology of client experience from within their client's frame of reference. Consequently, PCE theory does not provide proscriptions or prescriptions of therapeutic practice for helping clients with discrete forms of psychological distress. This research study provides a phenomenological account using person-centered theory for how the complex experiences of eating distress can be understood without relying on the medicalized diagnosis of anorexia nervosa. A pilot qualitative research study was conducted to explore participants' experiences of eating distress. An inductive and deductive thematic analysis was employed to construct themes within the data; four main themes were identified. Inductive analysis was used to code participant's experiences, and PCE theory was used to provide a deductive coding of those participant experiences. The data suggested eating distress can be understood as an expression of incongruence, linked to the theory of conditions of worth within the self-concept, characterized by the presence of a dominant inner critic and is often accompanied by intense feelings of shame.

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Eating distress; inner critic; shame; incongruence; unconditional positive regard

Introduction

Person-centered therapy is based on a phenomenological encounter and does not require the therapist to engage in a process of diagnosing clients. Indeed, there are strong and well-argued critiques of the system of medical model working in psychotherapy and challenging the specificity of psychological distress within the literature (Bozarth, 2001). However, the language and practices associated with the medical model and its diagnostic categories of mental distress are endemic in all of Western society and are rapidly spreading throughout the East, and global south; consequently, many person-centered therapists feel a need to understand how their practice and theory articulates to a medically informed, socially constructed reality whilst not succumbing to the medical model realism (Murphy, 2017). A criticism often leveled at person-centered therapy is the

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lack of scientific evidence supporting the efficacy of the approach for clients with formal diagnoses. Whilst there is some truth to this, some authors have shown how person-centered theory can account for the phenomenological experiences associated with various diagnostic categories. Three well-documented examples are the categories of post-traumatic stress (Joseph & Linley, 2006), depression (Murphy, 2019; Sanders & Hill, 2012) and schizophrenia (Shlien, 1961/2003) which have all been articulated through the lens of person-centered theory. A benefit of this is that person-centered therapists can confidently commit to working within the person-centered paradigm, within traditional psychiatric settings, when clients present to therapy having received a formal diagnosis. These articulations of theory can also provide a basis for further research on the effectiveness of person-centered therapy within samples where a shared experience has been diagnosed and labeled. This has recently been the case for a pragmatic randomized controlled trial comparing the effectiveness of person-centered experiential therapy for depression with cognitive-behavioral therapy (Barkham et al., 2021).

One area that has received little attention within the person-centered literature is eating distress. In this paper, we report on a thematic analysis carried out on the accounts of people who had been diagnosed with anorexia nervosa. The task here was to then situate the main themes within person-centered theory. The aim is to provide the first steps toward an articulation of a person-centered theory for eating distress.

Rogers' theory of personality postulates that individuals continually engage with their experience of reality derived from their 'perceptual field' (1951, p. 484). Through this interaction, the individual has the potential to grow and develop toward autonomy, independence and self-responsibility. Of course, life brings with it many challenges; individuals endure physical pain and illness, uncertainty and setbacks to the fulfillment of these potentials. Regardless, the actualizing tendency is always present, and the organismic valuing process provides the intrinsic datum whereby all experiences can be evaluated by the individual (Rogers, 1951) through the awareness of 'I experience(s)' (1951, p. 499).

The emotions that are elicited during 'I experiences', Rogers suggested, can be distilled into two distinct categories: 'the unpleasant and/or excited feelings, and the calm or satisfied emotions' (1951, p. 493). In this regard, emotions can be thought of as carrying information embedded within experience and this information provides the opportunity to recognize where or not needs are satisfied.

An awareness of need satisfaction develops early in childhood; as infants stop perceiving themselves in isolation, they come to identify their existence in a broader social-relational context, surrounded by people who also have their own experiences, needs and expectations. This can present conflicting needs for the child; for example, the need for positive regard and their need to be authentic.

Standal (1954) suggested that children are susceptible to their feelings of positive regard being thwarted. This is due, in large part, to children's dependency on others for need satisfaction. In the quest for positive regard, significant social others have considerable influence on the ideas, thoughts and behaviors of developing children. Due to a young person's awareness that some self-experiences are more desirable to others; this can result in avoiding or seeking experiences based on their perception of the acquisition of positive regard and, subsequently, the experience of positive self-regard (Standal, 1954; Rogers, 1951). The adjustment in a person's self-experience is created by

the introjection of values, and once behavior is more consistent with introjected values than organismic valuing, a condition of worth has developed (Rogers, 1959; Standal, 1954). It is hypothesized in person-centered theory that the development of conditions of worth, resulting in incongruence between the self-concept and organismic valuing of experience, is the singular cause of psychological maladjustment in human beings (Rogers, 1959).

A well-functioning person lives in harmonious open communications between all levels of the organism (Seeman, 2008). The distress experienced as a result of incongruence is due to a physiological and psychological need to deny or distort experience to match the conditions of worth, in order to maximize the likelihood of achieving positive regard and maintenance of the self-concept. The process of denial or distortion then maintains existing incongruence; an internal bodily and emotional experience of 'tension and internal confusion' (Rogers, 1959, p. 203), which then elicits a feeling of 'vulnerability and anxiety' (p. 204). In brief, Rogers (1957) hypothesized that when the six necessary and sufficient conditions are present then constructive personality change will follow. The kinds of changes we observe include the movement from fixity to fluidity. As the conditions of worth are relinquished, the person is reconnected to a more congruent contact with the organismic valuing process. Personal constructs are held less tightly and the person becomes open to new experiences. Change exists along a continuum that Rogers defined in his *Process conception of Psychotherapy* (Rogers, 1958).

Rogers' understanding of distress through incongruence stands counter to the medical model which uses diagnostic symptoms to categorize experience as a means to classify a person's condition. Anorexia Nervosa is one of eight diagnosable classifications of eating distress. The diagnostic criteria for anorexia nervosa are:

(1) *'Restriction of energy intake leading to significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory and physical health).*
(2) *Either an intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain (even though at a significantly low weight).*
(3) *Disturbance in the way one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight'.*
(American Psychological Association, 2013).

In many parts of the world, access to support from health care professionals is dependent upon first receiving a diagnosis, where the experience of the individual is understood entirely through these diagnostic criteria, in the search of a fit between experiences described and the rubric of the diagnostic category, where there is often a notable absence of the significance given to meaning in the experience of distress.

In the UK, for example, all individuals who have a diagnosis of anorexia nervosa are likely to be prescribed a course of psychiatric drugs together with Cognitive-Behavioral Therapy for Eating Disorders (CBT-ED) as the recommended treatment of choice (National Institute for Health and Care Excellent [NICE], 2020). However, these preferred forms of treatment have been shown to be largely ineffective, and anorexia in particular is viewed as highly resistant to change (Fassino & Abbate-Daga,

2013). This has motivated research into the process of neurosurgical procedures such as deep brain stimulation and repetitive transcranial magnetic stimulation (Murray et al., 2020) in order to understand how the brains of people diagnosed with anorexia may differ from those without. However, such procedures are highly invasive, carry a large degree of risk and have been shown to vary in effects (Murray et al., 2020).

Eating distress affects around 1.25 million people in the UK alone, with the majority of those affected being females (Beat, 2023). This number has increased exponentially since the COVID-19 pandemic and the ensuing lockdowns began in 2020, particularly in teenage girls (Roxby & Rackham, 2023). Subsequently, the UK parliament has called for changes in support for people with eating distress, to avoid further increases in mortalities and to address the lack of expertise surrounding eating distress within the health care system (McGovern, 2023).

Prior research within the PCE paradigm looking into eating distress has identified the therapeutic effectiveness of Emotion Focused Therapy (Ivanova & Watson, 2014) and Emotion Focused Family Therapy (Strahan et al., 2017). It has also demonstrated the importance of unconditional positive regard (Worsley, 2003) and congruence (Marchant & Payne, 2002) in the therapeutic relationship when working with clients experiencing eating distress. However, there exists a significant gap in the literature that provides an articulation of the phenomenon in terms of person-centered personality theory. For therapists working with clients experiencing eating distress in a clinical setting, it can be a challenging and often concerning situation. When a client seems in all intents and purposes to be slowly starving themselves toward extinction, it is understandable that they might want to know that their approach to therapy has at least some merit in its potential helpfulness. In the absence of any controlled studies of person-centered therapy with clients experiencing eating distress, it seems a logical necessity to begin with first a theoretical account of the phenomenon that can later form the basis of further research, possibly in the form of case studies and/or effectiveness and trials of efficacy.

In light of the above, the aim of this research is to first understand the experiences of people diagnosed with anorexia nervosa and to then situate these experiences within a person-centered experiential theoretical perspective. The main objective of the study being, to contribute toward a more diverse ecology for understanding eating distress to the dominant monotheism of the prevailing medical model ideology.

Method

A qualitative approach was adopted as the most appropriate way to gain access to and explore the intricacies of the lived experiences (McLeod, 2011) of eating distress. Qualitative research can uncover the humanness and individual characters of those who have often felt isolated, marginalized and unheard because of their distress (Fisher, 2012). In our research, we wanted to give a voice to the lived experience of eating distress in ways that went beyond the diagnostic criteria, to hear from people directly and to then step back and consider what these experiences might mean if looked at through the lens of Rogers's (1959) theory of personality. This pilot study is the first of its kind and so it was designed with a small and distinct sample.

Sample

The sample consisted of four, white British, female students who were all over the age of 18 and all of whom were studying at a UK university. All four participants had previously been diagnosed with anorexia nervosa. Participants were recruited to the study through notices distributed around the university campus and through advertising on a closed/private Facebook group, created for a course within the university.

The study was approved through the university and departmental ethics committee and in keeping with this, participants were supplied with an information sheet, a consent form and a privacy notice. They were asked to read all three documents and all signed an informed consent form prior to taking part in the research interviews.

Data collection and analysis

Face-to-face interviews were conducted with participants, where an initial open question was offered, centered around their prior diagnosis of anorexia nervosa serving as an invitation to share anything relevant surrounding their experience of their eating distress. A non-directive approach to the interviews was chosen to allow for gaining an in-depth understanding without introducing interviewer bias (Rogers, 1945). Both inductive (bottom-up) and deductive (top-down) approaches to thematic analysis were then utilized for coding and interpreting the data (Braun & Clarke, 2006). This allowed for the lead researcher to immerse fully into the details of each participant's story and understand the general patterns that existed in the data (Pérez et al., 2015).

All interviews were audio recorded and transcribed by the first author. The transcripts were read in full and initial thoughts were made in note form. These notes were then read, in order to identify any consistent and reoccurring ideas. Another reading of the transcripts, along with the notes, initiated the initial coding process, which was conducted manually and allowed for the data to be organized into meaningful categories. Once the coded data were compiled, similarities between these data were found and linked together; this allowed for themes to become discoverable. Six initial themes were found, which, after reviewing and identifying their boundaries (Braun & Clarke, 2012), showed that two themes could be merged with two separate existing themes. This left four main themes, which were thought to be individual and unique from each other (Braun & Clarke, 2013).

Data extracts for the four themes were found and were placed in a table, where theme names were created. Once the themes were fully identified, a deductive analysis was conducted on the data, where the themes were understood by accessing well-documented concepts from person-centered theory. One important feature of this study is that it acts as a pilot study of the phenomenon and therefore we do not make any claims to whether our dataset was sufficiently broad to have reached saturation on the topic. Notwithstanding, we are confident that our analysis reached saturation within the dataset for this group of participants as we reached a point in the analysis where no new properties of each category were being developed.

Reflexivity

The first author and lead researcher is a white British woman, a graduate of a master's degree from a UK university in Person-Centered Experiential Psychotherapy. She has personal experience of eating distress, having lived with it for several years in her early twenties. She has also had experience of working with people with eating distress in a support group and outpatient environment. Throughout the research process regular meetings were held with the research supervisor who is the second author, where they discussed the themes and how her experiences may be impacting upon her understanding of the data. The first author wrote an extended version of this paper for their dissertation and then the two authors worked together to synthesize the initial study into the current one.

Ethical considerations

Ethical approval was provided by the university department where the study was being conducted as part of a master dissertation project. Due to the nature of the interviews, a stance of ethical mindfulness and ethical responsibility was taken in the interaction with participants (Bond, 2012). Care and consideration in the interviews following a non-directive approach and the length of the interviews ranged from 40 to 60 min. The researcher checked with the participants several times throughout the interview to ensure they were not feeling overwhelmed by distress.

Once the interviews were completed, the researcher allowed the participants to talk about how they were feeling before leaving the room. Ensuring that the participants felt comfortable, the researcher took time for the participants to share any strong emotions they had after the interview, discussed what if any support they may need to seek upon leaving, with relevant signposting to services within the university and ensuring any questions were answered. The researcher did this based on the understanding that this can increase the likelihood of the interview process being cathartic, healing and empowering as opposed to damaging (Hutchinson et al., 1994).

Results

Four major themes were identified using an inductive followed by deductive thematic analysis. Whilst the researchers have endeavored to remain true to the original transcripts, certain omissions were felt necessary, e.g. utterances such as ‘um’ or ‘err’. Ellipses indicate where words are missing, and the use of brackets [] denote where clarifying information has been provided to aid the understanding for the reader. All participants have been allocated pseudonyms in order to maintain anonymity.

Theme 1: the development of conditions of worth

‘If I grow up, they won’t have a sweet little daughter anymore’

This theme describes the way all participants reported experiencing dominating female influence from an early age, including from family members and/or peers. This influence was pervasive, meaning that participants often thought and behaved in ways perceived

as more pleasing and less likely to result in judgment from others. Certain behaviors and appearances were seen as more positive to those in an influential, powerful role and acting accordingly participants were prized.

The participants' memories of their experiences as children demonstrated their fundamental need for positive regard (Rogers, 1951, 1959; Standal, 1954). They sensed that receiving positive regard from female significant others allowed their positive self-regard to develop, which, in turn ensured their need satisfaction was achieved and any 'physiological tension' (Rogers, 1951, p. 491) was diminished. This could often be achieved by behaving in ways which were more likely to result in receiving positive regard from others. Jenny said:

> Being the only girl in my family, there was always the label on me of the high-achieving one that was going to get good grades and behave well and there was no question about that . . . I was just obsessed with this, with wanting to be the perfect daughter and just not make mistakes or not get things wrong.

It was evident that participants could reflect on and were aware of introjected values and the impact these had on their thoughts and feelings. Louise commented:

> I think it was a kind of learning it is not acceptable to have fat or curves, so I have watched someone [the mother] who is not comfortable with that so then I guess I have kind of inferred from that 'oh it's not good to look like that.

Yet at times, the inferences that are made from the introjections can be more ambiguous (Standal, 1954). The child's need for affection, or positive regard, which Standal suggested is 'a mature form of this primary need' (p. 28) is always present, and due to life circumstances can be withdrawn by significant others. The perceived loss of positive regard occurred for Rebecca when her mother became unwell and appeared to encourage the idea that loss of positive regard through the withdrawal of affection and her weight were related.

> My mum had a car accident and she used to be quite active but she really hurt her neck and so she couldn't do a lot, and she put a lot of weight on in response to that . . . that was kind of the turning point for me when I started saying no, I don't want to put any weight on at all . . . and I became quite obsessive over it in lots of ways.

It appeared that her mother's weight gain and frequent bed rest meant that Rebecca's life as she knew it had changed and the time she spent with her mother became less frequent and the perceived quality of their relationship worsened;

> . . . we couldn't go out for long country walks or things which we used to do quite frequently. I remember her being in bed for about a month, well, her being at home for about a month.

The confusion created for Rebecca due to her mother being at home, but not being able to spend meaningful time with her and show her affection, created a bodily tension as a result of not having her needs satisfied which resulted in feeling strong emotions.

> I became so angry at her and I became quite spiteful.

Rebecca attempted to verbalize her frustration about the situation to her female care-givers. Her expression of anger, confusion and fear about her mother's changing body shape and physical abilities appeared to go unacknowledged.

> . . . the responses that I would get from her . . . and my grandma were "oh you know you won't be skinny forever".

For Rebecca, her anger was not at her mother's weight gain but what the weight gain meant for Rebecca; increased separation and a perception of a change in positive regard from her mother, which saw increased 'unsatisfied physiological tension' (Rogers, 1951, p. 492). The perception of a conditional response from her other caregivers, which failed to recognize the underlying reasons for her distress, also sent a message to Rebecca, that her tension could not be eased through any motherly figure she had contact with and instead her need for affection became channeled 'through cultural conditioning into needs which are only remotely based on the underlying physiological tension' (Rogers, 1951, p. 492). Rebecca said:

> . . . I do feel that kind of fine lined my thoughts around controlling what I eat and the size I am.

Through her need for positive regard, weight loss appeared to be a convenient way she could satisfy both needs, ease her tension and feel she was satisfying the needs of those she felt close to.

For other participants, the link between positive regard and weight loss was more overt. Kelly; a professional dancer, was actively rewarded for her weight loss by female staff.

> The other really sad thing is that when I lost a lot of weight, I was given better parts in the dance shows.

Another participant felt the older she became the more she looked like her mother, which resulted in her mother treating her differently. Louise stated that:

> I have just watched somebody try to hide themselves because they think they are so disgusting. I suppose also I have been encouraged; I think prized for looking slightly different to her.

Through this process of internalizing the values and expectations of others, conditions of worth develop (Standal, 1954; Rogers, 1959), and it is the authentic self that is the sacrifice of living up to the needs of others (Wolter-Gustafson, 2004), in order to ensure the need for positive regard is satisfied. Participants could be heard speaking the needs of others and how they were living in accordance with their conditions of worth. As Jenny puts it:

> I need to be a child because I am the last one my parents have and so if I grow up, they won't have a sweet little daughter anymore and I didn't really want any of that.

And Louise:

> My body reflected how well I was achieving this new thing so if I was thinner that meant I was doing well on this whole new domain that I had created in my life and if I wasn't getting thinner, then it meant I was not managing.

And Rebecca:

> I have to be good, not good; I have to be the best; that then manifested itself into wanting to be the prettiest or the skinniest.

Whilst each of these accounts presents a unique version of socialization, they also each present a common thread underlying the distress they experience associated with eating. Each participant shared examples of how their self-concept developed in response to conditional positive regard and how this found an expression through the culturally mediated responses such as being 'good', being 'pretty', being 'successful' and being 'thin'. Each of these could be achieved and would lead to the satisfaction of the need for positive regard.

Theme 2: the role of emotion in accompanying behavior

'It's like walking around the streets naked, it is that uncomfortable'

This theme describes how emotions played a significant role in participants' eating distress. Participants showed considerable insight into how feelings propelled them toward the eating distress behaviors such as restricting calorie intake and/or over exercising. Eating distress behavior was reported to be a way out of experiencing intense emotion; such behaviors were able to act as tension releasing and bring much-needed distraction from strong and often overwhelming emotion experiencing. However, all participants also described sitting with the feelings associated with eating distress as deeply painful, confusing and disorientating. Self-harming behavior, including self-starvation, felt like a way of moving out of and away from difficult emotions. Strong self-criticism was also a common cognitive experience for all participants that precipitated emotional experiences.

Rogers (1959) used the term anxiety to describe the embodied sense and feeling of incongruence; the process by which an individuals' lived experience at the organismic level and how experiences are symbolized in their self-concept are mis-matching, yet the individual does not perceive the experience as a discrepancy (Mosher et al., 2008). Participants described a feeling which supported this idea as they talked about emotional experiences and various associated behaviors.

Rebecca said:

> It's like anxiety but it's different. I can feel it and it's here (points to stomach), it's always here and it's got bubbles. It's like anxiety but it's not anxiety and it's like nothing else can relieve it but harming myself in some way.

Kelly reported that:

> (. . .)there was something that made me want to do that and it didn't feel like it wasn't me, it just felt a bit strange and I just felt a bit confused.

The feeling that participants described appeared to be multi-layered and complex. It often incorporated an uncomfortable, uneasy bodily sensation as well as an intense perception of being visible by others. The feelings of the participants reflect descriptions of shame described by Tomkins who presents shame as a 'torment of self-consciousness' and 'a sickness within the self' (cited in Sedgwick and Editors, 1995, p. 136).

Louise said:

> I can probably describe it best like pulling at the hem of something just not being comfortable in your own skin I suppose.

And Kelly said:

> It just feels wrong if you're not doing these things [ED behaviour], you just feel discomfort like a massive discomfort like, walking around the streets naked, it's that uncomfortable. It just feels so alien not to do those things or do those things, that you can't almost handle the feeling.

Rebecca also commented:

> I can't put a name to it, but I know the feeling within me that evokes these responses of restricting my eating or wanting to self-harm.

Feelings of shame were deeply uncomfortable to tolerate and meant that participants sought comfort in eating distress behavior to reduce emotional tension. Eating distress was effective in withdrawing from their shame feelings, retreating into an experience where exercise and restriction gave participants an escape from internalizing the belief about the self that accompanies shame (Nathanson, 1992). As Kelly said:

> I couldn't really see a way of stopping that noise or making those thoughts or even changing those thoughts. I did try to challenge those thoughts that felt so wrong, [but] it would just feel like I had to punish myself or something by some form of exercise or restriction to feel ok again.

The role of emotion in Rogers's (1951, 1959) theory of personality development suggests that emotion accompanies and facilitates the goal directed action of the organism. The participants in this study reported that feelings experienced within the self-concept facilitated behaviors that would maintain their self-concept. Feeling shame, for example, facilitated behaviors associated with withdrawal and avoidance of eating, or being seen by others in a certain way and also from being known within the self. Emotions facilitate behaviors associated with eating distress.

Theme 3: the lived experience of denial and distortion

'It wasn't like someone else as it was always me'

This theme describes the two-way inner dialog that exists for participants within eating distress. It was reported as consistent and intrusive; however, there was clarity for all participants that any 'voices' were theirs.

Rebecca said:

> I've never had the voices that people talk about, because I feel like that's my voice, that's me talking to myself completely.

They disputed the idea that had been offered to them in prior treatment environments, that the 'anorexic voice' existed outside themselves with a separate identity to their own. They were left trying to make sense of it in metaphorical terms, for example the devil and angel on their shoulders creating a push and a pull toward behaviors which might be

more or less enhancing to the self-concept. This dialogue was relentless and sought to keep participants in an isolated, malnourished state.

Louise:

> The idea of a devil on my shoulder and there being a voice [although] that feels like me.

Jenny said:

> So, I remember coming up with a metaphor and ideas of the anorexia being like something that has a hold of my brain which, I also think in hindsight whilst it isn't actually true It does feel the truth.

Kelly added:

> . . . that is all you're hearing, that is all that is going on up there and I think to the point where I became very numb to everything else you know emotionally

The critic can keep people locked in a paradoxical relationship, encouraging them to seek out the damaging behavior to keep unbearable feelings from emerging (Leijssen, 1998) and then chastising them for doing so (Firestone et al., 2002). Self-attacks create significant emotional pain that then reinforces the need to seek out the destructive behaviors once more, due to the erosion of self-confidence (Stinckens et al., 2013). For the participants in this study, it is a cyclical process where participants were in the grip of a demanding, critical and damaging inner 'voice'.

Kelly suggests that:

> It felt like it wasn't somebody else, because it was me; but it was almost like a different part of me, like you need to do this you know this. The guilt is going to go away if you do this, then it [the voice] would say you shouldn't have done this.

Similarly, Jenny said:

> My Mum always asked me why do you want to do this? As if it was me actually consciously making this decision, but I think it was intertwined because I was saying back to her 'I just don't want to gain weight I just want to be thin, I want to be anorexic' but at the same time I didn't.

However, distressing the critical dialog was, it also appears a way for participants to be able to gain awareness of this inner push and pull; a way to recognize that despite suffering, their organism wills them to survive.

Kelly said:

> It is a bit like two people, having a bit of an argument in your head because you want nothing more to go back to being normal, but at the same time you have these urges that you feel so strongly you have to do, or not do, that this person (pointing to herself) is on the side-lines.

The experience of the tension between conditions of worth and the organismic valuing process can be symbolized as internal 'voices' (Mosher et al., 2008). This experience is the predominant reason individuals experience distress, as they are in a constant process of trying to resolve their internal tension, by distorting or denying experiences, some of which are consistent with the self-concept and others not (Rogers, 1959).

Those with strong conditions of worth may be more susceptible to a louder, more dominant 'voice' symbolizing their incongruence (Vahrenkamp & Behr, 2004).

One way of constructing the idea of 'voice' is the inner critic (Gendlin, 1981). The inner critic, lies at the root of many self-damaging behaviors including eating distress (Firestone et al., 2002). The inner critic, as it is experienced, can lure people into behavior such as over-exercise and/or calorie counting. These behaviors act as a way of keeping out of awareness feelings that threaten the self-concept.

Theme 4: seeking to satisfy the need for positive regard

'I almost remember thinking i'll show you'

This theme describes the participants' perception of choice over eating distress behavior. The choices available were centered on seeking distraction, forming an identity and creating a sense of structure and control. Through choices, the participants appeared to direct the eating distress behavior at or toward family members, friends, health care workers and/or themselves as a way of delivering a message or proving a point and gaining recognition for their physical and emotional exertion. These can be understood as participants' intended 'points of communication'.

Participants found that the eating distress allowed them to feel a sense of control and predictability at times where emotional pain felt at its strongest. This control felt as if it was their only choice.

Rebecca said:

> When I was in inpatient care that was a turning point because I had no other outlet and it was this insane control and it was the only thing I could control.

Louise also reported that:

> If I was some kind of computer game and I could control myself in a robotic way, I think I would have flicked to control mode button, rather than be free of all of this and happy whatever weight that means, I don't think I would have ever chosen that option.

The eating distress behavior seems to be signaling a message to others such as proving a point; communicating something they had struggled to communicate verbally, a message they understood could be communicated through their body. For example, Rebecca stated that:

> It was just this constant dialogue with myself like this is the only thing you can do and it is the only thing that will make you feel better and show them! Prove this point that wasn't proving a point to anybody except for myself.

Kelly:

> I'm not doing this for nothing, I do want some recognition for it. I think that was part of that, this is how serious I am, I need you to be shocked or surprised.

Jenny also wanted to prove to others and recalled a memory:

> I couldn't believe I ever looked like that. I remember thinking when I saw that picture (of herself in the midst of her self-starvation) if I had a point to prove then I definitely proved it because that was horrendous.

Lastly, Louise said:

> I think there was something about wasting away, it really confirmed my achievements.

The perception of choice within Rogers's (1959) theory of personality development is critical in change being possible.

Discussion

The aim of this pilot study was to develop an understanding of the experiences of women who experienced eating distress and to then theorize those experiences using concepts within the person-centered experiential theory of personality development. Initial inductive thematic analysis of the interviews with these women yielded four main themes that were subsequently deductively analyzed using person-centered experiential theory.

The findings provide some support for the idea that, for women experiencing eating distress, the need for positive regard is strong and plays a significant role in the development and maintenance of eating distress. Participants reported that female significant others were a predominant influence in feeling connected and valued. These female significant others had previously been associated with the provision of positive regard, and therefore future instances of relating to them were perceived as increasingly more meaningful (Standal, 1954). Yet, participants understood the subtle ways in which they were influenced by female caregivers to think and behave. Weight loss became synonymous with feeling cared for, heard and valued by all of the women.

This research raises questions about the significant role of positive regard in the development of eating distress. Early person-centered experiential research suggested that positive regard is a secondary or learned need (Standal, 1954; Rogers, 1959). Whilst it is not possible to reject this hypothesis on the basis of this study, our findings suggest that positive regard can be so dominant, it overrides other primary needs such as hunger and rest. This supports the idea proposed by Rogers (1959) that needs of the self-concept can override the needs of the organism. This was evident when even in the depths of self-starvation, all participants felt a need to be seen by their caregivers for what they were doing and the physiological sacrifices they underwent. The behaviors expressing eating distress were proof of a process that was uncommunicable, oriented toward and achieving a goal, that all women knew that acknowledgment from their families, of their endurance, would satisfy their need for positive regard. It could be argued that their insatiable need for positive regard was one of the few bodily processes that had not lost its energy or momentum due to malnutrition and never waned.

Gaining weight had come to be 'perceived as threatening [the] self-structure' (Rogers, 1959, p. 227) as the consequence was directly or indirectly perceived as making them less worthy of positive regard. This, it can be said, evoked physiological, cognitive and affective responses. Intense affective experience was then reduced through withdrawing from food; in turn, participants experienced a perception of self-efficacy and control (Firestone, 1985).

The emotions, which the participants described as playing the most significant role in determining their actions, closely resembled descriptions of shame. Tomkins (1963) expressed that shame is common in all individuals (Sedgwick & Editors, 1995) and is one of nine universal affects, which are specific physiological reactions, ranging from

positive to negative in their experience. Shame or humiliation can be triggered through the incomplete interruption of any positive affect. For example, whilst being excited or joyous, something interrupts the process, yet the desire to continue to feel happy and excited persists. An example of this could be a child wanting to express their feelings of excitement to their caregiver yet are met with indifference showing conditional regard.

Shame can be understood by person-centered theory as an embodied experience of the seeking for the satisfaction but achieving only the denial of positive regard. Conditions of worth develop as children learn that some behaviors or actions are unworthy of positive regard, even though this conflicts with their organismic valuing. Attempts to alleviate shameful feelings allow an individual to withdraw from the direct experience (either externally or internally), by 'changing the effective meaning of the stimuli by perceiving them selectively' (Standal, 1954). However, living in accordance with conditions of worth means one cannot 'live as a unified whole person' (Rogers, 1959, p. 226) and a feeling of anxiety from incongruence follows as a result.

The 'voice' of internal incongruence can be understood using a metaphorical construction of a feature within the self-concept known as the inner critic (Gendlin, 1981) or an interfering character (Leijssen, 1998). This internal dialog can be experienced as 'a harsh voice that interrupts loudly when one tries to listen inwardly' (Gendlin, 1981, p. 81) and which is rooted in large numbers of conditions of worth that 'form the cradle of the inner critic' (Stinckens et al., 2002a, p. 43).

This 'voice' may re-iterate a critical feeling or idea an individual may have about themselves or the world. However, depending upon how much of the self-structure is 'contaminated' (Stinckens et al., 2013, p. 63), an inner critic can lodge itself more firmly. A person then fully identifies with their critic and other more positive aspects of the self are denied to awareness as the inner critic immerses itself into the totality of the person's sense of identity.

The 'voice' of the inner critic proves functional in maintaining incongruence as it serves as a type of emotional self-protection (Stinckens et al. 2013). The rigidity of the inner critic is a mirror image of the rigidity of the individual's self-concept and ensures the denial to awareness, a need for growth, maturity and communication of honest, authentic needs.

Participants' experiences within this study support the idea of an inner critic as providing a better and closer fit than that of an external 'anorexic voice', something prior research has suggested the existence of (Hormoz et al., 2019; Pugh, 2016; Tierney & Fox, 2010). Instead, participants understood their internal dialog was bringing to awareness a critical part of themselves, in negotiation with a kinder part who wills them to be free of the self-harming behavior. The person-centered experiential concept of the inner critic as an anorexic voice provides a more growth-oriented approach to working with clients than the external anorexic voice (Tierney & Fox, 2010). The concept of the inner critic gives potential for the client to be empowered and understand the protective quality the inner critic can provide leading to more unconditional positive self-regard. Rather than seeing the voice as other and external, it can be framed as part of the self and internal.

This study suggests the inner critic is a crucial aspect in understanding eating distress as an expression of conditions of worth, as opposed to a diagnosable medical disorder; something a person 'has' as 'separate' to the self. The inner critic's pervasiveness is so influential that the participants sought out eating distress as a creative adjustment to

alleviate the emotional pain of incongruence and shameful feelings; doing so encouraged a sense of taking control. These behaviors have been described as 'painkillers' (Firestone, 1985, p. 160) which help individuals with dominant inner critics avoid the emotional pain they would otherwise be immersed into (Firestone, 1985; Stinckens et al., 2013).

The inner critic can be a challenging process to work with as a therapist (Firestone et al., 2002; Stinckens et al., 2002b). This feeling is often compounded when a client presents with eating distress, as they are often understood by therapists as challenging and resistant to change (Vitousek et al., 1998).

However, this research can help therapists develop their appreciation of how and why the inner critic may have developed, as well as understand the ways in which it is presented in clients experiencing ED. Perceiving the inner critic in eating distress as a vocalization of conditions of worth can hopefully allow for acceptance from therapists of its presence, rather than resistance, when clients present with a diagnosis of a specific form of ED such as anorexia nervosa. Through acceptance, therapist and client work to differentiate the critic (Leijssen, 1998), to see that although a part of them, the critic is not their whole being. This is a powerful way for clients to develop awareness of how their inner critic keeps them locked in an incongruent way of being and as a result, diminishes the dominance of their ED (Stinckens et al., 2002b).

PCE therapists can aspire to work on an individual basis with each client to hear and empathize toward the specific messages the inner critic is communicating. Integral to the therapeutic process is the curiosity of the therapist toward this powerful source of awareness (Ivanova & Watson, 2014) which for so long has been ignored and labeled a symptom (Tierney & Fox, 2010). By doing so, those who have struggled with ED could come to identify that their inner critic's roots do not lie in their fear of food and weight gain, but instead the fear of becoming themselves.

Limitations and future directions for research

The sample for this research consisted of white, British women under the age of 40. It could be argued that this, along with the size of the sample, poses a challenge in the ability to generalize these findings to a wider population (McLeod, 2011). However, it was precisely the combination of this sample who have a high propensity for ED and the skills of the researcher that allowed for some significant themes to emerge as the participants felt safe, and a relationship could develop. Nevertheless, it is necessary to note that one man for every 10 women develops eating distress (Stedal & Dahlgren, 2016) and future research might look to also include the experiences of men and/or boys who self-starve, to ensure that a PCE understanding of eating distress can continue to evolve.

The contributions from the women presented in this research did not highlight the significance of sociocultural factors in the development of ED; however, this could be a consideration for future research. The British population is bombarded with imagery, promoting the ethos that to be thin, is to be more attractive, popular and successful. In addition, the thin-ideal is prevalent in all areas of the world including the Far East (Rochelle & Hu, 2017). Therefore, it could be of interest to understand if and how conditions of worth are culturally determined and how this impacts the development of ED.

This research also showed that shame is a core emotional experience of eating distress and how this can support and maintain conditions of worth and a dominant inner critic. Therefore, further PCE research into this connection will be important, in order to develop a more nuanced way of working with eating distress. In particular, how therapists can work with the information the inner critic provides, to facilitate increased awareness for the clients to understand the role of their emotions.

This research has also demonstrated the need for wider discussion around the influence of family in those who develop ED. By doing so, it could help challenge stereotypical views of those who self-starve. Commonly, the media portrays the image of the woman with ED as desiring weight loss due to her preference for popularity and attractiveness (Lager & McGee, 2003). Such one-sided discourse can cause significant omissions in understanding the complex evolution of ED and how conditions of worth, are the result of conditional relationships.

Conclusion

This research has shown how ED can be understood as emerging from the development of conditions of worth and how they can be experienced as an internal critical 'voice'. Shame was the dominant emotion that emerged from living with ED and allowed the internal critical dialog to persist. It is hoped that by providing a PCE, understanding of the experiences of ED can encourage therapists to conceive it as something other than a medicalized disorder, and instead an expression of the organism rooted in prior lived experiences. By doing so, the hope is that therapists become more aware of how each experience of ED is unique and with greater acceptance, empathy and patience with these clients, we can help facilitate them to make meaningful, authentic life-choices.

Disclosure statement

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