

**NARCISSISM: INVESTIGATION OF AN ASSESSMENT TOOL AND
UNDERSTANDING ITS CONTRIBUTION TO EATING DISORDER
TREATMENT USING A SELF PSYCHOLOGY PERSPECTIVE**

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Helen Jane Bailey

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Declaration of Originality for the Thesis Entitled:

“Narcissism: Investigation of an Assessment Tool and Understanding its Contribution to Eating Disorder Treatment Using a Self Psychology Perspective”

This thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma.

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All research procedures reported in the thesis received the approval of the relevant Ethics/Safety Committees.

Helen Jane Bailey

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Abstract

The framework of self psychology suggests that narcissism can play a significant role in the pervasive treatment resistance in eating disorders (EDs). The primary focus of this research program is to examine the differential roles of grandiose narcissism and vulnerable narcissism in treatment resistance in a clinical population of individuals with anorexia nervosa or bulimia nervosa. This research explored the factor structure of the Narcissistic Personality Inventory (NPI), assessed grandiose narcissism and vulnerable narcissism among ED patients including their influence on resistance, and examined whether therapists endorse eating symptomatology and narcissism (in turn, contributing to clients' resistance). Study 1 assessed the factor structure of the NPI and examined GN in the ED population. Using a sample of the general population ($N = 905$), a three-factor solution of the NPI was found: 1) authority and self-sufficiency; 2) entitlement, exhibitionism and exploitativeness; and 3) superiority and vanity, highlighting the three main components of GN. Study 2 explored whether the two facets of narcissism, grandiose narcissism (including its factors as identified in Study 1) and vulnerable narcissism, are present in individuals with either anorexia nervosa or bulimia nervosa and whether these facets of narcissism predict treatment resistance in this population. Using a self-report questionnaire with a sample of adults ($N = 180$), findings revealed that 1) VN was elevated in individuals with anorexia nervosa and bulimia nervosa compared to a mental health control group and a healthy control group; 2) both ED groups scored significantly higher on entitlement, exhibitionism and exploitativeness; 3) both ED groups endorsed state-like resistance; 4) both ED groups endorsed one trait-like resistance measure (i.e., significantly lower expectation of benefit); 5) anorexia nervosa endorsed an additional trait-like resistance measure (i.e.,

significantly higher self-orientation/narcissism); 6) authority and self-sufficiency contributed to state-like resistance in the bulimia nervosa group; and 7) entitlement, exhibitionism, exploitativeness, superiority and vanity contributed to trait-like resistance in the AN group. Study 3 explored narcissism and eating disorder symptoms in treatment providers of individuals with eating disorders as the presence of these characteristics in this population may result in treatment hindering countertransference. In Study 3, ED therapists, non-ED therapists, individuals with anorexia or bulimia nervosa and a healthy control group ($N = 955$) completed self-report measures. Results revealed that ED therapists scored 1) higher on GN and authority and self-sufficiency compared to all groups; 2) significantly higher on entitlement, exhibitionism and exploitativeness than non-ED therapists; and 3) significantly lower on superiority and vanity than non-ED therapists and healthy controls. Study 4 aimed to clarify and obtain a deeper understanding of the findings of Study 2 and Study 3 by interviewing patients with EDs ($N = 14$). The data confirmed that participants identified with the characteristics of GN and VN and that these characteristics contributed to resistance. However, there was little evidence that ED-therapists were perceived as eating disordered or narcissistic. This research provides the first psychometrically sound three-factor solution of the NPI in a general population sample. Also, this research is the first to examine the two facets of narcissism (VN and GN) in a clinical eating disorder population and demonstrates the importance of including VN and aspects of GN in the conceptualisation of AN and BN as these play some role in treatment resistance.

Chapter 1

Introduction

Anorexia nervosa and bulimia nervosa are disorders with serious physical, psychological and social consequences. It is well-documented that the prognosis for the approximate half a million Australians who have anorexia nervosa, bulimia nervosa or subclinical levels of these disorders is poor (Paxton et al., 2012). Across studies examining gold standard treatments, 25% to 88% of individuals do not recover (Agras, Crow, Mitchell, Halmi, & Bryson, 2009; Byrne, Fursland, Allen, & Watson, 2011; Dalle Grave, Calugi, Doll, & Fairburn, 2013; Fairburn et al., 2009; Fairburn et al., 2013; Keel & Brown, 2010; Lampard & Sharbanee, 2015; C. Miller & Golden, 2010; Poulsen et al., 2014; Wonderlich et al., 2014). This prognosis can be partly accounted for by individuals' treatment resistance (M. Cooper, 2005; Fassino & Abbate-Daga, 2013; Vitousek & Watson, 1998), which remains problematic despite research efforts. Developing best practice guidelines to overcome treatment resistance will require a better conceptualisation of anorexia nervosa and bulimia nervosa (Wilson, Grilo, & Vitousek, 2007).

Self psychology (Kohut, 1971) is often overlooked in the treatment of eating disorders despite its evidence base (Bachar, Latzer, Kreidler, & Berry, 1999; Shedler, 2010), its unique approach to understanding the disorder, and its emphasis on treatment resistance (which is prevalent in the eating disorder population). Interventions for eating disorders using a self psychology perspective focus less on weight and eating; instead the treatment formulation focuses on the eating disorder identity and the use of it to meet narcissistic needs, that is, a means of regaining self-esteem (Bachar, 1998; Barth, 1988; Bruch, 1978, 1982; Fassino & Abbate-Daga, 2013; Geist, 1989; Kohut, 1977; S.

Sands, 1989). The inclusion of narcissism is not to say that all individuals with eating disorders are also individuals with high levels of narcissism. Rather, it is argued that the pendulum has swung too far in one direction by excluding narcissism in the conceptualisation of anorexia nervosa and bulimia nervosa. To yield positive treatment outcomes, a shift in clinicians' approach to eating disorder treatment is recommended to allow the pendulum to return to equilibrium; to include narcissism in the conceptualisation of these disorders without patient blaming.

Self psychologist Heinz Kohut (1977) explained pathology as disorders of narcissistically compromised individuals, utilising themes of grandiosity and vulnerability to describe central aspects of maladjusted narcissism which result from poor identity development. In order to include narcissism in the conceptualisation of anorexia nervosa and bulimia nervosa, a clearer understanding of the relationship between the two facets of narcissism, as discussed by Kohut (1977), and anorexia nervosa and bulimia nervosa is required. Interventions are contingent upon which facet of narcissism is present (Pincus & Lukowitsky, 2010) and may be the key to treatment resistance in this population. Study 1 explores the factor structure of the measure of grandiose narcissism utilised in this research project – the Narcissistic Personality Inventory (NPI) – as its psychometric properties have been inconsistent in previous research (Ackerman, Witt, Donnellan, Trzesniewski, Robins & Kashy, 2011; Corry, Merritt, Mrug, & Pamp, 2008; Emmons, 1984, 1987; Kubarych, Deary, & Austin, 2004). Study 2 then uses the NPI, including its new factors, and a measure of vulnerable narcissism to determine whether either of these facets of narcissism is present in individuals with either anorexia nervosa or bulimia nervosa and whether grandiose narcissism, including its factors, or vulnerable narcissism predict treatment resistance in

this population. Understanding the contribution of grandiose narcissism and vulnerable narcissism in both eating disorders will have implications for whether treatment of narcissism assists with treatment engagement. If either facet of narcissism predicts treatment engagement, this suggests that addressing that facet of narcissism may assist in overcoming resistance in eating disorders.

Self psychology also proposes that resistance can be considered as a gauge of the therapeutic relationship (Plakun, 2012) and that countertransference and therapists' reactions can inadvertently perpetuate eating disorders (Strober, 2004). The self psychology approach provides a unique understanding of the therapist's stance, focusing on empathic enquiry and interpretation (Bienenfeld, 2005; Kohut, 1959), and suggests how deviating from this stance may inadvertently perpetuate eating disorders (Plakun, 2012). Narcissism (Seligson, 1992) and eating symptomatology (Babarich, 2002; Johnston, Smethurst, & Gowers, 2005) have been suggested to be characteristics of therapists who treat general mental health presentations and who treat eating disorders, respectively. Therefore, research into these factors is required as they may contribute to unique countertransference reactions (Person, Cooper, & Gabbard, 2005) resulting in treatment resistance among eating disorder patients. Study 3, whilst still examining the self psychology framework, investigates whether either grandiose narcissism or vulnerable narcissism, in addition to eating symptomatology, is elevated in individuals who treat people with eating disorders. By identifying how these characteristics present in this population, one can explore the impact it may have on treatment. For example, the extent of countertransference amongst eating disorder treatment providers based on their own eating behaviours and narcissism (both

grandiose and vulnerable) can be explored in future research beyond the scope of this thesis.

Given the limitations of the quantitative results, Study 4 uses qualitative interviews to expand on the findings of Study 2 and Study 3 by investigating the perspectives of individuals with either anorexia nervosa or bulimia nervosa on treatment and their response to excerpts on characteristics of narcissism presented in the interview. Whether and how participants ascribe characteristics of grandiose and vulnerable narcissism to themselves, and how these characteristics may impede or assist engagement in treatment is investigated. Furthermore, Study 4 examines whether participants identified disordered eating or an eating disorder and narcissism in their therapists, and whether the presence of these impacted eating disordered individuals' engagement in treatment.

Overall, this program of research is the first to explore some understandings of the self psychology approach in the context of eating disorders. It is the first to clarify the factors of the grandiose narcissism measure in the general population, prior to examining the role of grandiose narcissism and vulnerable narcissism in treatment resistance in a clinical population of individuals with anorexia nervosa or bulimia nervosa.

Chapter 2

Eating Disorders

2.1 Overview

Anorexia nervosa and bulimia nervosa can be both chronic and fatal illnesses, with burgeoning prevalence rates affecting up to 7 million people both in Australia and worldwide (Paxton et al., 2012; Soh, Touyz, & Surgenor, 2006; The Renfrew Center Foundation for Eating Disorders, 2002). This trend is occurring irrespective of age (Fursland, Allen, Watson, & Byrne, 2011; Halmi, 2009; McLean, Paxton, & Wertheim, 2010; Nicholls, Lynn, & Viner, 2011; Scholtz, Hill, & Lacey, 2010), gender (Domine, Berchtold, Akre, Michaud, & Suris, 2009; Gadalla, 2009; Madden, Morris, Zurynski, Kohn, & Elliot, 2009), socioeconomic status (Soh et al., 2006) and ethnicity (K. Ball & Kenardy, 2002; McCabe, Ricciardelli, Waqa, Goundar, & Fotu, 2009; Paxton et al., 2012; Ricciardelli, McCabe, Ball, & Mellor, 2004). Anorexia nervosa and bulimia nervosa pose serious health and economic burden to the society. The conditions have detrimental physical, psychological and social consequences for individuals (Al-Habeeb & Qureshi, 2005; Andrews, 2012; Arcelus, Mitchell, Wales, & Nielsen, 2011; Hartmann, Zeeck, & Barrett, 2010; Hudson, Hiripi, Pope, & Kessler, 2007; Keel & Levitt, 2006; Mehler & Weiner, 2007; Paxton et al., 2012; Rieger et al., 2010) and cost Australia up to \$69.7 billion annually (Paxton et al., 2012). Eating disorders will become a major public health crisis, if it is not already here, without urgent action from the government in collaboration with eating disorder organisations, health care providers, and researchers.

2.2 Classification

In order to research anorexia nervosa and bulimia nervosa, an understanding of how these disorders are defined is required. Eating disorders in this thesis (consistent with the majority of previous psychological research) are defined according to the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revision (DSM-IV-TR; American Psychiatric Association, 2000) or Fifth Edition (DSM 5; American Psychiatric Association, 2013). There is scientific debate regarding the validity and reliability of diagnostic classification (Dalal & Sivakumar, 2009). One main criticism is that classification is reductionist, omitting an individual's experience and social contexts (Dalal & Sivakumar, 2009). Despite these criticisms, the DSM classification system assists clinicians communicate understanding of constructs embodied in the diagnostic criteria and provides researchers with a means to compare across research.

2.2.1 DSM-IV-TR classification. The DSM-IV-TR separates the diagnoses of eating disorders into three main categories; anorexia nervosa, bulimia nervosa, and eating disorders not otherwise specified. Eating disorders not otherwise specified represent eating disorders that do not meet the diagnostic criteria for anorexia nervosa or bulimia nervosa yet are still clinically significant (Fairburn & Bohn, 2005). The discrimination between anorexia nervosa and bulimia nervosa in the DSM-IV-TR is sensible given the differences seen in these disorders regarding response to treatment and patterns of recovery (Keel & Brown, 2010), health complications (Keel & Levitt, 2006), and mortality rates (Huas et al., 2013; Mitchell & Crow, 2006; Paxton et al., 2012). For the purpose of this thesis, only anorexia nervosa and bulimia nervosa will be discussed further; binge eating disorder and obesity are not addressed as they are not

included in the DSM-IV-TR nor is it a focus of the approach (see Chapter 5 self psychology, to be discussed) examined in this thesis.

The characteristic behaviours of an individual with anorexia nervosa is a restrictive eating pattern and significant weight loss accompanying distorted body image and a pathological fear of gaining weight (Keel & Levitt, 2006). DSM-IV-TR outlines four diagnostic criteria for anorexia nervosa (A-D with a subsequent specifier) which must be met in order to be diagnosed with the disorder (American Psychiatric Association, 2000). Full diagnostic criteria for anorexia nervosa, according to the DSM-IV-TR (American Psychiatric Association, 2000) are displayed in Appendix A. Criterion A establishes whether an individual meets the threshold for being underweight based on specific guidelines. Criteria B and C address the perceptions of individuals with eating disorders in relation to weight gain and their own weight and shape, and criterion D indicates the physiological dysfunction in anorexia nervosa. Upon meeting full diagnostic criteria for anorexia nervosa it must be specified whether there is the absence or presence of regular binge eating or purging, thus whether the individual has restricting type or binge-eating/purging type, respectively (American Psychiatric Association, 2000).

The characteristic behaviour of an individual with bulimia nervosa involves regular episodes of binge eating with a sense of lack of control followed by compensatory behaviour (Keel & Levitt, 2006). As per the DSM-IV-TR, there are five diagnostic criteria for bulimia nervosa (A-E with a subsequent specifier) which must be met in order to be diagnosed with the disorder (American Psychiatric Association, 2000). Full diagnostic criteria for bulimia nervosa, according to the DSM-IV-TR (American Psychiatric Association, 2000) are displayed in Appendix B. Subsequent to

establishing that an individual has recurrent episodes of binge eating (criteria A [1] and [2]) followed by inappropriate compensatory behaviour (criterion B), criterion C indicates that the duration of the individual's experience of symptoms related to criteria A and B is at least twice a week for three months, criterion D addresses self-evaluation and criterion E acts to distinguish the symptoms from a differential diagnosis of anorexia nervosa. Upon meeting full diagnostic criteria for bulimia nervosa it must be specified whether there is the presence or absence of regular use of purging methods as a means to compensate for the binge eating, thus whether the individual has purging type or nonpurging type, respectively (American Psychiatric Association, 2000).

2.2.2 DSM 5 classification. Since the commencement of this program of research, a fifth edition of the DSM has been released (DSM 5; American Psychiatric Association, 2013). Approximately 60% of those with eating disorders did not meet DSM-IV-TR anorexia nervosa and bulimia nervosa categories, instead being diagnosed with eating disorder not otherwise specified (Fairburn & Bohn, 2005) despite having psychopathology and adverse consequences comparable to anorexia nervosa and bulimia nervosa (Thomas, Vartanian, & Brownell, 2009). Thus, the DSM 5 includes several changes to the classification of eating disorders to better capture the symptoms and behaviours of individuals with these disorders. Full diagnostic criteria for anorexia nervosa and bulimia nervosa, according to the DSM 5 are displayed in Appendix C and D, respectively. Amenorrhea, or the absence of at least three menstrual cycles, was not included in the DSM 5 as it was an inaccurate and unreliable feature (Attia & Roberto, 2009); the lifetime prevalence of anorexia nervosa doubled when the amenorrhea criteria was dropped (Smink, van Hoeken, Oldehinkel, & Hoek, 2014). Specifically, this criterion could not be applied to males, pre-menarchal females, females taking oral

contraceptives or hormones, and post-menopausal females (Attia & Roberto, 2009). Bulimia nervosa classification saw the reduction of frequency of binge eating and compensatory behaviours to once a week in the DSM 5 from twice weekly in the DSM-IV-TR and the removal of the definition of a binge including consuming food that is definitely larger than what most people would eat. The former failed to receive empirical support (Crow, Agras, Halmi, Mitchell, & Kraemer, 2002) and the latter was problematic to operationalise (Pratt, Niego, & Agras, 1998). Another addition to the DSM 5 is the inclusion of a severity rating scale, ranging from mild to extreme. As expected, there has already been a decrease in the number of people diagnosed with eating disorder not otherwise specified and an increase in the number of people diagnosed with anorexia nervosa and bulimia nervosa (Arcelus et al., 2011; Brewin, Baggott, Dugard, & Arcelus, 2014; Keel, Brown, Holm-Denoma, & Bodell, 2011; Machado, Goncalves, & Hoek, 2013; Smink et al., 2014).

Despite the considered changes to better capture the symptoms and behaviours of eating disorders, there are still important limitations of the DSM diagnostic system. Distinguishing between eating disorders can be challenging. Firstly, patients with anorexia nervosa commonly traverse to bulimia nervosa (Tozzi et al., 2005). Secondly, there are diagnostic similarities between an individual with anorexia nervosa bingeing/purging subtype and an individual with bulimia nervosa (Keel & Levitt, 2006). Importantly, the DSM classification fails to provide a causative or explanatory basis of diagnosis. Therefore, the DSM is only used in this program of research to best reflect the signs and symptoms that are typical of the different eating disorders for grouping purposes, and for ease of statistical and clinical comparisons to previous research.

Moreover, both version of the DSM is used due to the various ways clinicians may diagnoses these individuals.

Due to the timing of this thesis (during the new DSM edition release), participants could have received a diagnosis using either DSM-IV-TR or DSM 5 criteria. No foreseeable concerns were noted given that the measures used in this thesis were founded in the literature of the DSM-IV-TR yet allowed for subthreshold diagnosis which met DSM 5 criteria. Moreover, frequently provisional DSM-IV-TR diagnoses of anorexia nervosa or bulimia nervosa were made due to meeting subthreshold diagnosis which were on par with the DSM 5 criteria. Subthreshold diagnoses required the presence of all of the symptoms of the disorder, but the severity of one of these symptoms could be sub-diagnostic severity (e.g., binge eating only once per 2 weeks, having a body mass index of just over 18.5 when all other symptoms are present, or menarche; Fairburn & Harrison, 2003; Stice, Fisher, & Martinez, 2004).

2.3 The Prevalence of Anorexia Nervosa and Bulimia Nervosa

2.3.1 Eating disorders: A global issue. Eating disorders have long been considered a western phenomenon (Keel & Klump, 2003). However, eating disorder symptomatology has been present in non-Western cultures for centuries and globalization has seen eating disorders increasingly extend to various cultures worldwide (Soh et al., 2006). Alarmingly, in 2002 up to 7 million individuals worldwide were affected by eating disorders (The Renfrew Center Foundation for Eating Disorders, 2002). International data show that the lifetime prevalence of anorexia nervosa is between 0.3% and 3.7% for females and between 0.1% and 0.5% in males, and the lifetime prevalence of bulimia nervosa is between 0.9% and 2.8% for females

and between 0.2% and 1.1% in males (Carr & Kaplan, 2010; Hudson et al., 2007; Paxton et al., 2012; Rosen, 2010).

2.3.2 The prevalence of eating disorders in Australia.

2.3.2.1 Current prevalence. Eating disorders are also a public health concern in Australia (Paxton et al., 2012). At the end of 2012 it was estimated that nearly one million Australians, approximately 4% of the Australian population, had an eating disorder (Paxton et al., 2012). Moreover, an estimated 20% of females have an undiagnosed eating disorder (Paxton et al., 2012), due to the secretive nature of these disorders (Hart, Granillo, Jorm, & Paxton, 2011). The lifetime prevalence of eating disorders is approximately 9% of the total population (Paxton et al., 2012). Of the almost 1 million Australians with an eating disorder, 3% (approximately 30,000 people) have anorexia nervosa and 12% (approximately 120,000 people) have bulimia nervosa. Thirty-eight percent (approximately 380,000 people) have other eating disorders which comprise individuals who meet the criteria for eating disorders not otherwise specified and exclude binge eating disorder (Paxton et al., 2012).

The prevalence of eating disorders has been found to fluctuate with age. The onset of anorexia nervosa symptoms has been documented across all ages, with peak onset between 13 and 18 years of age. The peak onset of bulimia nervosa in females is in the age range of 16 to 18 years (Paxton et al., 2012). However, research suggests that child, pre-pubertal and early adolescent onset of eating disorder symptoms is increasing (Halmi, 2009; Nicholls et al., 2011). Older adults are also increasingly affected by eating disorders (Fursland et al., 2011; McLean et al., 2010; Scholtz et al., 2010); with an increase both in those whose onset was at a younger age and in those who developed

the illness after 50 years of age (Scholtz et al., 2010). Regardless, the peak prevalence for eating disorders is in the 20 to 24 year age group in both genders (Begg et al., 2007).

Eating disorders are highly gendered. Females are substantially overrepresented among cases (Paxton et al., 2012). Ninety percent of cases of anorexia nervosa and bulimia nervosa in Australia occur in females (Paxton et al., 2012). It is suspected that males suffer at higher rates than is captured by prevalence data; males are more likely to be undiagnosed as they are less likely to present for eating disorder treatment due to the associated stigma whereby eating disorders are predominantly seen as a female illness (Domine et al., 2009; Gadalla, 2009). In the past, diagnostic methods were limited in detecting eating disorders in males. For example, the DSM-IV-TR anorexia nervosa diagnosis included amenorrhea. This may help explain why males are more represented in childhood (pre-pubertal) anorexia nervosa where a female to male ratio of three to one has been estimated (Madden et al., 2009). Prevalence rates of eating disorders are increasing in both males and females in Australia (Paxton et al., 2012). It has now been suggested that approximately 15% of females in the general population in Australia will have an eating disorder in their lifetime (Paxton et al., 2012).

It has been suggested that eating disorders are associated with socioeconomic status (SES) more powerfully than with ethnicity. Women of higher SES are more likely to diet and have a lower body weight (Soh et al., 2006). In addition, in comparison to their peers living in low income households, adults living in households with high income are more likely to exercise, and are less prone to purchasing poorer quality but high caloric and cheaper foods (Australian Bureau of Statistics, 2011). However, high income is not irrefutably related to a high prevalence of eating disorders (Nasser, 1997).

Indeed, there are individuals from disadvantaged backgrounds who develop eating disorders (Soh et al., 2006).

2.3.2.2 Prevalence: an upward trend. The prevalence of eating disorders has risen at a frightening speed, doubling between 1995 and 2005 among both males and females in Australia (Hay, Mond, Buttner, & Darby, 2008; Paxton et al., 2012). Approximately half a million people in Australia have anorexia nervosa, bulimia nervosa, or eating disorders not otherwise specified, a significant increase from the 23,500 Australians in 2003 (Begg et al., 2007). The increase in prevalence rates may be partly due to improved diagnostic methods, heightened awareness of symptomatology in society, and increased help-seeking of affected individuals. Regardless, the figures are concerning and it is vital that a deeper understanding of eating disorders is formulated to stop the upward trend of prevalence rates.

2.4 The Consequences of Anorexia Nervosa and Bulimia Nervosa

2.4.1 Medical consequences.

2.4.1.1 Mortality. Mortality is an ever-present risk for individuals with eating disorders. The risk of premature death from an eating disorder is 6 to 12 times higher than the general population (Arcelus et al., 2011). The highest mortality rate from psychiatric disorders is amongst individuals with anorexia nervosa (Paxton et al., 2012), ranging from 5% to 16% across studies (C. Miller & Golden, 2010). These mortalities are primarily caused by cardiac arrest followed by other complications related to malnutrition (National Eating Disorders Collaboration [NEDC], 2010), and one in five premature deaths are caused by suicide (Arcelus et al., 2011). The mortality rate for bulimia nervosa ranges between 2.33% (Franko et al., 2013) and 19% (World Health Organisation, 1997). These mortalities have been accounted for by medical

complications associated with vomiting, laxative abuse and other purging behaviours (Mitchell & Crow, 2006) and low weight.

2.4.1.2 Morbidity. Given the high risk of premature mortality, it is unsurprising that eating disorders are associated with high rates of physical morbidity. For both anorexic and bulimic individuals, morbidity includes cardiovascular issues, gastrointestinal complications, osteoporosis, muscle waste, severe dehydration (which can result in kidney failure), low body temperature, amenorrhea and infertility in females, and sleep disturbances (Al-Habeeb & Qureshi, 2005). In individuals who vomit as a means of purging, dental problems such as erosion to teeth enamel and inflammation of gums, scarring of knuckles, damage to the oesophagus, and broken capillaries in eyes and facial skin are common (Keel & Levitt, 2006). Individuals with anorexia nervosa often require re-feeding in order to restore body weight. This can result in re-feeding syndrome, the disturbances of metabolism (e.g., edema, the swelling of body tissues) which result from restoring nutrition in starved individuals (Mehler & Weiner, 2007). In summary, anorexia nervosa and bulimia nervosa are associated with a number of grave medical concerns.

2.4.2 Comorbid psychological disorders. Anorexia nervosa and bulimia nervosa have been linked to higher rates of psychiatric comorbidities (Andrews, 2012). Anorexia nervosa is associated with more serious psychopathology than bulimia nervosa. The prevalence rates of comorbidity vary substantially in the literature; common rates reported are 50% of individuals with anorexia nervosa and up to 95% of individuals with bulimia nervosa meeting DSM-IV-TR criteria for at least one other diagnosis (Hudson et al., 2007). The most common of these include depressive disorders (see Godart et al., 2007, for a review), anxiety disorders (see Swinbourne &

Touyz, 2007, for a review) and personality disorders (see Cassin & von Ranson, 2005, for a review). It is not always clear whether eating disorder pathology precipitates other psychopathology or whether eating disorders are secondary to psychopathology.

Moreover, psychological factors can both cause and then maintain eating disorders.

Eating disordered individuals often present with a history of trauma (Backholm, Isomaa, & Birgegard, 2013; Briere & Scott, 2007), self-harming (see Cucchi et al., 2016, for a review) and suicidal thoughts (see Kostro, Lerman, & Attia, 2014, for a review).

Although these are not considered comorbid diagnoses, they are additional symptoms that should be addressed in treatment plans.

2.4.3 Interpersonal and social correlates. Individuals with eating disorders are more isolated and interpersonally ineffective than others in the community (Hartmann et al., 2010). Interpersonal problems cause, result from and perpetuate the eating disorder. The secretive nature of eating disorders frequently results in social withdrawal (Hart et al., 2011). Additionally, these individuals commonly have a submissive pattern of relating to others (Troop, Allan, Treasure, & Katzman, 2003). Despite the common presentation of being withdrawn and submissive, other interpersonal problems are associated with dominance in these individuals (usually in relation to eating behaviours, e.g., meal organisation). As a result, eating disordered individuals can become isolated due to the overbearing nature of the dominance causing those around them to distance themselves (Hartmann et al., 2010). Regardless of how individuals with eating disorders become socially isolated, this isolation leads to a lack of positive influence of peers, a feeling of being uncared for and perpetuates eating disordered behaviours (Rieger et al., 2010). Additionally, there is preliminary evidence that pre-existing interpersonal problems, such as poor adult attachment, might moderate poor response to treatment

(Tasca, Taylor, Ritchie, & Balfour, 2004). Other social consequences may include poor employment engagement as disruptions caused by health appointments and lengthy hospitalisations adversely affect employment (Hartmann et al., 2010).

Limited research has investigated ethnic differences in eating disorders in Australia. However, the available research demonstrates that no ethnic group is impervious to eating disorders. One Australian study which investigated a community sample of almost 15,000 18 to 23-year-old ethnic women from European countries and other English-speaking countries, and Asia or other non-English-speaking countries revealed all demonstrated risk factors for eating disorders (K. Ball & Kenardy, 2002). Another study demonstrated that the desire for the thin ideal was present in Pacific Islander populations (McCabe et al., 2009) and the Indigenous Aboriginal population of Australia (Ricciardelli et al., 2004) which is very often overlooked. However, Indigenous youth are less concerned and less dissatisfied with body weight and shape compared to Caucasian adolescents in Australia (Mellor, McCabe, Ricciardelli, & Ball, 2004). The fact that no ethnic group is impervious to the influence of eating disorders has been accounted for by the acculturation effect, whereby exposure to Western society that adopts the slim ideal female body size increases weight-related values and behaviours in individuals (K. Ball & Kenardy, 2002). Acculturation and adoption of the slim ideal body size were revealed as the primary factors that contributed to higher levels of eating pathology among Asian women (Humphry & Ricciardelli, 2004) and Muslim Australian women (Mussap, 2009) compared to those who did not acculturate. However, other research has demonstrated the tendency to over simplify the relationship between acculturation and eating disorders, highlighting the role of cognitive and affective factors in this relationship (Chan & Owens, 2006). Specifically, negative

perfectionism was related to increased eating symptomatology in Chinese (Chan & Owens, 2006) and Korean immigrants (Chan, Ku, & Owens, 2010) in New Zealand, and high levels of positive perfectionism and a strong identification with their culture whilst appreciating Western culture, related to higher eating pathology in Chinese (Chan & Owens, 2006). It follows that experiencing Western culture is not categorically related to eating disorders (Soh et al., 2006). For example, one study two examining two Australian university cohorts revealed that Australian-born females reported more dissatisfaction with their bodies compared to females from Hong Kong living in Australia and the more traditional and less acculturated to Australian culture the Hong Kong individuals were the more similar their responses were to the Australian females (Lake, Staiger, & Glowinski, 1999). The reasons for these differences are unclear however other individual differences were not accounted for.

2.4.4 Economic consequences. In addition to the medical, psychological, interpersonal and social consequences, there are substantial economic costs, for both individuals and society at large (employers, state and federal government), as a direct result of eating disorders. The overall cost of eating disorders in Australia in 2012 was estimated at \$69.7 billion. The cost of eating disorders to economic output was an estimated \$15.1 billion in 2012 (Paxton et al., 2012), nearing the cost of anxiety and depression (\$17.9 billion in 2010) which are more widely acknowledged amongst the community to have negative productivity costs (Paxton et al., 2012). Of the \$15.1 billion, almost \$2 billion was owing to mortality in young people. Moreover, lower employment participation cost \$6 billion, greater absenteeism cost \$1.8 billion and lower productivity at work cost \$5.3 billion (Paxton et al., 2012). Informal care of eating disorders costs \$8.5 million (Paxton et al., 2012). The burden of disease costs

\$52.6 million. Eating disorders are the twelfth highest cost of hospitalisations due to mental health (Paxton et al., 2012). In Australia, anorexia nervosa is the second largest cost to the private health system, behind cardiac artery bypass surgery (Paxton et al., 2012). Australia faces continuing financial burden without rapid intervention.

2.5 Conclusion

After consideration of the issues surrounding eating disorder classification, the DSM classification of anorexia nervosa and bulimia nervosa will be used in this program of research to provide a means to group eating disordered individuals and for simplicity of statistical and clinical comparisons to the current body of literature. It is hoped that exploration of these DSM diagnosed disorders will address Australia's fast increasing prevalence of anorexia nervosa and bulimia nervosa, which is reflective of a worldwide crisis affecting most ages, and all genders, socioeconomic status and ethnicity. Without further research, consequences are dire; premature mortality, severe morbidity including cardiovascular and gastrointestinal complications, other psychopathology, social problems such as unemployment and interpersonal difficulties, and prolific financial costs. The next section details the poor prognosis associated with anorexia nervosa and bulimia nervosa which contribute to this crisis.

Chapter 3

The Current State of Treatment of Anorexia Nervosa and Bulimia Nervosa

3.1 Overview

In an attempt to overcome the debilitating disorders of anorexia nervosa and bulimia nervosa, experts in the field have developed diverse, albeit coinciding, treatments. Internationally, the current psychological treatment of choice for anorexia nervosa is family-based therapies, such as the Maudsley Approach, for adolescents and individual cognitive behavioural therapy (CBT) for adults (American Psychiatric Association [APA], 2006; National Institute for Clinical Excellence [NICE], 2004; Royal Australian and New Zealand College of Psychiatrists [RANZCP] et al., 2014). The least restrictive environment possible such as outpatient or day treatment, with hospital admission for those at high risk of medical and/or psychological complications is also recommended (RANZCP, 2014). Internationally, the current psychological treatment of choice for bulimia nervosa regardless of age is CBT (APA, 2006; NICE, 2004; RANZCP et al., 2014). Individual face-to-face CBT is preferred; however, internet- and self-help-based delivery is also accepted. However, even these heralded gold standard treatments have shown inconsistent evidence and failed to treat all individuals with eating disorders. Across studies, 25% to 88% of individuals do not recover (Agras et al., 2009; Byrne et al., 2011; Dalle Grave, Calugi, Doll, et al., 2013; Fairburn et al., 2009; Fairburn et al., 2013; Keel & Brown, 2010; Lampard & Sharbanee, 2015; C. Miller & Golden, 2010; Poulsen et al., 2014; Wonderlich et al., 2014). This chapter examines the current state of treatment of eating disorders and highlights the need for further understanding of these disorders to better treat them.

3.2 Cognitive Behavioural Therapy

CBT was originally used to treat bulimia nervosa however it is also now considered a treatment of choice for adults with anorexia nervosa (APA, 2006; NICE, 2004; RANZCP et al., 2014). The original CBT model has evolved to include four modules that were introduced with the intent to treat those eating disordered individuals who were non-responders to traditional CBT, namely Enhanced CBT (CBT-E; Fairburn, Cooper, & Shafran, 2003). A description of the original CBT and CBT-E and the evidence-base of both follow.

3.2.1 CBT conceptualisation. CBT proposes that dysfunctional thought patterns (core psychopathology), such as an overemphasis on weight and shape as a source of self-worth, underlie dysfunctional eating and other-weight related behaviours (Fairburn, 1981; Fairburn et al., 2013). Often these behaviours involve following rigid rules. Breaking any of these rules, effectively unavoidable due to their restrictiveness, can precipitate a binge eating episode. Even the smallest episode of rule breaking is perceived as evidence of lack of self-control. Subsequent guilt triggers even stricter dietary restrictions. Binge eating can also be followed by compensatory behaviour (e.g., induced vomiting, exercise, laxative abuse), leaving the individual susceptible to another binge eating episode due to a dysfunctional belief that compensatory behaviour facilitates weight control. Those eating disordered individuals who do not binge-eat are usually underweight due to the rigid dietary restrictions. Being underweight often results in a cognitive deterioration (e.g., problems with focusing and decision making, obsessive thoughts about food) which, in turn, contributes to core psychopathology (Fairburn et al., 2013; Fairburn et al., 2003).

CBT aims to improve individuals' quality of life by resolving symptoms. CBT modifies maladaptive beliefs about the importance of weight, shape, and having them under control, and eliminates resulting behaviours (e.g., restriction, binge eating, compensatory behaviour; Fairburn et al., 2003). Moreover, reinforcers, such as weight and shape checking, are prohibited. The therapeutic relationship is acknowledged as important in CBT due to its facilitation of the application of specific techniques (Beck, Rush, Shaw, & Emery, 1979; Fairburn et al., 2013). The treatment is outpatient-based and involves 15 to 20 sessions over approximately five months (Fairburn et al., 2013).

3.2.2 CBT efficacy. CBT is promoted in international guidelines as the treatment of choice for individuals with bulimia nervosa (APA, 2006; NICE, 2004; RANZCP et al., 2014). However, an Australian Psychological Society review paper of the original CBT model revealed that across randomised control trials only between 30% and 50% of bulimic patients who completed therapy entered remission in terms of binge eating and purging (Lampard & Sharbanee, 2015). Moreover, whilst the Australian Psychological Society, which adopts the National Health and Medical Research Council (National Health and Medical Research Council [NHMRC], 1999) guidelines for evaluating evidence and developing clinical practice guidelines, showed Level II evidence (i.e., “at least one properly designed randomised control trial”) for CBT-based self-help, there was no evidence to indicate that individual CBT was effective for bulimia nervosa.

Although originally developed to treat bulimia nervosa, CBT is also promoted as the treatment of choice for adults with anorexia nervosa (APA, 2006; NICE, 2004; RANZCP et al., 2014). Yet, the evidence for the effectiveness of CBT in treating adults with anorexia nervosa is weak; there has been no systematic review of CBT for adults

with anorexia nervosa and the Australian Psychological Society summarised that only one study provided Level III-2 evidence (i.e., “comparative studies with historical control, two or more single-arm studies, or interrupted time series without a parallel control group”; NHMRC; 1999) for CBT for adults with anorexia nervosa.

3.2.3 Enhanced CBT conceptualisation. Due to the identified high nonresponse rates and weak evidence base, an extended version of CBT, enhanced CBT (CBT-E) was developed. CBT-E intentionally extends its focus beyond the treatment of bulimia nervosa to other eating disorders, to treat core psychopathology regardless of eating disorder diagnosis. That is, the CBT-E model considers eating disorders transdiagnostically. In addition to CBT, CBT-E also addresses reinforcers common to eating disorders including clinical perfectionism, mood intolerance, low self-esteem, and interpersonal difficulties (Fairburn et al., 2013; Hoiles, Egan, & Kane, 2012).

3.2.3.1 Clinical perfectionism. Clinical perfectionism is the “overevaluation of, striving for, and achieving, personally demanding standards, despite adverse consequences” (Z. Cooper & Fairburn, 2011). Perfectionism is common in the eating disorder population (see Bardone-Cone et al., 2007, for a review) and when applied to eating, weight and shape (e.g., achieving low weight), it perpetuates the eating disorder. Achieving relentless weight and eating standards can be the source of the eating disordered individual’s self-worth. In individuals with eating disorders, fear of failure is expressed as fear of overeating and weight gain. Discriminating attention is given to performance in the form of, for example, body checking and calorie counting. Negatively biased self appraisals encourage even more resolute weight, shape and eating goals. The addition of clinical perfectionism into the CBT conceptualisation of

eating disorder allows for this problem behaviour to be targeted in treatment (Fairburn, Cooper, & Cooper, 1986).

3.2.3.2 Mood intolerance. Although mood states were considered to precipitate binge eating in the CBT model (Fairburn et al., 1986), mood intolerance is an additional external factor incorporated in the CBT-E model as a perpetuating factor. Instead of managing mood changes, these patients engage in “dysfunctional mood modulatory behaviour” such as self harm or substance abuse to alter the mood state. The inclusion of mood intolerance in the CBT conceptualisation of eating disorders is in the context of an increasing number of researchers focusing on the importance of symptomatology in emotion regulation in this population (e.g., Haynos & Fruzzetti, 2011). The current body of literature recognises that in individuals with bulimia nervosa, binge eating, vomiting, and excessive exercising acts to modulate mood. Yet there is little research examining emotion regulation in individuals with anorexia nervosa (Haynos & Fruzzetti, 2011), despite much earlier research highlighting that anorexia nervosa emerged from emotional difficulties including the ability to accurately read and respond to internal sensations (Bruch, 1962, 1981). Considering that CBT-E considers eating disorders transdiagnostically it is surprising that little research has evolved addressing mood intolerance in anorexia nervosa. CBT-E suggests cognitive processes strengthen mood intolerance and treatment addresses these cognitions (Fairburn et al., 2013).

3.2.3.3 Low self-esteem. A pervasive low self-esteem, extending beyond eating and weight, is apparent in some individuals with eating disorders (Fairburn et al., 2013). CBT-E identifies core low self-esteem as perpetuating eating disorders due to the individual’s belief in their incapacity to change, which undermines treatment compliance, and the co-occurring pursuit of achievement in a valued domain (i.e. eating

disordered behaviours) in an attempt to offset low self-esteem. CBT-E notes that negative cognitive processing biases and the overgeneralisation of failures exacerbates negative self-esteem. CBT-E addresses domains of self-evaluation and cognitive biases.

3.2.3.4 Interpersonal difficulties. Interpersonal problems have been associated with eating disorders, including control issues within the family (Fairburn, Shafran, & Cooper, 1998; Hartmann et al., 2010) and interpersonal conflict (which when chronic also contributes to low self-esteem). Interpersonal dysfunction has been shown to predict inadequate treatment outcomes (Agras et al., 2000; Steiger, Leung, & Thibaudeau, 1993). Interpersonal Psychotherapy which addresses interpersonal issues, not eating disorder symptoms, has similar treatment outcome as CBT (Agras et al., 2000; Fairburn, Jones, Peveler, Hope, & O'Connor, 1993; Fairburn et al., 1995). The evidence, therefore, could not be overlooked and it was considered necessary to include an interpersonal module into CBT to address interpersonal difficulties perpetuating eating disorder symptomatology.

3.2.4 CBT-E efficacy for bulimia nervosa. Although at the theoretical level, CBT-E is designed to have better treatment outcomes, little research has examined CBT-E in individuals with bulimia nervosa. Most of the available research focuses only on adults in the outpatient settings. Of this research, the investigation of treatment response is still limited.

A randomised control trial compared “focused” CBT-E (targeting eating disorder psychopathology exclusively), “broad” CBT-E (also addressing the four modules mood intolerance, clinical perfectionism, low self-esteem and interpersonal difficulties), and a waitlist control condition in an outpatient setting (Fairburn et al., 2009). Results revealed that, unlike the waitlist control group, both “focused” and

“broad” CBT-E lowered symptom severity. However, for both CBT-E groups, at the 60-week follow-up, whilst 61.4% of patients had eating disorder symptomatology nearing normality in the general population, 38.6% of patients had relapsed or remained unwell at follow-up. Similarly, at the 60-week follow-up, whilst 45.6% of patients reported no episodes of bingeing and purging within the previous 28 days, approximately 55% of individuals continued to binge and/ or purge. These CBT-E recovery rates are similar to those rates seen with CBT, questioning the effectiveness of the additional modules.

In another study of outpatient CBT-E for eating disordered individuals who were not significantly underweight (resulting in a sample of predominantly bulimic adults) results were worse; only 53% of patients completed treatment and two thirds of these patients (that is, 35% of the total patient group) entered full or partial remission (Byrne et al., 2011). Additional low symptom abstinence rates were evident in a study comparing CBT-E and integrative cognitive-affective therapy; whilst both treatments equally reduced outpatient adults’ bulimic symptoms at four-month follow up, only approximately 22% of individuals were abstinent (Wonderlich et al., 2014). Despite evidence demonstrating that CBT-E is more effective than other therapies (e.g., CBT-E resulted in faster reduction in symptomatology compared to psychoanalytic psychotherapy in outpatient bulimic adults; Poulsen et al., 2014), still only approximately 45% of individuals stopped binge eating and purging. These abstinence rates are also equivalent to those observed in the original CBT model.

3.2.5 CBT-E efficacy anorexia nervosa. CBT-E is also promoted as a treatment of choice for adults with anorexia nervosa (APA, 2006; NICE, 2004; RANZCP et al., 2014). Research on CBT-E in this population has generally found improvements over time in eating disorder symptoms (e.g., weight gain), with one

review summarising that CBT has “consolidated and extended [its] position as treatment of choice” (Waller, 2016). However, the only recent systematic review of the effectiveness of CBT-E in the adult anorexic population (Galsworthy-Francis & Allan, 2014) included studies which had a combination of adult and adolescent participants (e.g., J. Ball & Mitchell, 2004) and/ or employed modifications of CBT (e.g., Bowers & Ansher, 2008) and/ or did not include a control group (e.g., Dalle Grave, Calugi, Conti, Doll, & Fairburn, 2013), and results demonstrated that CBT-E was not superior to other treatments (Galsworthy-Francis & Allan, 2014). Across studies, a high percentage of patients either terminated early or had stagnated or declined in health at follow-up (e.g., 36%; Fairburn et al., 2013), leading Waller (2016) to suggest the need for further developments to improve recovery rates. Given the limited gains from treatment evident from this research, the contributions of CBT-E above CBT is questioned.

Although family therapy is the treatment of choice for adolescent anorexia nervosa (APA, 2006; NICE, 2004; RANZCP et al., 2014), some research has also examined the effectiveness of CBT-E in this population and revealed more promising results (Dalle Grave, Calugi, Doll, et al., 2013). However, this benchmark study examining CBT in adolescents employed an adapted version of CBT-E with many atypical elements including parent involvement and reduced time length. One third of patients were considered non-responders due to the need for additional treatment or treatment attrition (Dalle Grave, Calugi, Doll, et al., 2013). A recent review on evidence based psychological treatments for eating disorders did not support CBT-E as treatment choice for adolescents with anorexia nervosa (J. Lock, 2015).

3.2.6 Summary. Whilst some research demonstrates that CBT-E contributes to improvements over time in eating disordered symptoms in patients with bulimia nervosa

and anorexia nervosa, with more promising results in the anorexic adolescent population, most of the studies which compared CBT-E to another treatment did not demonstrate any additional benefit of CBT-E. The inclusion of the four modules in the formulation of CBT has not resulted in improved treatment outcomes for individuals with anorexia nervosa or bulimia nervosa. At the end of treatment, abstinence rates from eating disorder symptomatology is still high across studies, sitting at approximately 50%, equivalent to rates observed with the original CBT model. Dropout from treatment also remained high. Methodological issues such as difficulties retaining participants, some research lacking a control group and differences in follow-up times further challenged identification of consistent results. Long-term follow-up is also required to determine sustainability of outcomes. The research questions the promotion of CBT in treating individuals with bulimia nervosa and adult patients with anorexia nervosa.

3.3 Family Therapy

Given the lack of substantive evidence for the success of CBT in treating individuals with eating disorders coupled with the promotion of family therapy as a first line treatment for adolescents with anorexia nervosa in the same international guidelines (APA, 2006; NICE, 2004; RANZCP et al., 2014), it is important to examine the evidence base of Family therapy in this population. Family therapy encompasses a number of models predominantly including structural (Minuchin, Baker, & Rosman, 1978), behavioural (Robin & Foster, 1989), Milan systemic (Selvini-Palazzoli, 1974), and strategic (Madanes, 1981). However, Maudsley Family Therapy which, like the other approaches, requires parental support in the treatment is widely accepted as the leading family approach for eating disorders (Dare & Eisler, 1995; J. Lock, Le Grange,

Agras, & Dare, 2001). In fact, the term *family therapy* is often considered synonymous with Maudsley Family Therapy (Couturier, Kimber, & Szatmari, 2013).

At the premise of Family therapy is the notion that psychopathology reflects entrenched relational problems among family members (J. Lock et al., 2001) yet an agnostic stance towards the origin of the eating disorder is taken, promoting “treatment with the family and not the treatment of the family” (Simic & Eisler, 2012). Family therapy helps identify the family system problems that may be associated with the eating disorder whilst being able to subtly educate parents and relevant people about how to support the eating disordered family member (J. Lock et al., 2001).

3.3.1 Maudsley Family Therapy. The Maudsley approach consists of three phases over 15 to 20 sessions in one year. In the first phase of treatment, the aim is weight restoration whilst preventing hospitalisation of the eating disordered individual. Parents and other family members are encouraged to be responsible for the individual’s recovery including feeding and support, whilst openly absolving them from blame (J. Lock et al., 2001). Parents are educated by the therapist regarding management of the eating disordered individual. Education incorporates both psychological and physiological information pertinent to the eating disorder as well as what health eating looks like. ‘Externalizing conversations’ (White & Epston, 1989) occur to highlight that the eating disorder is separate from the individual to mitigate patient blame by the family and to promote therapeutic alliance. Discussions occur within the family regarding emotion management, the benefits and potential losses of recovery for the whole family, and hope and expectations. Meal plans and medical issues are conducted separately to family therapy and assist to externalise the eating disorder.

Once the eating disordered individual consistently accepts the increased food intake and eating disorder symptomatology reduces, then therapy continues into the second phase where supervision is titrated and age-appropriate autonomy is sought for the eating disordered individual. Parents shift focus onto intergenerational boundaries, co-parenting and their own couple relationship.

The third phase occurs when the individual's weight achieves a weight value that is 95% of what is expected for their height and weight. The therapist ensures the eating disordered individual can independently demonstrate weight maintenance at this stage. The high risk of relapse is instilled in the parents (J. Lock et al., 2001). The third phase involves furthering the individual's autonomy, including around meal planning, and focuses on adolescent identity development. Common issues to young individuals with anorexia nervosa include anxiety, perfectionism, impulsivity, physical development concerns, self-identity, and fear of uncertainty; these are addressed in treatment. Therapy also assists with social integration, taking responsibility, tolerance to uncertainty, and appropriate parental boundaries.

There are limitations to Maudsley therapy for treating individuals with eating disorders. Adults with eating disorders are typically unable to relinquish control over eating to others and therefore family therapy needs to be significantly modified to treat this population (J. Lock et al., 2001). For adolescent patients, some refuse parental control and it can be contraindicating to empower parental control whilst promoting individuation in the eating disordered individual, which is concerning given parental control is the primary predictor of remission (R. Ellison et al., 2012). Parents can find that acting as a proxy for the therapist is challenging and effortful and that they can become reliant on clinicians to assist them (Parent & Parent, 2008; Rhodes, 2003).

Unity and consistency across all involved family members and professionals is required; however, due to the considerable challenge of aligning the frameworks of varying professionals, family therapy can be underutilised in clinical settings, undermined when used, or integrated with and replaced by other approaches. Splitting behaviours of the eating disorder individual can occur within the treatment team (Lyon, Silber, & Atkins, 2005). Finally, the feasibility of utilising family therapy is low if there is no family support or the patient requires critical care (Couturier et al., 2013).

3.3.2 Family Therapy Treatment Efficacy. Despite the limitations of the Maudsley approach, the international guidelines promote family therapy as a first line treatment for adolescents with anorexia nervosa (APA, 2006; NICE, 2004; RANZCP et al., 2014). The current body of research continues to support the guidelines, highlighting family therapy as a promising treatment for the adolescent anorexic population (see Couturier et al., 2013, for a review). In addition, the Australian Psychology Society reports there is Level I evidence (i.e., “systematic review of all relevant randomised control trials” NHMRC, 1999) for family therapy in the treatment of this population. The first randomised control trial revealed that family therapy was more effective for patients under 19 years of age with less than three years duration of the disorder compared to supportive intervention (Russell, Szmulker, Dare, & Eisler, 1987), with 90% returning to normal weight at 5 year follow-up (Eisler et al., 1997). Interestingly, for adolescents with bulimia nervosa, there is Level II evidence (i.e., “at least one properly designed randomised control trial”; NHMRC, 1999) for family therapy although the guidelines do not recommend it as a first line treatment in this population.

Although not promoted as treatment of choice for adults with anorexia nervosa, there is some support for family therapy in treating this population. The Australian

Psychological Society suggests there is Level II evidence (i.e., “at least one properly designed randomised control trial”; NHMRC, 1999) for family therapy in the treatment of anorexia nervosa in adults. Additionally, a Cochrane review and meta-analysis examined a variety of family interventions compared to treatment as usual on individuals with anorexia nervosa regardless of age (C. Fisher, Hetrick, & Rushford, 2010). The authors concluded that family therapy had higher remission rates compared to treatment as usual, but that further research was required to determine its standing compared to other psychological interventions. Furthermore, relapse rates and attrition rates did not differ between those treated with family therapy and treatment as usual, still affecting approximately half of those who entered treatment. In summary, the Maudsley approach provides encouraging treatment outcomes for adolescents with anorexia nervosa as per the international guidelines.

3.4 Recovery, Non-responders, Relapse and Attrition

The completion of treatment and full recovery from eating disorders is possible. One study of 385 participants meeting DSM-IV criteria demonstrated that 47% of bulimic and 57% of anorexic patients were in remission at four-year follow-up (Agras et al., 2009). A review of 15 outcome studies from 2004 to 2009 revealed that approximately 50% of individuals with anorexia nervosa and 75% of individuals with bulimia nervosa were in remission at 10 or more years following intake (Keel & Brown, 2010). Alarmingly, this means that up to 50% of individuals never recovered, had partial recovery or that they relapsed. The prognosis for adolescents is more optimistic than for adults, especially if the treatment is in an outpatient setting, with approximately 76% of adolescents fully recovering (C. Miller & Golden, 2010).

It is very common that successfully recovered individuals later meet criteria for an eating disorder again (i.e., relapse; C. Miller & Golden, 2010). Relapse is more likely to occur in individuals with lower weights at discharge (Sly & Bamford, 2011) and a longer length of duration of symptoms (M. Fisher, 2003). Depending on how relapse is defined and when follow-up occurs, relapse rates range from 15% to 63% for anorexia nervosa and bulimia nervosa (McFarlane, Olmsted, & Trottier, 2008), with anorexia nervosa having higher relapse rates. Although 70% of patients regain weight (one measure of recovery) within six months of the start of treatment, 15% to 25% of these patients relapse usually within two years (Paxton et al., 2012). One study, reporting a relapse rate of 35% in individuals diagnosed with anorexia nervosa, noted that the highest risk period was between six to 17 months post-treatment (Carter, Blackmore, Sutandar-Pinnock, & Woodside, 2004).

Treatment attrition rates are also noteworthy regardless of intervention type (Mahon, 2000). Attrition rates as high as 50% to 60% have been found for both outpatient-and inpatient groups (Eivors, Button, Warner, & Turner, 2003; Huas et al., 2011; Mewes, Tagay, & Senf, 2008; Sly, Morgan, Mountford, & Lacey, 2013). One systematic review of treatment attrition in anorexia nervosa found most attrition rates across interventions ranged between 20% and 40% (Dejong, Broadbent, & Schmidt, 2012). Similarly, treatment attrition rates in bulimia nervosa are consistently around 30% to 40% (Schnicker, Hiller, & Legenbauer, 2013). Other reviews demonstrated that purging was the most consistent predictor of attrition from anorexia nervosa treatment (Abdelbaky, Hay, & Touyz, 2013; Fassino, Piero, Tomba, & Abbate-Daga, 2009; Schnicker et al., 2013) and personality characteristics were also associated with attrition across treatment settings for both anorexia nervosa and bulimia nervosa (Abdelbaky et

al., 2013; Agras et al., 2000). Readmission occurred more frequently after treatment attrition compared to treatment completion (Baran, Weltzin, & Kaye, 1995).

3.5 Conclusion

CBT and Family Therapy are considered the gold standard treatments for bulimia nervosa and anorexia nervosa, respectively (APA, 2006; NICE, 2004; RANZCP et al., 2014). However, the evidence behind these interventions is mixed. Moreover, even these treatments fail to help approximately 50% of individuals with these disorders. Clearly further research is required to improve both treatment adherence rates and prognosis of those who engage in treatment. Efforts have been made to address these issues and will be discussed in Chapter 4.

Chapter 4

Treatment Resistance

4.1 Overview

Although treatment resistance is regarded as one of the reasons for the poor treatment response in eating disorders (M. Cooper, 2005; Fassino & Abbate-Daga, 2013; Vitousek & Watson, 1998), it has been difficult to address resistance given the challenge in measuring this phenomenon. Motivation based questionnaires and the Butcher Treatment Planning Inventory or the Negative Treatment Indicators scale of the Minnesota Multiphasic Personality Inventory, combined, provide the closest measure of resistance available (Perry, 2009). Eating disorder interventions aimed at overcoming resistance mostly are based on motivation. Whilst motivation may be useful to assess an individual's momentary readiness to engage in treatment and to gauge resistance, its use as the foundation of intervention has done little to overcome resistance to treatment in the eating disorder population (Knowles, Anokhina, & Serpell, 2013).

4.2 Resistance

Resistance was first conceptualised in psychoanalysis. Freud discussed several types of resistance, such as refusal to discuss associations and to interpret dreams (Greenson, 1967), suggesting resistance was “when we undertake to cure a patient of his symptoms (and) he opposes against us a vigorous and tenacious resistance throughout the entire course of treatment” (Freud, 1973, p. 297). Freud proposed resistance was the manifestation of defenses, the unconscious processes which protect an individual against threat and hurt, as they are evoked in the analytic situation in the way in which they would be observed in the patient's outside life (Greenson, 1967). More recently,

resistance has been explained as “any behaviour that indicates covert or overt opposition to the therapist, the counselling process or the therapist’s agenda” (Bischoff & Tracey, 1995), even if it defies the patient’s own understanding of what is required to recover (Beutler, Harwood, Michelson, Song, & Holman, 2011; Leahy, 2001). For clients with eating disorders, common behavioural indicators of this resistance include not seeking professional help, missing treatment sessions, ceasing therapy prematurely, adamantly refusing aspects of treatment, and often being interested in treating some symptoms (e.g., binge eating) whilst adamantly refusing treatment of others (e.g., restrictive eating; Fassino & Abbate-Daga, 2013; Serpell, Treasure, Teasdale, & Sullivan, 1999; Williams & Reid, 2010). These indicators of resistance highlight the challenge in trying to conceptualise resistance; non-behavioural manifestations of resistance are not captured (e.g., individuals often deny or are unaware that resistance is the reason for not engaging in treatment) and the behavioural indicators can be unrelated to resistance (e.g., attrition may be due to external factors).

4.3 Measuring Resistance

The challenges in measuring resistance accounts for the paucity of research into this construct in the eating disorder field. A feasible way of measuring resistance was proposed by Perry (2009) who highlighted questionnaires which assess *state-like* and *trait-like* resistance (Beutler et al., 1991).

State-like resistance suggests that resistance is situational and is specific to the behaviour of focus (Beutler et al., 1991). The Stages of Change Questionnaire is proposed as a means of measuring state-like resistance. The Stages of Change model examines a person’s motivation towards recovery (W. Miller & Rollnick, 2002; Prochaska & DiClemente, 1983; Waller, 2012). The model classifies individuals into

one of five stages; pre-contemplation, contemplation, preparation, action, and maintenance. Treatment is adapted to the client's particular stage of change. Pre-contemplation refers to a stage in which an individual is not consciously aware that there is a problem or concern or is not motivated or resistant to change. Contemplation refers to a stage in which an individual intends to change but has not taken action. Preparation refers to a stage in which an individual begins taking steps to change behaviour and intends to take action in the immediate future. Action refers to a stage in which an individual has made changes and maintenance refers to a stage in which the individual continues the desired result and manages relapse. These stages are not considered to occur sequentially; rather the individual usually reverts to prior stages, possibly a number of times, before advancing to the action and maintenance stages (Prochaska, Redding, & Evers, 2002). Moreover, it has been proposed that the word "states" replace "stages" to better capture this dynamic process which can even occur within the same therapy session (Freeman & Dolan, 2001; Waller, 2012). The Stages of Change Questionnaire (Rieger et al., 2000) is commonly used to measure an eating disordered individual's resistance and readiness to engage in treatment. Individuals with eating disorders are often at a low stage of readiness to change. In previous literature, a low readiness to change and the striking ambivalence regarding symptoms and towards recovery in these individuals has been associated with patients liking the secondary gains and the adaptive functions of the illness (Leahy, 2001). These adaptive functions include emotion regulation (e.g., self-soothing; Corstorphine, Mountford, Tomlinson, Waller, & Meyer, 2007), a nonverbal means to communicate emotion (Corstorphine et al., 2007), having a sense of control, predictability, structure (Cohen & Petrie, 2005; Reid, Burr, Williams, & Hammersley, 2008) and achievement (Striegel-Moore,

Silberstein, Grunberg, & Rodin, 1990), and a means to avoid the demands of adulthood by avoiding development (e.g., menses; Fornari & Dancyger, 2003).

In combination with state-like resistance measures, trait-like resistance measures which identify resistance that is persistent and pervasive for an individual best indicate treatment resistance. Little research has examined trait-like resistance in individuals with eating disorders. The Butcher Treatment Planning Inventory and the Negative Treatment Indicators (TRT) content scale of the Minnesota Multiphasic Personality Inventory are measures of trait-like resistance. The Butcher Treatment Planning Inventory is behaviourally oriented, however, its intention is to be atheoretical. The Butcher Treatment Planning Inventory assesses psychological symptomatology (e.g., unusual thinking) as well as particular characteristics (e.g., narcissism), that are likely to impede psychological treatment across 14 scales. The Validity scales assess the respondent's attitudes toward completing the inventory and psychotherapy, the Treatment Issues scales assess personality characteristics that may obstruct the establishment of an effective therapeutic relationship and experience, and the Current Symptom scales provides data about prominent patient psychological symptoms (Butcher, 1999). Of specific interest are the Treatment Issues Scales, Problems in Relationship Formation, Somatisation of Conflict, Low Expectation of Benefit, Self-Oriented/Narcissism, and Perceived Lack of Environmental Support.

The Minnesota Multiphasic Personality Inventory (MMPI) Negative Treatment Indicators content scale focuses on respondents' attitudes toward accepting psychological intervention, other types of treatment and behavioural changes (Butcher & Williams, 2000). Elevated scores on this scale signify negative attitudes toward health-care professionals, wilfulness against behaviour change, and scepticism that

change is possible (Craig & Olson, 2003). Rather than predicting treatment attrition or outcome (as supported by research into its predictability of prognosis), the scale assesses low motivation and inability to disclose (Butcher, 1990). Whilst the Butcher Treatment Planning Inventory was created specifically for use in psychological treatment planning, the Minnesota Multiphasic Personality Inventory was not designed to guide treatment planning and psychological intervention issues. Thus, the Butcher Treatment Planning Inventory is used for this program of research.

Despite the usefulness of the Butcher Treatment Planning Inventory and the Minnesota Multiphasic Personality Inventory Negative Treatment Indicator to assist researchers better identify therapeutic resistance, there are weaknesses of conceptualising resistance as trait-like. This conceptualisation assumes that resistance is part of personality but there is no evidence to suggest that resistance is a personality trait, though it may be related to personality characteristics (e.g., aggressiveness, defensiveness, cynicism). Additionally, interactionism (Endler, 1983), that is the situational influence on behaviour, is not necessarily captured. Moreover, a somewhat standard critique of personality assessments is that they neglect the individual in favour of group trends (e.g., Caprara & Cervonee, 2000; Pervin, 2002). Regardless, these measures provide the best indication of resistance for researching factors that may predict resistance.

4.4 Overcoming Resistance

Whilst the stages of change model (along with the Butcher Treatment Planning Inventory or the Minnesota Multiphasic Personality Inventory Negative Treatment Indicator) forms the closest measure of resistance available (Perry, 2009), the two prominent eating disorder interventions which are based on this model fail to improve

prognosis in the eating disorder population. Despite the uptake in the field, the Transtheoretical Model, the model comprising Stages of Change, and Motivational Enhancement Therapy, a combination of the Stages of Change model and Motivational Interviewing established by Miller and Rollnick (2002), have a weak evidence base.

4.4.1 The Transtheoretical Model. The Transtheoretical Model can be divided into three categories: stages of change (pre-contemplation, contemplation, preparation, action and maintenance) as discussed in *4.3 Measuring Resistance*, decisional balance and self-efficacy, and ten processes of change (Prochaska & DiClemente, 1983).

The decision making process, also known as decisional balance, evaluates the benefits (pros) and costs (cons) of the target behaviour. The pros and cons have varying degree of emphasis at the varying stages of change; cons outweigh the pros in the pre-contemplation stage through to pros far outweighing cons in the action stage (Hall & Rossi, 2008). Similar to Motivational Enhancement Therapy, resolving ambivalence towards recovery (which is common in the eating disorder population) is a key aim of the decisional balance process.

Self-efficacy is also assessed by the model. Self-efficacy conceptualises an individual's perceived ability to do a task as influencing future performance on the task (Bandura, 1977). Increases in self-efficacy can predict long-term behaviour change if individuals have adequate motives and competence. The Transtheoretical Model measures an individual's self-efficacy by means of a total confidence score. Situational temptations assess how specific situations tempt individuals into the problem behaviour.

The Transtheoretical Model also includes ten processes of change which comprises strategies that assist individuals change and maintain this change.

Consciousness raising increases awareness of the target behaviour via the provision of

knowledge and person-specific feedback about the target behaviour. *Environment re-evaluation* supports the individual to realise how their unhealthy behaviour affects others and how changing the behaviour can have a positive effect. *Dramatic relief* (or catharsis) involves relieving anxieties regarding the unhealthy behaviour and providing hope regarding changing this behaviour. *Social liberation* means the individual understands that society endorses the healthy behaviour. *Self-re-evaluation* refers to the reappraisal of the problem and the clients' self-assessment toward the end of the process, whereby the new healthy behaviour is identified as an important aspect of self. *Self-liberation* (commitment) means the individual accepts responsibility for change, demonstrates the ability to change, and commits to change. *Helping relationships* encourages relationships, other than professional ones, whereby the relationship fosters the change of behaviour. *Counterconditioning* refers to replacing unhealthy responses with healthier ones. *Reinforcement management* (rewards) refers to increasing reward for the healthy behaviour and decreasing reward for the unhealthy behaviour. *Stimulus control* refers to reducing triggers for unhealthy behaviours and using reminders and cues that encourage the substitute healthy behaviours. Under each of these processes are a number of techniques found across the various psychotherapies (Prochaska & Norcross, 2010).

4.4.2 Motivational Interviewing. Motivational interviewing aims to empower an individual to take responsibility, have self-efficacy and be intrinsically motivated to change eating disordered behaviour. Motivational Interviewing involves exploring the individual's personal values and views and the pros and cons of the eating disorder from his or her own perspective, amplification of discrepancies to overcome ambivalence regarding recovery, and endowing psychoeducational information. The therapist focuses

on resolving ambivalence by expressing empathy, normalising and validating the client's experience, and rolling with resistance by minimising dissonance in the therapeutic relationship (Knowles et al., 2013). It is proposed that by maintaining a nonjudgmental stance and matching the pace of the therapy to the patient's own readiness to change and values and goals, the individual is usually forthcoming in disclosing the cons of the disorder and is open to change (Eivors & Nesbitt, 2005).

4.4.3 Efficacy. Many clinicians employ motivational interventions. However, the efficacy of those interventions is largely assumed rather than confirmed (Knowles et al., 2013). A recent review that examined the efficacy of motivational interventions in facilitating change in a clinical eating disorder population (Waller, 2012) provided clarity to this common misconception. Firstly, there is only mixed evidence that motivation is enhanced through intervention, whereby strongest effects are in non-controlled, non-clinical populations where the core treatment has weak effects. Secondly, even though readiness scores per se predict attrition, motivational interventions do not reduce attrition. Thirdly, motivational interventions do not reduce restrictive eating pathology, have little effect on purging behaviours, however, may assist bingeing. Finally, there is inconclusive evidence that improvements in motivation influence improvement in treatment outcome (i.e., stage progression being different to behaviour change; Waller, 2012).

A recent review and meta-analysis on motivational interventions in the eating disorder population (Knowles et al., 2013) has also revealed that only a handful of empirical studies in the area had been conducted, with many suffering from methodological limitations, inconsistent findings, and only weak support for the use of Motivational Interviewing in the eating disorder population; at best, only binge eating

symptomatology seemed to be effectively treated (Knowles et al., 2013). When motivation interviewing was used in conjunction with Cognitive Behavioural Therapy (Geller & Dunn, 2011) and psychodynamic psychotherapy (Prochaska & Norcross, 2010) optimal long-term treatment outcome could not be confirmed.

Another recent systematic review (Hoetzel, von Brachel, Schlossmacher, & Vocks, 2013) highlighted that the limitations of motivational interventions stemmed from the stages of change being more descriptive than explanatory as there are no identifying mechanisms of how patients move from one stage to the next. Other research has emphasised problems with the Transtheoretical Model including its arbitrary dividing lines (including time frames), the use of it to explain complex health behaviour (e.g. automated, entrenched behaviours), and the lack of understanding of long-term effects due to its short term focus (West, 2005). There is also disagreement between prominent researchers regarding the relationship between the Transtheoretical Model and Motivational Interviewing. It has been argued that “motivational interviewing is not” the Transtheoretical Model (W. Miller & Rollnick, 2009, p. 129), and in only one of his many articles does Prochaska mention Motivational Interviewing and the conclusion drawn is that it is in competition with the Transtheoretical Model (Prochaska et al., 2008).

4.5 Conclusion

Whilst the Stages of Change model, along with the Butcher Treatment Planning Inventory or the MMPI, is the closest measure the field has to assessing resistance in individuals with eating disorders, its corresponding motivational interventions (i.e., motivational interviewing) does not significantly improve treatment engagement or reduce eating pathology. The enthusiasm and recommendations to use motivational

interventions in the treatment of eating disorders outweigh the reality of the current body of evidence (Knowles et al., 2013). The finding that resistance remains in the treatment of eating disorders suggests the need to revisit the conceptualisation of eating disorders (Wilson et al., 2007). The conceptualisation of eating disorders should take into consideration all that each perspective has to offer.

Chapter 5

Self Psychology

5.1 Overview

Self psychology provides a unique and alternative pathway to understanding eating disorders. What is especially relevant about a self psychology approach to individuals with eating disorders is the conceptualisation of these disorders as disorders of self, in particular, as narcissistic behaviour disorders (Goldberg, 1995, 1999, 2000; Kohut, 1977). This conceptualisation explains the high rates of treatment resistance because the eating disordered behaviour plays an important role in meeting the individual's narcissistic needs. The eating disorder identity and the use of it to meet narcissistic needs is potentially the key to creating resistance in this population; there is the need to control eating and weight-related behaviours as a means of regaining self-esteem (Bachar, 1998; Barth, 1988; Bruch, 1978; Fassino & Abbate-Daga, 2013; Kohut, 1977; S. Sands, 1989). Additionally, self psychology's unique understanding of therapist (i.e., empathic enquirer and interpreter; Bienenfeld, 2005; Kohut, 1959) provides a rationale of how the therapist may contribute to resistance and poor prognosis. Psychodynamic therapists posit that resistance can be considered as a regulator of the therapeutic relationship (Plakun, 2012) and that countertransference and the therapist's reactions can inadvertently perpetuate eating disorders (Strober, 2004). Despite its unique and alternative understanding, much of self psychology's contribution to the conceptualisation of eating disorders has been overlooked. It is not argued here that one therapeutic perspective is better than the other. Rather, the conceptualisation of eating disorders should take into consideration all that each

perspective has to offer. Self psychology should be included in the conceptualisation of eating disorders in an attempt to overcome treatment resistance.

5.2 Self Psychology Definitions

Self psychology is a school of psychoanalytic theory and therapy begun by Heinz Kohut. Self psychology focuses on the development of self and disorders of self, particularly those that have a narcissistic basis. It considers eating disorders as one of many disorders of self which have a narcissistic basis. Self psychology as a psychoanalytic therapy focuses on empathic immersion, vicarious introspection and understanding (Kohut, 1971, 1977, 1984). Further explanation follows.

5.2.1 The Self. Kohut (1977) stated,

My investigation contains hundreds of pages dealing with the psychology of the self - yet it never assigns an inflexible meaning to the term self. But I admit this fact without contrition or shame. The self is, like all reality, not knowable in its essence. We can describe the various cohesive forms in which the self appears, can demonstrate the several constituents that make up the self...and explain their genesis and functions. We can do all that, but we still will not know the essence of the self as differentiated from its manifestations (p. 310)

At best, the self can be defined as a matrix of reliably established psychological functions consisting of sensations, motivations, feelings, thoughts, and attitudes toward oneself and the world, which usually operates outside of awareness. For example, a child may have an inner drive to be successful in the eyes of the world. The self cannot be defined without reference to *selfobjects* and the *selfobject milieu*. The selfobjects,

initially in the form of primary caregivers, supply the needs of the developing self and continue to be needed throughout life. When person A needs and expects person B to fulfil a self-enhancing need that A cannot fulfil independently, A is referring to B as a selfobject. Moreover, A expects and needs B to behave as if B were part of the self (Bachar, 1998).

Kohut (1984) proposed that a sense of self is developed using narcissism. He regarded narcissism as integral to every person's development rather than pathology. He posited a line of healthy narcissistic development resulting in a cohesive self-structure sufficient for meeting needs of the self and psychological health. Development was described as a process of increased reliance on self, not significant other, to fulfil selfobject functions, to the point where dependence only occurs when a traumatic experience temporarily disrupts a person's narcissism (Kohut, 1977). Kohut (1971) coined this process as "transmuting internalization", the internalisation of the ability to self-regulate (e.g., calming and self-soothing) that were fulfilled in the beginning of life by primary caregivers.

Kohut (1984) proposed to achieve transmuting internalisation, three types of selfobject relationships are necessary: the mirroring selfobject relationship, the idealizing selfobject relationship and the twin-ship/alter ego selfobject relationship. Mirroring selfobject needs include affirmation, recognition, acceptance, appreciation and value from primary caregiver (Lessem, 2005). Wink (1991) highlighted that this description reflects a person seeking acknowledgement of their grandiose narcissistic self. Through the self's internalisation of the mirroring selfobject the person has self-cohesion, including stable and positive self-esteem, realistic ambitions, the ability to commit, be assertive and accomplished (Kohut, 1984). The idealising selfobject refers

to a connection to an admired other (usually in the form of primary caregiver), enabling a sense of calming, safety, soothing, strength and inspiration. Wink (1991) highlighted that this description reflects a person's vulnerable narcissistic self. The appropriate internalisation of idealising selfobject functions results in the individual's capability for stable, strong and healthy goals; ideals and values; and to self-soothe. The alter ego/twin-ship selfobject relationship allows for the development of skills to communicate, connect, and feel understood and accepted by others (Kohut, 1984). In summary, a healthy, cohesive self is the product of a normal developmental process of the internalisation of mirroring, idealising, and alter ego/twin-ship responses of the primary caregiver (Kohut, 1971, 1977, 1984).

5.2.2 Disorders of Self. The deficiency in identity development in self psychology is coined as "disorders of self" (Kohut, 1977). Kohut (1971) believed that when primary selfobjects fail to meet selfobject needs and the transmuting internalisation process is disrupted or was never initiated, then an underdeveloped inner structure results, leading to unstable narcissism; disorders of the self. Lingering needs for admiration, commanding others, and twin-ship relationships remain. Specifically, the individual retains a hunger for selfobjects, thus, acts in ways (e.g., exhibitionistic) in an ongoing attempt to get selfobject needs met, characteristic of narcissistic disorders. According to Kohut (as cited in Jacoby, 1999), however, having any needs from others at all causes a deep sense of shame for narcissistically disturbed patients. Alternatively, the individual may defend against a repeat of failed selfobject experiences, usually by avoidance or denial of selfobject needs (Kohut & Wolf, 1978).

An individual with a disorder of self lacks self-cohesion, distrusts their own permanence and resilience, and has a vulnerable self-esteem, especially sensitive to

perceived slights and failures (Kohut, 1971; Kohut & Wolf, 1978). They perceive they are different and alone, and struggle with all-consuming negative emotions and thoughts (Kohut, 1971). Disorders of self typically present, in current clinical praxis, as DSM-5 Cluster B personality disorders which are marked by histrionic, emotional and erratic characteristics. Of particular relevance to self psychology are the two DSM-5 diagnoses, narcissistic personality disorder and borderline personality disorder, which self psychology considers disorders of self (Kohut, 1984). Defining these disorders becomes complicated due to the contradictory use of these words in self psychology and mainstream psychology. Kohut's differentiation of borderline states and narcissistic personality disorder have, in general, similarities with the DSM-5 categories of borderline personality disorder and narcissistic personality disorder respectively. However, self psychology believes these disorders are on a continuum with borderline personality disorder at one end and narcissistic personality disorder at another.

5.2.2.1 Narcissistic behaviour disorders. Between borderline personality disorder and narcissistic personality disorder, self psychology posits another disorder of self, narcissistic behaviour disorders (Goldberg, 1995, 1999, 2000). Narcissistic behaviour disorders manifest clinically as mixtures of these DSM-5 categories, ranging from low functioning to high functioning (Goldberg, 1995, 1999, 2000). People with a narcissistic behaviour disorder have an unstable narcissism whereby they have megalomaniacal fantasies and when the self becomes threatened, a particular defensive behaviour is triggered (e.g., extramarital relationships, alcohol abuse; Kohut & Wolf, 1978). The behaviour is used as an attempt to coerce the environment to provide needed selfobject experiences, such as comforting responses in interpersonal relationships, but the behaviour itself may meet an individual's needs (Wolf, 1988).

To assist in defining narcissistic behaviour disorders, Kohut and Wolf (1978) compared narcissistic behaviour disorders to narcissistic personality disorder as categorised in the DSM-5 based on the apparent behaviours and the psychological states that underlie these. In narcissistic behaviour disorders, the behaviour is triggered when the self becomes weakened, distorted and broken-up only temporarily. In narcissistic personality disorder, the disturbance of the self is also temporary, but relates not just to behaviour, but also to an entire psychological state that is more enduring. In narcissistic behaviour disorders, it is not enough to relate to others as selfobjects in order to feel contained; the self, rather, uses other, human and non-human, at whatever cost to avoid narcissistic embarrassment and to promote their own narcissistic pleasure (Ulman & Paul, 2006). For example, an individual may engage in infidelity whilst another may engage in alcohol abuse, both to support self-esteem and cohesiveness.

5.3 Self Psychology Conceptualisation of Eating Disorders

Self psychology views eating disorders as disorders of the self, specifically a narcissistic behaviour disorder. In the eating disorder population, food and its control is a restitutive system in which disordered eating behaviours, not people, become the vehicles for meeting selfobject and narcissistic needs (Bachar, 1998; Barth, 1988; Bruch, 1978, 1982; Fassino & Abbate-Daga, 2013; Geist, 1989; Kohut, 1977; S. Sands, 1989). A person with anorexia nervosa obtains fulfilment of selfobject needs through food. Narcissistic needs are met, not by admiration or approval from others directly, although this may occur as a secondary outcome, but rather from their own perception that they are omnipotent as they can avoid eating. Kohut and Wolf (1978) stated mirror-hungry individuals had an excessive need for confirming and admiring responses, even fleeting attention, to feed a famished self. The avoidance of food fulfils mirroring

selfobject needs of affirmation, recognition, acceptance, appreciation and value (Bachar, 1998). On the other hand, a person with bulimia nervosa obtains fulfilment of selfobject needs through food, mainly through idealizing selfobject experiences. The ideal-hungry individuals seek admiration toward a selfobject because of their prestige, beauty or power. Food is experienced as a supreme object because it soothes, calms and comforts the person, overall regulating affect (Bachar, 1998; Barth, 1988; S. Sands, 1991). Feelings of emptiness are managed by binge eating, or by "controlled emptiness", that is purging or restricting (Bachar, 1998).

Pioneer in the field of eating disorders, Hilder Bruch (1973, 1978), stated the theory of self psychology best explained her life-long contribution to the field. Bruch explained eating disorders as in the manifestation of underlying deficits in the development of identity and selfhood (Bruch, 1982). Eating disordered individuals rely on body weight, which is obvious, self-controllable, and coveted (in western cultures), to define self in lieu of a clear identity and self-worth (Bruch, 1981). Discontent and obsession with body in these individuals reflect a maladaptive "search for selfhood and a self-respecting identity" (Bruch, 1979, p. 255). In other words, such an impaired development results in eating symptomatology as a pseudo-adaptive response to profound worthlessness (Bruch, 1982; Fairburn et al., 2003).

5.4 Resistance, Eating Disorders and Self Psychology

Self psychology proposes that resistance to recovering from an eating disorder partly stems from the role food plays in managing affective instability (Goodsitt, 1983) and minimising the bodily changes inherent in becoming an independent adult (Caparrotta & Ghaffari, 2006; Fassino & Abbate-Daga, 2013; Goodsitt, 1983; Kohut, 1971). See Chapter 4.2 *Resistance* for similar and more recent developments.

In addition to common understandings, self psychology provides a more extensive framework around resistance. The self-psychology view of symptoms renders self psychology potentially helpful in addressing treatment resistance in eating disorders. Eating disordered individuals defend the eating disorder as if they were defending the very existence of their self. Without an appropriate selfobject substitute, relinquishing the eating disorder threatens self-cohesion (Bachar, 1998). According to self psychology, eating disordered symptoms of restriction and/ or binging then purging are viewed as vital to protect a vulnerable self from further weakening or fragmentation (Geist, 1989).

The Vertical Split, a construct present in most narcissistic behaviour disorders, also provides an explanation as to why eating disorders are resistant to treatment.

Goldberg (1999) described the vertical split as,

...a significant division of the organisation of personality into a divided pair. The division is not always neat, and the parts are never equal either in frequency of emergence or length of stay, but the experience for the person is one of a separation: a parallel and coexisting other... These individuals reveal a severe and striking split in their personalities, a vertical split in which side-by-side individuals seem to reside in but one mind (p. 3)

Goldberg (1999) distinguished the vertical split from ambivalence by stating, the short-lived split is resolved by the winning side claiming victory over the entire person, and the losing side ceasing to clamour for attention and concern. It is only when we begin to see that victory does not always have a worthwhile resolution, and

that neither side is able to tolerate losing that we start to delineate a pathology (p. 9).

It is clear that the vertical split could be a better explanation for the chronic ambivalence to both symptoms and recovery seen in the eating disorder population.

5.5 Therapist

In addition to the unique understanding of eating disorder symptoms and how their vital role to self explains the pervasive resistance in this population, self psychology's unique understanding of therapist and therapeutic relationship provides a rationale of how the therapist may contribute to poor prognosis. Self psychology's general approach to narcissistic behaviour disorders is through its introduction of empathy as essential to therapy as a mode of enquiry, and therapeutic intervention via the exploration and extension of subjectivity (Kohut, 1959). The introduction of empathy was a radical diversion from the authoritarian approach of traditional psychoanalysis (Lessem, 2005). Self psychology theorises that the inner world can only be accessed "in ourselves through the process of introspection and in others through the phenomenon of empathy" (Lessem, 2005, p.67). The therapist engages in empathic immersion, or vicarious introspection, to become selfobject to the patient, thus allowing the functions of the selfobject to be internalised (Kohut, 1959). The first phase of self psychology, the understanding phase, involves the therapist accepting the empathic observational stance, and the second phase, interpretation, involves the empathic communication of interpretations to the client without intruding on the narcissistic balance of the patient, the therapist and the relationship. Self psychology proposes that interpretation, which could be seen as acts of a "superior other", is used after the client feels consistently empathised with so the therapist is considered a selfobject, not distant

object (Bachar, 1998). Consequently, interpretations will be considered as “imposed from without but given from within” (Bachar, 1998). In the eating disorder population, the resistance to relinquish the eating disorder is vital for the individual to preserve a cohesive self (Barth, 1988). Therapists must accept their clients’ need for self-preservation so eventually the client trusts the therapist as a selfobject (Barth, 1988). Thus, resistance is not considered maladaptive like with other approaches.

It is important to note that subsequent approaches such as cognitive behavioural therapy and person centred therapy also emphasise the importance of empathy and the therapeutic relationship (in fact, Kohut did not see empathy as specific to self psychology). In cognitive behavioural therapy, however, even founder Beck and colleagues (1979) stated that the therapeutic relationship was important to treatment, only because it “facilitate(s) the application of specific techniques” (p. 45). The therapist acts objectively as an educator of the patient’s mental processes, teaching skills for ongoing implementation post-treatment (Beck et al., 1979). Rather than just having a cognitive and objective understanding of the client’s presenting issue, self psychology focuses on a subjective and affective understanding of experience (Siegel, 1996). The role of the therapist is more difficult to differentiate between self psychology and person centred therapy. Whilst in person centred therapy, self actualisation is encouraged via the necessary and sufficient therapeutic conditions of congruence, unconditional positive regard, and empathy (Rogers, 1957), it refrains from self psychology empathic questioning and interpretation, and optimal frustration (i.e., the inevitable, manageable and non-traumatic failures of the empathic joining between the patient (self) and the therapist (selfobject) which must occur for the resultant

internalisation of functions associated with the selfobject for resilience against inevitable future empathic failures).

Self psychology promotes empathic enquiry and empathic interpretation as essential to positive treatment outcomes. In the eating disorder population, positive outcome is the construction of a new and mature identity, a complete sense of self, which replaces the “eating disorder identity” (Bruch, 1979), ceasing the use of the eating disorder as a vehicle to meet an individual’s narcissistic needs (Kohut, 1971, 1984). Also essential is the therapist’s awareness and management of countertransference (i.e., the redirection of the therapist’s personal response towards a client; discussed in more detail in Chapter 6) and their own emotions in addition to the patient’s ones (Plakun, 2012).

Given the importance of the self psychology therapist’s stance of empathic enquiry, empathic interpretation and awareness of transference/countertransference to outcome, conversely, it can be argued that, without this stance, outcomes would be limited. Kohut (1971, 1977) stated therapists face inevitable empathic failures. But it is the continuous absence of empathic attunement which impedes on therapy outcome. Under what conditions would a therapist not have empathic attunement? Maintaining a self psychology perspective, it is suggested that countertransference and therapist factors may play a role in the breach of empathic immersion (Plakun, 2012). One recognised impeding characteristic which lends itself to the self psychology framework is narcissism. Narcissism, in the past, was noted as a common characteristic of therapists (Seligson, 1992). Moreover, in those therapists with narcissistic characteristics, it was theorised that they were unable to maintain an empathic position, rather jumping in to validate the client to allay their own anxieties (Seligson, 1992).

Given the pervasive resistance in the eating disorder population, it is plausible to explore whether therapists endorse narcissism as a characteristic as this may interfere with the self psychology stance thus perpetuate resistance in clients. Narcissism in therapists has not been examined a) in the literature recently, b) empirically, nor c) in therapists who treat individuals with eating disorders. First, it is important to examine the current evidence supporting self psychology.

5.6 Efficacy

Despite the knowledge provided by self psychology which may be used to investigate resistance in the eating disorder population, compared to other forms of therapy, there is a limited body of research which examines the effectiveness of self psychology in the treatment of eating disorders. Empirical outcome studies of other therapies, particularly cognitive behavioural therapy, dominate the literature (Shedler, 2010). It is difficult to identify why there is little empirical research in self psychology but it is proposed that this is due to the challenges in assessing effectiveness, defining and measuring self psychology constructs and in specifying its patients (as often focus is on a range of symptoms rather than specific diagnostic criteria; Sandell, 2012). Instead, case studies, which better fit the first-person data uncovered in psychoanalysis (Goldberg, 2004), have been employed.

The only accessible randomised controlled trial found that examined self psychology in the treatment of eating disorders compared self psychology with a cognitive orientation treatment (Bachar et al., 1999). Comparing cognitive orientation treatment, rather than the more frequently employed cognitive behavioural therapy, with self psychology controlled for the variables of therapy duration and absence of direct focus on the patients' eating attitudes or behaviour. Senior clinical psychologists who

were not involved in the study judged whether therapists adhered to the specific treatment approach. Both psychological treatment groups received nutritional counselling in addition to their psychotherapy. Thirty-three participants were randomly assigned to either self psychology, cognitive oriented therapy, or, in the case of bulimic patients ($n = 25$), a control group of nutritional counselling for weekly sessions over the course of one year. Participants completed pre- and post-treatment measures conducted by independent, trained and qualified clinicians. These measures assessed eating disorder symptomatology, food, weight and eating attitudes, self states, and general psychopathology. The results revealed that only in the self psychology group were there significant improvements in eating pathology and self cohesion (i.e., fewer discrepancies between self states) between pre- and post-treatment. Additionally, self psychology significantly improved diagnostic symptomatology compared to the cognitive oriented therapy and the nutritional group. Moreover, at the end of treatment, self cohesion was significantly improved in the self psychology group compared to the cognitive oriented treatment (Bachar et al., 1999). However, follow-up on a much larger sample is required for generalisability of the results.

Despite the promising outcomes and additional contributions of self psychology, concern has been raised that it does not involve the provision of facts about the disorder or advice giving about the management of the disorder. Due to the often precarious health, weight and eating behaviours in eating disorders, this has been considered as “potentially harmful, even fatal” (Bruch, 1973, 1978). As a result, therapists often practice outside of the framework, integrating other more directive approaches (Bruch, 1962, 1978). It is argued that the provision of facts as well as the incorporation of

empathic enquiry and interpretation and narcissism, as used in self psychology, may overcome treatment resistance.

5.7 Conclusion

Self psychology provides understanding, not provided by cognitive behavioural therapy and family therapy, which could be incorporated into the conceptualisation of eating disorders. Specific contributions include eating disorders being considered as a product of poor self-development whereby the individual relies on the eating disorder to meet their narcissistic needs. Consequently, the individual is resistant to treatment which aims to rid the individual of the disorder. An additional benefit of self psychology is the importance it places on empathic enquiry and interpretation. Whilst the effectiveness of self psychology is not examined in this thesis, narcissism and therapist factors that may impede the provision of empathic enquiry and interpretation are examined as they may contribute to treatment resistance in the eating disorder population. Consequently, Chapter 6 examines narcissism in eating disorder individuals and Chapter 7 examines the role of the therapist in the treatment of eating disorders, examining what may be factors that contribute to the inability to act as empathic enquirer and interpreter; therapists own eating disorder history and narcissism.

Chapter 6

Narcissism: Its Role in Eating Disorders

6.1 Overview

Engaging in moderate narcissistic self-esteem enhancing activities is an important adaptive psychological need for most individuals (Kohut, 1971). However, excessive attention to the physical self represents a maladaptive form of narcissism, and can cause body-image related disorders (Davis, Karvinen, & McCreary, 2005). In narcissistically compromised individuals (i.e., those with deficiencies in overall identity development), the preoccupation with the physical self is an attempt to offset the fragile sense of self and vulnerable self-image (Davis et al., 2005; Kohut, 1971; I. Miller, 1992). Unfortunately, although this strategy can be effective to offset vulnerability, a preoccupation with the physical self causes problems in other areas of life (Davis et al., 2005). Despite these problems, narcissistic characteristics and disorders are entrenched and difficult to treat (W. Ellison, Levy, Cain, Ansell, & Pincus, 2013; Hilsenroth, Holdwick, Castlebury, & Blais, 1998; Kernberg, 2007; Ronningstam, 2011). Kohut (1971) described the difficulties in navigating the particular kinds of transferences that occur during psychoanalytic treatment of individuals with narcissism.

Eating disorders have been considered to be disorders of narcissistically compromised individuals, who are extremely resistant to treatment (Kohut, 1977; Goldberg, 1999). This consideration is important to explore as it infers that addressing narcissistic needs will overcome the resistant nature of eating disorders, thus improving prognosis. In order to explore this perspective, narcissism in the context of eating disorders requires investigation. Kohut (1977) identified both grandiose and vulnerable

aspects of narcissistic disorders. Therefore, it is useful to explore these facets of narcissism in the eating disorder population and how these facets may relate to treatment resistance.

6.2 Narcissism

6.2.1. Definitions. Generically, narcissism is defined as “excessive or erotic interest in oneself and one’s physical appearance” (Moore, 2009). To the lay person, a person with narcissism is perceived as demanding attention and needing admiration (A. Cooper & Ronningstam, 1992; K. Wright & Furnham, 2014). In psychological praxis narcissism was first described as relating to vanity and self-admiration by Otto Rank in 1911 (Rubins, 1983). More recently, from a summary of Steiger and colleagues’ discussions on narcissism in eating disorders, it was described as “pathological concern with physical appearance and presentation, need for external validation from the social environment, intense interpersonal sensitivity, and proneness to deflation of self-esteem” (Cassin & von Ranson, 2005). Moreover, individuals with narcissism present as loving themselves, having grandiose views of their own talents and devaluation of others, craving admiration, egotistical, arrogant, competitive, exhibitionist, manipulative, and lacking empathy (Kernberg, 1970; Kohut, 1977). Underlying the vain presentation is the person with narcissism’s inability to regulate self-esteem and represent themselves in a satisfying manner (A. Cooper & Ronningstam, 1992; K. Wright & Furnham, 2014). At the extreme end, narcissism is classified as a psychological disorder by the DSM (American Psychiatric Association, 2000, 2013) as narcissistic personality disorder. Narcissistic personality disorder is assessed with symptoms including entitlement, grandiose behaviours and fantasies (e.g., of success,

wealth, status), a lack of empathy, and feelings of specialness and superiority. These symptoms are considered relatively stable across time and context.

Whether eating disordered individuals have narcissistic personality disorder is not the primary discussion in this thesis. Rather, it is argued these individuals demonstrate some narcissistic traits although not to the same level seen in individuals with narcissistic personality disorder. In individuals who are narcissistically compromised, such as eating disordered individuals, when the self is weakened, the person relies on others to provide needed comfort, regulation of self-esteem and a sense of value, essentially looking for an empathic response missing from their development (Kohut & Wolf, 1978). The person can also meet these needs via certain behaviour such as purging (Wolf, 1988); for example, they feel accomplished for completing the behaviour.

6.2.2 Two facets: Grandiose narcissism and vulnerable narcissism.

Narcissism is most commonly described as a single construct, although there has been long term recognition that it comprises both a vulnerable and grandiose aspect (Davis, Claridge, & Cerullo, 1997; Kohut, 1977). One meta-analysis (see Cain, Pincus, & Ansell, 2008) demonstrated that narcissism could be synthesised across the literature into grandiose narcissism and vulnerable narcissism with differing treatment utility (Pincus & Lukowitsky, 2010). This meta-analysis contributed to the increasing acceptance of these two separate facets of narcissism (e.g., Kealy & Rasmussen, 2011; Ronningstam, 2011; Russ, Shedler, Bradley, & Westen, 2008; A. Wright, Lukowitsky, Pincus, & Conroy, 2010). Grandiose and vulnerable narcissism show considerably different associations with external factors such as early life experience (e.g. abuse and neglect), attachment, psychopathology, self-esteem, and engagement in externalisation

of emotions and behaviour (Dickinson & Pincus, 2003; J. Miller et al., 2010; J. Miller et al., 2011; Pincus et al., 2009; Wink, 1991).

6.2.2.1 Grandiose narcissism. Grandiose narcissism is described as “having a grandiose sense of self, a preoccupation with fantasies of unlimited success, power, and ideal love, a belief that one is ‘special’, a requirement for excessive admiration, a sense of entitlement, a pattern of exploiting others for personal gain, a lack of empathy, a tendency to envy others and a belief that one is envied, and the display of arrogant, haughty behaviours and attitudes” (Gordon & Dornik, 2010). These individuals typically externalise emotion, often exhibitionistic or aggressively, and lack self-awareness and insight of the impact on relationships (Dickinson & Pincus, 2003; Pincus & Lukowitsky, 2010). To regulate self-esteem, the individual with grandiose narcissism exaggerates superiority and shows-off, whilst understating weakness and devaluing others who threaten self-esteem (Dickinson & Pincus, 2003; Pincus & Lukowitsky, 2010). Grandiose narcissism has been coined as adaptive narcissism as, despite being negatively viewed by others, it meets the individuals’ need to regulate self-esteem (Davis et al., 1997).

6.2.2.2 Vulnerable narcissism. Vulnerable narcissism has characteristics similar to grandiose narcissism, however it is predominantly characterised by “hypersensitivity to the opinions of others, insecurity, an intense desire for approval, and poor self-image” (Gordon & Dornik, 2010) despite concern about their physical appearance (Pincus & Lukowitsky, 2010; Ronningstam, 2005). Individuals with vulnerable narcissism tend to be ambitious and somewhat successful (Pincus & Lukowitsky, 2010; Ronningstam, 2005; Russ et al., 2008). Individuals with vulnerable narcissism are observed as shy, anxious, constrained and empathic. However, at their core is grandiose expectations and

entitlement. The individual with vulnerable narcissism attempts to disavow underlying feelings of grandiosity and entitlement; however, this disavowal leads to frustration and hostility, in turn, shame and depression. Lacking self-enhancement strategies, the individual with vulnerable narcissism is less able to regulate self-esteem as the individual with grandiose narcissism (Pincus & Lukowitsky, 2010). Rather than conveying arrogance when they encounter narcissistic injury, individuals with vulnerable narcissism become overwhelmed by shame, anxiety, depression and feelings of inadequacy such that they withdraw to tend to their self-esteem (Dickinson & Pincus, 2003; Pincus & Lukowitsky, 2010). Individuals with vulnerable narcissism are avoidant, anxious about, and lack confidence in their interpersonal abilities. Interpersonally, they also fear disappointment and are ashamed of their needs (J. Miller & Campbell, 2008; Pincus & Lukowitsky, 2010). These individuals are challenged to have their needs met by others whilst protecting their vulnerability (Kohut, 1977).

Vulnerable narcissism comprises cognitive constructs of self-esteem and body image. Vulnerable narcissism, however, is more than the cognitive set of beliefs and thoughts; rather it is a disorder of self-esteem vulnerability to the emotional responses of others. Whilst the individual with vulnerable narcissism may demonstrate cognitive characteristics consistent with cognitive-theoretical definitions of self-esteem and body-image issues, vulnerable narcissism is not reducible to cognitive-level pathology. Additionally, whilst an intense desire for approval of others may show its anticipated cognitive traces, a dynamic formulation can account for the cognitive disavowal of this desire, which produces conflicting levels of psychological experience. There may be an apparent cognitive reduction in identifiable neediness of others, yet this neediness remains on an unconscious level. The evidence of this conflicting unconscious level is

revealed by other dynamic symptoms indicating a persistence of the need despite cognitive dispensing with the related thoughts. Kohut has discussed the primacy of such a requirement of the responses of others (e.g., 1971), which gives them the status of legitimate psychological need that is no more amenable to cognitive alteration than the (physical) need for oxygen and water. Denial can only be a substitute for eradicating these needs. This theoretical stance highlights a clear incongruence between an indispensable affective need and any cognitive-level disavowal of the need instigated cognitive-therapeutic intervention.

6.3 Narcissism in Individuals with Eating Disorders

Eating disorders have been theorised as narcissistic disorders, comprising both vulnerable and grandiose aspects, which results from poor identity development (Kohut, 1977). Yet narcissism has long been a sensitive topic, especially when applied to individuals with eating disorders. This can be accounted for by the relationship between narcissism and patient-blaming (Roehrig & McLean, 2010). The stigma toward individuals with eating disorders is based on ideas that individuals are responsible for their illness, attention seeking, and motivated, in part, by narcissism (Chiodo, Stanley, & Harvey, 1984; Gowers & Shore, 1999; Stewart, Keel, & Schiavo, 2006). To counter the stigma, eating disorder support organisations highlight that eating disorders are not linked to attention seeking, often citing that these individuals go to great lengths to hide their behaviours from those around them. Moreover, it has been argued that eating disorders are not about exhibiting what is promoted as fashionable (i.e., thinness), highlighting that although individuals may engage in dieting and other weight-control behaviours due to the influence of friends, eating disorders do not develop simply for this reason (Paxton et al., 2012).

However, excluding narcissism from the conceptualisation of eating disorders may be a damaging omission as it provides an avenue for further research which may overcome eating disordered individuals' resistance. Moreover, these arguments contradict the well-established research demonstrating there is an aesthetic aspect that perpetuates the disorders (Stice & Shaw, 2002; Thomsen, McCoy, Gustafson, & Williams, 2002) and that people who diet are more susceptible to developing an eating disorder (Gerner & Wilson, 2005; Schutz & Paxton, 2007). The inclusion of narcissism into a conceptualisation of eating disorders needs to be undertaken with sensitivity and it needs not go hand-in-hand with patient blaming. Eating disorders are considered serious illnesses that the individual should not be considered responsible for *and* the inclusion of narcissism in the conceptualisation may provide understandings to overcome chronic resistance to treatment.

6.3.1 Eating disorders, grandiose narcissism and vulnerable narcissism. A link between narcissism and eating disorders has already been consistently reported (Davis et al., 1997; Steiger, Jabalpurawa, Champagne, & Stotland, 1997; Steinberg & Shaw, 1997; Waller, Sines, Meyer, Foster, & Skelton, 2007). Narcissism, as measured as a unitary construct, is elevated in individuals with eating disorders compared to healthy and psychiatric control groups (Lehoux, Steiger, & Jabalpurawa, 2000; McLaren, Gauvin, & Steiger, 2001; Mogul, 1980; R. Sands, 2000; Steiger et al., 1997). However, grandiose narcissism and vulnerable narcissism have not been explored separately in clinical eating disorder groups. Instead, research has explored the relationship between these facets of narcissism and eating disorder symptoms in healthy university students. Results from this non-clinical study demonstrated that it is only the vulnerable facet of narcissism that is associated with weight preoccupation (Davis et al.,

1997), drive for thinness (Gordon & Dombek, 2010), and the bingeing and purging characteristic of bulimia nervosa (Maples, Collins, Miller, Fischer, & Seibert, 2011), suggesting that vulnerable narcissism may be more important in predicting disordered eating. The research that explored narcissism as a unitary construct (as discussed above) utilised a measure of grandiose narcissism (although the research intended to measure ‘narcissism’) and an association between it and eating disorders was consistently found. Given grandiose narcissism has been found to be high across eating disorders yet in other research, has not been found to be associated with a number of the symptoms characteristic of bulimia nervosa, the results are mixed. Thus, further research to examine the role of narcissism in disordered eating is warranted.

The relationship between the two facets of narcissism (i.e., grandiose narcissism and vulnerable narcissism) and diagnosed eating disorders (i.e., anorexia nervosa and bulimia nervosa) needs to be explored. Not only will this clarify previous findings, but it is important to explore whether grandiose narcissism, vulnerable narcissism or both facets of narcissism are present in individuals with either anorexia nervosa or bulimia nervosa to support the employment of the self psychology approach in eating disorders.

6.3.2 Components of grandiose narcissism. Seven theoretical aspects of grandiose narcissism based on the characteristics of narcissism as classified in the Diagnostic and Statistical Manual of Mental Disorders- Third Edition (American Psychiatric Association, 1980) were targeted in the development of the Narcissistic Personality Inventory (NPI; Raskin & Terry, 1988), although this factor structure has not been upheld in more recent studies. Whilst grandiose narcissism has not been explored in individuals with anorexia nervosa or bulimia nervosa, a number of the seven theoretical aspects of grandiose narcissism have been linked to eating disorders. How

these characteristics are described in the context of the NPI and how they relate to eating disorders are detailed below.

6.3.2.1 Exhibitionism. Exhibitionism is described as sensation seeking, extraversion and impulsivity (Raskin & Terry, 1988). An exhibitionist person requires constant attention and admiration (Ronningstam, 2010). Research has investigated the relationship between exhibitionism and eating disorders. Some studies demonstrated that individuals with eating disorders can be impulsive, not considering consequences of immediate behaviours (Cavedini et al., 2006; Garrido & Subira, 2013; Tchanturia et al., 2012) whilst others demonstrated these individuals were rigid and introverted, particularly individuals with anorexia nervosa (Cassin & von Ranson, 2005; Rossier, Bolognini, Plancherel, & Halfon, 2000). Sensation seeking, expressiveness and impulsivity were more typical when there was bingeing involved (Hartmann et al., 2010; Rossier et al., 2000). Moreover, the binge eating with a sense of lack of control seen in individuals with bulimia nervosa (Keel & Levitt, 2006) suggests these individuals are impulsive. However, little research has examined the link between “showing-off” and eating disorders.

6.3.2.2 Authority. Authority is described as dominance, assertiveness, leadership, criticality, and self-confidence (Raskin & Terry, 1988). Research has demonstrated that individuals with eating disorders largely express themselves through non-assertive (Bruch, 1973; Hartmann et al., 2010) and submissive behaviours (Bruch, 1973; Hartmann et al., 2010; Troop & Baker, 2008). However, it has been proposed that these individuals can also have an

overly dominant pattern of relating to others, demanding so much from friends or family members that the person ends up isolated

and alone when others pull away. Such rejection can lead to hostility towards others and disaffiliation or result in a desperate need for others and intrusiveness (Hartmann et al., 2010, p. 619).

Moreover, individuals with high authority characteristics have been described as critical of others (M. Campbell & Waller, 2010; Riebel, 2000). Such claims are supported by cognitive theorists suggesting that narcissistic schemas entail demands from self and others of perfection and chronic frustration with others' perceived imperfections (Beck, Freeman, & Davis, 2004). Given the mixed results of the traits of authority in the eating disorder population, greater understanding of authority and whether it relates to motivation to engage in treatment is required.

6.3.2.3 Vanity. Vanity was described as an individual believing that they are physically attractive and are perceived this way by others (Raskin & Terry, 1988). Research indicates that the need to gain approval from others is higher among individuals with eating disorders and that this approval is often sought based upon perceived worth in the form of attractiveness (Reel, 2013). Moreover, individuals with eating disorders, particularly those with bulimia nervosa, had higher standards and care for physical appearance than healthy controls (Gunnard et al., 2012). However, to the researcher's knowledge, no research has explored vanity in eating disorders. Again, it is argued that the sensitivity of this construct and the stigma of eating disorders as a method of attention seeking hinder important avenues of research.

It is important to highlight the difference between the need to gain approval from others and body image concerns; the latter which has been extensively studied in people with eating disorders (e.g., Cash & Smolak, 2011). The first speaks to the need to alter the body in order to elicit needed responses, while the latter speaks to a need to

alter the body because of an erroneous ability to perceive the body accurately. Body image concerns, thus, would be rectified with a cognitive intervention designed to restore realistic perception and it would be totally free of inputs from others (real or imagined). Gaining approval from others could be addressed by self psychology, using analysis of the impact on self-esteem of the links to the other person who functions as a selfobject (i.e., other person who regulates one's self-esteem). This, however, has not yet been tested.

6.3.2.4 Self-sufficiency. Self-sufficiency was described as assertiveness, independence, self-confidence, and achievement need (Raskin & Terry, 1988). Research has not only demonstrated that individuals with eating disorders tend not to be assertive (Bruch, 1973; Hartmann et al., 2010), they also demonstrate low levels of self-confidence (Perry, Silvera, Neilands, Rosenvinge, & Hanssen, 2008). Moreover, individuals with eating disorders want to be independent, yet are heavily dependent on others for validation and regulation of self-esteem (Narduzzi & Jackson, 2000). Therefore, eating disordered individuals might not demonstrate self-sufficiency. People with eating disorders have higher standards for self-achievement than healthy controls (Gunnard et al., 2012). This achievement need is reflected in their perfectionist standards (for reviews, see Bardone-Cone et al., 2007; Jacobi, Hayward, de Zwaan, Kraemer, & Agras, 2004), where they set unrealistically high standards for themselves, despite the costs (e.g., physical illness; Shafran, Cooper, & Fairburn, 2002), especially when on the relentless pursuit of the 'thin ideal' (Goldner, Cockell, & Srikameswaran, 2002; Stice, 2002).

Whilst self-sufficiency includes cognitive components of perfectionism and self-esteem, in the context of narcissism there are subtle differences in how self psychology

views these constructs. Rather than focusing on negatively biased self appraisals, role of perfectionism in narcissism is that the core of narcissism rests in a ‘*felt quality of perfection*’ (Rothstein, 1999, p.17). Narcissism is the *process* of maintenance and regulation of self-esteem (Freud, 1957; Stolorow, 1975; Val, 1982). As such, the psychoanalytic literature spoke for a century to a complex model of the mind, in which the cognitive aspect is only one branch. The subsequent cognitive literature aimed to demonstrate how cognition alone is sufficient to explain pathology, organise treatment, and measure outcomes. The poor outcomes and drop-out rates for eating-disorder treatments suggest otherwise (Agras et al., 2009; Carter et al., 2004; Dejong et al., 2012; Eivors et al., 2003; M. Fisher, 2003; Huas et al., 2011; Keel & Brown, 2010; Mahon, 2000; McFarlane et al., 2008; Mewes et al., 2008; Paxton et al., 2012; Schnicker et al., 2013; Sly & Bamford, 2011; Sly et al., 2013).

The relationship between self-sufficiency and recovery in eating disorders has received little attention, however, the more autonomous or intrinsically motivated and individuals is, the more likely they will achieve behavioural change (van der Kaap-Deeder et al., 2014). Understanding the role of self-sufficiency and the eating disorders may provide knowledge to increase clinical utility in the eating disorder population.

6.3.2.5 Entitlement. Entitlement is a shared characteristic of grandiose and vulnerable narcissism. Entitlement was described as ambitiousness, need for power, dominance, hostility, toughness, intolerance of others, and lack of self-control (Raskin & Terry, 1988). Little research has been conducted examining the relationship between entitlement and eating disorders. However, the relationship has been theorised to exist (Maine, Davis, & Shure, 2008). Again, it is argued that the sensitivity of this construct

may have excluded it from research in the eating disorder population which already is stigmatised.

Sense of entitlement tends to emerge as an insistence of how the world should be, anger about how they have suffered, and believing only they have been hurt, betrayed, or rejected (Maine et al., 2008). Riebel (2000) described the sense of entitlement felt by people with bulimia nervosa by stating,

Of all my clients, it is the bulimics who park in the reserved spots, put their shoes on the sofa, come to group screening sessions without a chequebook saying they did not know there would be a fee, or do not return calls after missed sessions. The message seems to be, “That rule doesn't apply to me” (p. 183).

Given research has not examined the relationship between entitlement and eating disorders, it is unsurprising that research has not examined how entitlement relates to treatment resistance which may provide information about how to support change in individuals with eating disorders.

6.3.2.6 Exploitativeness. Exploitativeness was described as rebelliousness, nonconformity, hostility, and inconsideration and intolerance of others (Raskin & Terry, 1988). Little research has explored exploitativeness in the eating disorder population but it appears individuals with bulimia nervosa, rather than anorexia nervosa, demonstrate exploitative characteristics. Specifically, bulimics reportedly “break common rules of honesty and civility, in a kind of rebellious selfishness” (Riebel, 2000). Moreover, consistently theft and other impulse control related behaviours have been demonstrated by bulimic patients (see Fischer, Smith, & Cyders, 2008, for a review). Interestingly,

rebellious and nonconforming behaviours mirror the impulsivity of individuals with narcissism. As impulsivity (i.e., sensation seeking) is used by Raskin and Terry (1988) to define exhibitionism, the overlapping content may contribute to the poor internal consistency of factors (see 6.3.2.8 *Critique of seven factors*). Whilst the narcissistic characteristic exploitativeness has been explored in the eating disorder population, the contribution of exploitativeness to treatment resistance in the eating disorders has not been established.

6.3.2.7 Superiority. Superiority is a shared characteristic of grandiose and vulnerable narcissism. Superiority was described as concern for status, social presence, and self-confidence (Raskin & Terry, 1988). Individuals with eating disorders have been described as having an inflated sense of specialness generally stemming from self-restraint in anorexic individuals (Bruch, 1973, 1978; Faer, Hendriks, Abed, & Figueredo, 2005) and being able to beat the biological process of overeating leading to being overweight in bulimic individuals (Riebel, 2000). Individuals with anorexia nervosa often reach the illusion of grandiosity through power through control, constraint and discipline related to eating and weight behaviours, and being comparatively thin (Tobin, 1993). Anorexic individuals often use a “tone of empowerment” and a “voice of elite superiority” (Curry & Ray, 2010), reflecting the embracement of pride attached to their eating disorder (A. Lock, Epston, Maisel, & Faria, 2005). Additionally, lower body weight has been associated with higher self-esteem in individuals with anorexia nervosa (Brockmeyer et al., 2013). Sands (1989) demonstrated the aforementioned superiority, by quoting a patient with bulimia nervosa who stated,

I was the Miss America of purging. I was the best. Friends of mine got exhausted after two times. I could do it nine or ten. I

could always make the food come up...it was amazing what I could do (p. 80).

Like individuals with clinically diagnosed narcissism, individuals with eating disorders may flaunt their achievements because, without superior achievements, they feel themselves to be of little value (Ronningstam, 2010). The self-perception of superiority is likely a defense against their fragility and lack of defined identity (Horner, 2005). To assure their feelings of superiority, individuals with eating disorders are frequently making comparisons to others and are aware of rank in relation to appearance (M. Campbell & Waller, 2010; Cardi, Di Matteo, Gilbert, & Treasure, 2014; Fox, Ward, & O'Rourke, 2005; Riebel, 2000).

6.3.2.8 Critique of seven factors. Whilst the seven factors of grandiose narcissism are theoretically important and provide another avenue to explore the role of narcissism in eating disorders, the psychometric properties of the factors are inadequate. Although the internal consistency of the total score for the NPI indicates good reliability (.83), the seven factors (authority, self-sufficiency, superiority, exhibitionism, exploitativeness, vanity and entitlement, accounting for 52% of the total NPI score variance) had concerning internal consistencies of .73, .63, .54, .50, .52, .50, and .64, respectively, questioning the application of these factors (Raskin & Terry, 1988). Factor correlations ranged from .11 to .42. Del Rosario & White (2005) replicated the seven-factor solution and examined the internal consistency of the scale, finding the same results; only authority and the overall scale score had high internal consistency (> .70) whilst the other factors ranged from .39 to .64. It is unsurprising that there is some inconsistency given the overlap in items. For example, the “inflated sense of specialness” definition of superiority is somewhat related to entitlement. Furthermore,

the need for constant attention and admiration, which is weighted under exhibitionism, appears similar to vanity.

Several researchers have examined the factor structure of the NPI with inconsistent results (Ackerman et al., 2011; Corry, Merritt, Mrug, & Pamp, 2008; Emmons, 1984, 1987; Kubarych, Deary, & Austin, 2004; Raskin & Hall, 1981; Raskin & Terry, 1988). Emmons (1984) conducted a principal components factor analysis of an earlier version of the NPI which comprised 54-items. Using scores from 451 college students, a 40-item four-factor solution accounting for 72% of variance in NPI score was produced. Emmons (1987) used scores from 388 college students to replicate this four-factor solution and 37-items were retained. The four factors represented Leadership/Authority ($\alpha = .69$), Self-Absorption/Self-Admiration ($\alpha = .81$), Superiority/Arrogance ($\alpha = .70$) and Exploiteness/Entitlement ($\alpha = .68$). Factor correlations ranged from .16 to .57 (Emmons, 1987). In contrast, Raskin and Terry's (1988) principal components factor analysis of the 54-item NPI (Raskin & Hall, 1981), using scores from 1018 undergraduate university students, revealed a seven-factor solution with inadequate internal consistencies on four factors. In an attempt to improve the psychometric properties of this seven-factor solution, Raskin and Terry (1988) deleted seven items with a negative or near-zero correlation to the total scale score, three items that showed significant negative loadings in the pattern matrix, and four items which did not significantly load on one or more of the components. More recently, Kubarych and colleagues (2004) conducted a principal component analysis of the NPI using the current 40-item version (Raskin & Terry, 1988) with 338 undergraduate university students. A two-factor solution, Power ($\alpha = .82$) and Exhibitionism ($\alpha = .72$), explaining 22% of the variance was produced. Kubarych and colleagues (2004) noted the poor fit

of this model. Corry and colleagues (2008) also revealed a two-factor model (Leadership/Authority and Exhibitionism/Entitlement) of the 40-item NPI (Raskin & Terry, 1988) in a sample of 1686 college students, and further analyses revealed the two-factor model obtained in their study had both goodness of fit and acceptable internal consistency (Corry et al., 2008).

Two three-factor models of the NPI have been found by researchers (Ackerman et al., 2011; Kubarych et al., 2004). A three-factor solution, Power ($\alpha = .80$), Exhibitionism ($\alpha = .70$) and Being a Special Person ($\alpha = .63$), explaining 27% of the variance was by produced Kubarych and colleagues (2004). However, they noted poor fit of this model, deleting items with nonsignificant loadings or high correlations, and allowing for correlated errors. Moreover, Ackerman and colleagues (2011) attempted to replicate Kuybarych and colleagues (2004) three-factor solution but it was not easily identified. Instead Ackerman and colleagues (2011) reported a three-factor solution consisting of the dimensions of Leadership/Authority, Grandiose Exhibitionism, and Entitlement/Exploitativeness. Ackerman and colleagues (2011) did not examine the internal consistency of the factors that emerged from their analyses, due to their expectation that some important factors of the NPI may comprise too small number of items to meet sound internal consistency. This omission highlights the ambiguity of factor extraction.

Overall, the least reliable factor structure was the seven-factor solution proposed by Raskin and Terry (1988) whilst two- to four-factor structures demonstrated sound psychometric properties. As Kubarych and colleagues (2004) stated, “the NPI is a scale in transition: a measure of important human characteristics that has yet to reach an agreed psychometric structure” (p. 860).

A major limitation of the testing of the NPI factor structure to date is the reliance on university students, often in undergraduate study, limiting generalisability of results to the general population. The NPI factor structure requires evaluation in a more generalised population. Additionally, the NPI contains items. (e.g., “I would prefer to be a leader”) with poor discriminant validity (Rosenthal & Hooley, 2010), failing to distinguish between individuals with narcissism and individuals without narcissism (rather with self-esteem issues). The poor discriminant validity of some NPI items (i.e., measuring narcissism and other constructs) may be contributing to the difficulties determining a factor structure.

6.3.2.9 Summary. In summary, research has demonstrated to varying degrees a relationship between the seven components of grandiose narcissism (entitlement, exploitativeness, superiority, vanity, exhibitionism, self-sufficiency and authority) and eating disorders. Yet the capacity to measure these aspects of grandiose narcissism are limited given the low reliability of these subscales, especially in clinical populations. It is important to explore these aspects of grandiosity in the eating disorder population.

6.4 Narcissism in Treatment

Eating disorders are difficult to treat, with individuals often presenting as resistant to absolving eating disorder behaviours. In non-eating disordered client populations, narcissism has a strong, mostly negative, influence on therapeutic outcomes if it is not addressed in therapy (W. Ellison et al., 2013; Hilsenroth et al., 1998; Kernberg, 2007; Ronningstam, 2011). Therefore, it is argued that narcissism could account for the treatment resistance in eating disordered individuals. There is preliminary evidence to suggest that narcissism is associated with eating disorder symptomatology (Davis et al., 1997; Gordon & Dombeck, 2010; Lehoux et al., 2000;

McLaren et al., 2001; Mogul, 1980; R. Sands, 2000; Steiger et al., 1997; Steinberg & Shaw, 1997; Waller et al., 2007). However, no research into eating disorders has explored the relationship between the two facets of narcissism and resistance, and whether there are differential relationships across diagnoses. This needs to be explored; if either facet of narcissism predicts treatment engagement this suggests that addressing that facet of narcissism may be the key to overcoming resistance in eating disorders.

Even though there is consistent theoretical agreement and case evidence that prominent narcissistic pathology interferes with treatment leading to poorer outcomes, little empirical research has investigated the influence of narcissism as a unitary construct on treatment. Using retrospective notes to diagnose personality disorder symptoms, one study found that outpatients that met the “requires excessive admiration” criteria for narcissistic personality disorder were at increased risk of attrition from long term psychodynamic psychotherapy compared to those outpatients who did not meet this criterion (Hilsenroth et al., 1998). Another study found that although overall scores on the O’Brien Multiphasic Narcissism Inventory (O’Brien, 1987) were unrelated to attrition from cognitive behavioural therapy in an eating disorder population, the “narcissistically abused” subscale was higher among those who ceased attending compared to those who completed treatment (M. Campbell, Waller, & Pistrang, 2009). This study was confined to only one patient group and only one type of therapy, however, making it problematic to generalise this finding to the broader population of patients, therapies, and settings. In line with the move to breaking narcissism down into facets, more recent research addresses the role of the two facets of narcissism on treatment engagement.

When narcissism is broken down into its two facets, different associations between grandiose and vulnerable narcissism and utilisation of clinical resources is evident (Cain et al., 2008). Individuals with grandiose narcissism are typically resilient to problems and this characteristic is negatively related or unrelated to distress (J. Miller et al., 2010). Unsurprisingly, in an outpatient psychotherapy clinic sample (comprising of individuals with at least one Axis I disorder and 68% of these with at least one personality disorder diagnosis), grandiose characteristics were associated with reduced treatment utilisation including more cancellations, non-attendance and fewer treatment admissions (Pincus et al., 2009). Whilst grandiosity has been related to decreased utilisation of therapeutic services and a higher rate of client-initiated drop-out (W. Ellison et al., 2013), vulnerability has been related to increased treatment seeking (Cain et al., 2008; W. Ellison et al., 2013). Individuals endorsing vulnerable narcissism have more contact with crisis services, more hospitalisation and less nonattendance at therapy compared to individuals with grandiose narcissism (A. Wright et al., 2010). Vulnerable narcissism manifests “little positive affect and a substantial degree of negative affect (i.e., depression, anxiety, hostility, and paranoia)” (J. Miller et al., 2010), which may contribute to greater access of intervention. Whilst the relationship of the two facets of narcissism and reluctance to engage in treatment and on treatment attrition has been examined, their impact on therapeutic benefit has not been examined.

Dividing narcissism into its two facets, grandiose and vulnerable, improves clinical utility due to differing presentations which require differing treatment approaches (Pincus & Lukowitsky, 2010). If clients do strongly endorse grandiosity or require excessive admiration, therapists must be aware of risk of dropout for these individuals (Hilsenroth et al., 1998; Pincus et al., 2009). Negotiation, particularly

considering the demands made by these patients (e.g., dictating frequency of sessions, treatment rules and permissible topics), can be helpful to reduce attrition (Ivey, 1995; Kernberg, 2007; Maldonado, 2003) despite usually negotiation compromising aspects of treatment. To reduce risk of dropout it can also be helpful to firstly discuss explicitly and tactfully the narcissistic characteristics that may result in attrition (Kernberg, 2009; Ornstein, 2009). Additionally, increasing the connection between the individual and therapist can mitigate narcissistic behaviours in therapy. This can be done by providing empathy and creating a sense of similarity (Finkel, Campbell, Buffardi, Kumashiro, & Rusbult, 2009; Konrath, Bushman, & Campbell, 2006). Caution in treatment is required when treating those individuals with grandiose narcissism who present as well adjusted to ensure that underlying pathology is assessed and addressed. With an established therapeutic relationship comes grandiosity. For individuals with high vulnerable narcissism, therapy focusing on interpersonal effectiveness will assist lack of confidence in interpersonal ability. It will be important to assess the underlying, less apparent feelings of grandiosity and entitlement. Frustration, hostility, shame and depression may indicate less apparent feelings of grandiosity and entitlement. Individuals with vulnerable narcissism are likely to want the therapist's approval and will be hypersensitive to perceived slights, increasing risk of drop-out to manage self-esteem. They are also at risk of drop-out due to avoidance and highlighting to the client this and the importance of ongoing attendance, even when feeling well, can minimise the risk of its occurrence.

6.5 Summary

Despite the established link between eating disorders and narcissism (Davis et al., 1997; Gordon & Dombeck, 2010; Lehoux et al., 2000; McLaren et al., 2001; Mogul,

1980; R. Sands, 2000; Steiger et al., 1997; Steinberg & Shaw, 1997; Waller et al., 2007), narcissism has been excluded from the conceptualisation of individuals with eating disorders. It is argued that without the inclusion of this factor in the conceptualisation of individuals with eating disorders, interventions targeting treatment resistance in the anorexia nervosa and bulimia nervosa populations are likely to continue to be inadequately equipped to address the current state of treatment efficacy. The current research therefore aims to address the shortfalls in the literature by reintroducing narcissism into the conceptualisation of anorexia nervosa and bulimia nervosa and exploring its role. Not only will this help clarify some previous inconsistent research findings, it is also important to explore whether grandiose narcissism, vulnerable narcissism or both facets of narcissism are present in individuals with either anorexia nervosa or bulimia nervosa because interventions are contingent upon which narcissism is present. From the perspective of assessing narcissism, the NPI requires an exploration of its factor structure. Moreover, no research into eating disorders has explored the relationship between the two facets of narcissism and treatment resistance, and whether there are differences across diagnoses. This needs to be explored. If either facet of narcissism predicts treatment engagement this suggests that addressing that facet of narcissism may be the key to overcoming resistance in eating disorders.

Chapter 7

The Role of Therapists in Eating Disorder Treatment

7.1 Overview

Self psychology's unique understanding of therapist and therapeutic relationship provides a rationale of how the therapist may perpetuate resistance. Self psychology suggests that without empathic enquiry and empathic interpretation from the therapist, the clients' presenting issue can be enabled (Kohut, 1959). It is suggested that countertransference and therapist factors may play a role in the breaking of empathic immersion (Plakun, 2012). One recognised impeding factor which suitably fits into the self psychology framework is narcissism (see Chapter 5). Individuals with narcissism suffer interpersonal difficulties (American Psychiatric Association, 2013), therefore it is unsurprising that this would extend to the therapeutic relationship. Narcissism, in the past, was noted as a common characteristic of therapists (Seligson, 1992). Moreover, in those therapists with narcissistic characteristics, it was theorised that they were unable to maintain an empathic position, instead, hastily validating the client to allay their own anxieties (Seligson, 1992). Narcissism in therapists has not been examined a) in the literature recently, b) empirically, nor c) in therapists who treat individuals with eating disorders. Given narcissism in therapists interrupts empathic immersion, contributing to resistance in clients, it is important to determine the extent of narcissism in therapists.

7.2 Self psychology and countertransference

Self psychology emphasises empathic enquiry and empathic interpretation as crucial to the curative process (Bienenfeld, 2005; Kohut, 1959) and key to treating narcissistic behaviour disorders (Kohut, 1959). Countertransference can interfere with

empathic immersion making it difficult for the therapeutic space to accommodate the client's complete exploration of his or her needs (Plakun, 2012). The notion of countertransference was established in psychoanalysis, the predecessor to self psychology. Countertransference has been conceptualised in a few different ways; firstly, as traditionally understood, as the therapist's unconscious reaction to a patient's transference during analysis (Freud, 1958); secondly, a more encompassing definition, whereby the therapist could also react consciously to the patient's transference (Heimann, 1950); and thirdly, would consciously or unconsciously view the patient as someone from the past or react to the patient based on the therapist's own unresolved conflicts, regardless of transference from the patient, therefore feel personal stress and have difficulty treating the patient (Person et al., 2005). For the purpose of this thesis, countertransference is the therapist's conscious or unconscious response to a client based on their own experience and unresolved conflicts. As psychoanalyst Hanna Segal said, "countertransference can be the best of servants but it is the most awful of masters" (Segal, 1981). Countertransference can be managed with good insight and supervision, and can be used to indicate client needs and underlying psychology. However, countertransference can also result in the therapist's difficulty in treating the client and ineffectiveness to facilitate change (Bloomgarden, Gerstein, & Moss, 2003; Costin & Johnson, 2002; Freud, 1958; Johnston et al., 2005; Person et al., 2005; Rance, Moller, & Douglas, 2010), both of which can stem from the therapist projecting their own needs onto clients, thus overlooking real dynamics (Glickauf-Hughes & Mehlman, 1995), and by therapists enforcing change through directive interventions (Bamford & Mountford, 2012) which is resisted by the client (Strober, 2004).

Strong emotional and countertransference reactions are common in treatment providers of individuals with eating disorders (Colli et al., 2015; Daniel, Lunn, & Poulsen, 2015; Kaplan & Garfinkel, 1999; Satir, Thompson-Brenner, Boisseau, & Crisafulli, 2009; Strober, 2004; Thompson-Brenner, Satir, Franko, & Herzog, 2012). A meta-analysis of 20 studies, published between 1984 and 2010, revealed that clinician countertransference typically reflected frustration, hopelessness, lack of competence, and worry (Thompson-Brenner et al., 2012). Countertransference responses have also been around appearance, body size and body shape (DeLucia-Waack, 1999; Warren, Crowley, Olivardia, & Schoen, 2009) and include a heightened awareness of, and changes in, eating habits, appearance, body image and physical health, especially immediately after interactions with clients (DeLucia-Waack, 1999; Warren et al., 2009). It has been noted that “patient’s distorted projection of the therapist’s body or her own” influences therapist’s own body image (Lowell & Meader, 2005, p. 243).

Therapist characteristics can influence countertransference (Strober, 2004). The most likely cause of countertransference for therapists treating individuals with eating disorders is their own struggle with eating pathology. Up to one-third of therapists who treat patients with eating disorders have a personal history of an eating disorder (Babarich, 2002; Johnston et al., 2005) and it is proposed that some eating disorder therapists have current eating disorders for a number of reasons; current disturbances in eating attitudes, body image, or self-esteem have been found in therapists (Bamford & Mountford, 2012) one quarter of clinicians with a past eating disorder relapsed after entering the field as a professional (Babarich, 2002); and the profession is dominated by females (Willyard, 2011) which as a group has an estimated 20% of undiagnosed eating disorders (Paxton et al., 2012). Whether recovered therapists should treat individuals

with eating disorders is highly contentious with practical and ethical implications (Bloomgarden et al., 2003; Costin & Johnson, 2002; Johnston et al., 2005; Rance et al., 2010). Concern surrounds over-identification with clients, enmeshment and boundary violations, using treatment of others for self, vulnerability and subjectivity (Bloomgarden et al., 2003; Costin & Johnson, 2002; Hughes, 1997; Jacobs & Nye, 2010; Johnston et al., 2005; Warren, Schafer, Crowley, & Olivardia, 2013), which may have influenced the already documented countertransference responses related to body and weight. Additionally, denial of eating disorder pathology existed amongst past eating disordered therapists, such that they were shown to, for example, exaggerate their normality to avoid stigma, which was argued to increase the risk of poor outcome for the client they were treating (Rance et al., 2010). The lack of clear guidelines regarding when someone is considered sufficiently recovered to work with eating disordered clients perpetuates the controversy (Bloomgarden et al., 2003).

Another therapist characteristic which may influence countertransference is narcissism, the core of the school of self psychology (see Chapter 5). Kohut (1971), founder of self psychology, shifted the perception of narcissism as a pathological issue and having pejorative connotations to being an imperative aspect of development resulting in a cohesive state. He noted the resultant disorders of self from failed narcissistic development manifested in substance abuse, eating disorders, narcissistic personalities, borderline states, antisocial personalities and psychosis. Exploration of narcissism as a characteristic of therapist is warranted given the influence narcissism has on interpersonal relationships and that therapists may have eating pathology and the established link between narcissism and eating pathology (see Chapter 6). The influence of narcissism on relationships, including the therapeutic one, is examined next.

7.3 Self Psychology and Narcissism

7.3.1 Narcissism in Everyday Relationships. Individuals with narcissistic characteristics suffer interpersonal difficulties (American Psychiatric Association, 2013). Kohut (1977) described individuals with narcissism as being self-absorbed, devaluing others, and impulsively relating to others. Research has focused on grandiose narcissism rather than vulnerable narcissism, due to the marked negative impact of grandiose narcissism; individuals with vulnerable narcissism tend to have lesser interpersonal difficulties, rather presenting with fear of relating to others and lacking confidence in interpersonal abilities (J. Miller & Campbell, 2008; Pincus & Lukowitsky, 2010).

Initially individuals with high levels of grandiose narcissism tend to be popular, however, they lose popularity over time (Blair, Hoffman, & Helland, 2008). One rare longitudinal study in the area (Paulhus, 1998) examined student study groups that met weekly for 20 minutes for seven consecutive weeks. In each meeting, set discussions related to their learning but also facilitated the emergence of personality characteristics. After the first week, students with narcissism were perceived as more agreeable, conscientious, open, competent, entertaining, and well-adjusted by their peers. However, at week seven students with narcissism annoyed others by displaying a socially superior stance and not reciprocating positive attention from others.

More recent research has demonstrated why and how the decline in popularity may happen. Rivalry in individuals with narcissism (i.e., this social superior stance) consistently showed a predictive pattern unfavourable for the maintenance of close relationships (Back et al., 2013; Carlson, Vazire, & Oltmanns, 2011; Leckelt, Kufner, Nestler, & Back, 2015; J. Miller et al., 2011). Aggression in individuals with narcissism

also hinders maintenance of relationships. For example, a recent meta-analysis examining 84 studies ($N = 11297$) revealed that narcissism was positively related to aggression across studies (K. Rasmussen, 2015). Research revealed that when provided the opportunity to aggress against someone who had insulted them, praised them or against an innocent third person, an individual endorsing narcissism had significantly higher levels of aggression toward the insulter. Research has also revealed that narcissism was related to unprovoked aggression. Using electric shock on others, results indicated that more narcissistic-like participants engaged in more unprovoked antagonism compared to participants with little narcissism (Reidy, Foster, & Zeichner, 2010). Inability of individuals with narcissism to forgive people also hinders maintenance of relationships. In a series of studies, four self-report and one in a real-time, controlled laboratory context, it was found that narcissistic entitlement predicted less forgiveness, less inclination to agree with forgiveness in general and high demands for repayment of transgressors in a cohort of undergraduate students (Exline, Baumeister, Bushman, Campbell, & Finkel, 2004).

Individuals with narcissism have success in dating but are unsuccessful in long term romantic relationships. Recent research revealed that narcissism increased mate appeal, stronger than friendship appeal, mediated by physical attractiveness and social boldness (Dufner, Rauthmann, Czarna, & Denissen, 2013). Whilst initial ratings are favourable, conflict emerges over time in romantic relationships. Partners report negative interpersonal characteristics of individuals with narcissism including exploitation of others, an exaggerated sense of self-worth and arrogance (W. Campbell, Foster, & Finkel, 2002). Wink (1991) found that the spouses of individuals with narcissism described them as aggressive, demanding, and argumentative. Individuals

with narcissism describe less commitment to their ongoing romantic relationship and more interest in alternative relationship options (thus coined as game-playing) compared to individuals that do not have narcissism (W. Campbell et al., 2002).

A similar trend of decreasing popularity in individuals with narcissism from first acquaintance is evident in workplace relationships; individuals with narcissism are initially liked by colleagues, however are soon viewed negatively due to poor-quality exchanges creating tension within the workplace (W. Campbell, Hoffman, Campbell, & Marchisio, 2011). However, individuals with narcissism can be productive workers, especially successful when in roles of authority (W. Campbell et al., 2011). In summary, the breadth of research highlights that individuals with narcissism have considerable interpersonal problems.

7.3.2 Narcissism in therapists. Given the associations between narcissism and relationships, it is unsurprising this would extend to the therapeutic relationship. Research has demonstrated that narcissism in therapists can impede on therapeutic outcomes with any client presentation (Clark, 1991; Seligson, 1992). Narcissism in the therapist may create blind-spots that would impede the successful practice of psychotherapy (Clark, 1991). Therapists with high narcissism may project their own needs onto clients, thus overlooking real dynamics. Moreover, therapists with narcissism may attempt to get their needs met via their clients, either vicariously or directly. It has also been established that clients with narcissism can envy and compete with their therapists (Kernberg, 2007; B. Rasmussen, 2005). Therapists, in turn, may compete with the client. This comparison has already been noted between therapists and clients regarding eating and body image, interfering with their own ability to treat the patient (Bordo, 2003; Gorman-Ezell, 2009).

The role of narcissism in therapists is further complicated when they treat individuals with narcissistic characteristics. When a therapist with narcissism meets a client with narcissism, the pathology of each is intensified (Seligson, 1992). The “co-narcissist” can identify the therapist as narcissistic, and unconsciously modifies his or her presentation. The client tends to be unassertive, or may be defiantly assertive in an attempt not to comply. The lack of empathy in the therapist perpetuates the client’s presentation. Neither therapist nor client feel they can consider each other’s needs without sacrificing his or her own (Seligson, 1992).

More commonly, therapists, sympathetic to presentations identified in themselves, respect narcissistic characteristics in clients. Manifestations of this respect include therapist condoning the behaviour of patients with narcissism and allowing overindulgence of their own narcissism in their practice (Seligson, 1992). Whilst interpretation not confrontation is recommended as intervention (Kohut, 1977), a therapist with narcissism sensitive to narcissistic injury fails to interpret the patient’s injury, rather validates it. Pathology is intensified due to the therapist colluding with the patient’s narcissistic need. Therapists unconsciously project their own anxieties of narcissistic injury into the dynamics of patients, and in turn patients act to preserve the therapist’s wholeness by enacting the therapist’s unconscious wishes. Resultantly, the therapist, not the patient, benefits in therapy (Seligson, 1992).

7.4 Conclusion

It is argued that due to the therapists own unresolved conflicts (i.e. current eating behaviour and narcissism) they enact countertransference, resulting in a break of empathic immersion, thus counterproductive to therapeutic outcomes. It is argued that countertransference fosters treatment resistance from the client in eating disorder

treatment. To start examining this argument, confirmation of evidence of eating pathology in current therapists of eating disordered individuals is required. Furthermore, exploration into the facets of narcissism in the eating disorder therapist is needed. Specifically, investigating whether eating pathology and narcissism exist in eating disorder treatment providers will provide the knowledge required to guide future research to examine the inclusion of self psychology into the treatment of individuals with eating disorders.

Chapter 8

Rationale

8.1 Overview

The literature presented so far indicates burgeoning prevalence rates of anorexia nervosa and bulimia nervosa, seriously affecting individuals with noteworthy medical, psychological, social and economic consequences (Chapter 2). Even the most widely accepted treatments, cognitive behavioural therapy and family therapy, fail to treat approximately 50% of individuals; non-responders, high attrition rates and high relapse rates are common (Chapter 3). Affected individuals demonstrate resistance which is at best measured using state- (stages of change questionnaire) and trait-like (personality questionnaires) measures (Chapter 4). Despite researchers' best efforts to improve eating disorder recovery through motivational interventions, motivation has only been useful to assess an individual's momentary readiness to engage in treatment and to gauge resistance, rather than as an avenue for effective intervention (Chapter 4). Self psychology provides an alternative way to conceptualise eating disorders (Chapters 5). With its conceptualisation of eating disorders as narcissistic behaviour disorders, known to be resistant to treatment (Chapter 6), and its explanation of how therapists may perpetuate this resistance (Chapter 7), the use of the self psychology perspective may provide additional understandings to offset poor prognosis. In order to strengthen these understandings, a comprehensive investigation of narcissism in patients and therapists including how narcissistic characteristics may contribute to treatment resistance in eating disorders is essential.

8.2 Summary of the Salient Findings and Gaps

Currently, the best practice treatment guidelines promote the use of family-based therapies for younger people with anorexia nervosa, and individual manualised psychological therapies, predominantly CBT for bulimia nervosa and for individuals with anorexia nervosa where family therapy is not appropriate (e.g., adults; APA, 2006; NICE, 2004; RANZCP, 2014). However, successful recovery rates are ominous (Agras et al., 2009; Byrne et al., 2011; Dalle Grave, Calugi, Conti, et al., 2013; Dalle Grave, Calugi, Doll, et al., 2013; Fairburn et al., 2009; Galsworthy-Francis & Allan, 2014; Keel & Brown, 2010; Lampard & Sharbanee, 2015; McFarlane et al., 2008; C. Miller & Golden, 2010; Wonderlich et al., 2014), even when CBT and family-based therapy are used. Poor prognosis has been attributed to the highly resistant nature of these disorders (M. Cooper, 2005; Fassino & Abbate-Daga, 2013; Vitousek & Watson, 1998). Despite the use of motivation as one means of assessing resistance, little evidence demonstrates that motivational interventions overcome resistance to treatment (Knowles et al., 2013). Enduring resistance in eating disorders suggests the need to revisit the conceptualisation of eating disorders (Wilson et al., 2007).

The self psychology perspective provides an alternative way to conceptualise eating disorders and the widespread resistance in this population. This perspective views eating disorders as narcissistic behaviour disorders, disorders resulting from a disrupted healthy narcissistic development (Kohut, 1971, 1977, 1984). Self psychology treatment includes a strong emphasis on empathic enquiry and empathic interpretation from the therapist (Kohut, 1959). The self psychology understanding presents a rationale for resistance in the eating disorder population as eating disorder behaviours are seen to play an important role in meeting the individual's narcissistic needs (Bachar, 1998;

Barth, 1988; Bruch, 1978, 1982; Fassino & Abbate-Daga, 2013; Geist, 1989; Kohut, 1977; S. Sands, 1989), and a lack of therapist empathic enquiry and empathic interpretation (Bienenfeld, 2005; Kohut, 1959; Lessem, 2005), in the form of countertransference, perpetuates already present resistance (Plakun, 2012; Strober, 2004). Thus, a self psychology stance may be a key approach to containing and overcoming treatment resistance in eating disorders. To empirically test the appropriateness of the self psychology understanding of eating disorders, further research into narcissism and the role of therapist, and their impact on treatment resistance in the eating disorder population is required. It is not suggested that a universal approach with a narrow focus solely on narcissism and therapist factors instead of other established conceptualisations is necessary. Rather, the addition of these emphasised factors as key components is required to ensure a more comprehensive explanatory model which may help inform the development of more effective treatments.

Individuals with narcissistic behaviour disorders exhibit high levels of narcissism (Goldberg, 1999; Kohut, 1977). Therefore, to empirically determine that eating disorders can be considered narcissistic behaviour disorders, the facets and levels of narcissism need to be examined in this population. Kohut (1977) identified both grandiose and vulnerable aspects of narcissistic disorders (i.e., those with deficiencies in overall identity development), and empirical evidence has revealed that narcissism could be separated into its grandiose and vulnerable components across the literature (see Cain et al., 2008, for a review). Therefore, in establishing the usefulness of incorporating narcissism into explanatory models of eating disorders, these facets of narcissism in the eating disorder population should be explored. The studies to date that

have explored narcissism in the eating disorder population (e.g., Lehoux et al., 2000; McLaren et al., 2001; Mogul, 1980; R. Sands, 2000; Steiger et al., 1997) have failed to explore the two facets of narcissism, rather conceptualising narcissism as a unitary construct. The studies that did differentiate narcissism into its two facets (e.g., Davis et al., 1997; Gordon & Dombek, 2010; Maples et al., 2011) only used nonclinical samples of convenience of undergraduate students, often without a control group, and focused only on particular eating disorder criteria (e.g., drive for thinness). Whilst current questionnaires that assess grandiose narcissism and vulnerable narcissism exist, in order to examine grandiose and vulnerable narcissism in the eating disorder population, the first step will be to explore the factor structure of the Narcissistic Personality Inventory (NPI) given there is inconsistency regarding the internal consistency of factors of this grandiose narcissism questionnaire (Ackerman et al., 2011; Corry et al., 2008; del Rosario & White, 2005; Emmons, 1984, 1987; Kubarych et al., 2004; Raskin & Terry, 1988), despite it being the most commonly used measure of narcissism in the literature.

In order to further examine whether self psychology's conceptualisation of eating disorders is empirically supported, the relationship between both grandiose narcissism and vulnerable narcissism and treatment resistance in the eating disorder population requires exploration. These relationships have not been examined in the eating disorder population at all despite the evidence in other psychiatric populations that the presence of narcissism contributes to reduced treatment engagement (W. Ellison et al., 2013; Hilsenroth et al., 1998; Kernberg, 2007; Ronningstam, 2011). The lack of research may be due to the lack of assessment tools that directly measure resistance. The closest means of measuring resistance available is assessing both state- and trait-

like resistance via the stages of change questionnaire, and the Butcher Treatment Planning Inventory or MMPI Treatment Indicator Scale, respectively (Perry, 2009).

Despite the lack of research into the relationship between both grandiose narcissism and vulnerable narcissism and treatment resistance in the eating disorder population, the insubstantial research thus far does provide some insight into expected outcomes of the current research project. Grandiosity, not vulnerability, was related to decreased treatment utilisation in a population with narcissism (W. Ellison et al., 2013), and individuals with anorexia nervosa have been found to be the most resistant to treatment (Geller, Zaitsoff, & Srikameswaran, 2005). However, whether there is a relationship between anorexic individuals and grandiose narcissism has not been examined. Additionally, the mirroring selfobject need (Kohut, 1977), the need to feel affirmed, recognised, accepted, appreciated and valued, which is a characteristic of individuals with anorexia nervosa (Bachar, 1988), is a need of a person seeking acknowledgement of their grandiose self (Wink, 1991). However, whether there is a positive relationship between anorexia nervosa and grandiose narcissism has not been explored. Moreover, the idealising selfobject need (Kohut, 1977), the need to feel a connection to an admired other enabling a sense of safety, soothing and strength, which is a characteristic of individuals with bulimia nervosa (Bachar, 1988), is a need of a person with a vulnerable narcissistic self (Wink, 1991). However, whether there is a positive relationship between bulimia nervosa and vulnerable narcissism has not been explored. Three findings make it plausible to hypothesise that individuals with bulimia nervosa have vulnerable narcissism, *and* thus, be likely to engage in treatment; vulnerable narcissism and bulimia nervosa share traits such as inability to self-soothe and low self-esteem (Maples et al., 2011), vulnerable narcissism was not related to

decreased treatment utilisation in a population of individuals with narcissism (Ellison et al., 2013), and individuals with vulnerable narcissism were more likely to engage in treatment when feeling shame and withdrawn (Pincus & Lukowitsky, 2010). However, it remains unknown whether individuals with bulimia nervosa have vulnerable narcissism and, if so, whether it is because of this vulnerable narcissism that individuals with bulimia nervosa are likely to engage in treatment.

The role of the therapist is emphasised in self psychology because through the use of empathic immersion and empathic interpretation, the therapist facilitates the development of insights which surface within the therapeutic relationship, resulting in a complete identity that does not rely on the eating disorder to meet narcissistic needs (Kohut, 1971). Equally, problems in the therapeutic relationship such as countertransference can impede the process of identity development and overcoming the eating disorder (Colli et al., 2015; Daniel et al., 2015; Kaplan & Garfinkel, 1999; Rance et al., 2010; Satir et al., 2009; Strober, 2004; Thompson-Brenner et al., 2012). Therefore, research into therapist factors is warranted. Narcissism is a therapist factor, previously detected in therapists (Seligson, 1992), which has been implicated as a barrier to client recovery. Narcissism in therapists fits well into the self psychology model, which views narcissism as a core aspect of healthy or disrupted development resulting in a cohesive or pathological self, respectively. Narcissism in therapists impedes on therapeutic outcomes (Clark, 1991), and this is worsened when treating individuals who also present with narcissism as therapists are unable to maintain an empathic position, instead colluding with the client's narcissistic need (Seligson, 1992). It is unknown whether narcissism is elevated in therapists who treat individuals with eating disorders.

Therefore, the association between narcissism and eating disorders and the knowledge that eating disorder pathology is or has been present in therapists (Warren et al., 2013), suggests that practitioners who treat individuals with an eating disorder may have current eating pathology and narcissism accordingly. Therefore, as a starting point, an investigation of whether disordered eating is present in therapists, particularly in those therapists who primarily treat individuals with eating disorders, is warranted. Initially, whether eating disorder symptomatology and narcissism is elevated in therapists, as well as the experience of this from the perspective of individuals with eating disorders should be examined. This examination, covered by this program of research, will provide the knowledge to explore, beyond the scope of this thesis, treatment outcomes, as necessary.

Introducing the notion of narcissism and eating disorder behaviours in therapists as contributors to poor prognosis is not about attributing blame. The qualities that make being a therapist difficult (i.e., personal experience of mental illness) also foster success as a psychotherapist (Glickauf-Hughes & Mehlman, 1995). As Freud stated, "every analyst ought periodically ... to enter analysis once more, at intervals of, say, five years, and without any feeling of shame in doing so" (Freud, 1963, pp. 267-268).

8.3 Research Aims

To address some of the shortfalls in this field of research, the current research project has four core aims. The first aim is to determine the factors of the grandiose narcissism measure, the NPI, for use in the subsequent studies. The second aim is to examine the role of various facets of narcissism in eating disorders. The third aim is to explore the role of narcissism in treatment resistance in eating disorders. The fourth aim is to explore narcissism and eating disorder symptoms in treatment providers of

individuals with eating disorders as treatment providers are the vehicle for successful treatment.

8.3.1 Study 1. The aim of Study 1 is to explore the factor structure of the NPI, the measure of grandiose narcissism utilised in the subsequent research. The literature demonstrated inconsistent use of the seven factors of this scale due to poor psychometric properties, specifically reliability. Instead, two-, three- and four-factor solutions have been researched with varying reliability (Ackerman et al., 2011; Corry, Merritt, Mrug, & Pamp, 2008; Emmons, 1984, 1987; Kubarych, Deary, & Austin, 2004;). Study 1 aims to determine the factors of grandiose narcissism to employ in subsequent studies.

8.3.2 Study 2. The aim of Study 2 is to examine whether grandiose narcissism (and its factors identified in Study 1) and vulnerable narcissism scores are elevated in individuals with either anorexia nervosa or bulimia nervosa above those levels seen in individuals with mental health diagnoses which are commonly comorbid with eating disorders (i.e., anxiety and depression) and the general population. Moreover, this study will investigate the differences between eating disorder groups on grandiose narcissism (including its factors) and vulnerable narcissism. Additionally, Study 2 aims to determine whether either grandiose narcissism (including its factors) or vulnerable narcissism predicts state- and trait-like resistance in individuals with either anorexia or bulimia nervosa. Understanding the potential differential roles of grandiose narcissism and vulnerable narcissism will have significant implications for the treatment approach. Moreover, understanding the potential differential roles of grandiose narcissism and vulnerable narcissism will have implications for whether narcissism needs to be treated to ensure engagement in treatment of the eating disorder.

8.3.3 Study 3. Study 3 investigates whether either grandiose narcissism or vulnerable narcissism, in addition to eating symptomatology, is elevated in individuals who treat people with eating disorders (i.e., eating disorder therapists) compared to individuals who do not treat individuals with eating disorders (i.e., non-eating disorder therapists). Additionally, eating disorder therapists will be compared to a community sample to determine whether eating and narcissism scores are significantly elevated in therapists. Moreover, to determine whether eating disorder therapists have narcissism scores at levels similar to clients, which has been suggested to worsen therapeutic outcome, these groups' scores will be compared.

By identifying how eating symptomatology and narcissism present in the therapist population, future research, beyond the scope of this thesis, can examine the extent of countertransference among eating disorder treatment providers based on their own eating behaviours and narcissism (both grandiose and vulnerable).

8.3.4 Study 4. Study 4, qualitative interviews, expands on the findings of Study 2 and Study 3 by investigating the perspectives of individuals with either anorexia nervosa or bulimia nervosa on treatment and their response to excerpts on characteristics of narcissism presented in the interview. Whether and how participants ascribe characteristics of grandiose and vulnerable narcissism to themselves, and how these characteristics may impede or assist engagement in treatment will be investigated. Furthermore, Study 4 examines whether participants identified disordered eating or an eating disorder and narcissism in their therapists, and whether the presence of these impacted eating disordered individuals' engagement in treatment.

8.4 Summary

Self psychology provides an alternative way to conceptualise eating disorders which could offset poor eating disorder prognosis (Bachar, 1998; Barth, 1988; Fassino & Abbate-Daga, 2013; Gordon & Dombeck, 2010; Kohut, 1977; S. Sands, 1989). In order to determine the appropriateness of its conceptualisation in effecting treatment outcomes, first, a comprehensive exploration of its understandings is required. This program of research is the first to explore the two facets of narcissism as identified by Kohut (1971) and Cain and colleagues (2008) in individuals with an eating disorder and how these facets relate to treatment resistance. Previous research either explored these two facets in a non-clinical population (e.g., Davis et al., 1997; Gordon & Dombeck, 2010; Maples et al., 2011) or explored narcissism as a unitary construct (e.g., Lehoux et al., 2000; McLaren et al., 2001; Mogul, 1980; Steiger et al., 1997). This program of research is also the first to explore whether disordered eating is present in therapists, particularly in those therapists who primarily treat individuals with eating disorders and whether this related to clients' readiness to engage in treatment. Previous research only explored eating disorder history in therapists (Barbarich, 2002; Johnston, Smethurst, & Gowers, 2005). This research is also the first to explore levels of narcissism in therapists given the well-established link between narcissism and eating disorders and the potential of therapists to have current eating pathology. In order to examine the factors of grandiose narcissism in individuals with eating disorders and eating disorder therapists, a factor analysis of the NPI will be conducted to clarify the factor structure of this measure.

Chapter 9

Method

9.1 Introduction

The primary focus of this research program is to examine the differential role of grandiose narcissism and vulnerable narcissism in treatment resistance in a clinical population of individuals with anorexia nervosa or bulimia nervosa. The current research project aims to explore the factor structure of the Narcissistic Personality Inventory (NPI); examine the role of various facets of narcissism in eating disorders; investigate the relationship between narcissism and trait- and state-like resistance in eating disordered individuals, and; explore narcissism and eating disorder symptoms in treatment providers of individuals with eating disorders. In order to achieve these aims, a cross-sectional mixed-method design was utilised.

9.2 Design

9.2.1 Mixed-methods approach. This program of research utilises a sequential explanatory mixed-methods design strategy characterised by collection and analysis of quantitative data via online questionnaires (Study 1, Study 2 and Study 3) followed by semi-structured interviews (Study 4). The qualitative results illuminate the findings of the first three studies. The qualitative information provided by Study 4 overcame the reductionist nature of quantitative research and captured richness of the subjects' experience that was not captured in Study 2 and 3. The interviews elicited data that were used to clarify the results of Study 2 and 3.

9.3 Study 1

9.3.1 Participants. Across Australia, a sample of adults ($N = 903$) from the general population aged between 18 and 71 years old was recruited using a snowballing technique. Inclusion criterion was being over 18 years of age. The study advertisement was sent out via email (see Appendix E) to undergraduate university students, colleagues and friends (who then also forwarded on the email). Additionally, undergraduate university psychology students were recruited through the School of Psychology research participation system. Of the 1027 respondents, one was excluded from further analysis based on being less than 18 years of age. Cases were deleted where they had completed only the demographic items of the questionnaire. A small number of cases were deleted if they had any missing data on any of the variables but the missing data seemed to be at random. The 903 remaining respondents were then used for subsequent factor analyses.

9.3.2 Measures. Study 1 focused on the psychometric properties of the NPI (Raskin & Terry, 1988). The questionnaire utilised in Study 1 included demographic questions and the NPI. For a copy of the questionnaire see Appendix F. The NPI is a measure of grandiose narcissism and is the most widely used measure of narcissism in psychological research. Although based on the DSM criteria for Narcissistic Personality Disorder, the NPI also captures these features in the general population; it measures subclinical narcissism. The NPI consists of 40 forced-choice items. Specifically, respondents are directed to choose the response they most identify with for each pair of items, *A* or *B*, and if they identify with both equally to choose which one is most important. One point is scored for each narcissistic response. Total scores are generated from summing all individual scores with a possible score range of 0 to 40. The average

score for the general population is 15.3. Low scores are considered to be scores of 8.5 or less and high scores are considered to be scores of 22.1 or more.

The NPI total score (i.e., 40 items) shows evidence of good reliability and validity (Raskin & Terry, 1988). The Guttman lambda 3 (alpha) estimate of internal consistency for the total score indicated good reliability at .83 (Raskin & Terry, 1988). Adequate construct validity was demonstrated for the total score whereby the NPI loaded on the grandiosity factor of the MMPI-2 at .83 (Rathvon & Holmstrom, 1996) and correlated with a large battery of personality inventories and social attitude questionnaires (Raskin & Terry, 1988).

Raskin and Terry (1988) identified seven components using principal component analysis including (a) Authority (e.g., “I have a natural talent for influencing people”), (b) Self-Sufficiency (e.g., “I always know what I am doing”), (c) Superiority (e.g., “I think I am a special person”), (d) Exhibitionism (e.g., “Modesty doesn’t become me”), (e) Exploitativeness (e.g., “I can usually talk my way out of anything”), (f) Vanity (e.g., “I like to show off my body”), and (g) Entitlement (e.g., “I will never be satisfied until I get all that I deserve”). The inter-factor correlations ranged from .11 between Self-sufficiency and Vanity to .42 between Authority and Exhibitionism. Concurrent and construct validity was sound based on significant correlations with other personality self-report measures and observer ratings (Raskin & Terry, 1988). Moreover, the internal consistencies of the component scales were low, below the acceptable range of .70. Subsequent research has not confirmed the factor structure of this measure (see Chapter 6 for further discussion). Therefore, it is necessary to examine the factor structure for use in the subsequent studies.

9.3.3 Procedure. Following university ethics approval (2013 242Q; see Appendix G) potential participants were recruited from the general population via an advertisement sent in a mass delivered email (see Appendix E) to the professional and social networks of the researcher. This email included a link to access the questionnaire electronically. Additionally, undergraduate university psychology students could access the questionnaire link via the School of Psychology research participation system. Interested individuals were directed to an online information page (see Appendix H) informing them of the procedures involved in the study and their right to withdraw from the project at any time without penalty prior to submitting online. Respondents provided consent to participate. Participants who were unable to participate online completed a hard copy upon request. Participants were encouraged to circulate the email to assist recruitment of other participants.

9.3.4 Analyses. The data were analysed using Statistical Package for the Social Sciences (SPSS version 23.0). Data were first checked for accuracy of data entry, missing values and violation of assumptions. Minimum and maximum values were examined to ensure all data fell within the range of the measure utilised. To assess the means and standard deviation, descriptive analyses of the data were examined. Because subscale scores cannot be accurately derived in the presence of missing data, participants were removed if they recorded missing data. Less than 5% of the data was missing, demonstrating it was sound to delete these participants from subsequent analyses. Outliers were identified on the stem and leaf plots and histograms. Extreme cases were investigated by calculating whether their deviation from the variable mean exceeded the criterion of three or more standard deviations (Field, 2005; Tabachnick & Fidell, 2007). Using this criterion, no outliers were identified. Principal component

analysis was the conducted (see Chapter 10 Study 1: Assessing the Factor Structure of Grandiose Narcissism).

9.4 Study 2

9.4.1 Participants. Across Australia, a sample of adults ($N = 180$) aged between 18 and 71 years old was recruited using a snowballing technique. Participants were recruited from the general population, undergraduate university student samples, and private practices in Brisbane, Australia. Utilising private practices was a means to access individuals with a diagnosis of anorexia nervosa or bulimia nervosa as well as a mental health control group of adults experiencing anxiety and/ or depression, diagnoses which are common comorbidities of eating disorders. Recruiting participants from the general population and the undergraduate university cohort assisted with accessing a healthy control group but had two other benefits. First, this method of recruitment would result in individuals with a clinically diagnosed eating disorder who may not be in treatment to be included in this pool of individuals (approximately 15% of females in the Australian population will have an eating disorder in their lifetime and an estimated 20% of females have an undiagnosed eating disorder [Paxton et al. 2012]). Secondly, individuals with a clinically diagnosed anxiety or depressive disorder (i.e., the mental health control group) would also be targeted given the prevalence rates of anxiety and depressive disorders in Australia are approximately 14% and 6%, respectively (Australian Bureau of Statistics, 2007). The study advertisement was sent out via email (see Appendix I) to colleagues and friends (who then also forwarded on the email) in addition to colleagues who verbally agreed to advertise a hard copy (see Appendix J) at their private practice so the findings could be generalised to a broad group of people with eating disorders.

Of the 200 respondents, 20 people were excluded from further analysis based on: exclusion criteria of individuals who self-reported a diagnosis of narcissistic personality disorder or who were under 18 years of age; completing only the demographic items of the questionnaire; and having missing data on any of the variables. The 180 remaining respondents were classified into four groups (anorexia nervosa, bulimia nervosa, mental health control, and healthy control) based on self-reported diagnoses (i.e., having anorexia nervosa, having bulimia nervosa, having an anxiety or depressive disorder or not having any of these disorders, respectively).

9.4.2 Measures. After consideration of the key concepts, narcissism and treatment resistance, reviewed in the literature, a test battery was compiled. This test battery included seven established self-report instruments which assess eating disorder symptomatology, depression, anxiety, grandiose narcissism, vulnerable narcissism, trait-like resistance, and state-like resistance for anorexia nervosa and bulimia nervosa. For a copy of the questionnaire see Appendix K.

9.4.2.1 Eating Disorder Diagnostic Scale (EDDS; Stice, Telch, & Rizvi, 2000). The EDDS was used as an additional source of evidence to corroborate participants' self-reported presence or absence of an eating disorder, thus strengthening the reliability of grouping method. The EDDS was also used to measure participants' overall level of eating pathology. The EDDS contains 22 items that assess DSM-IV (APA, 1994) symptoms for all three eating disorders (that is, anorexia nervosa, bulimia nervosa, and binge eating disorder). It was adapted from validated structured psychiatric interviews including the Eating Disorders Examination (Fairbum & Cooper, 1993) and the eating disorder module of the Structured Clinical Interview for DSM Disorders (Spitzer, Williams, Gibbon, & First, 1990). Four items assess the attitudinal symptoms of

anorexia nervosa and bulimia nervosa in the past 3 months, such as fear of fatness (e.g., “have you had a definite fear that you might gain weight or become fat?”) and overvaluation of weight and shape (e.g., “has your weight influenced how you think about [judge] yourself as a person?”) measured on a 7-point scale, ranging from 0 (*not at all*) to 6 (*extremely*). Four items measure the frequency of uncontrollable consumption of a large amount of food (e.g., “during the past 6 months have there been times when you felt you have eaten what other people would regard as an unusually large amount of food [e.g., a quart of ice cream] given the circumstances?”) with a focus on the number of days per week over the past 3 months. Four items assess the frequency of behaviours that are used to compensate for binge eating over the past 3 months, including vomiting, laxative or diuretic use, fasting and excessive exercise (e.g., “how many times per week on average over the past 3 months have you made yourself vomit to prevent weight gain or counteract the effects of eating?”). Finally, participants were asked to fill in their weight and height and to answer two questions about missed menstrual cycles and birth control pills use (e.g., “over the past 3 months, how many menstrual periods have you missed?”).

The EDDS consists of a diagnostic scale and a symptom composite scale. The diagnostic scale can be used to diagnose anorexia nervosa and bulimia nervosa as detailed below.

A EDDS diagnosis of anorexia nervosa is made if an individual reports (a) height and weight data on EDDS Items 19 and 20 that result in a body mass index (BMI = kg/m^2) of less than 17.5; (b) a fear of weight gain or becoming fat as indexed by a score of 4 or greater on EDDS Item 2; (c) undue influence of body weight or shape on self-evaluation as indexed by a score of 4 or greater on either EDDS Item 3 or 4; and (d)

amenorrhea in post-menarcheal females as indexed by a 3 on EDDS Item 21. If an individual meets the first and fourth criteria above, it is not necessary for the individual to endorse the second and third criteria. Also, oral contraceptives can cause a regular menstrual cycle therefore participants taking oral contraceptives that meet the low weight criteria are considered amenorrheic. The Eating Disorder Examination (Z. Cooper & Fairburn, 1987) also follows this method.

A EDDS diagnosis of bulimia nervosa is made if an individual reports (a) regular eating binges marked by a perceived loss of control and the consumption of a large amount of food as indexed by a response of *yes* to EDDS Item 5, a *yes* to EDDS Item 6, and a response of greater than 2 on EDDS Item 8; (b) regular use of compensatory behaviours as indexed by a response of 8 or greater on the sum of EDDS Items 15, 16, 17, and 18; and (c) undue influence of body weight or shape on self-evaluation as indexed by a score of 4 or greater on either EDDS Item 3 or 4.

The EDDS symptom composite score reflects participants' overall level of eating pathology. The continuous eating disorder symptom composite score was originally calculated by summing up standardised scores across all items except for items asking for weight, height and birth control use. However, summing the raw items (again excluding height, weight and birth control items), the approach later used by founder of the instrument Stice himself (Stice & Ragan, 2002), provided an internally consistent composite score. A cut-off point of 16.5 was used to differentiate clinical patients from healthy controls (Krabbenborg et al., 2012).

The EDDS demonstrated evidence of good test-retest reliability for diagnosis of anorexia nervosa ($\kappa = .95$) and bulimia nervosa ($\kappa = .98$; Stice et al., 2000) and for the composite score ranging from $\kappa = .87$ to $\kappa = .95$ (Krabbenborg et al., 2012; Stice et al.,

2004; Stice et al., 2000). The EDDS demonstrated good internal consistency ranging from $\alpha = .89$ to $\alpha = .94$ (Krabbenborg et al., 2012; Stice et al., 2004; Stice et al., 2000). The criterion validity of the EDDS was examined by testing whether, for each eating disorder, the EDDS accurately distinguished interview-identified individuals with the disorder and those without an eating disorder. The kappa coefficient reflecting level of agreement between the diagnoses from the structured interview and the EDDS was .93 for anorexia nervosa and .81 for bulimia nervosa. Sensitivity and specificity for anorexia nervosa was $\kappa = .93$ and $\kappa = 1.00$, respectively. Sensitivity and specificity for bulimia nervosa was $\kappa = .81$ and $\kappa = .98$, respectively (Stice et al., 2000). The EDDS demonstrated adequate convergent validity with extant eating pathology scales (Stice et al., 2000) in previous research.

9.4.2.2 The Centre for Epidemiological Studies-Depression Scale (CES-D; Radloff, 1977). The CES-D was used as an additional source of evidence to corroborate participants' self-reported presence or absence of depression, thus strengthening the reliability of grouping method. The CES-D is a 20-item measure that asks respondents to rate "how often you have felt this way over the past week" regarding symptoms associated with depression (e.g., "I thought my life had been a failure", "I was happy", "I felt sad") on a 4 point Likert scale from 0 (*Rarely or None of the Time, < 1 day*) to 3 (*Most or Almost All of the Time, 5 – 7 days*). Scores range from 0 to 60, with high scores indication greater depressive symptoms. Four items are reverse scored. Scores of 16 or greater are suggestive of depressive symptoms and referral for further depression evaluation and treatment may be needed (Radloff, 1977).

The CES-D has demonstrated excellent internal consistency across studies, reported at $\alpha = 0.84$, $\alpha = 0.85$, $\alpha = 0.90$ (Radloff, 1977), $\alpha = 0.90$ and $\alpha = 0.93$

(Verdier-Taillefer, Gourlet, Fuhrer, & Alperovitch, 2001) and $\alpha = 0.85$ (Hann, Winter, & Jacobsen, 1999). Good discriminant validity has also been found whereby psychiatric patients scored significantly higher on the CES-D compared to a community sample (Radloff, 1977).

9.4.2.3 The State Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, & Lushene, 1970). The STAI was used as an additional source of evidence to corroborate participants' self-reported presence or absence of anxiety, thus strengthening the reliability of grouping method. The STAI distinguishes between trait anxiety (A-Trait) and state anxiety (A-State). A-Trait is a pervasive anxiety response to perceived negative stimuli and situations and A-State is a transitory anxiety to perceived negative stimuli and situations. The frequency and intensity of A-State is dependent on A-Trait level.

The scale consists of 40 items with the first 20 items measuring A-State and the second 20 items measuring A-Trait. For each A-State item the respondent is asked to indicate how he or she feels "right now, that is, at this moment" by selecting the appropriate response on a 4 point Likert scale from 1 (*not at all*) to 4 (*very much so*) to a number of anxiety related statements (e.g., "I feel calm", "I am tense", "I am worried"). For each A-Trait item the respondent is asked to indicate how they "generally feel" by selecting the appropriate response on a four-point Likert scale from 1 (*almost never*) to 4 (*almost always*) to a number of anxiety related statements (e.g., "I am a steady person", "I lack self-confidence", "I worry too much over something that doesn't really matter"). The total score is derived from summing the item scores and range between 20 and 80 for the A-Trait and between 20 and 80 for the A-State. Half of the A-State items

and seven of the A-Trait items are reversed scored. Higher scores reflect higher levels of anxiety.

The STAI shows evidence of satisfactory reliability and validity (Spielberger, 1983). The STAI demonstrates excellent internal consistency (average $\alpha = .89$). The A-Trait has evidenced excellent test-retest reliability (average $r = .88$) at multiple time intervals (Barnes, Harp, & Jung, 2002). Also, as would be expected given that A-State may vary in intensity and fluctuate over time, Barnes and colleagues (2002) reported lower test-retest reliability for the A-State (average $r = .70$). Adequate convergent validity with alternative measures of anxiety ($r = .80$ for Taylor Manifest Anxiety Scale, $r = .75$ for IPAT Anxiety Scale, and $r = .52$ for the Multiple Affect Adjective Check List) was demonstrated. Discriminant validity is adequate as the state and trait anxiety have been shown to differentiate participants in highly stressful situations (e.g., military recruits) from control samples (e.g., student samples) on the A-State (Spielberger, 1983).

9.4.2.4 The Narcissistic Personality Inventory (NPI; Raskin & Terry, 1988).

The NPI was used to measure grandiose narcissism. See **9.3.1** for details. Whilst there are varying findings regarding the validity of the NPI (i.e., whether it measures subclinical narcissism rather than Narcissistic Personality Disorder and whether it measures maladaptive and/or adaptive narcissistic characteristics; see Pincus & Lukowitsky, 2010) coupled with the development of the Pathological Narcissism Inventory (PNI; Pincus et al., 2009) which assesses both grandiose and vulnerable affect and self states, the decision was made to use the NPI in this research given its established use and ease of comparison with other research. Even Pincus and Lukowitsky (2010) identified much research had employed the NPI and that this

research "...can make important contributions to the study of narcissism by conceptualising normal narcissism and pathological narcissism as distinct individual differences". Moreover, given the psychometric problems of the seven factors, Study 1 of this research clarified the factor structure of the inventory for use in the current study.

9.4.2.5 Hypersensitive Narcissism Scale (HSNS; Hendin & Cheek, 1997). The HSNS was used to assess vulnerable narcissism. The HSNS is a self-report questionnaire consisting of ten items that reflect characteristics of vulnerable narcissism such as self-absorption, insecurity, and criticism sensitivity. Items are rated on a 5 point Likert scale from 1 (*very uncharacteristic or untrue, strongly disagree*) to 5 (*very characteristic or true, strongly agree*). The total score is derived from summing the item scores and range between 10 and 50. Higher scores reflect higher levels of vulnerable narcissism. In a general population sample, the mean score was 29 with score of 23 or below considered low and scores of 35 or above considered high. Sample items include "I dislike being with a group unless I know that I am appreciated by at least one of those present" and "my feelings are easily hurt by ridicule or by the slighting remarks of others".

The HSNS shows evidence of satisfactory reliability and validity (Hendin & Cheek, 1997). The HSNS demonstrates good internal consistency ranging from $\alpha = .72$ to $\alpha = .76$. Acceptable convergent validity with an alternative measure of vulnerable narcissism ($r = .61$) was demonstrated. Moreover, it showed good discriminant validity as it negatively correlated with a measure of grandiose narcissism ($r = -.18$).

9.4.2.6 The Butcher Treatment Planning Inventory (BTPI; Butcher, 1998).

The BTPI was used to assess trait-like resistance to treatment. The BTPI contains 210 items with responses in a true-false format. Items reflect 14 scales; The Validity scales

(Inconsistent Responding, Overly Virtuous Self-Views, Exaggerated Problem Presentation, and Closed Mindedness) provide information about a respondent's attitude toward completing the inventory and his or her receptivity to therapy; The Treatment Issues scales (Problems in Relationship Formation, Somatisation of Conflict, Low Expectation of Benefit, Self-Oriented/Narcissism, and Perceived Lack of Environmental Support), which were the focus in this research, assess personality characteristics that may hinder the formation of a working alliance and a successful therapeutic experience; The Current Symptom scales (Depression, Anxiety, Anger-Out, Anger-In, and Unusual Thinking) provide therapists with information about the psychological symptoms frequently experienced by individuals receiving mental health services. Two global indices can also be calculated. The Treatment Difficulty Composite, derived from all of the Treatment Issues scales plus the Unusual Thinking scale score, provides a global index of receptivity to the therapeutic process and a respondent's willingness to change. The General Pathology Composite, derived from summing the Depression, Anxiety, Anger-Out and Anger-In, scores, provides an overall index of psychological distress.

The BTPI demonstrates concurrent validity with the MMPI-2 which includes the Negative Treatment Indicators (TRT) scale, which was designed to measure respondents' attitudes toward psychological treatment, demonstrating correlations of at least $r = .30$ for 12 of the 14 regular scales in college students. Additionally, the BTPI demonstrated concurrent validity with the Survey of Treatment Attitudes, a 7-item inventory the researchers designed to measure attitudes toward mental health care (Butcher, Rouse, & Perry, 1998). In a college sample, coefficient α values ranged from a low of .23 for inconsistent responding to a high of .88 for the General Pathology Composite (Mdn $r = .69$); In a subset of the college normative sample, test-retest

reliability estimates (30 minutes between administrations) ranged from a low of .69 for Inconsistent Responding to a high of .97 for Exaggerated Problem Presentation (Mdn $r = .92$). Research has revealed that clients who terminated therapy prematurely scored higher on the Closed Mindedness, Problems in Relationship Formation, Somatisation of Conflict, Self-Orientation/Narcissism, and Perceived Lack of Environmental Support scales, with medium to large effect sizes (Hatchett, Hann, & Cooker, 2002). The BTPI was chosen over the MMPI-2 in this program of research because it is much briefer (210 items versus 567 items), thus efficiently uses respondents time, and because it was specifically designed to assess symptoms and characteristics specific to treatment.

9.4.2.7 Anorexia Nervosa Stages of Change Questionnaire (ANSOCQ; Rieger et al., 2000). The ANSOCQ was used to measure state-like resistance via readiness to change and recover from anorexia nervosa across a range of behaviours and symptoms. The ANSOCQ is a 20-item self-report questionnaire designed specifically for individuals with anorexia nervosa assessing a broad range of anorexic symptomatology including aspects of body shape and weight, eating behaviours, weight control strategies, emotional difficulties, problematic personality characteristics, and interpersonal difficulties. The ANSOCQ is based on the stages of change model (Prochaska & Di Clemente, 1982) and assigns a stage of change (either pre-contemplation, contemplation, preparation, action, or maintenance) for each symptom domain of the eating. Because of this, a person can be at varying stages of change across domains.

For each item, individuals are asked to select the statement which best describes his or her current attitude or behaviour regarding the symptom. Scores on each item range from 1 (*pre-contemplation stage*) to 5 (*maintenance stage*). If the individual

endorses more than one statement per item, the average score for the item is calculated. To obtain an overall stage classification score for the individual, average scores are calculated by dividing the total score by the number of items (i.e., 20). Average scores thus range from 1 to 5. Scores of less than 1.5 are considered to correspond to pre-contemplation, scores of 1.5 to 2.4 are contemplation, 2.5 to 3.4 are preparation, 3.5 to 4.4 are action and greater or equal to 4.5 are considered to correspond to maintenance. An individual categorised as being in the higher stage of change is thus said to have a greater level of readiness to change than an individual in a lower stage of change.

The ANSOCQ shows evidence of good to excellent reliability and validity (Rieger et al., 2000). One-week test-retest reliability was good ($r = .89$) and internal consistency indicated excellent reliability at .90 for a clinical sample ($N = 71$; Rieger et al., 2000). Criterion validity was good with adequate convergent validity ($r = .70$).

9.4.2.8 *Bulimia Nervosa Stages of Change Questionnaire (BNSOCQ;* *Martinez et al., 2007*). The BNSOCQ was used to measure state-like resistance via readiness to change and recover from bulimia nervosa across a range of behaviours and symptoms. The BNSOCQ is an adaptation of the ANSOCQ for use with people with bulimia nervosa. It shares 16 questions with the ANSOCQ. It is a self-report questionnaire with 20 items related to eating disorder symptomatology, specifically aspects of body satisfaction, bingeing, weight control, compensatory behaviours, sense of a lack of control and emotional, personality and interpersonal problems. Scoring and classification matched the scoring and classification of the ANSOCQ.

The BNSOCQ shows evidence of good to excellent reliability and validity (Martinez et al., 2007). One-week test-retest reliability was excellent with overall accuracy rate of $r = .93$ and internal consistency indicated high reliability at $r = .94$ for a

clinical sample ($N = 30$). Criterion validity was good with high convergent validity with 9 of 11 scales scores of an eating symptom measure (ranging from $r = .51$ to $r = .84$).

9.4.3 Procedure. Following university ethics approval (2015 297H; see Appendix L) potential participants were recruited from the general population via an advertisement sent in a mass delivered email (see Appendix I) to friends and colleagues of researcher. This email included a link to access the questionnaire electronically. Additionally, undergraduate university psychology students could access the questionnaire link via the School of Psychology research participation system. Moreover, hard copy advertisements (see Appendix J) were placed at a couple of private practices in Brisbane, Australia and interested participants could note down the URL link to complete the survey online. When the URL link was used by interested individuals, they were directed to an online information page (see Appendix M) informing them of the procedures involved in the study and their right to withdraw from the project at any time without penalty prior to submitting online. Respondents provided consent to participate. Participants who were unable to participate online completed a hard copy upon request from the receptionist at private practices or via email request to the researcher. Participants were encouraged to circulate the email to assist recruitment of other participants.

9.4.4 Analyses. The data were analysed using SPSS version 23.0. Data were first checked for accuracy of data entry, missing values and violation of univariate and multivariate statistic assumptions. See **9.3.4** for screening procedures.

The Kolmogorov-Smirnov test of normality was utilised to examine the distribution of scores was normal for each measure (Field, 2005) and indicated that the

eating disorder symptomatology measure, the grandiose narcissism measure (and its three factors), one state-like resistance measure (ANSOCQ) and trait-like resistance (as measured by five scales) violated the assumption of normality. To assess normality further, the skewness and kurtosis were calculated for each variable. Skewness values (-.04 EDDS, .86 NPI, 1.07 NPI Factor 1, 1.13 NPI Factor 2, 1.30 NPI Factor 3, -.18 BTPI-Problems in Relationship Formation, .61 BTPI- Somatisation of Conflict, .39 BTPI-Low Expectation of Benefit, .45 BTPI-Self-Orientation/Narcissism, -.42 BTPI-Perceived Lack of Environmental Support, and .40 ANSOCQ, respectively) and kurtosis values (-.87 EDDS, .34 NPI, 2.03 NPI Factor 1, .99 NPI Factor 2, 1.11 NPI Factor 3, -1.17 BTPI-Problems in Relationship Formation, -.23 Somatisation of Conflict, -.92 BTPI-Low Expectation of Benefit, -1.14 BTPI-Self-Orientation/Narcissism, -.62 BTPI- Perceived Lack of Environmental Support, and -.82 ANSOCQ, respectively) were divided by their standard errors to produced Z-scores that were then compared to standardised alpha levels (1.96, $p = .05$; 2.58, $p = .01$; 3.29, $p = .001$). Variables that deviated from normality above the .05 level were considered problematic and required further examination (Field, 2005; Tabachnick & Fidell, 2007). Examination of skewness and kurtosis statistics confirmed that the assumption of normality for eating disorder symptomatology, grandiose narcissism (and its 3 factors) and trait-like resistance (BTPI-Problems in Relationship Formation, BTPI-somatisation of conflict, BTPI-Low Expectation of Benefit, BTPI-Self-Orientation/Narcissism) was violated. Follow up analysis indicated that normality was restored for grandiose narcissism (and Factor 1 and 2) and BTPI-Low Expectation of Benefit through transformation; therefore, the transformed variables were used in subsequent analyses. However, normality for the eating disorder symptomatology, Factor 3 of grandiose

narcissism, and trait-like resistance (BTPI-Problems in Relationship Formation, BTPI-Somatisation of Conflict, BTPI-Self-Orientation/Narcissism) was not restored therefore the original variables were used. Nonparametric tests were conducted with the same results (see Appendix N).

Levene's test verified the equality of variances in the samples (homogeneity of variance) ($p > .05$) for vulnerable narcissism and grandiose narcissism, including its 3 factors. Levene's test was violated for the eating disorder symptom scale and the five Butcher Treatment Planning Inventory scales. To ensure validity of results, a series of Welch F tests were conducted on these violated scales with the same results as the parametric analyses (see Appendix O).

Separate assumption checks were conducted for regression analyses. Due to the small sample size in the two separate groups to be analysed (anorexia nervosa $n = 40$ and bulimia nervosa $n = 43$) and issues of multicollinearity, not all five narcissism variables (grandiose narcissism and its 3 factors, and vulnerable narcissism) could be entered into a single regression analysis. Instead, grandiose narcissism and vulnerable narcissism were entered as predictor variables for regression analyses on the six different outcome variables (state-like resistance [stages of change questionnaire] and trait-like resistance [BTPI-Problems in Relationship Formation, BTPI-Somatisation of conflict, BTPI-Low Expectation of Benefit, BTPI-Self-Orientation/Narcissism, BTPI-Perceived Low Environment Support] in the anorexia nervosa group then the bulimia nervosa group. Next, the three factors of grandiose narcissism were entered as predictor variables for regression analyses on the six different outcome variables (state-like resistance [stages of change questionnaire] and trait-like resistance [BTPI-Problems in Relationship Formation, BTPI-Somatisation of conflict, BTPI-Low Expectation of

Benefit, BTPI-Self-Orientation/Narcissism, BTPI- Perceived Low Environment Support] in the anorexia nervosa group than the bulimia nervosa group.

For regression analyses, scatter plots revealed no outliers in both the anorexia nervosa group and bulimia nervosa group. Moreover, the Mahalanobis and Cook's distance was utilised to assess for multivariate outliers (Field, 2005) and there were no breaches of this assumption. Tests to see if the data met the assumption of collinearity indicated that multicollinearity were sound for both the anorexia nervosa regression analyses (Tolerance range = .62 – 1.00 and *VIF* range = 1.08 – 1.42) and the bulimia nervosa regression analyses (Tolerance range = .59 - .90 and *VIF* range = 1.11 – 1.69). Scatterplots were produced to test the assumptions of homoscedasticity and linearity across each independent and dependent variables. There were no violations of these assumptions to report. The normal P-P plot of standardised residuals showed points lying in a reasonably straight diagonal line from bottom left to top right that were not completely on the line, but close. The scatterplot of standardised predicted values showed that the data met the assumptions of homogeneity of variance and linearity.

An independent groups ANOVA was conducted to compare grandiose narcissism across the four groups of participants grouped based on eating disorder and mental health status. The independent variable was category of eating disorder (4 levels: anorexia nervosa, bulimia nervosa, mental health control, health control). This was a between-subjects variable. The dependent variable was grandiose narcissism as measured by the NPI. Additionally, based on the factors of the NPI from Study 1, independent groups ANOVAs were conducted to compare factors 1 and 3 and an independent groups ANCOVA, controlling for relationship and education status, compared factor 2, in the same four groups of participants. An independent groups

ANCOVA, controlling for relationship status and education level, was conducted to compare vulnerable narcissism in the same four groups of participants. The independent variable was category of eating disorder (4 levels: anorexia nervosa, bulimia nervosa, mental health control and health control). The dependent variable was vulnerable narcissism as measured by the HSNS. Independent groups ANOVAs were conducted to compare all scales of trait-like resistance in three groups of participants except for perceived lack of environmental support which used a one way ANCOVA controlling for whom they live with. The independent variable for both the ANOVA and ANCOVA were category of eating disorder (3 levels: anorexia nervosa, bulimia nervosa and mental health control). The dependent variables were the five scales of the BTPI which measure trait-like resistance. An independent samples *t*-test was conducted to compare state-like resistance between the two groups of participants with eating disorders (2 levels: anorexia nervosa, bulimia nervosa). The dependent variable was state-like resistance as measured by the ANSOCQ and the BNSOCQ.

Regression analyses were conducted to test the relationship between the different facets of narcissism and state- and trait-like resistance in the different eating disorder groups and to explore predictive relationships. Cases with anorexia nervosa were selected and for these participants, both vulnerable narcissism and grandiose narcissism were entered as predictor variables with the outcome variable firstly as the ANSOCQ and then each of the pertinent BTPI scales individually. The individual contribution of each type of narcissism in predicting the dependent variable in question was measured. Next, the three factors of grandiose narcissism were entered as predictor variables with the outcome variable firstly as the ANSOCQ and then each of the pertinent BTPI scales individually. Again, the individual contribution of each factor of

grandiose narcissism in predicting the dependent variable in question was measured. When predicting perceived lack of environmental support, whom the participant lived with was controlled for due to the differences between groups on this variable. These analyses were repeated in the bulimia nervosa group using the BNSOCQ instead of the ANSOCQ. See Chapter 11 Study 2: Narcissism and Resistance in Eating Disorders.

9.5 Study 3

9.5.1 Participants. A sample of mental health therapists who primarily treat individuals with eating disorders (i.e., eating disorder therapists), mental health therapists who do not treat individuals with eating disorders (i.e., non-eating disorder therapists), individuals with anorexia nervosa or bulimia nervosa, and a community sample ($N = 955$) aged between 23 and 67 years was recruited across Australia. Both therapist samples were recruited from various mental health services in Australia including BodyMatters Australasia, the National Eating Disorder Collaboration, the Eating Disorders Association, a large community service and private practices. Both eating disorder groups and the community sample were recruited from the general population (via colleagues and friends, then snowballing technique) and an undergraduate university student cohort, knowing individuals with clinically diagnosed eating disorders would be in this pool (see **9.4.1 Participants** for further explanation). The study advertisement was sent out via email (see Appendix P) to colleagues and friends (who then also forwarded on the email). The exclusion criteria included self-report of a diagnosis of narcissistic personality disorder or age under 18 years. Analyses primarily focused on the therapists who primarily treat individuals with eating disorders ($n = 32$) compared to therapists who do not treat individuals with eating disorders ($n = 62$).

9.5.2 Measures. The questionnaires used during Study 3 incorporated some of the previously described standardised measures. These included the EDDS, NPI and HSNS. For a copy of the questionnaire see Appendix Q.

9.5.3 Procedure. Following university ethics approval (2013 273Q; see Appendix R), participants were recruited from BodyMatters Australasia, the National Eating Disorder Collaboration, the Eating Disorders Association, undergraduate psychology students, and family, friends and colleagues of the researcher via an advertisement sent in a mass delivered email (see Appendix P). This email included a link to access the questionnaire electronically. Additionally, undergraduate university psychology students could access the questionnaire via the School of Psychology research participation system. Interested individuals were directed to an online information page (see Appendix S) informing them of the procedures involved in the study and their right to withdraw from the project at any time without penalty prior to submitting online. Respondents provided consent to participate. Participants who were unable to participate online completed a hard copy upon request.

9.5.4 Analyses. The data were analysed using SPSS version 23.0. Refer to section 9.4.4 for screening procedures. The Kolmogorov-Smirnov indicated that all of the measures violated assumptions of normality. To address normality further, the skewness and kurtosis were calculated for each variable. Skewness values (.38 EDDS, -.02 HSNS, .67 NPI, .32 NPI Factor 1, .99 NPI Factor 2 and .86 NPI Factor 3) and kurtosis values (.18 EDDS, .09 HSNS, .24 NPI, -.61 NPI Factor 1, .56 NPI Factor 2 and .01 NPI Factor 3) were divided by their standard errors to produced Z-scores that were then compared to standardised alpha levels (1.96, $p = .05$; 2.58, $p = .01$; 3.29, $p = .001$). Variables that deviated from normality above the .05 level were considered problematic

and required further examination (Field, 2005; Tabachnick & Fidell, 2007). Analysis confirmed that all measures except for vulnerable narcissism violated the assumption of normality. A square root transformation was applied in an attempt to correct normality (Tabachnick & Fidell, 2007) however no measures were restored so the original variables were used. Nonparametric tests were conducted with the same results (See Appendix T). Levene's test verified the equality of variances in the samples (homogeneity of variance) ($p > .05$) except for the eating scale and NPI Factor 2 of grandiose narcissism. Given two of the five dependent variables violated Levene's test and also the unequal sample sizes, separate Welch F tests were conducted on all of the dependent variables with the same results (see Appendix U).

An independent groups ANOVA was conducted to compare individuals with eating disorders to treatment providers of individuals with eating disorders, treatment providers who do not treat individuals with eating disorders, individuals with eating disorders, and a community sample. The independent variable was group type (4 levels: eating disorder therapist, non-eating disorder therapist, eating disorders, and health control). The dependent variable was grandiose narcissism as measured by the NPI, and vulnerable narcissism as measured by the HSNS. Independent groups ANCOVAs were conducted to compare individuals with eating disorders to treatment providers of individuals with eating disorders, treatment providers who do not treat individuals with eating disorders, individuals with eating disorders, and a community sample. The independent variable was group type (4 levels: eating disorder therapist, non-eating disorder therapist, eating disorders, and healthy control). The dependent variables included eating disorder symptoms as measured by the EDDS, controlling for relationship status and education level, and vulnerable narcissism as measured by the

HSNS, controlling for relationship status and education level. Additionally, based on the factors of the NPI from Study 1, independent groups ANOVAs were conducted to compare the three factors in the same four groups of participants. See Chapter 12 Study 3: Assessing Narcissism in Treatment Providers of Eating Disordered Individuals.

9.6 Study 4

9.6.1 Participants. A sample of adults ($N = 14$) aged between 18 and 46 years old was recruited from a private eating disorder clinic in Queensland. Participants were recruited from a private eating disorder clinic via a hard copy advertisement (see Appendix V) displayed in the clinic and handed out at eating disorder therapy groups. Exclusion criteria included a diagnosis of narcissistic personality disorder. Inclusion criteria were individuals with either anorexia nervosa or bulimia nervosa as diagnosed by a qualified mental health professional.

9.6.2 Interview questions. Semi-structured interviews were conducted after Study 1, Study 2 and Study 3 data collection and analysis. A literature review on narcissism and eating disorders informed the development of open-ended questions used to elicit data from participants. Questions and quotes used for the semi-structured interviews were generated from the research pertaining to narcissism, treatment resistance, treatment experience and experience of the therapeutic relationship. These questions were refined in consultation with eating disorder specialists and psychologists. For a copy of the interview questions see Appendix W. Narcissism was explored in line with the seven components of the grandiose narcissism scale (i.e., authority, entitlement, exhibitionism, vanity, superiority, self-sufficiency, exploitativeness), the overall definition of grandiose narcissism and the overall definition of vulnerable narcissism. Interviews covered the key structured topic but were

also be responsive to participants' narratives. In this way, the interviews not only addressed the key research questions but also allowed for the discovery of new themes and theories that were relevant to the participants (Lyons, 2007).

9.6.3 Procedure. Following the analysis of Study 2 and Study 3, and university ethics approval (2013 266Q; see Appendix X), participants were recruited from a private eating disorder clinic via a hard copy advertisement (see Appendix V) displayed in the clinic and handed out at eating disorder therapy groups. Fourteen individuals volunteered to participate. The choice of interview location used in this study was intended to facilitate participation since ensuring that research involvement is easy for interviewees can increase the willingness of potential interviewees to be involved (Axinn & Pearce, 2006). In all cases, only the researcher and interviewee were present. Private rooms were chosen to offer participants confidentiality during the interview, a safe space to discuss sensitive topics, to minimise distractions, and reduce extraneous noise to improve the audio recording.

Upon meeting, individuals were provided an information letter, informing them of the procedures involved in the study and their right to withdraw from the project at any time without penalty, and two copies of a consent form to sign; one for the student researcher to keep and one for the participant to keep (see Appendix Y). It was emphasised to participants there were no wrong or right answers, and that the aim of the interviews was to obtain their opinions and thoughts (whatever they may be). Following this, a semi-structured 'in-depth' interview was conducted covering treatment engagement, the therapeutic relationship and characteristics of narcissism (see Appendix W for interview items). Interviews covered the key topics using open-ended questions. The interviewer was also responsive to the participant's narratives whereby

additional prompts were used to elicit greater description of, or to clarify, information provided by interviewees. The duration of the interviews ranged from 45 to 60 minutes.

To begin the interview, participants were asked to describe their treatment history for their eating disorder. This question encouraged participants to provide the salient points of their treatment experience from their point of view. Subsequent questions targeted interviewees' experience of treatment and therapeutic alliance (e.g., "what do you find helpful and unhelpful in the treatment process?") followed by excerpts related to eating disorders, narcissism and treatment resistance (e.g., narcissistic characteristics in eating disordered individuals as observed by professionals, and eating disordered behaviours of treatment providers) which participants were asked to provide their opinions and thoughts. At the conclusion of the interview, participants were given the opportunity to comment on any aspects covered in the interview or related to eating disorder treatment that they felt may be useful to the researcher.

9.6.4 Analyses. Analysis of the interviews was considered as commencing with the first interview and continued in an ongoing fashion with subsequent interviews. The first two participants were considered to pilot the interview process and trial the questions. This number was arbitrarily chosen, based upon the timing of the scheduled interviews. At the conclusions of each of these interviews, the researcher explored each question in terms of three aspects; clarity (i.e., whether the participant easily understood the question), openness of the response (i.e., whether the question elicited detailed responses/ data), and appropriateness and sensitivity of the terms used (i.e., whether the terms used fit well with the participant's experience and were non-offensive). On the basis of the two pilot interviews and the subsequent reflection, no items were changed.

Fourteen interviews were conducted. During the first nine interviews, interviewees described new concepts. However, after this, no new information was forthcoming from the interviews. As no new information was probable in additional interviews, no further participants were contacted. Regardless, the final 14 interviews were completed and included in the data analysis as they had been already arranged with interviewees.

Qualitative content analysis is typically conducted on written text. Therefore, all interviews were audio-recorded (with consent) and subsequently transcribed verbatim. Interviews were transcribed by a transcription service and then checked against the audio-recording for accuracy by the researcher. To best address the research questions, the transcriptions included the observations made during the interview (e.g., both audible and inaudible behaviours). The text was the unit classified during content analysis. Variance in unit type influences coding decisions as well as the ability to compare results to previous research (De Wever, Schellens, Valcke, & Van Keer, 2006), thus the importance of highlighting text as unit (Weber, 1990). Qualitative content analysis typically focuses on individual themes for analysis. Themes are conveyed by single words, a phrase, a sentence, a paragraph, or an entire document. In this way, themes express ideas (Minichiello, Aroni, Timewell, & Alexander, 1990). This unit of analysis was employed in this study.

The focus of the analysis of the interview data was to examine, in more detail, individuals' experience of their eating disorder, individuals' experience of treatment for their eating disorder, including both the intervention and the therapeutic relationship, and whether narcissistic characteristics were present in these individuals. An initial list of coding categories based on this was established; however, new themes that emerged

inductively were also coded. When developing categories inductively the constant comparative method was utilised (Glaser & Strauss, 1967). This method involved the systematic comparison of text to text already assigned to a theme, to facilitate full understanding of their theoretical relevance of emergent categories. After the sample was coded, the coding consistency needed to be verified. This was done via inter-coder agreement. Three (21%) of the transcripts were coded by an independent reviewer, experienced in qualitative data analysis. This process enabled the interviewer to reflect on the data from another perspective in order to improve the accuracy of the interpretation of the data. The analysis of the data involved making inferences and presenting reconstructions of meanings derived from the data. The data were considered in light of the results of Study 2 and Study 3, and the results of the previous studies were re-examined in light of the data from this phase. To maximise validity, triangulation with colleagues occurred. See Chapter 13 Study 4: Exploring Narcissism in Eating Disorder Patients Using Interviews.

9.7 Summary

The current program of research utilised a mixed-method design to explore the role of narcissism in eating disorders (exploring both the client and therapist population) and how it may contribute to treatment resistance. Following quantitative data collection from both eating disorder clients and eating disorder therapists, analyses on the results were conducted. Qualitative interviews were subsequently conducted to extend on and complement findings obtained from Study 1, Study 2 and Study 3.

Chapter 10

Study 1: Assessing the Factor Structure of Grandiose Narcissism

10.1 Purpose of the Study

Study 1 explored the psychometric properties of the Narcissistic Personality Inventory (NPI). The developers of the NPI, Raskin and Terry (1988), proposed a seven-factor structure of the NPI that measured important theoretical components of narcissism. However, subsequent studies have found six of the seven factors to be unreliable (del Rosario & White, 2005; Raskin & Terry, 1988). The present study was conducted to examine whether a more reliable factor structure of the NPI could be found using a general population sample.

10.2 Brief Introduction

Self psychology proposes that eating disorders are narcissistic behaviour disorders, with both vulnerable and grandiose narcissistic dysfunction (Kohut, 1977). The established relationship between narcissism and treatment (M. Campbell et al., 2009; W. Ellison et al., 2013; Hilsenroth et al., 1998; Pincus et al., 2009) and between resistance and eating disorders (Lehoux et al., 2000; McLaren et al., 2001; Mogul, 1980; R. Sands, 2000; Steiger et al., 1997) suggests that the narcissism may contribute to the resistance in the eating disorder population. In order to determine the appropriateness of the self psychology understanding of eating disorders, vulnerable and grandiose narcissism needs to be examined in this population. Questionnaires that assess grandiose narcissism and vulnerable narcissism exist, however the measure of grandiose narcissism, the NPI (Raskin & Terry, 1988), has failed to demonstrate good internal consistency on important theoretical factors (del Rosario & White, 2005; Raskin & Terry, 1988). This seven-factor solution including Authority, Self-Sufficiency,

Superiority, Exhibitionism, Exploitativeness, Vanity and Entitlement, whilst accounting for 52% of the total NPI score variance and the total score having good reliability ($\alpha = .83$), had only good internal consistency for Authority ($\alpha = .73$), Self Sufficiency ($\alpha = .63$) and Entitlement ($\alpha = .64$) whilst the remaining factors had poor internal consistency at .54, .50, .52, .50, and .64, respectively (Raskin & Terry, 1988).

A number of additional studies have examined the factor structure of the NPI with varying results. A four-factor structure, comprising 37 items, representing Leadership/Authority ($\alpha = .69$), Self-Absorption/Self-Admiration ($\alpha = .81$), Superiority/Arrogance ($\alpha = .70$) and Exploitativeness/Entitlement ($\alpha = .68$) has been reported (Emmons, 1987). A two-factor solution, labelled Power ($\alpha = .82$) and Exhibitionism ($\alpha = .72$), which explained 22% of the variance was extracted (Kubarych et al., 2004). An alternate two-factor model (Leadership/Authority and Exhibitionism/Entitlement) utilising all 40 items was produced. Each of these factors had satisfactory internal consistency, and, at the time, was argued as having the best fit to the data from all of the research into NPI factor structure (Corry et al., 2008). Two three-factor solutions have been produced. Kubarych and colleagues (2004) produced one three-factor solution, Power ($\alpha = .80$), Exhibitionism ($\alpha = .70$) and Being a Special Person ($\alpha = .63$), which explained 27% of the variance. Most recently, Ackerman and colleagues (2011) produced the other three-factor solution, Leadership/Authority, Grandiose Exhibitionism, and Entitlement/Exploitativeness. The NPI factor structure has only been evaluated in university students and is yet to be evaluated in the general population. Given the psychometric problems of the seven factors yet usefulness of these dimensions, before further research is conducted, clarification of the factor structure of the inventory is required.

10.3 Method

As described in detail in Chapter 9, a general population sample of adults ($N = 903$) aged between 18 and 71 years old was recruited online to complete the NPI. The first section of the questionnaire contained demographic questions regarding the participant's age, gender, education level, area of residence, race/ethnicity, marital status and primary area of employment. See Chapter 9 for in-depth methodology.

10.4 Results

10.4.1 Sample characteristics. Adults from the general public ($N = 903$) aged between 18 to 71 years ($M = 24.05$ years, $SD = 8.90$ years) were included in analyses. The sample was comprised of 108 males aged between 18 and 65 years ($M = 26.80$ years, $SD = 11.51$ years) and 795 females aged between 18 and 71 years ($M = 23.69$ years, $SD = 8.43$ years). See Table 1 for demographic data.

Table 1

Study 1 Characteristics of Participants

Demographic		<i>N</i>	%
Gender	Male	108	12.00
	Female	795	88.00
Education	Did not complete high school	8	.90
	High school	399	44.20
	Trade/technical/vocational training	53	5.90
	Undergraduate degree	344	38.10
	Postgraduate degree	99	11.00
Marital Status	Single	666	73.80
	Defacto	114	12.60
	Married	100	11.10
	Separated	6	.70
	Divorced	15	1.70
	Widowed	2	0.20
Living Area	Metropolitan	763	84.50
	Rural	116	12.80
	Remote	5	.60
	Did not respond	19	2.10
Ethnicity	Anglo/Caucasian	780	86.40
	Aboriginal	6	.70
	Asian	70	7.80
	Hispanic	14	1.60
	Middle Eastern	23	2.50
	African	10	1.10

10.4.2 Descriptive statistics. The mean of grandiose narcissism ($M = 11.82$, $SD = 6.29$) was below the mean identified in the development of the scale ($M = 15.55$). Scores ranged from 1 to 34. The overall scale score demonstrated good internal consistency ($\alpha = .83$), consistent with prior research findings.

10.4.3 Correlations of items. The correlation matrix revealed that the items had low correlations, ranging from .00 to .32, with the majority of these correlations near .10. Therefore, the use of orthogonal rotation (varimax) was appropriate above the use of oblique rotation (Field, 2013; Pedhazur & Schmelkin, 1991). Additionally, there was no evidence of multicollinearity (determinant = .001).

10.4.4 Principal component analysis. The 40 NPI items were subjected to principal component analysis with orthogonal rotation (varimax) as oblique rotation produced negligible correlation between extracted factors (Pedhazur & Schmelkin, 1991). The Kaiser-Meyer-Olkin measure verified the sampling adequacy for the analysis, $KMO = .84$ (meritorious according to Hutcheson & Sofroniou, 1999) and all KMO values for individual items well above the acceptable limit of .50 (Field, 2013). Bartlett's test of sphericity was significant, $\chi^2(780) = 6045.21$, $p < .001$. An initial analysis examined eigenvalues for each factor in the data. Twelve factors had eigenvalues over Kaiser's criterion of 1 and in combination explained 52.35% of the variance. However, because no communalities exceed .70 and the average communality does not exceed .60, Kaiser's rule is inappropriate for this data. The scree plot (Figure 1) was ambiguous and showed inflexions that would justify retaining either 3 or 7 factors therefore corresponding analyses were conducted. Item loadings greater than or equal to .30 were retained in the solution.

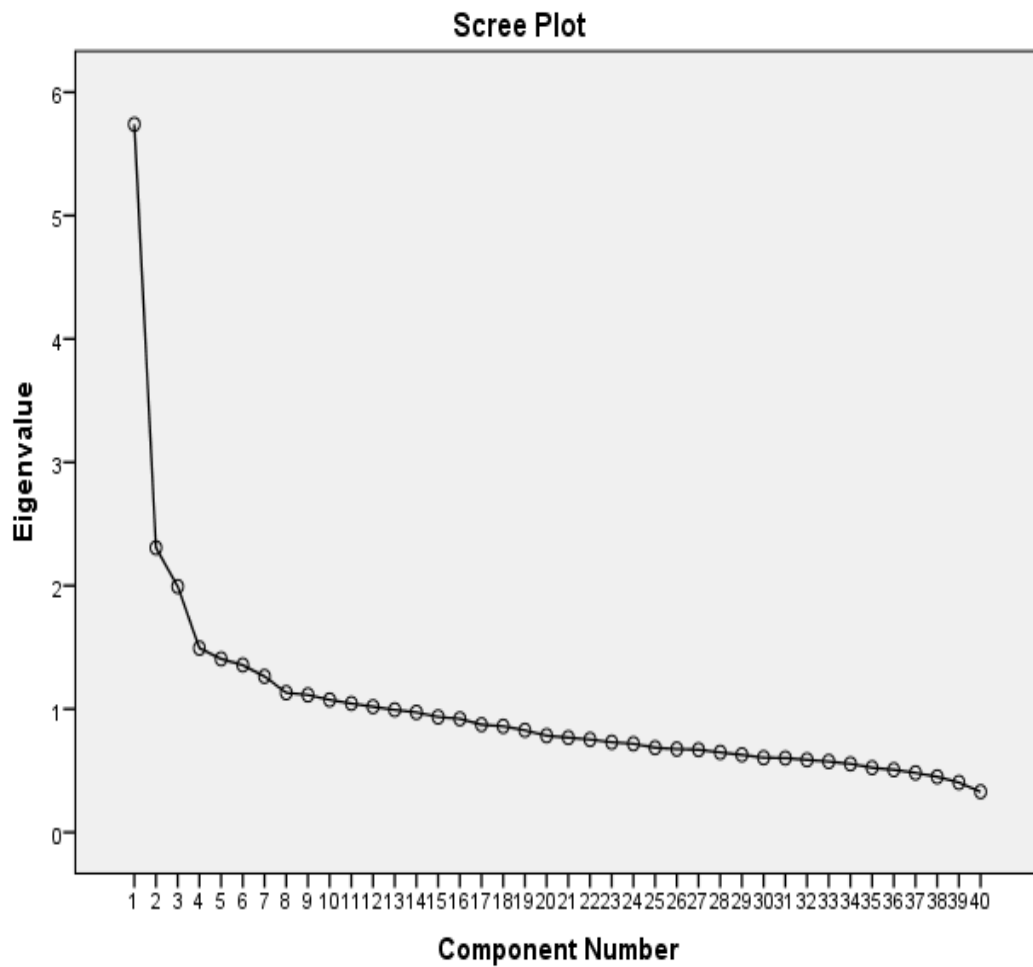


Figure 1. Scree Plot

Seven factors were retained due to the established component structure of the scale which identified seven conceptually meaningful factors (Raskin & Terry, 1988). Table 2 shows factor loadings after orthogonal rotation (varimax). The seven factors in combination explained 38.9% of the variance over 39 items. The items that cluster on the same factor suggest that Factor 1 represents authority (e.g., leadership, need for power, centre of attention, ruler), Factor 2 represents vanity (e.g., focus on body, liking compliments, self-orientation), Factor 3 represents a combination of exploitativeness and entitlement (e.g., manipulative, deserving, more capable than others, expecting a

great deal from others, power hungry), Factor 4 represents superiority (e.g., special, extraordinary), Factor 5 represents exhibitionism (e.g., live life how they want, influential, daring, talk way out of things, read people), Factor 6 represents self-sufficiency (e.g., competent, responsibility, self-dependent) and Factor 7 represents success. The item (A) “I don't care about new fads and fashions”, or (B) “I like to start new fads and fashions” was discarded due to its loading below .30 (.28) on Factor 3 and it did not change the internal consistency of Factor 3. See Table 3 for inter-factor correlations and Tables 4 to 10 for inter-item correlations of each factor.

Table 2

Factor Loadings of the Seven Factor Solution

	1	2	3	4	5	6	7
10. (B) I see myself as a good leader.	.71						
33. (A) I would prefer to be a leader.	.67						
32. (B) People always seem to recognize my authority.	.54						
36. (A) I am a born leader.	.52						
11. (A) I am assertive.	.51						
12. (A) I like to have authority over other people.	.49		.48				
30. (A) I really like to be the center of attention.	.42	.36		.40			
5. (B) If I ruled the world it would be a better place.	.39						
19. (B) I like to look at my body.		.68					
29. (A) I like to look at myself in the mirror.		.65					
15. (B) I like to show off my body.		.62					
26. (B) I like to be complimented.		.56					
4. (B) I know that I am good because everybody keeps telling me so.		.45					
25. (A) I will never be satisfied until I get all that I deserve.			.59				
24. (A) I expect a great deal from other people.			.54				
39. (A) I am more capable than other people.			.53				
14. (A) I insist upon getting the respect that is due me.			.49				
13. (A) I find it easy to manipulate people.			.45		.37		
27. (A) I have a strong will to power.	.31		.38				
38. (A) I get upset when people don't notice how I look when I go out in public.			.37				-.34
9. (B) I think I am a special person.				.58			
40. (B) I am an extraordinary person.				.52			.32
20. (B) I will usually show off if I get the chance.				.49			
2. (A) Modesty doesn't become me.				.46			
7. (B) I like to be the centre of attention.	.37	.36		.38			-.32
23. (B) Everybody likes to hear my stories.				.35			
37. (A) I wish somebody would someday write my biography.				.34			
16. (A) I can read people like a book.					.52		
31. (A) I can live my life in any way I want to.					.51		
3. (A) I would do almost anything on a dare.					.48		
1. (A) I have a natural talent for influencing people.	.44				.46		
35. (B) I can make anybody believe anything I want them to.					.44		
34. (A) I am going to be a great person.					.43		
6. (A) I can usually talk my way out of anything.					.42		
22. (B) I rarely depend on anyone else to get things done.						.58	
21. (A) I always know what I am doing.						.41	
17. (B) I like to take responsibility for making decisions.						.39	
18. (B) I want to amount to something in the eyes of the world.							.64
8. (A) I will be a success.							.53
Eigenvalues	5.74	2.31	1.99	1.49	1.41	1.36	1.26
% of variance	14.35	5.77	4.98	3.73	3.51	3.39	3.16
α	.74	.64	.60	.59	.55	.35	.35

Note. Factor loadings appear in bold; only factor loadings over .30 are shown

Table 3

Seven Factors Inter-Subscale Correlations

	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7
Factor 1	1						
Factor 2	.26**	1					
Factor 3	.38**	.15**	1				
Factor 4	.48**	.39**	.29**	1			
Factor 5	.42**	.20**	.33**	.35**	1		
Factor 6	.23**	.10**	.00	.12**	.16**	1	
Factor 7	.27**	.14**	.21**	.25**	.24**	.06	1

Note. ** $p < .01$

Table 4

Factor 1 Inter-Item Correlations

	5	10	11	12	30	32	33	36
5. (B) If I ruled the world it would be a better place.	1							
10. (B) I see myself as a good leader.	.26**	1						
11. (A) I am assertive.	.16**	.38**	1					
12. (A) I like to have authority over other people.	.24**	.23**	.18**	1				
30. (A) I really like to be the center of attention.	.19**	.27**	.24**	.23**	1			
32. (B) People always seem to recognize my authority.	.23**	.24**	.20**	.31**	.26**	1		
33. (A) I would prefer to be a leader.	.25**	.46**	.21**	.40**	.30**	.31**	1	
36. (A) I am a born leader.	.12	.36	.22**	.23**	.25**	.26	.31**	1

Note. ** $p < .01$; Narcissistic responses of items listed only

Table 5

Factor 2 Inter-Item Correlations

	4	15	19	26	29
4. (B) I know that I am good because everybody keeps telling me so.	1				
15. (B) I like to show off my body.	.19**	1			
19. (B) I like to look at my body.	.25**	.38**	1		
26. (B) I like to be complimented.	.29**	.21**	.25**	1	
29. (A) I like to look at myself in the mirror.	.18**	.27**	.40**	.26**	1

Note. ** $p < .01$; Narcissistic responses of items listed only

Table 6

Factor 3 Inter-Item Correlations

	13	14	24	25	27	38	39
13. (A) I find it easy to manipulate people.	1						
14. (A) I insist upon getting the respect that is due me.	.12**	1					
24. (A) I expect a great deal from other people.	.20**	.13**	1				
25. (A) I will never be satisfied until I get all that I deserve.	.20**	.26**	.19**	1			
27. (A) I have a strong will to power.	.26**	.15**	.10**	.24*	1		
38. (A) I get upset when people don't notice how I look when I go out in public.	.22**	.15**	.13**	.20**	.13**	1	
39. (A) I am more capable than other people.	.18**	.12**	.21**	.26**	.12**	.20**	1

Note. * $p < .05$, ** $p < .01$; Narcissistic responses of items listed only

Table 7

Factor 4 Inter-Item Correlations

	2	7	9	20	23	37	40
2. (A) Modesty doesn't become me.	1						
7. (B) I like to be the centre of attention.	.17**	1					
9. (B) I think I am a special person.	.16**	.22**	1				
20. (B) I will usually show off if I get the chance.	.16**	.32**	.17**	1			
23. (B) Everybody likes to hear my stories	.03	-.02	.08*	-.10**	1		
37. (A) I wish somebody would someday write my biography.	.08*	.17**	.12**	.13**	-.08*	1	
40. (B) I am an extraordinary person.	.17**	.24**	.41**	.19**	.02	.19**	1

Note. * $p < .05$, ** $p < .01$; Narcissistic responses of items listed only

Table 8

Factor 5 Inter-Item Correlations

	1	3	6	16	31	34	35
1. (A) I have a natural talent for influencing people.	1						
3. (A) I would do almost anything on a dare.	.11**	1					
6. (A) I can usually talk my way out of anything.	.15**	.20**	1				
16. (A) I can read people like a book.	.19**	.10**	.10**	1			
31. (A) I can live my life in any way I want to.	.17**	.18**	.16**	.14**	1		
34. (A) I am going to be a great person.	.19**	.11**	.02	.13**	.19**	1	
35. (B) I can make anybody believe anything I want them to.	.15**	.12**	.21**	.20**	.15**	.12**	1

Note. ** $p < .01$; Narcissistic responses of items listed only

Table 9

Factor 6 Inter-Item Correlations

	17	21	22
17. (B) I like to take responsibility for making decisions.	1		
21. (A) I always know what I am doing.	.15**	1	
22. (B) I rarely depend on anyone else to get things done.	.14**	.16**	1

Note. ** $p < .01$; Narcissistic responses of items listed only

Table 10

Factor 7 Inter-Item Correlations

	8	18
8. (A) I will be a success.	1	
18. (B) I want to amount to something in the eyes of the world.	.21**	1

Note. ** $p < .01$; Narcissistic responses of items listed only

Three factors were retained based on inflection of the scree plot. Table 11 shows factor loadings after rotation. The three factors in combination explained 25.10% of the variance over 34 items. The items that cluster on the same factor suggest that Factor 1 represents authority and self-sufficiency (e.g., leadership, influential, ruler, great person, success, self-reliant), Factor 2 represents entitlement, exhibitionism and exploitativeness (e.g., manipulative, authority, deserving, talk my way out of things, upset when not noticed, capable than others, expect a great deal from others, power hungry, manipulative, daring, start new trends) and Factor 3 represents superiority and vanity (e.g., gets and likes compliments, show-off body, look at self in mirror, centre of attention, special, extraordinary). Items that loaded onto Factor 1 below .30 were discarded as this increased the internal consistency of the factor. The discarded items for Factor 1 were (A) "I will be a success", or (B) "I am not too concerned about success" (.29), (A) "I sometimes depend on people to get things done", or (B) "I rarely depend on anyone else to get things done" (.27), (A) "I can live my life in any way I want to", or (B) "People can't always live their lives in terms of what they want" (.27) and (A) "Sometimes I tell good stories", or (B) "Everybody likes to hear my stories" (.24). However, low loading items (< .30) for Factor 2 were retained due to their exclusion reducing the internal consistency to below acceptable levels (< .70) The items retained were, (A) "Modesty doesn't become me", or (B) "I am essentially a modest person" (.24) and (A) "I just want to be reasonably happy", or (B) "I want to amount to something in the eyes of the world" (.20). No items loaded onto Factor 3 below .30. See Table 12 for inter-factor correlations and Table 13 to 15 for inter-item correlations of each factor.

Table 11

Factor Loadings of the Three Factor Solution

	1	2	3
10. (B) I see myself as a good leader.	.68		
11. (A) I am assertive.	.55		
1. (A) I have a natural talent for influencing people.	.52		
33. (A) I would prefer to be a leader.	.52	.33	
36. (A) I am a born leader.	.50		
32. (B) People always seem to recognize my authority.	.42	.34	
5. (B) If I ruled the world it would be a better place.	.41		
34. (A) I am going to be a great person.	.38		
21. (A) I always know what I am doing.	.38		
17. (B) I like to take responsibility for making decisions.	.36		
16. (A) I can read people like a book.	.31		
13. (A) I find it easy to manipulate people.		.60	
12. (A) I like to have authority over other people.	.32	.54	
25. (A) I will never be satisfied until I get all that I deserve.		.52	
6. (A) I can usually talk my way out of anything.		.50	
38. (A) I get upset when people don't notice how I look when I go out in public.		.49	.31
39. (A) I am more capable than other people.		.48	
24. (A) I expect a great deal from other people.		.47	
14. (A) I insist upon getting the respect that is due me.		.41	
27. (A) I have a strong will to power.		.40	
35. (B) I can make anybody believe anything I want them to.		.37	
28. (B) I like to start new fads and fashions.		.31	
3. (A) I would do almost anything on a dare.		.31	
2. (A) Modesty doesn't become me.		.24	
18. (B) I want to amount to something in the eyes of the world.		.20	
19. (B) I like to look at my body.			.63
26. (B) I like to be complimented.			.60
29. (A) I like to look at myself in the mirror.			.58
15. (B) I like to show off my body.			.55
7. (B) I like to be the centre of attention.			.53
30. (A) I really like to be the center of attention.	.32		.53
4. (B) I know that I am good because everybody keeps telling me so.			.47
20. (B) I will usually show off if I get the chance.		.32	.44
9. (B) I think I am a special person.			.43
40. (B) I am an extraordinary person.	.31		.38
37. (A) I wish somebody would someday write my biography.			.30
Eigenvalues	5.74	2.31	2.00
% of variance	14.35	5.77	4.98
α	.70	.70	.74

Note. Factor loadings appear in bold; only factor loadings over .30 are shown except for the last two items of Factor 2 which were retained due to internal consistency; Narcissistic responses of items listed only

Table 12

Item Subscale Correlations

	Factor 1	Factor 2	Factor 3
Factor 1	1		
Factor 2	.38**	1	
Factor 3	.41**	.35**	1

Note. ** $p < .01$

Table 13

Factor 1 Inter-Item Correlations

	1	5	10	11	16	17	21	32	33	34	36
1. (A) I have a natural talent for influencing people.	1										
5. (B) If I ruled the world it would be a better place.	.12**	1									
10. (B) I see myself as a good leader.	.31**	.26**	1								
11. (A) I am assertive.	.32**	.16**	.38**	1							
16. (A) I can read people like a book.	.19**	.12**	.11**	.14**	1						
17. (B) I like to take responsibility for making decisions.	.13**	.15**	.16**	.12**	-.00	1					
21. (A) I always know what I am doing.	.18**	.10**	.16**	.18**	.11**	.15**	1				
32. (B) People always seem to recognize my authority.	.18**	.23**	.24**	.20**	.10**	.13**	.15**	1			
33. (A) I would prefer to be a leader.	.18**	.25**	.46**	.21*	.06	.12**	.10**	.31**	1		
34. (A) I am going to be a great person.	.19**	.11**	.19**	.18**	.13**	.06	.11**	.00	.05	1	
36. A) I am a born leader.	.26**	.12**	.36**	.22**	.10**	.05	.13**	.26**	.31**	.16**	1

Note. * $p < .05$, ** $p < .01$; Narcissistic responses to items listed only

Table 14

Factor 2 Inter-Item Correlations

	2	3	6	12	13	14	18	24	25	27	28	35	38	39
2. (A) Modesty doesn't become me	1													
3. (A) I would do almost anything on a dare	.14**	1												
6. (A) I can usually talk my way out of anything	.10**	.20**	1											
12. (A) I like to have authority over other people	.16**	.09**	.26**	1										
13. (A) I find it easy to manipulate people	.09**	.17**	.31**	.32**	1									
14. (A) I insist upon getting the respect that is due me	.09**	.08*	.13**	.18**	.12**	1								
18. (B) I want to amount to something in the eyes of the world.	.03	.03	.07*	.12**	.06	.02	1							
24. (A) I expect a great deal from other people	.11**	.14**	.12**	.20**	.20**	.26**	.12**	1						
25. (A) I will never be satisfied until I get all that I deserve	.08*	.17**	.15**	.25**	.26**	.15**	.14**	.24**	1					
27. (A) I have a strong will to power	.06	.02	.08*	.15**	.14**	.13**	.09**	.13**	.16**	1				
28. (B) I like to start new fads and fashions	.08*	.12**	.21**	.19**	.27**	.06	.17**	.13**	.11**	.06	1			
35. (B) I can make anybody believe anything I want them to	.12**	.15**	.15**	.22**	.18**	.12**	.04	.26**	.12**	.06	.14**	1		
38. (A) I get upset when people don't notice how I look when I go out in public	.13**	.06	.09**	.23**	.20**	.13**	.01	.19**	.10**	.10**	.12**	.21**	1	
39. (A) I am more capable than other people	.04	.11**	.20**	.18**	.22**	.15**	.15**	.20**	.13**	.25**	.16**	.20**	.13**	1

Note. * $p < .05$, ** $p < .01$; Narcissistic responses of items listed only

Table 15

Factor 3 Inter-Item Correlations

	4	7	9	15	19	20	26	29	30	37	40
4. (B) I know that I am good because everybody keeps telling me so	1										
7. (B) I like to be the centre of attention	.18**	1									
9. (B) I think I am a special person	.21**	.22**	1								
15. (B) I like to show off my body	.19**	.22**	.14**	1							
19. (B) I like to look at my body	.25**	.21**	.19**	.38**	1						
20. (B) I will usually show off if I get the chance	.18**	.32**	.17**	.17**	.20**	1					
26. (B) I like to be complimented	.30**	.28**	.19**	.21**	.25**	.19**	1				
29. (A) I like to look at myself in the mirror	.18**	.16**	.17**	.27**	.40**	.12**	.26**	1			
30. (A) I really like to be the center of attention	.28**	.61**	.23**	.19**	.14**	.32**	.36**	.20**	1		
37. (A) I wish somebody would someday write my biography	.04	.17**	.12**	.06	.10**	.13**	.17**	.10**	.22**	1	
40. (B) I am an extraordinary person	.12**	.24**	.41**	.10**	.22**	.19**	.20**	.14**	.23**	1	.13**

Note. * $p < .05$, ** $p < .01$; Narcissistic responses of items listed only

10.5 Discussion

The NPI (Raskin & Hall, 1979), which assesses grandiose narcissism, is the most commonly employed narcissism measure; however, its interpretation is challenged by its untenable factor structure. The seven-factor solution, despite attempting to assess important theoretical characteristics of grandiose narcissism, had poor internal consistency. In this study, principal component analysis was used to explore the factor structure of the 40-item NPI.

Principal component analyses suggest that, consistent with previous research (Ackerman et al., 2011; Corry et al., 2008; del Rosario & White, 2005; Emmons, 1984; Kubarych et al., 2004; Raskin & Terry, 1988), the NPI has a multidimensional factor structure. Moreover, the NPI single factor consistently demonstrates high internal consistency and the first unrotated principal component has positive loadings from all items. However, the principal component analysis did not provide an obvious factor solution. Based on the scree plot, both a three- and seven-factor- solution were explored. Due to low internal consistencies on some factors of the seven-factor model, the three-factor model best fits the data. Only one of the seven factor scales produced satisfactory internal consistency values, whereas the three-factor solution had both a good fit to the data and satisfactory internal consistency values (.70).

It is important to compare the current results to the other three-factor solutions proposed (Ackerman et al., 2011; Kubarych et al., 2004). All items of Factor 2 (exhibitionism) from Kubarych and colleagues (2004) study were shared with Factor 3 (entitlement, exhibitionism and exploitativeness) of the current study, highlighting this factor as stable across samples. Whilst most items of Factor 1 (power) from Kubarych and colleagues (2004) study were shared with Factor 1 (authority and self-sufficiency)

from the current study, there were six items from Factor 1 (power) that instead loaded onto Factor 2 (entitlement, exhibitionism and exploitativeness) in the current study (e.g., “I find it easy to manipulate people”, “I like to have authority over other people”, “I will never be satisfied until I get all that I deserve”, “I can usually talk my way out of anything”, “I expect a great deal from other people” and “I have a strong will to power”). Perhaps power underlies the authority, exploitativeness and entitlement components of narcissism. Regardless, the factor structure of the NPI remains unclear.

Ten of the 11 items of Factor 1 (authority and self-sufficiency) of the current study are shared by Factor 1 of Ackerman and colleagues (2011) study. The current study also includes one additional item under Factor 1 (i.e., item 17. “I like to take responsibility for making decisions”) whilst Ackerman and colleagues (2011) Factor 1 (Leadership/authority) included 1) five items which loaded onto Factor 2 (entitlement, exhibitionism and exploitativeness) of the current study (i.e., item 6 “I can usually talk my way out of anything”, item 12 “I like having authority over other people, item 27 “I have a strong will to power”, item 35 “I can make anybody believe anything I want them to”, item 39 “I am more capable than other people”) and 2) two items which loaded onto Factor 3 (superiority and vanity) of the current study (i.e., item 9 “I think I am a special person” and item 40 “I am an extraordinary person”). Eight of the 11 items of Factor 3 (superiority and vanity) of the current study are shared by Factor 2 (Grandiose/exhibitionism) of Ackerman and colleagues’ (2011) study. The current study also includes item 37 “I wish somebody would someday write my biography” in Factor 3 (superiority and vanity) in addition to item 9 and 40 as mentioned. Item 28 “I like to start new fads and fashions” and item 38 “I get upset when people don’t look notice how I look when I go out in public” which were included under Ackerman and

colleagues (2011) study's Factor 2 (Grandiose/exhibitionism) loaded onto Factor 2 (entitlement, exhibitionism and exploitativeness) of the current study. The remaining items were either shared as Factor 2 (entitlement, exhibitionism and exploitativeness) of the current study and Factor 3 (entitlement and exhibitionism) of Ackerman and colleagues' (2011) study.

There appears to be more similarities in factor extraction between the current study and Ackerman and colleagues' (2011) study than there is between the current study and Kubarych and colleagues' (2004) study. Yet there are still differences between the studies in terms of which items loaded onto each factor. It cannot be argued that the current study's three-factor solution is the best available compared to the three-factor solutions in the literature. However, for the purpose of this research, the factor solution of Study 1 will be used in subsequent analyses. Further research is required in the general population to replicate the current results. Further research is also required in more targeted populations such as in undergraduate cohorts to replicate previous results and in clinical populations. The factors in the three-factor model of the current study do capture the main aspects of narcissism discussed in the literature (Dickinson & Pincus, 2003; Gordon & Dornbeck, 2010; Pincus & Lukowitsky, 2010; Wink, 1991).

10.5.1 Implications. The findings of Study 1 have important theoretical and clinical implications. This study confirmed that the Raskin and Terry (1988) seven-factor solution was not appropriate for use in the general population; internal consistencies were low. Furthermore, despite the scree plot demonstrating that both a three- or seven-factor solution could be appropriate for the data set, it was revealed that only the three factor solution had good internal consistency. Therefore, this study demonstrates that to examine the factors of grandiose narcissism in the general

population, quantitative methods will only be able to employ the three-factor solution. Moreover, to examine the important theoretical components captured by the seven factor solution (i.e., authority, self-sufficiency, superiority, exhibitionism, exploitiveness, vanity and entitlement,) this will need to be examined in qualitative research.

Despite the three-factor solution produced here, there were differences between this structure and previous three-factor solutions in terms of item loading. This discrepancy may be accounted for by the populations used (i.e., the current study utilised individuals from the general population whilst previous studies relied on undergraduate populations) but further research to replicate the factors is required. The current study's three-factor structure will be used for the subsequent studies given participants will be recruited from the general population. Additionally, the current study's three-factor solution also appears best at reducing the seven-factor model which has important theoretical foundations, thus fits best with the current research questions which aims to examine those seven factors of narcissism in subsequent studies.

Generally, there is a need for NPI item re-development so that one version of the NPI exists which can be used by practitioners and researchers for ease of comparison. A contemporary version should have a fixed number of factors which are consistently supported by empirical data. To further explore the NPI factor structure, facilitate interpretation, and provide a more thorough and representative measure, a Likert scale could be introduced, with responses ranging from non-narcissistic to extremely narcissistic. Moreover, highly similar or correlated items should be altered or eliminated to minimise the chance of extraction of factors based on items being almost identical in content instead of theoretically related. For example, Item 7, "I like to be the centre of

attention,” and Item 30, “I really like to be the centre of attention” are almost identical. Additionally, theoretically identified aspects of narcissism that are not or minimally captured in the scale should have established items.

10.5.2 Limitations of the present study. The findings should be considered in light of a number of factors. Firstly, there is a significant gender imbalance with a predominantly female sample; therefore, the results cannot be generalised to males. Secondly, due to the nature of self-report, the subjective experiences of respondents cannot be compared for accuracy. Additionally, the sample did not have adequate cultural diversity, therefore differences in factor or total scores between ethnic groups could not be considered. Future research should include more diverse samples.

It is important to note that the current study did not employ minimum average partial analyses to guide decision on factor extraction (i.e., Velicer’s Minimum Average Partial test; Zwick & Velicer, 1986). Instead, analyses were run using the scree plot and interpretability of the factors to guide factor extraction. Kaiser’s criterion of 1, which has been suggested as “rarely an optimal strategy for determining the number of dimensions given its general tendency to lead to an overextraction” (Ackerman et al., 2011), was not employed because no communalities exceeded .70 and the average communality did not exceed .60. Thus, contemporary recommendations for conducting factor analytic work was followed (Ackerman et al., 2011). Whilst minimum average partial analyses provides an alternative and accurate extraction method of factor extraction, it likely underestimates the number of factors when item numbers and loadings are low on a factor (Zwick & Velicer, 1986) and, based on all research on the NPI, factor underestimation was likely for the current study. Additionally, the multiplicity of approaches to factor analysis ensures that more than one outcome could

be regarded as correct. However, it is recommended that in future research, the NPI is analysed in a variety of populations, also using the less frequently employed yet increasingly valued alternative method of minimum average partial analyses.

Additionally, confirmatory analyses were not conducted as this is beyond the scope of this thesis. Thus, it is recommended that the three-factor solution is utilised pending further psychometric testing and development of the NPI. Although the NPI is prolifically used in measuring grandiose narcissism, it is evident in the present study that it requires revision. Narcissism has both a grandiose and vulnerable component and research demonstrates further components of grandiose narcissism.

10.6 Summary

The current study examined the psychometric properties of the NPI. Although developing a new version of the NPI was beyond the scope of this thesis, the current findings assist the interpretation of the current NPI and will provide information for future development of the NPI. Until this is done, researchers should be cautious about using the seven-factor NPI scales (Raskin & Terry, 1988) due to their lower internal consistency values. Examination of grandiose narcissism, the three-factor structure of grandiose narcissism and vulnerable narcissism in individuals with anorexia nervosa and bulimia nervosa is presented in Study 2 (Chapter 11).

Chapter 11

Study 2: Narcissism and Resistance in Eating Disorders

11.1 Purpose of the Study

Study 2 examined whether vulnerable narcissism or grandiose narcissism was elevated in individuals with anorexia nervosa or bulimia nervosa compared to a comorbid diagnoses control group and a healthy control group, and whether there were differences between these eating disorder groups on these two facets of narcissism. The presence of narcissism would support the case for including these two facets of narcissism in the conceptualisation of eating disorders. Additionally, Study 2 aims to determine whether either grandiose narcissism (including its factors identified in Study 1) or vulnerable narcissism predicts state- and trait-like resistance in individuals with either anorexia or bulimia nervosa. Understanding the potential differential roles of grandiose narcissism and vulnerable narcissism will have significant implications for the treatment approach. Moreover, understanding the potential differential roles of grandiose narcissism and vulnerable narcissism will have significant implications for whether it is in fact narcissism which needs to be treated to ensure engagement in treatment of the eating disorder. The following sections are an account of Study 2 including a brief background, brief overview of the method (see Chapter 9 for a detailed account), results and discussion in the context of the literature.

11.2 Brief Introduction

High levels of treatment resistance and low motivation to engage in treatment is seen in eating disorder populations (M. Cooper, 2005; Fassino & Abbate-Daga, 2013; Vitousek & Watson, 1998). Clients do not seek professional help, miss treatment

sessions, drop-out from treatment, and often are willing to reduce less morbid symptoms (e.g., binge eating) whilst being averse to change life-threatening ones (e.g., restrictive eating; Fassino & Abbate-Daga, 2013; Serpell et al., 1999; Williams & Reid, 2010).

Attention has been given to reasons for treatment resistance in eating disordered patients (Abdelbaky et al., 2013; Bruch, 1978; Corstorphine et al., 2007; Fassino & Abbate-Daga, 2013; M. Fisher, 2003; Fornari & Dancyger, 2003; Leahy, 2001; Reid et al., 2008; Serpell et al., 1999; Striegel-Moore et al., 1990; Williams & Reid, 2010).

However, the limitations of the research into overcoming eating disorders (i.e., small sample sizes, high attrition rates, inconclusive results and modest benefits) coupled with the continuing resistance to treatment in clinical settings (Waller, 2012) means it is important to explore other factors that may cause, promote and maintain treatment resistance in eating disordered individuals (Wilson et al., 2007).

While narcissism has been excluded from the conceptualisation of eating disorders, there is evidence linking narcissism to eating disorders (Davis et al., 1997; Lehoux et al., 2000; McLaren et al., 2001; Steiger et al., 1997; Steinberg & Shaw, 1997; Waller et al., 2007), and for narcissism being barrier to treatment in other client groups (W. Ellison et al., 2013; Hilsenroth et al., 1998; Kernberg, 2007; Ronningstam, 2011). The self psychology approach uses narcissism as a model to understand deficiency in identity development, that is, disorders of self, of which eating disorders are one type (Kohut, 1971). Disorders of self have been noted as resistance to treatment (Goldberg, 1999; Kohut, 1977). This consideration provides a hypothesis that narcissism creates treatment resistance in this population. In line with Kohut's (1977) conceptualisation of narcissism having a grandiose and vulnerable component, exploring these facets of narcissism in the eating disorder population and how these facets relate to treatment

resistance is the first step to assess how narcissism may play a critical role in the conceptualisation of eating disorders and/ or tailor interventions to overcome resistance.

Research is yet to examine the relationship between the two facets of narcissism (i.e., grandiose narcissism and vulnerable narcissism) and diagnosed eating disorders (i.e., anorexia nervosa and bulimia nervosa). Based on the idealising selfobject need (Kohut, 1977), reflecting vulnerability (Wink, 1991), being characteristic of individuals with bulimia nervosa (Maples et al., 2011), it is expected that vulnerable narcissism will be higher in individuals with bulimia nervosa. Based on the mirroring selfobject need (Kohut, 1977), reflecting grandiosity (Wink, 1991), being characteristic of individuals with anorexia nervosa (Bachar, 1988), it is expected that grandiose narcissism will be higher in individuals with anorexia nervosa.

Research is also yet to examine the relationship between the two facets of narcissism and treatment resistance in eating disorders, and whether there are differential relationships between the two kinds of narcissism and treatment resistance across diagnoses. Previous research in a population with narcissism demonstrated that grandiosity, not vulnerability, was associated with lower use of therapeutic services (W. Ellison et al., 2013; Pincus et al., 2009). Additionally, individuals with anorexia nervosa are the most resistant to treatment (Geller et al., 2005), and vulnerable narcissists, which individuals with bulimia nervosa may be (binging and purging, characteristic of bulimia nervosa, has been associated with vulnerable narcissism in a university cohort; Maples et al., 2011), were more likely to participate in treatment when feeling shame and withdrawn (Pincus & Lukowitsky, 2010). These previous findings together suggest that individuals with anorexia nervosa will have high levels of grandiose narcissism and

show greater resistance to treatment whilst individuals with bulimia nervosa will have high levels of vulnerable narcissism and be less resistant to treatment.

11.3 Hypotheses

Based on the reviewed research, the following hypotheses were made.

- H1: It is hypothesised that there will be a significant difference between the four groups (anorexia nervosa, bulimia nervosa, mental health control, healthy control) on vulnerable narcissism such that participants with bulimia nervosa will show significantly higher levels of vulnerable narcissism compared to participants with anorexia nervosa and both eating disorder groups will score significantly higher than mental health controls and healthy controls.
- H2: It is hypothesised that there will be a significant difference between the four groups (anorexia nervosa, bulimia nervosa, mental health control, healthy control) on grandiose narcissism (including its 3 factor) such that participants with anorexia nervosa will show significantly higher levels of grandiose narcissism (including its 3 factors) compared to participants with bulimia nervosa and both eating disorder groups will score significantly higher than mental health controls and healthy controls.
- H3: It is hypothesised that the anorexia nervosa group will show significantly higher levels of state-like resistance compared to the bulimia nervosa group.
- H4: It is hypothesised that there will be a significant difference between the three diagnosed groups (anorexia nervosa, bulimia nervosa and mental health control group) on trait-like resistance (across all scores) such that

the anorexia nervosa group will show significantly higher levels of trait-like resistance compared to the bulimia nervosa group and both eating disorder groups will show significantly higher levels of trait-like resistance compared to the mental health control group.

- H5: It is hypothesised that vulnerable narcissism will have a significant positive relationship with state-like resistance in the bulimia nervosa group, such that the higher the level of vulnerable narcissism the more likely the bulimic individual will be on a higher stage of change.
- H6: It is hypothesised that vulnerable narcissism will have a significant negative relationship with trait-like resistance in the bulimia nervosa group, such that the higher the level of vulnerable narcissism the more likely the bulimic individual will score low across the five trait-like resistance scales.
- H7: It is hypothesised that grandiose narcissism (including its three factors) will have a significant negative relationship with state-like resistance in the anorexia nervosa group, such that the higher the level of grandiose narcissism the more likely the anorexic individual will be on a lower stage of change.
- H8: It is hypothesised that grandiose narcissism (including its three factors) will have a significant positive relationship with trait-like resistance in the anorexia nervosa group, such that the higher the level of grandiose narcissism the more likely the anorexic individual will score high across the five trait-like resistance scales.

11.4 Method

As described in detail in Chapter 9, a general population sample of adults ($N = 180$) aged between 18 and 71 years old was recruited to complete a self-report questionnaire. The first section of the questionnaire contained demographic questions regarding the participant's age, gender, education level, postcode, ethnicity, relationship status, employment, and whether they had a current diagnosis of anorexia nervosa, bulimia nervosa, anxiety, depression or other as diagnosed by a qualified mental health practitioner. Five established self-report instruments which assess eating disorder symptomatology (Eating Disorder Diagnostic Scale [EDDS]), anxiety (State Trait Anxiety Inventory [STAI]), depression (The Centre for Epidemiological Studies-Depression Scale [CES-D]), grandiose narcissism (Narcissistic Personality Inventory [NPI]), vulnerable narcissism (Hypersensitive Narcissism Scale [HSNS]), trait-like resistance (The Butcher Treatment Planning Inventory [BTPI]), and state-like resistance for anorexia nervosa (Anorexia Nervosa Stages of Change Questionnaire [ANSOCQ]) and bulimia nervosa (Bulimia Nervosa Stages of Change Questionnaire [BNSOCQ]) were also included. Respondents were grouped into an anorexia nervosa group, a bulimia nervosa group, a mental health control group and a healthy control group for analysis. See Chapter 9 for in-depth methodology.

11.5 Results

11.5.1 Sample characteristics. One hundred and eighty participants aged between 18 to 71 years ($M = 28.35$ years, $SD = 11.61$ years) were included in analyses. The sample was comprised of 18 males aged between 18 and 71 years ($M = 36.61$ years, $SD = 19.31$ years) and 161 females aged between 18 and 71 years ($M = 27.37$ years, $SD = 10.06$ years). Among the group of participants with a self-reported current diagnosis

of anorexia nervosa ($n = 40$), 100% were females and age ranged between 18 and 46 ($M = 24.38$ years, $SD = 6.94$ years). Among the group of participants with a self-reported current diagnosis of bulimia nervosa ($n = 43$), 90.70% were females and age ranged between 18 and 35 ($M = 22.84$ years, $SD = 4.24$ years). Among those who were used as mental health control group based on those who did not self-report a current diagnosis of anorexia nervosa or bulimia nervosa but did report a diagnosis of an anxiety or depressive disorder as diagnosed by a mental health professional ($n = 41$), 87.80% were females and age ranged between 18 and 65 ($M = 29.31$ years, $SD = 12.66$ years). Among those who were used as a healthy control group based on those who did not self-report a current diagnosis of anorexia nervosa, bulimia nervosa, a depressive disorder or an anxiety disorder ($n = 56$), 82.10% were females and age ranged between 18 and 71 ($M = 35.25$ years, $SD = 14.10$ years). A summary of the demographic variables of the participants grouped based on a diagnosis provided by qualified mental health professional is presented in Table 16.

Given there were significant group differences on the demographic variables – relationship status, whom you live with and education level – these were examined in relation to the main variables of interest (i.e., grandiose narcissism [including its 3 factors], vulnerable narcissism and resistance measures) to assess if group differences exist. A one-way ANOVA revealed that there was no significant difference in grandiose narcissism between participants based on relationship status, $F(5, 157) = .37, p = .87$, whom they live with, $F(2, 160) = .42, p = .66$, or education level, $F(4, 158) = .37, p = .83$. A one-way ANOVA revealed that there was no significant difference in Factor 1 of grandiose narcissism (authority and self-sufficiency) between participants based on relationship status, $F(5, 170) = 1.37, p = .24$, whom they live with, $F(2, 173) = .56, p$

= .58, or education level, $F(4, 169) = 1.75, p = .14$. A one-way ANOVA revealed that there was no significant difference in Factor 2 of grandiose narcissism (entitlement, exhibitionism and exploitativeness) between participants based whom they live with, $F(2, 166) = 3.47, p = .04$. However, there was a significant difference in Factor 2 of grandiose narcissism between participants based on relationship status, $F(5, 163) = 3.06, p < .01$, and education level, $F(4, 164) = 8.10, p < .01$. A one-way ANOVA revealed that there was no significant difference in Factor 3 of grandiose narcissism (superiority and vanity) between participants based on relationship status, $F(5, 168) = 2.06, p = .07$, whom they live with, $F(2, 171) = 1.82, p = .17$, or education level, $F(4, 167) = .84, p = .50$. A one-way ANOVA revealed that there was no significant difference in vulnerable narcissism between participants based on whom they live with, $F(2, 172) = 3.79, p = .03$. However, there was a significant difference in vulnerable narcissism between participants based on relationship status, $F(5, 169) = 6.63, p < .01$ and education level, $F(4, 168) = 8.88, p < .01$.

For participants where the treatment resistance measures are to be used in analyses (i.e., the anorexia nervosa, bulimia nervosa, mental health control groups), a series of one-way ANOVAs were conducted to test the effects of the demographic variables relationship status, whom they live with and education level. A one-way ANOVA revealed that there was no significant difference in trait-like resistance (problems in relationship formation) between participants based on relationship status, $F(4, 108) = 1.43, p = .23$, whom they live with, $F(6, 106) = .88, p = .51$, or education level, $F(4, 106) = .94, p = .44$. A one-way ANOVA revealed that there was no significant difference in trait-like resistance (somatisation of conflict) between participants based on whom they live with, $F(6, 110) = .71, p = .64$, relationship status,

$F(4, 112) = 1.69, p = .16$ or education level, $F(4, 110) = .52, p = .72$. A one-way ANOVA revealed that there was no significant difference in trait-like resistance (low expectation of benefit) between participants based on relationship status, $F(4, 110) = 1.68, p = .16$, whom they live with, $F(6, 108) = 1.44, p = .21$, or education level, $F(4, 108) = 1.50, p = .21$. A one-way ANOVA revealed that there was no significant difference in trait-like resistance (self-orientation/narcissism) between participants based on relationship status, $F(4, 113) = .93, p = .45$, whom they live with, $F(6, 111) = .89, p = .50$, or education level, $F(4, 111) = .77, p = .55$. A one-way ANOVA revealed that there was no significant difference in trait-like resistance (perceived lack of environmental support) between participants based on relationship status, $F(4, 113) = .56, p = .69$, or education level, $F(4, 111) = .34, p = .85$. However, there was a significant difference on perceived lack of environmental support based on whom they live with, $F(6, 111) = 3.07, p < .01$. The demographic variables that had significant difference on key variables were controlled for in subsequent analyses.

Table 16

Study 2 Characteristics of Participants

Demographic	Anorexia Nervosa (<i>n</i> = 40) <i>n</i> (%)	Bulimia Nervosa (<i>n</i> = 43) <i>n</i> (%)	Mental Health Control (<i>n</i> = 41) <i>n</i> (%)	Healthy Control (<i>n</i> = 56) <i>n</i> (%)	Total (<i>N</i> = 180) <i>N</i> (%)	Statistic
Gender						$\chi (6, 180) = 9.35, p = .16$
Male	0 (0.0)	4 (9.3)	5 (12.2)	9 (16.1)	18 (10.0)	
Female	40 (100.0)	39 (90.7)	36 (87.8)	46 (82.1)	161 (89.4)	
Unspecified	0 (0.0)	0 (0.0)	0 (0.0)	1 (1.8)	1 (0.6)	
Do not wish to provide	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	
Education						$\chi (12, 180) = 46.70, p < .01$
Did not complete high school	0 (0.0)	2 (4.7)	1 (2.4)	0 (0.0)	3 (1.7)	
High school	23 (57.5)	26 (60.5)	16 (39.0)	11 (19.6)	76 (42.2)	
Trade/technical/vocational	5 (12.5)	2 (4.7)	6 (14.6)	5 (8.9)	18 (10.0)	
Undergraduate university	9 (22.5)	8 (18.6)	15 (36.6)	17 (30.4)	49 (27.2)	
Postgraduate university	3 (7.5)	3 (7.0)	3 (7.3)	23 (41.1)	32 (17.8)	
Postcode						$\chi (3, 147) = 4.28, p = .23$
Metropolitan	27 (67.5)	27 (62.8)	37 (90.2)	55 (98.2)	146 (81.1)	
Rural	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	(0.0)	
Remote	0 (0.0)	1 (2.3)	0 (0.0)	0 (0.0)	1 (0.6)	
Did not respond	13 (32.5)	15 (34.9)	4 (9.8)	1 (1.8)	33 (18.3)	
With whom do you live?						$\chi (21, 180) = 60.31, p < .01$
Alone	7 (17.5)	4 (9.3)	2 (4.9)	5 (8.9)	18 (10.0)	
Parents (with/without siblings)	19 (47.5)	19 (44.2)	12 (29.3)	10 (17.9)	60 (33.3)	
Siblings without parents	1 (2.5)	0 (0.0)	2 (4.9)	1 (1.8)	4 (2.2)	
Friends	5 (12.5)	2 (4.7)	1 (2.4)	0 (0.0)	8 (4.4)	
Acquaintances	2 (5.0)	5 (11.6)	3 (7.3)	2 (3.6)	12 (6.7)	
Partner and children	1 (2.5)	0 (0.0)	6 (14.6)	17 (30.4)	24 (13.3)	
Partner	5 (12.5)	13 (30.2)	15 (36.6)	16 (28.6)	49 (27.2)	
Children	0 (0.0)	0 (0.0)	0 (0.0)	4 (7.1)	4 (2.2)	
Ethnicity						$\chi (12, 180) = 17.82, p = .12$
Aboriginal	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	
Torres Strait Islander	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	
Anglo/Caucasian	39 (97.5)	40 (93.0)	39 (95.1)	47 (83.9)	165 (91.7)	

Asian		0 (0.0)	0 (0.0)	2 (4.9)	2 (3.6)	4 (2.2)	
Hispanic		0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	
Middle Eastern		1 (2.5)	1 (2.3)	0 (0.0)	0 (0.0)	2 (1.1)	
African		0 (0.0)	0 (0.0)	0 (0.0)	2 (3.6)	2 (1.1)	
Other		0 (0.0)	2 (4.7)	0 (0.0)	5 (8.9)	7 (3.9)	
Relationship status							$\chi (15, 180) = 45.61, p < .01$
Single		34 (85.0)	28 (65.1)	17 (41.5)	17 (30.4)	96 (53.3)	
Defacto		2 (5.0)	11 (25.6)	11 (26.8)	18 (32.1)	42 (23.3)	
Married		4 (10.0)	3 (7.0)	11 (26.8)	18 (32.1)	36 (20.0)	
Separated		0 (0.0)	0 (0.0)	2 (4.9)	0 (0.0)	2 (1.1)	
Divorced		0 (0.0)	1 (2.3)	0 (0.0)	2 (3.6)	3 (1.7)	
Widowed		0 (0.0)	0 (0.0)	0 (0.0)	1 (1.8)	1 (0.6)	
AN Dx							$\chi (6, 180) = 221.78, p < .01$
Yes- Current Diagnosis		40 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	40 (22.2)	
No- Past Diagnosis		0 (0.0)	17 (39.5)	2 (4.9)	1 (1.8)	20 (11.1)	
No		0 (0.0)	26 (60.5)	39 (95.1)	55 (98.2)	120 (66.7)	
BN Dx							$\chi (6, 180) = 194.46, p < .01$
Yes- Current Diagnosis		0 (0.0)	43 (100.0)	0 (0.0)	0 (0.0)	43 (23.9)	
No- Past Diagnosis		8 (20.0)	0 (0.0)	1 (2.4)	2 (3.6)	11 (6.1)	
No		32 (80.0)	0 (0.0)	40 (97.6)	54 (96.4)	126 (70.0)	
Anxiety Disorder Dx							$\chi (6, 180) = 74.89, p < .01$
Yes- Current Diagnosis		13 (32.5)	10 (23.3)	32 (78.0)	0 (0.0)	55 (30.6)	
No- Past Diagnosis		4 (10.0)	14 (32.6)	3 (7.3)	17 (30.4)	38 (21.1)	
No		23 (57.5)	19 (44.2)	6 (14.6)	39 (69.6)	87 (48.3)	
Depressive Disorder Dx							$\chi (6, 180) = 58.10, p < .01$
Yes- Current Diagnosis		18 (45.0)	19 (44.2)	29 (70.7)	0 (0.0)	66 (36.7)	
No- Past Diagnosis		5 (12.5)	7 (16.3)	3 (7.3)	22 (39.3)	37 (20.6)	
No		17 (42.5)	17 (39.5)	9 (22.0)	34 (60.7)	77 (42.8)	
Receiving treatment							$\chi (2, 124) = 4.56, p = .10$
Yes	Inpatient	5 (12.5)	2 (4.7)	1 (2.4)	-	8 (6.5)	
	Outpatient	14 (35.0)	24 (55.8)	27 (65.8)	-	65 (52.4)	
No		21 (52.5)	17 (39.5)	13 (31.7)	-	51 (41.1)	

11.5.2 Descriptive statistics. The means and standard deviations for the scales can be found in Table 17. The mean score of vulnerable narcissism for the healthy control group (26.98) was lower than the mean score in the psychometric testing of the HSNS (29) and the eating disorder groups approached high scores as defined by the HSNS (>35). The means of grandiose narcissism across groups were below the means identified in the development of the scale ($M = 15.55$). The scores of the stages of change demonstrated that individuals were at the low end of contemplation, with individuals contemplating treatment. All scales demonstrated good internal consistency ranging from .65 to .91. These figures were consistent with prior research findings.

Table 17

Study 2 Descriptive Statistics of Grandiose Narcissism and its 3 Factors, Vulnerable Narcissism, Trait-like Resistance and State-like Resistance

		<i>n</i>	<i>M</i> [#]	<i>SD</i>	Min	Max	Statistic
Eating symptomatology (EDDS; $\alpha = .83$)	AN	32	49.75 ^{ab}	15.71	16	89	$F(3, 140) = 41.98, p < .01, \eta_p^2 = .47$
	BN	37	49.29 ^{cd}	10.73	30	70	
	Mental Health Control	31	23.74 ^{ac}	16.06	0	57	
	Health Control	44	21.07 ^{bd}	15.60	0	61	
Depression ^{##} (CES-D; $\alpha = .93$)	AN	40	19.43	15.76	2	49	$F(3, 171) = 4.32, p < .01, \eta_p^2 = .07$
	BN	41	19.17	19.14	0	54	
	Mental Health Control	39	25 ^a	11.21	3	46	
	Health Control	52	14.07 ^a	11.48	0	45	
Anxiety (STAI-Trait; $\alpha = .44$)	AN	40	45.75	3.70	37	50	$F(3, 169) = 2.19, p = .09, \eta_p^2 = .04$
	BN	43	47.21	3.77	38	55	
	Mental Health Control	38	46.61	4.05	38	53	
	Health Control	52	45.35	3.79	37	58	
Vulnerable Narcissism (HSNS; $\alpha = .84$)	AN	39	34.13 ^{ab}	7.67	16	50	$F(3, 171) = 13.05, p < .01, \eta_p^2 = .19$
	BN	43	33.33 ^{cd}	5.41	22	43	
	Mental Health Control	38	27.82 ^{ac}	6.84	14	39	
	Health Control	50	26.98 ^{bd}	7.06	10	42	
Grandiose Narcissism (NPI; $\alpha = .81$)	AN	34	10.15	6.21	1	23	$F(3, 159) = 1.11, p = .35, \eta_p^2 = .02$
	BN	40	11.30	6.93	1	30	
	Mental Health Control	37	8.51	4.38	1	19	
	Health Control	52	9.88	5.85	2	28	
Authority, Self-Sufficiency (NPI Factor 1; $\alpha = .65$)	AN	38	2.66 ^a	2.80	0	16	$F(3, 172) = 4.63, p < .05, \eta_p^2 = .08$
	BN	42	3.67	2.89	0	9	
	Mental Health Control	41	2.93 ^b	2.31	0	10	
	Health Control	52	4.27 ^{ab}	2.26	0	9	
Entitlement, Exhibitionism, Exploitativeness (NPI Factor 2; $\alpha = .72$)	AN	38	3.92 ^a	2.97	0	11	$F(3, 165) = 8.79, p < .001, \eta_p^2 = .14$
	BN	41	4.37 ^{bc}	2.98	0	11	
	Mental Health Control	37	2.43 ^c	2.04	0	7	
	Health Control	52	2.08 ^{ab}	2.09	0	9	
Superiority, Vanity (NPI Factor 3; $\alpha = .78$)	AN	38	2.05	2.54	0	7	$F(3, 170) = .06, p = .98, \eta_p^2 = .00$
	BN	43	1.91	2.50	0	9	
	Mental Health Control	39	1.90	2.05	0	10	

	Health Control	52	1.85	2.12	0	9	
Trait-like Resistance							
Problems in Relationship Formation (BTPI; $\alpha = .78$)	AN	36	7.97	3.32	2	12	$F(2, 110) = .71, p = .50, \eta_p^2 = .01$
	BN	42	7.10	4.16	1	12	
	Mental Health Control	35	7.17	2.81	0	12	
Somatisation of Conflict (BTPI; $\alpha = .83$)	AN	36	4.61 ^a	2.60	0	11	$F(2, 114) = 5.89, p < .05, \eta_p^2 = .09$
	BN	42	4.90 ^b	4.15	0	15	
	Mental Health Control	39	7.10 ^{ab}	3.42	0	14	
Low Expectation of Benefit (BTPI; $\alpha = .78$)	AN	38	14 ^a	4.02	6	20	$F(2, 112) = 8.88, p < .01, \eta_p^2 = .14$
	BN	40	12.60 ^b	5.17	5	20	
	Mental Health Control	37	9.97 ^{ab}	2.97	4	16	
Self-orientation/Narcissism (BTPI; $\alpha = .87$)	AN	36	9.72 ^a	4.98	3	16	$F(2, 115) = 3.47, p < .05, \eta_p^2 = .06$
	BN	42	8.69 ^b	5.43	1	16	
	Mental Health Control	40	6.90 ^{ab}	3.63	1	14	
Perceived Lack of Environmental Support (BTPI; $\alpha = .69$)	AN	36	6.78 ^a	1.94	3	9	$F(2, 115) = 5.39, p < .05, \eta_p^2 = .09$
	BN	42	4.93 ^{ab}	2.78	0	8	
	Mental Health Control	40	6.57 ^b	3.34	0	12	
State-like Resistance							
AN Stages of Change (ANSOCQ; $\alpha = .91$)	AN	37	1.94	.73	1	4	$t(74) = -.24, p < .05$
	BN	39	2.30	.65	1	4	
BN Stages of Change (BNSOCQ; $\alpha = .89$)	AN	37	2.22	.74	1	4	$t(74) = -1.19, p = .24$
	BN	39	2.41	.62	1	4	

Note. EDDS = Eating Disorder Diagnostic Scale; CES-D = Centre for Epidemiologic Studies Depression Scale; STAI = State Trait Anxiety Inventory; NPI = Narcissistic Personality Inventory; HSNS = Hypersensitive Narcissism Scale; BTPI = Butcher Treatment Planning Inventory; ANSOCQ = Anorexia Nervosa Stages of Change Questionnaire; BNSOCQ = Bulimia Nervosa Stages of Change Questionnaire; AN = Anorexia Nervosa; and BN = Bulimia Nervosa; [#] Arabic letters mark significantly different pairs; ^{##} The nonparametric results differed slightly such that the mental health control group also scored significantly higher than the bulimia nervosa group ($U = 590.00, p < .05$), therefore interpret with caution.

11.5.3 Correlations of study variables. A Pearson's r bivariate correlation was conducted on all participants' data with HSNS, NPI, BTPI, ANSOCQ and BNSOCQ as the variables in question (see Table 18) prior to conducting the analyses which addressed the research questions. As expected, the vulnerable and grandiose narcissism scales had low correlation, although surprisingly the vulnerable narcissism scale had a significant medium correlation with Factor 2 (entitlement, exhibitionism and exploitativeness) of the NPI. As expected, the three factors of the NPI were highly correlated with the overall NPI score. All other scales were either unrelated or had significant low correlations. The high correlation between the BNSOCQ and the ANSOCQ was expected given they share 16 of 20 questions and the 4 remaining questions are variations of the same question (i.e., the BNSOCQ is an adaption of the ANSOCQ).

Table 18

Study 2 Correlations amongst grandiose narcissism and its 3 factors, vulnerable narcissism, anorexia stages of change, bulimia stages of change and trait-like resistance

	NPI Total	NPI Factor1	NPI Factor2	NPI Factor3	HSNS	ANSOCQ	BNSOCQ	BTPI- REL	BTPI- SOM	BTPI- EXP	BTPI- NAR	BTPI- ENV
NPI Total	1											
NPI Factor 1	.72**	1										
NPI Factor 2	.75**	.24**	1									
NPI Factor 3	.69**	.21**	.45**	1								
HSNS	.27**	-.05	.51**	.21**	1							
ANSOCQ	-.07	.28*	-.17	-.24*	-.04	1						
BNSOCQ	-.13	.25*	-.24*	-.26*	-.06	.96**	1					
BTPI-REL	-.12	-.16*	.09	-.24**	.38**	-.09	-.05	1				
BTPI-SOM	-.17*	-.12	-.08	-.23**	.02	.15	.15	.35**	1			
BTPI-EXP	.04	-.02	.24**	-.16*	.29**	-.14	-.14	.66**	-.02	1		
BTPI-NAR	.32**	.24**	.32**	.08	.26**	-.02	-.02	.52**	-.12	.72**	1	
BTPI-ENV	-.04	-.13	.15	-.14	.24**	-.17	-.13	.72**	.40**	.58**	.54**	1

Note. NPI = Narcissistic Personality Inventory; Factor 1 = Authority and Self-Sufficiency; Factor 2 = Entitlement, Exhibitionism and Exploitativeness; Factor 3 = Superiority and Vanity; HSNS = Hypersensitive Narcissism Scale; BTPI = Butcher Treatment Planning Inventory; REL = Problems in Relationship Formation; SOM = Somatisation of Conflict; EXP = Low Expectation of Benefit; NAR = Self-orientation/Narcissism; ENV = Perceived Lack of Environmental Support; ANSOCQ = Anorexia Nervosa Stages of Change Questionnaire; BNSOCQ = Bulimia Nervosa Stages of Change Questionnaire; * $p < .05$, ** $p < .01$.

11.5.4 Vulnerable narcissism. A one-way ANCOVA, controlling for relationship status and education level, revealed that there was a significant difference in vulnerable narcissism between the four groups of participants (anorexia nervosa, bulimia nervosa, mental health control and healthy control), $F(3, 167) = 6.18, p < .01, \eta_p^2 = .61$. Post hoc comparisons using the Tukey HSD test indicated that the mean score for the anorexia nervosa group ($M = 34.13, SD = 7.67$) was significantly higher than the mean score for the mental health control group ($M = 27.82, SD = 6.84$), $p < .01, d = .87$, and the healthy control group ($M = 26.98, SD = 7.06$), $p < .01, d = .97$, and the mean score for the bulimia nervosa group ($M = 33.33, SD = 5.41$) was significantly higher than the mean score for the mental health control group, $p < .01, d = .89$, and the healthy control group, $p < .01, d = 1.00$. However, there was no significant difference between the two eating disorder groups, $p = .94, d = .12$, and between the two control groups, $p = .93, d = .12$, on vulnerable narcissism.

11.5.5 Grandiose narcissism. A one-way ANOVA revealed that there was no significant difference in grandiose narcissism between the anorexia nervosa group ($M = 10.15, SD = 6.21$), the bulimia nervosa group ($M = 11.30, SD = 6.93$), the mental health control group ($M = 8.51, SD = 4.38$), and the healthy control group ($M = 9.88, SD = 5.85$) on grandiose narcissism, $F(3, 159) = 1.11, p = .35, \eta_p^2 = .02$.

11.5.5.1 Three factors of grandiose narcissism. A one-way ANOVA revealed that there was a significant difference between the four groups of participants (anorexia nervosa, bulimia nervosa, mental health control and healthy control) on Factor 1 of grandiose narcissism, representing authority and self-sufficiency, $F(3, 172) = 4.63, p < .01, \eta_p^2 = .08$. Additionally, a one-way ANCOVA on Factor 2 of grandiose narcissism (representing entitlement, exhibitionism and exploitativeness), controlling for

relationship and education status, revealed a significant difference between the four groups, $F(3, 151) = 8.73, p < .01, \eta_p^2 = .33$. However, there was no significant difference between the four groups on Factor 3 of grandiose narcissism, representing superiority and vanity, $F(3, 170) = .06, p = .98, \eta_p^2 = .00$. Post hoc comparisons (Tukey HSD) can be seen in Figure 2.

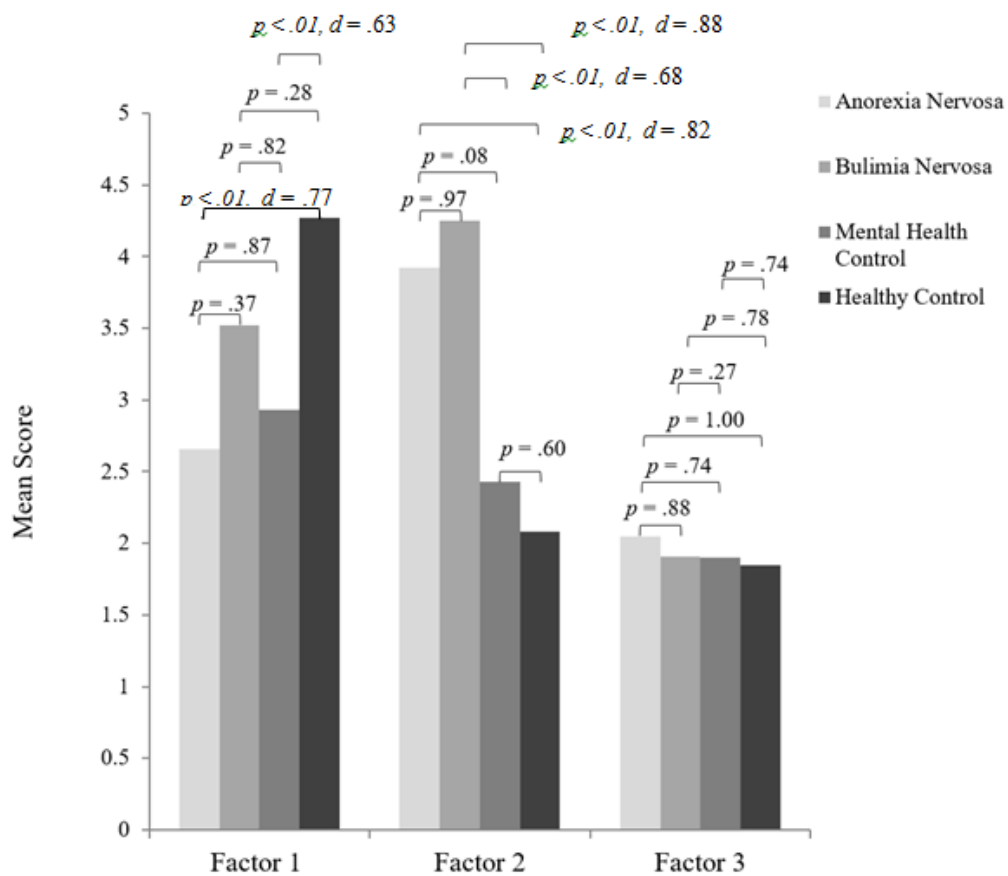


Figure 2. Post Hoc Comparisons Using Tukey HSD.

11.5.6 Trait-like resistance. One-way ANOVAs were conducted to compare trait-like resistance in three groups of participants (anorexia nervosa, bulimia nervosa, mental health control). A one-way ANOVA revealed that there was no significant difference in problems in relationship formation between the anorexia nervosa group (M

= 7.97, $SD = 3.32$), bulimia nervosa group ($M = 7.10$, $SD = 4.16$), and the mental health control group ($M = 7.17$, $SD = 2.81$), $F(2, 110) = .71$, $p = .50$, $\eta_p^2 = .01$.

A one-way ANOVA revealed that there was a significant difference in somatisation of conflict between the three groups of participants (anorexia nervosa, bulimia nervosa and mental health control), $F(2, 114) = 5.89$, $p < .01$, $\eta_p^2 = .09$. Post hoc comparisons using the Tukey HSD test indicated that the mean score for the mental health control group ($M = 7.10$, $SD = 3.42$) was significantly higher than the anorexia nervosa group ($M = 4.61$, $SD = 2.60$), $p < .01$, $d = .82$, and the bulimia nervosa group ($M = 4.90$, $SD = 4.15$), $p < .01$, $d = .58$, however there was no difference between the eating disorder groups, $p = .93$, $d = .08$, on somatisation of conflict.

A one-way ANOVA revealed that there was a significant difference in low expectation of benefit between the three groups of participants (anorexia nervosa, bulimia nervosa and mental health control), $F(2, 112) = 8.88$, $p < .01$, $\eta_p^2 = .14$. Post hoc comparisons using the Tukey HSD test indicated that the mental health control group ($M = 9.97$, $SD = 2.97$) scored significantly lower than the anorexia nervosa group ($M = 14.00$, $SD = 4.02$), $p < .01$, $d = 1.00$, and however there was no difference between the mental health control group and the bulimia nervosa group ($M = 12.60$, $SD = 5.17$), $p = .03$, $d = .62$, or between the two eating disorder groups, $p = .23$, $d = .30$, on low expectation of benefit.

A one-way ANOVA revealed that there was no significant difference in self-orientation/narcissism between the three groups of participants (anorexia nervosa, bulimia nervosa and mental health control), $F(2, 115) = 3.47$, $p = .03$, $\eta_p^2 = .06$.

A one-way ANCOVA, controlling for whom they live with, revealed that there was a significant difference in perceived lack of environmental support between the

three groups of participants (anorexia nervosa, bulimia nervosa and mental health control), $F(2, 114) = 5.32, p < .01, \eta_p^2 = .09$. Post hoc comparisons using the Tukey HSD test indicated that the bulimia nervosa group ($M = 4.93, SD = 2.78$) scored significantly lower than the anorexia nervosa group ($M = 6.78, SD = 1.94$), $p < .01, d = .77$; however, there was no significant difference between the bulimia nervosa group and the mental health control group ($M = 6.57, SD = 3.34$), $p = .03, d = .53$ and between the anorexia nervosa group and mental health group, $p = .95, d = .08$, on perceived lack of environmental support.

11.5.7 State-like resistance. A *t*-test was conducted to compare readiness to recover from the eating disorder between the two groups of participants with eating disorders (anorexia nervosa, bulimia nervosa) using the SOCQ. Levene's test for equality of variances was not violated, $F(74) = .02, p = .88$, therefore subsequent results, which assumed equal variances, was utilised. Results revealed that the bulimia nervosa group ($M = 2.46, SD = .76$) scored significantly higher than the anorexia nervosa group ($M = 1.97, SD = .83$) on stages of change, $t(74) = -2.68, p < .01, d = .62$.

11.5.8 Predicting Resistance. Standard regressions tested the prediction of grandiose narcissism and vulnerable narcissism on state- and trait-like resistance, and the three factors of grandiose narcissism (Factor 1, authority and self-sufficiency; Factor 2, entitlement, exhibitionism and exploitativeness; and, Factor 3, superiority and vanity) on state- and trait-like resistance in the anorexia nervosa group and followed by the bulimia nervosa group. Although the analysis plan was to examine all of the components of resistance, due to the small sample and being mindful of type 1 error, only those with sound statistical power (i.e., $\geq .80$) are reported.

11.5.8.1 Narcissism predicting trait-like resistance in the anorexia nervosa group.

11.5.8.1.1 Predicting trait-like resistance (problems in relationship formation).

A standard regression tested the prediction of the three factors of grandiose narcissism on trait-like resistance (problem in relationship formation) in the anorexia nervosa group. Results revealed that the three factors of grandiose narcissism significantly explained 54.7% of variance in problem in relationship formation, $R^2 = .55$, $F(3, 26) = 10.46$, $p < .01$, $f^2 = 1.22$, power = .99. Problems in relationship formation was significantly explained by entitlement, exhibitionism, and exploitativeness ($\beta = .35$, $p < .01$) and superiority and vanity ($\beta = -.86$, $p < .01$), but not authority and self-sufficiency ($\beta = .12$, $p = .38$).

11.5.8.1.2 Predicting trait-like resistance (low expectation of benefit). A

standard regression tested the prediction of the three factors of grandiose narcissism on trait-like resistance (low expectations of benefit) in the anorexia nervosa group. Results revealed that the three factors significantly explained 35.8% of the variance in low expectations of benefit, $R^2 = .36$, $F(3, 28) = 5.21$, $p < .01$, $f^2 = .56$, power = .92. Low expectation of benefit was significantly explained by entitlement, exhibitionism, and exploitativeness ($\beta = .44$, $p < .05$) and superiority and vanity ($\beta = -.66$, $p < .01$), but not authority and self-sufficiency ($\beta = .10$, $p = .52$).

11.5.8.1.3 Predicting trait-like resistance (self-orientation/narcissism). A

standard regression tested the prediction of the three factors of grandiose narcissism on trait-like resistance (self-orientation/narcissism) in the anorexia nervosa group. Results revealed that the three factors significantly explained 37.3% of the variance in self-orientation/narcissism, $R^2 = .37$, $F(3, 26) = 5.16$, $p < .01$, $f^2 = 0.59$, power = .91. Self-

orientation/narcissism was significantly explained by and superiority and vanity ($\beta = -.60, p < .01$), but not entitlement, exhibitionism, and exploitativeness ($\beta = .39, p = .05$) or authority and self-sufficiency ($\beta = .22, p = .19$).

11.5.8.1.4 Predicting trait-like resistance (perceived lack of environmental support). A standard regression, controlling for whom the participant lives with, tested the prediction of the three factors of grandiose narcissism on trait-like resistance (perceived lack of environmental support) in the anorexia nervosa group. Results revealed that 62% of perceived lack of environmental support was explained by the three factors of grandiose narcissism, $R^2 = .62, F(3, 27) = 11.11, p < .01, f^2 = 1.63$, power = .99. Perceived lack of environmental support was significantly explained by entitlement, exhibitionism, and exploitativeness ($\beta = .18, p < .01$) and superiority and vanity ($\beta = .63, p < .01$), but not authority and self-sufficiency ($\beta = .19, p = .31$).

11.5.8.2 Narcissism predicting state-like resistance in the bulimia nervosa group. A standard regression tested the prediction of the three factors of grandiose narcissism on state-like resistance (stage of change) in the bulimia nervosa group. Results revealed that the three factors of grandiose narcissism significantly explained 26.1% of variance in stage of change, $R^2 = .26, F(3, 32) = 3.77, p < .01, f^2 = .35$, power = .80. Stage of change was significantly predicted by authority and self-sufficiency ($\beta = .52, p < .01$) but not by entitlement, exhibitionism, and exploitativeness ($\beta = -.26, p = .20$) and superiority and vanity ($\beta = -.12, p = .54$).

11.6 Discussion

Study 2 aimed to examine whether the self psychology consideration of eating disorders as narcissistic behaviour disorders, comprising vulnerable and grandiose narcissism, was valid and useful to explain treatment resistance in the eating disorder

population. Specifically, Study 2 aimed to examine whether vulnerable narcissism and grandiose narcissism, including its three factors identified in Study 1, was elevated in individuals with anorexia nervosa or bulimia nervosa compared to a mental health control group and a healthy control group. Moreover, it examined whether levels of narcissism differed between anorexic and bulimic individuals. Study 2 also aimed to determine whether either grandiose narcissism (including its factors) or vulnerable narcissism predicted state- and trait-like resistance in individuals with either anorexia or bulimia nervosa.

As expected, the anorexia nervosa group and bulimia nervosa group scored significantly higher than the mental health control group and the healthy control group on vulnerable narcissism. However, unexpectedly, there was no difference between the eating disorder groups on vulnerable narcissism. Perhaps the fact that there was no difference in levels of vulnerable narcissism between eating disorder groups indicates that both eating disorders, not just bulimia nervosa (Maples et al., 2011), share traits such as inability to self-soothe and low self-esteem. Moreover, other mediating factors such as weight preoccupation and drive for thinness, shared factors of anorexia nervosa and bulimia nervosa, may have influenced the results. These results indicate that vulnerable narcissism is important to be considered in the conceptualisation of anorexia nervosa and bulimia nervosa, supporting the understanding of disorders of self using the self psychology perspective (Kohut, 1977; S. Sands, 1989), such as eating disorders.

Contrary to predictions, grandiose narcissism was not elevated in eating disorder individuals compared to the mental health and community samples, nor was there a difference between eating disorder groups. The results indicate that grandiose narcissism may be less important in the conceptualisation of anorexia nervosa and

bulimia nervosa. Grandiose narcissism may truly not be present; however, this explanation is at odds with current literature (Lehoux et al., 2000; McLaren et al., 2001; Steiger et al., 1997). Alternately, the measure of grandiose narcissism, the NPI, may not be an entirely accurate reflection of grandiose narcissism, supporting the concern of poor discriminant validity which was highlighted in one study (Rosenthal & Hooley, 2010). Alternatively, only some components of grandiose narcissism may be present in individuals with eating disorders. By employing the three factors of grandiose narcissism as identified in Study 1, a more thorough understanding of the relationship between grandiose narcissism and eating disorders could be explored.

Contrary to predictions, the healthy control group scored significantly higher on Factor 1 of grandiose narcissism, authority and self-sufficiency, than the anorexia nervosa group, which did not score significantly different to the bulimia nervosa group. Furthermore, the mental health control group did not score differently to the eating disorder groups. Whilst these findings were unexpected given previous research demonstrated that eating disordered individuals manifested characteristics of authority (i.e., dominance and criticality; M. Campbell & Waller, 2010; Hartmann et al., 2010; Raskin & Terry, 1988; Riebel, 2000) and self-sufficiency (i.e., achievement need; Goldner et al., 2002; Gunnard et al., 2012; Stice, 2002), it does support research that highlighted that individuals with eating disorders express themselves in non-assertive and submissive ways (Bruch, 1973; Troop & Baker, 2008) and generally have low self-confidence (Perry et al., 2008). Furthermore, the results that eating disordered individuals are less authoritative (i.e., less dominant, assertive, critical and self-confident) and less self-sufficient (i.e., less assertive, independent, self-confident, and achievement oriented) than the general population provides preliminary support of the

self psychology understanding that eating disorders are narcissistic behaviour disorders (Kohut, 1977); eating disordered individuals lack self-confidence and self-sufficiency thus they may be using the eating disorder to manage self. Alternatively, the results may be accounted for by some respondents being sensitive to the ideas of authority and self-sufficiency when responding. Alternatively, the internal consistency of Factor 1 in this study was below .70 ($\alpha = .65$) which may have contributed to the result. This low internal consistency again highlights the psychometric properties of the NPI factors; whilst a three-factor solution with sound internal consistencies of each factor was found in Study 1, it was not replicated in the current study.

As expected, the anorexia nervosa group and the bulimia nervosa group scored significantly higher than the healthy control group on Factor 2 of grandiose narcissism (entitlement, exhibitionism and exploitativeness). Eating disordered individuals are likely to be sensation seeking, impulsive, lacking self-control, rebellious, requiring excessive attention and intolerant of others (Raskin & Terry, 1988). Eating disordered individuals are also likely to be extraverted, needing power, dominant, hostile and tough (Raskin & Terry, 1988). The described characteristics appear at odds with the previous finding based on Factor 1 (authority and self-sufficiency) that eating disordered individuals are likely to be non-assertive and submissive. Additionally, the current result suggests eating disordered individuals are likely to be ambitious, yet, in contrast, the previous finding of the current study suggests these individuals are likely to not be achievement oriented. The discrepancies in results may be accounted for by the poor discriminant validity of some items such that they load above .30 (cut off) onto both Factor 1 and Factor 2. Alternatively, it may be that these individuals contain both aspects of grandiose narcissism and, according to Kohut (1977), these aspects of

personality are disintegrated (i.e., the vertical split). Unexpectedly, only the bulimia nervosa group scored significantly higher than the mental health group. There was no significant difference between the anorexia nervosa group and the mental health control group or between the eating disorder groups on entitlement, exhibitionism and exploitativeness. Whilst individuals with anorexia nervosa did not score differently to individuals with other mental health issues on entitlement, exhibitionism and exploitativeness, this is not to say that these characteristics should not be addressed in treatment. However, it does suggest that these characteristics are not specific to eating disorders.

Unexpectedly, the anorexia nervosa group and bulimia nervosa group did not score differently to the control groups on Factor 3 of grandiose narcissism (superiority and vanity). This result suggests that eating disordered individuals do not believe they are physically attractive and perceived this way by others (Raskin & Terry, 1988). However, consider 1) the previous result of Study 2 which suggests eating disordered individuals require excessive attention and 2) the need to gain approval from others is higher among individuals with eating disorders and that this approval is often sought based upon perceived worth in the form of attractiveness (Reel, 2013). Combined, it appears the any attention from others cannot be integrated into the eating disordered individual's self. A healthy individual would have internalised the mirroring selfobject during development such that they would have self-cohesion, including stable and positive self-esteem (Kohut, 1984). However, for eating disordered individuals, the need for attention and approval from others may soothe a narcissistic wound but does not provide healing, a sense of positive self-esteem, that only selfobjects could provide via the transmuting internalisation process (Kohut, 1971). Perhaps then these individuals do

not have a sense of superiority; rather have a perception of omnipotence specific to the eating behaviour which is not captured by Factor 3.

The current results pertaining to superiority and vanity also suggests that eating disordered individuals do not have concern for status, social presence, and self-confidence, which seems inconsistent with research suggesting that eating disorder individuals have an inflated sense of specialness due to eating disorder behaviours (e.g., restriction in anorexic individuals and purging of binge eating in bulimic individuals; Bruch, 1973, 1978; Curry & Ray, 2010; Faer et al., 2005; A. Lock et al., 2005; Riebel, 2000; Tobin, 1993) and that eating disordered individuals are frequently making comparisons to others and are aware of rank in relation to appearance (M. Campbell & Waller, 2010; Cardi et al., 2014; Fox et al., 2005; Riebel, 2000), but consistent with results, also found when examining Factor 1, that eating disordered individuals generally have low self-confidence (Perry et al., 2008). Inconsistencies can again be explained by the use of eating disorder to meet selfobject needs. Lingering needs for admiration remain but can only be fulfilled by the narcissistic behaviour disorder (Goldberg, 1999; Kohut, 1977). The eating disorder behaviour meets the individual's narcissistic needs but they do not have pervasive self-confidence. Superiority is based only on the narcissistic behaviour which affirms themselves and provides perception of omnipotence. The vertical split, two side-by-side personalities in the individual, can also account for the discrepancy (Goldberg, 1999) such that individual feels both a sense of superiority and a sense of inferiority.

The inconsistent results, both across the three factors of grandiose narcissism and with previous research, could also be accounted for by the measure of grandiose narcissism used, which has already produced inconsistent findings previously (e.g., del

Rosario & White, 2005; Raskin & Terry, 1988). Due to the preliminary nature of the factors from the factor analysis in Study 1, there is no normative data to compare results. Furthermore, in the population used for Study 2, Factor 1 ($\alpha = .65$) did not meet sound internal consistency (i.e., $\geq .70$) like it did in the population used for Study 1 ($\alpha = .70$). Further examination of the NPI is required (see 10.5.1 Implications). To clarify the inconsistent results and to clarify whether eating disorders are narcissistic behaviour disorders or whether the results are a product of an unreliable measure, grandiose narcissism requires exploration using qualitative research (see Study 4).

Study 2 examined whether state-like and trait-like resistance differed between anorexia nervosa, bulimia nervosa and the mental health control group. Based on previous research, it was expected that both eating disorder groups would be resistant to treatment (M. Cooper, 2005; Fassino & Abbate-Daga, 2013; Vitousek & Watson, 1998) but that the anorexia nervosa group in particular would be resistant (Bachar, 1998; W. Ellison et al., 2013; Geller et al., 2005; Kohut, 1977; Maples et al., 2011; Pincus et al., 2009; Wink, 1991). As predicted, the bulimia nervosa group endorsed a lower level of state-like resistance compared to the anorexia nervosa group, such that the anorexia nervosa group had a significantly lower level of readiness to engage in treatment. On average, the participants in the anorexia nervosa group were within the pre-contemplation state and the participants in the bulimia nervosa group were in the contemplation stage; the cons of recovery still outweighed the pros of recovery and the pros of the eating disorder outweighed the cons of the eating disorder (Hall & Rossi, 2008). This indicates that there is treatment resistance amongst individuals with eating disorders, as expected, and supports previous research highlighting low motivation to recover in eating disordered individuals (Leahy, 2001).

The results of the differences between groups (anorexia nervosa, bulimia nervosa, mental health control, healthy control) on trait-like resistance were inconsistent. Contrary to predictions, there was no significant difference between groups on problems in relationship formation. However, scores were considered high compared to a normative, college and clinical sample (Butcher, 2004), highlighting that all groups acknowledged interpersonal issues, which poses them at risk of difficulties within the therapeutic relationship. Interpersonal issues have been previously identified in individuals with eating disorders (Hartmann et al., 2010). Relationship problems likely to undermine treatment progress include trust difficulties, and viewing therapist and treatment as dispensable (Butcher, 2004). Butcher (2004) warned against therapists using relationship oriented treatment without recognising the clients' interpersonal vulnerability and providing longer time to establish the relationship. This aligns with self psychology that is long term and promotes empathic enquiry for the first half of treatment (Kohut, 1977).

Contrary to predictions, the mental health group scored significantly higher on somatisation of conflict and there was no difference between eating disorder groups. Moreover, the eating disorder groups were within the range of the clinical normative data of the BTPI (Butcher, 2004). Therefore, it appears individuals with anorexia nervosa and bulimia nervosa are not at risk of somatisation of conflict than any other patients (Butcher, 2004). It is proposed that individuals with eating disorders instead use the eating disorder behaviours to manage conflict.

As predicted, the anorexia nervosa group scored significantly higher than the mental health control group on low expectation of benefit. However, the bulimia nervosa group did not score significantly higher than the mental health control group

and there was no difference between eating disorder groups. Whilst both eating disorder groups scored above the normative data identified in a clinical population (Butcher, 2004), the bulimia nervosa group did not score above the clinical population they were compared to in the current study. Thus, the results suggest that individuals with anorexia nervosa are likely to have more negative attitudes towards treatment including reluctance to think psychologically, an inability or unwillingness to change or experiment with new behaviours and lacking confidence in and being sceptical about treatment and therapist (Butcher, 2004) compared to others with mental health concerns, but it is less clear whether this is the case for individuals with bulimia nervosa. The fact that individuals with anorexia nervosa scored significantly higher than the mental health control group supports research demonstrating resistance to treatment (M. Cooper, 2005; Fassino & Abbate-Daga, 2013; Vitousek & Watson, 1998). It remains unclear why there is no difference between the eating disorder groups on low expectation of benefit. Other variables may have influenced the results. For example, previous negative treatment experience (e.g., treatment failure) was not examined (controlling for confounding variables is difficult due to small sample sizes usually recruited in eating disorder research). Further research which examines the differences in treatment experience on expectation of benefit is required. Low expectation of benefit as characteristic of individuals with anorexia nervosa supports that it is a narcissistic behaviour disorder; relinquishing the illness through treatment is not beneficial to individuals with anorexia nervosa given the illness is the vehicle to meet his or her narcissistic needs.

Contrary to predictions, the anorexia nervosa group and the bulimia nervosa group did not score significantly higher than the mental health control group nor did the

bulimia nervosa group score significantly lower than the anorexia nervosa group on self-orientation/narcissism. Interestingly, narcissism in this context (trait-like resistance) was not elevated in the eating disorder samples. An explanation for this unexpected result is that the self-orientation/narcissism scale measures grandiose narcissism rather than vulnerable narcissism. It has been noted that most current measures of narcissism measure only the grandiose aspects (Cain & Pincus, 2008) and the items of the self-orientation/narcissism scale reflect grandiose narcissism characteristics (see Davis et al., 1997; Steiger et al., 1997; Steinberg & Shaw, 1997; Waller et al., 2007). The explanation that the self-orientation/narcissism measure captures grandiose narcissism would explain why the eating disorder participants did not score higher than the mental health control group on this measure but that they did score higher on the vulnerable narcissism scale and not the grandiose narcissism scale in the current study. The importance of separating narcissism into its two facets is again demonstrated (Cain & Pincus, 2008; Pincus & Lukowitsky, 2010).

As predicted, the anorexia nervosa group scored significantly higher than the bulimia nervosa group on perceived lack of environmental support. There were no significant differences between the mental health control group and the bulimia nervosa group or the anorexia nervosa group on perceived lack of environmental support. Individuals with anorexia nervosa and bulimia nervosa, similar to those with anxiety and depression, are likely to report feelings of loneliness and isolation (Hartmann et al., 2010). They may perceive others mistreat them and are uncaring and unsupportive, feeling resentful towards culprits who have disappointed them (Rieger et al., 2010). It is unclear why individuals with bulimia nervosa did not perceive as much lack of environmental support as individuals with anorexia nervosa. Whilst the current study

did not highlight any specific reasons for this, it is a significant finding for treatment because it indicates that individuals with bulimia nervosa (or with anxiety or depression) feel more connected to society which is useful to employ a strengths-based intervention and suggests increased capacity of external support whilst undergoing treatment. The results also suggest the importance of connection for individuals struggling with other mental health concerns, not just bulimia nervosa or anorexia nervosa.

The findings provide mixed results on trait-like resistance. Individuals with anorexia nervosa are more likely to present with lower expectations of benefit of treatment compared to their mental health counterparts. On the other hand, although both eating disorder groups scored highly on problems in relationship formation, this was at the same levels as individuals with anxiety and/ or depression. Additionally, although the anorexia nervosa group scored high on perceived lack of environmental support this was at the same levels as those individuals with anxiety and/or depression. Moreover, those with anxiety and/or depression were more likely to endorse somatisation of conflict compared to both eating disorder groups. It is unclear whether individuals with eating disorders overall do exhibit more trait-like resistance than the mental health group based on these findings. It is surprising that the results do not provide a clear outcome given the current body of literature consistently reports that eating disorders are especially resistant to treatment (M. Cooper, 2005; Fassino & Abbate-Daga, 2013; Vitousek & Watson, 1998). Perhaps the current study further highlights the inadequacy of the measures available to assess resistance (Perry, 2009). Specifically, previous research endorses significant resistance in this population, yet, whilst state-like resistance (stages of change measure) is high in both eating disorder

groups, only one scale of trait-like resistance (low expectation of benefit of treatment) is elevated in the eating disorder population compared to a mental health control group and this was only in the anorexia nervosa group. The results highlight the need for qualitative research to illuminate the expression of narcissism and resistance in individuals with eating disorders.

Study 2 examined whether either grandiose narcissism (including its factors identified in Study 1) or vulnerable narcissism predicted state- and trait-like resistance in individuals with either anorexia or bulimia nervosa. Results revealed that state-like resistance (stage of change) was predicted by Factor 1 of grandiose narcissism (authority and self-sufficiency) but not by Factor 2 of grandiose narcissism (entitlement, exhibitionism and exploitativeness) or Factor 3 of grandiose narcissism (superiority and vanity) in the bulimia nervosa group. The fact that entitlement, exhibitionism and exploitativeness, and superiority and vanity did not predict stage of change in the bulimia nervosa group may be due to the limited capacity of the stage of change questionnaire measuring resistance, despite being the best measure available (Perry, 2009). It is a state measure meaning its use is limited in explaining entrenched behaviours and long-term effects (West, 2005). However, this explanation minimises the result that authority and self-sufficiency significantly predict stage of change in the bulimia nervosa group. The results are difficult to understand in the context of the literature. The latter result that authority and self-sufficiency predicts stage of change in the bulimia nervosa group suggests the achievement need in bulimic individuals (Gunnard et al., 2012) may be harnessed toward recovery. Thus, a similar result to previous research that autonomous individuals are more likely to change behaviour (van der Kaap-Deeder et al., 2014) is revealed.

Results revealed that trait-like resistance (problems in relationship formation, low expectation of benefit, and perceived lack of environmental support) was predicted by high scores on Factor 2 of grandiose narcissism (entitlement, exhibitionism and exploitativeness) and low scores on Factor 3 of grandiose narcissism (superiority and vanity) in the anorexia nervosa group. However, Factor 1 (authority and self-sufficiency) did not predict trait-like resistance (problems in relationship formation, low expectation of benefit, and perceived lack of environmental support) in the anorexia nervosa group. It is unsurprising that the more entitled, exhibitionist and exploitative an individual with anorexia is, the more they are resistant to treatment (across all but one measure of resistance [self-orientation/narcissism] where it was only significantly explained by Factor 3). Given exploitativeness is characterised by rebelliousness and nonconformity, and entitlement is characterised by hostility and intolerance of others (Raskin & Terry, 1988), it is likely these traits manifest in anorexic individuals' attitudes towards treatment and capacity to form relationships and feel supported (in the case of treatment, by therapist). Additionally, an exhibitionist person requires constant attention and admiration (Ronningstam, 2010) therefore they may not engage in treatment because they perceive treatment as an assault on what may bring them attention and perceived admiration; the eating disorder. Alternatively, for those engaged in treatment, perhaps treatment provides the client with the arena for the attention they are seeking and attention seeking becomes the focus of treatment rather than recovery. Perhaps the anorexic individual is so focused on their eating disorder as selfobject (a narcissistic behaviour disorder; Kohut, 1977), traits of Factor 2 (e.g., non-conformity), which represent defensive and resistant traits, are mobilised in treatment. Recall individuals with eating disorders did not score differently to control groups on

superiority and vanity. Yet low levels of superiority and vanity predict high trait-like resistance (problems in relationship formation, low expectation of benefit, and perceived lack of environmental support, self-orientation/narcissism) in individuals with anorexia nervosa. Thus, it may be that the low levels of superiority and vanity that is found in this research is of importance as it may account for treatment resistance. Selfobjects are employed to meet an individual's needs (Kohut, 1984), therefore, the eating disorder may be relied on to meet needs of superiority and vanity when the individual feels diminished in these areas. In turn, it is possible this reinforces the eating disorder behaviour and increases treatment resistance because treatment would be seen as a threat to the selfobject they rely upon.

Further research needs to examine whether grandiose narcissism or vulnerable narcissism predicts trait-like resistance in the anorexia nervosa group, whether grandiose narcissism (and its 3 factors) predicts state-like resistance (stage of change) or trait-like resistance (somatisation of conflict) in the anorexia nervosa group, and whether grandiose narcissism (and its 3 factors) or vulnerable narcissism predicts trait-like resistance (problems in relationship formation, low expectation of benefit, somatisation of conflict, self-orientation/ narcissism, lack of environmental support) in the bulimia nervosa group. Again, there is the need for qualitative research to illuminate the expression of narcissism and resistance in individuals with eating disorders.

11.6.1 Implications. The findings of Study 2 have important theoretical and clinical implications. First, the results suggest that unitary conceptualisations of narcissism are inadequate for discerning the relationship between narcissism and eating disorders; the two facets of narcissism were revealed to relate uniquely to eating disorders. Both eating disorder groups had high levels of vulnerable narcissism, but not

grandiose narcissism; therefore, in this instance, eating disorders can be considered transdiagnostically. Given that there are significant results when grandiose narcissism is broken down into its three factors, the need for psychometrically sound factors of grandiose narcissism to be clarified is reiterated; further clarification of the relationship between grandiose narcissism and other constructs such as resistance requires replication.

Vulnerable narcissism appears to be useful to be included in the conceptualisation of eating disorders. The key characteristics of individuals with vulnerable narcissism include an inability to moderate their sense of self (i.e., attempts to deny underlying feelings of grandiosity and entitlement, leading to frustration and hostility, followed by shame and depression) and a lack of self-enhancement strategies to modify self-esteem (Dickinson & Pincus, 2003; Kohut, 1977; Pincus & Lukowitsky, 2010). Therefore, exploration of how the individual came to experience underlying grandiose expectations and entitlement in the first place (i.e., development) should be explored in therapy (via vicarious introspection) with the hope that a cohesive sense of self can be developed. Additionally, the lack of self-enhancement strategies needs to be addressed in therapy by client internalising selfobject functions of the therapist, an appropriate selfobject substitute, resulting in cohesive self which is able to withstand disturbances (Kohut & Wolf, 1978).

When individuals with vulnerable narcissism encounter a narcissistic injury, they tend to experience intense shame, anxiety, depression and feelings of inadequacy such that they withdraw in an effort to regulate self-esteem (Dickinson & Pincus, 2003; Pincus & Lukowitsky, 2010). Therefore, presentations of shame, anxiety, depression and feelings of inadequacy in therapy provide clues to the therapist that the client has

encountered a narcissistic injury which should be addressed in therapy. Individuals with vulnerable narcissism are also known to have problematic interpersonal relationships (J. Miller & Campbell, 2008; Pincus & Lukowitsky, 2010). They face a variety of challenges as they attempt to have their needs met by others whilst protecting their vulnerability (Kohut, 1977). This is further evidenced from their anxiety relating to others and their fear of disappointment and being ashamed of their needs (J. Miller & Campbell, 2008; Pincus & Lukowitsky, 2010). Additionally, they are hypersensitive to the opinions of others, insecure, and have a yearning for approval (Pincus & Lukowitsky, 2010; Ronningstam, 2005). The therapist-client dynamic will be especially important when treating the eating disordered client, to provide an environment for these aspects of self to be accepted by the therapist, but not colluded with, increasing client's sense of self.

Contrary to hypotheses, grandiose narcissism was not elevated in individuals with anorexia nervosa and bulimia nervosa. However, high levels of entitlement, exhibitionism and exploitativeness was present in both eating disorder populations. Moreover, entitlement, exhibitionism and exploitativeness predicted three of the five measures of trait-like resistance in individuals with anorexia nervosa. From a self psychology perspective, if eating disordered individuals do present for treatment they are likely to have mirroring transferences (Kohut, 1977) given the eating disordered individuals need for attention. Therefore, the therapist needs to be attentive to providing appropriate mirroring response without enacting inappropriate countertransferential reassurance as this would be seen as collusion with exhibitionistic and entitled behaviours (Kohut, 1971; Plakun, 2012). The therapist's stance of empathic enquirer will allow the client's disclosure of the underlying needs met by the eating disorder

“welcomed into the total self-structure, and experienced as part of me...(or) it will continue to clamour for attention, or it will go underground for a while, only to sprout up in unpredictable and often self-destructive manifestations” (S. Sands, 1991, p. 42). Whilst eating disordered individuals did not have elevated scores on superiority and vanity, low levels of superiority and vanity predicted high trait-like resistance in individuals with anorexia nervosa. It is likely that due to the use of eating disorder as selfobject an eating disorder individual may appear superior and vain. However, the therapist must not engage with the misleading eating disorder persona, rather focus on the underlying personality structure and narcissistic development. Finally, when treating an individual with bulimia nervosa it will be important to empower them in treatment given that authority and self-sufficiency in this individual will facilitate readiness to recover. From a self psychology perspective, this may include acting as an idealised object for them to integrate into their self (Kohut, 1977).

11.6.2 Limitations of the present study. The findings should be considered in light of a number of factors. Firstly, the sample, like most eating disorder research, is predominantly female, therefore the results cannot be generalised to males with eating disorders. Secondly, individuals were grouped based on self-reported eating disorder diagnosis therefore the diagnosis cannot be confirmed due to potential bias of reporting. Secondly, due to the nature of self-report, the subjective experiences of respondents cannot be compared for accuracy. For example, while individuals with eating disorders may describe themselves as submissiveness and non-assertive, others may perceive them as domineering due to their dominating discussions about food and weight (Hartmann et al., 2010). Thirdly, the snowballing approach of data collection may have resulted in a non-random sample so it cannot be certain that the results would generalise

to other samples. Additionally, the cross-sectional design of this study limits understanding of how the relationship between the factors of narcissism, state- and trait-like resistance, and eating disorders may change over time, which could be understood by future research by employing longitudinal design. Furthermore, given the groundbreaking nature of this research, additional factors were not measured. For example, despite having clinically diagnosed individuals participate in this study, it is unclear what level of care these individuals have received. Length of diagnosis was also not reported. The influence of level of care, exposure to treatment and length of diagnosis should be explored in future research in a larger sample. It has been proposed “for social science research, about 15 subjects per predictor are needed for a reliable equation” (Stevens, 1996, p. 72). Due to the small sample size of both groups separately examined in the current analysis (anorexia nervosa $n = 40$ and bulimia nervosa $n = 43$), hierarchical regression controlling for demographics (age, gender, living arrangements, relationship status, education level), treatment and comorbid mental health diagnoses could not be conducted; generalisability, thus scientific value, would be compromised. Whilst a strict p value was used to control for Type 1 error due to the sample size, replication of results is required in a larger population of individuals with eating disorders.

11.7 Summary

The current study examined the levels of two facets of narcissism (grandiose and vulnerable) in individuals with anorexia nervosa and bulimia nervosa. By not considering narcissism as a unitary construct, this study revealed unique relationships between eating disorders and the two facets of narcissism such that vulnerable narcissism was elevated in eating disordered individuals. Additionally, by examining

the factors of grandiose narcissism identified in Study 1, it was revealed that high levels of entitlement, exhibitionism and exploitativeness was present in eating disordered individuals. Building on the investigation of the two facets of narcissism, this study also contributes to existing research through its inclusion of resistance as predicted by three factors of grandiose narcissism. Trait-like resistance in individuals with anorexia nervosa was predicted by entitlement, exhibitionism and exploitativeness and superiority and vanity, whilst state-like resistance in individuals with bulimia nervosa was predicted by authority and self-sufficiency. However, it is still unclear whether grandiose narcissism and vulnerable narcissism predict resistance in the eating disorder population. Further examination of these factors in individuals with anorexia nervosa and bulimia nervosa is presented in Study 4 (Chapter 12).

Chapter 12

Study 3: Assessing Narcissism in Treatment Providers of Eating Disordered Individuals

12.1 Purpose of the Study

Study 3 examined whether eating disorder symptomatology, vulnerable narcissism and grandiose narcissism, including its three factors as identified in Study 1, were elevated in eating disorder therapists compared to non-eating disorder therapists, a community sample and individuals with an eating disorder. The presence of narcissism in therapists would support the case for future research, beyond the scope of this thesis, to explore therapist countertransference specific to eating disorders and narcissism and whether this contributes to treatment resistance in clients with eating disorders. The following sections are an account of Study 3 including a brief introduction to the literature, brief overview of the method (see Chapter 9 for a detailed account and assumption testing), results and discussion.

12.2 Brief Introduction

The role of the therapist is emphasised in self psychology because it is the therapist's technique of empathic immersion and interpretation that is self psychology treatment (Kohut, 1971). The therapist's technique results in the patient's integration of a complete identity that no longer requires the eating disorder to meet narcissistic needs (Gallese, 2007; Kohut, 1971). Equally, problems in the therapeutic relationship such as countertransference can impede the therapeutic process and treatment outcomes. Therefore, research into therapist factors that may influence the therapeutic process is warranted.

Narcissism, is one therapist factor that, if present, is likely to influence eating disordered clients' therapeutic outcomes. Clark (1991) concluded from her readings of the work of experts in the field that therapists' narcissism reduced therapeutic outcomes for any patient presentation. Outcomes were poorer when therapists were treating individuals who also presented with narcissism. Seligson (1992) found evidence of the narcissistic need of a therapist determining therapeutic intervention, a narcissistic therapist validating a patient's narcissistic injuries and narcissistic interpretations when she examined case studies. As narcissism is a characteristic described in the literature as likely to be present in individuals with eating disorders, the interplay between a therapist and a client with high levels of narcissism may be important to examine. If therapists endorse narcissistic characteristics and treat individuals with eating disorders who endorse narcissistic characteristics, this is problematic; therapists are unlikely to be able to maintain an empathic position, instead colluding with the client's narcissistic needs (Seligson, 1992). Thus, it is important to investigate whether narcissism is elevated in therapists, particularly for therapists who treat individuals with eating disorders because poor therapeutic outcomes may result.

A second, related therapist factor that is likely to influence eating disordered clients' therapeutic outcomes is the presence of current eating disorder or eating disordered symptoms. Research has demonstrated that many practitioners who treat individuals with an eating disorder have a past eating disorder diagnosis (Warren et al., 2013); however, no research has examined the proportion of eating disorder practitioners who have a current eating disorder. Hence, an examination of whether disordered eating is current in therapists, particularly in those therapists who primarily treat individuals with eating disorders, is necessary. Exploring eating disorder

symptomatology and narcissism in therapists in this study will determine whether there is the need to examine the proposition by Clark (1991) that therapists' narcissism impedes therapeutic outcomes; this may account for some of the poor response of individuals with eating disorders.

12.3 Hypotheses

- H1: It is hypothesised that eating disorder therapists will show significantly higher levels of eating disorder symptomatology compared to non-eating disorder therapists and a control group.
- H2: It is hypothesised that eating disorder therapists will show comparable levels of eating disorder symptomatology as eating disorder clients.
- H3: It is hypothesised that eating disorder therapists will show significantly higher levels of vulnerable narcissism compared to non-eating disorder therapists and a control group.
- H4: It is hypothesised that eating disorder therapists will show comparable levels of vulnerable narcissism as eating disorder clients.
- H5: It is hypothesised that eating disorder therapists will show significantly higher levels of grandiose narcissism compared to non-eating disorder therapists and a control group.
- H6: It is hypothesised that eating disorder therapists will show comparable levels of grandiose narcissism as eating disorder clients.
- H7: It is hypothesised that eating disorder therapists will show significantly higher levels of the three factors of grandiose narcissism compared to non-eating disorder therapists and a control group.

H8: It is hypothesised that eating disorder therapists will show comparable levels of the three factors of grandiose narcissism as eating disorder clients.

12.4 Method

As described in depth in Chapter 9, across Australia, a sample of adults ($N = 955$), including mental health therapists who work with eating disordered clients, mental health therapists who do not work with eating disordered clients, individuals with anorexia nervosa or bulimia nervosa, and a community sample, aged between 18 and 67 years was recruited online to complete a self-report questionnaire. The first section of the questionnaire contained demographic questions regarding the participant's age, gender, education level, area of residence, race/ethnicity, marital status, primary area of employment, whether they primarily treat individuals with eating disorders, the number of hours a week they work with eating disordered individuals if they were mental health professionals, length of employment in the field if they were mental health professionals, and whether they had a current diagnosis of anorexia nervosa, bulimia nervosa or narcissistic personality disorder as diagnosed by a qualified mental health practitioner. Following this was three established self-report instruments which assess eating disorder symptomatology, grandiose narcissism and vulnerable narcissism. Respondents were grouped into one of four groups; therapists who primarily treat individuals with eating disorders ($n = 32$), therapists who do not treat individuals with eating disorders ($n = 62$), individuals with an eating disorder ($n = 83$), and a control group ($n = 778$). See Chapter 9 for in-depth methodology.

12.5 Results

12.5.1 Sample characteristics. Nine hundred and fifty-five adults were included in analyses. Participants' ages ranged from 18 to 67 years ($M = 24.35$ years, $SD = 8.82$ years). The sample was comprised of 109 males age ranged between 18 and 65 years ($M = 27.14$ years, $SD = 11.63$ years) and 836 females aged ranged between 18 and 67 years ($M = 24.07$ years, $SD = 8.33$ years). Among those who did not primarily treat eating disorders ($n = 62$), 90.3% were females and age ranged between 23 and 52 ($M = 31.66$, $SD = 8.82$). Among those who did primarily treat eating disorders ($n = 32$), 100% were females and age ranged between 23 and 46 ($M = 31.41$, $SD = 7.02$). Among those participants used as the control group ($n = 778$), 87% were females and age ranged between 18 and 67 ($M = 23.60$, $SD = 8.71$). Among the group of participants with either anorexia nervosa or bulimia nervosa ($n = 83$), 95.20% were females and age ranged between 18 and 46 ($M = 23.95$, $SD = 6.31$). A summary of the demographic variables of the participants is presented in Table 19.

Given there were significant group differences on the demographic variables - relationship status and education level - these were examined in relation to the main variables of interest (i.e., eating symptomatology, grandiose narcissism [including its 3 factors], vulnerable narcissism) to assess if group differences exist. A one-way ANOVA revealed that there was a significant difference in eating symptomatology between participants based on relationship status, $F(5, 949) = 5.45$, $p < .01$, and education level, $F(4, 950) = 8.01$, $p < .01$. A one-way ANOVA revealed that there was no significant difference in grandiose narcissism between participants based on relationship status, $F(5, 947) = 1.59$, $p = .16$, or education level, $F(4, 948) = .58$, $p = .67$. A one-way ANOVA revealed that there was no significant difference in Factor 1 of grandiose

narcissism (authority and self-sufficiency) between participants based on relationship status, $F(5, 947) = .57, p = .72$, or education level, $F(4, 948) = 1.40, p = .23$. A one-way ANOVA revealed that there was no significant difference in Factor 2 of grandiose narcissism (entitlement, exhibitionism and exploitativeness) between participants based on relationship status, $F(5, 947) = 2.62, p = .02$, and education level, $F(4, 948) = 2.80, p = .03$. A one-way ANOVA revealed that there was no significant difference in Factor 3 of grandiose narcissism (superiority and vanity) between participants based on relationship status, $F(5, 947) = 1.19, p = .31$, or education level, $F(4, 948) = .88, p = .48$. A one-way ANOVA revealed that there was a significant difference in vulnerable narcissism between participants based on relationship status, $F(5, 933) = 7.43, p < .01$, and education level, $F(4, 934) = 3.32, p < .01$. Subsequent analyses controlled for the demographic variables that were significantly associated with the dependent variables.

Table 19

Study 3 Characteristics of Treatment Providers, Eating Disorder Clients and Control

Demographic	ED Therapists (<i>n</i> = 32)	Non ED Therapists (<i>n</i> = 62)	Eating Disorder Clients (<i>n</i> = 83)	Control (<i>n</i> = 778)	Total (<i>N</i> = 955)	Statistic
	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>N</i> (%)	
Gender						$\chi(3, 955) = 9.58, p < .05$
Male	0 (0.0)	6 (9.7)	4 (4.8)	101 (13.0)	111 (11.6)	
Female	32 (100.0)	56 (90.3)	79 (95.2)	677 (87.0)	844 (88.4)	
Education						$\chi(12, 955) = 102.70, p < .01$
Did not complete high school	0 (0.0)	1 (1.6)	3 (3.6)	5 (0.6)	9 (0.9)	
High school	2 (6.3)	5 (8.1)	37 (44.6)	357 (45.9)	401 (42.0)	
Trade/technical/vocational training	0 (0.0)	5 (8.1)	6 (7.2)	46 (5.9)	57 (5.9)	
Undergraduate degree	16 (50.0)	30 (48.4)	28 (3.7)	302 (38.8)	376 (39.4)	
Postgraduate degree	14 (43.8)	21 (33.9)	9 (10.8)	68 (8.7)	112 (11.7)	
Relationship Status						$\chi(15, 955) = 72.29, p < .01$
Single	14 (43.8)	27 (43.5)	59 (71.1)	591 (76.0)	691 (72.4)	
Defacto	4 (12.5)	12 (19.4)	12 (14.5)	94 (12.1)	122 (12.7)	
Married	14 (43.8)	20 (32.3)	10 (12.0)	73 (9.4)	117 (12.2)	
Separated	0 (0.0)	1 (1.6)	0 (0.0)	6 (0.8)	7 (0.7)	
Divorced	0 (0.0)	1 (1.6)	2 (2.4)	12 (1.5)	15 (1.6)	
Widowed	0 (0.0)	1 (1.6)	0 (0.0)	2 (0.3)	3 (0.3)	
Living Area						$\chi(6, 955) = 7.08, p = .31$
Metropolitan	32 (100.0)	53 (85.5)	72 (86.7)	653 (83.9)	810 (84.8)	
Rural	0 (0.0)	8 (12.9)	8 (9.6)	104 (13.4)	120 (12.6)	
Remote	0 (0.0)	0 (0.0)	1 (1.2)	4 (0.5)	5 (0.5)	

Did not respond	0 (0.0)	1 (1.6)	2 (2.4)	17 (2.2)	20 (2.1)	
Ethnic Background						$\chi (15, 955) = 16.03, p = .38$
Aboriginal	0 (0.0)	0 (0.0)	0 (0.0)	6 (0.8)	6 (0.6)	
Anglo/Caucasian	29 (90.6)	56 (90.3)	82 (98.8)	664 (85.3)	831 (87.0)	
Asian	3 (9.4)	4 (6.5)	0 (0.0)	64 (8.2)	71 (7.4)	
Hispanic	0 (0.0)	1 (1.6)	0 (0.0)	13 (1.7)	14 (1.5)	
Middle Eastern	0 (0.0)	1 (1.6)	1 (1.2)	21 (2.7)	23 (2.4)	
African	0 (0.0)	0 (0.0)	0 (0.0)	10 (1.3)	10 (1.1)	
ED Therapist						$\chi (1, 94) = 94.00, p < .01$
Yes	32 (100.0)	0 (0.0)	-	-	32 (34.0)	
No	0 (0.0)	62 (100.0)	-	-	62 (70.0)	
Full-time (> 30 hrs/week)						$\chi (1, 94) = 3.08, p = .08$
Yes	13 (40.6)	37 (59.7)	-	-	50 (53.2)	
No	19 (59.4)	25 (40.3)	-	-	44 (46.8)	
Length of time working with eating disorders (> 2 years)						
Yes	15 (46.9)	-	-	-	15 (46.9)	
No	17 (53.1)	-	-	-	17 (53.1)	
Bulimia Nervosa Diagnosis						$\chi (3, 955) = 43.35, p < .01$
Yes	0 (0.0)	3 (4.8)	53 (63.9)	0 (0.0)	56 (5.9)	
No	32 (100.0)	59 (95.2)	30 (36.1)	778 (100.0)	899 (94.1)	
Anorexia Nervosa Diagnosis						$\chi (3, 955) = 14.42, p < .01$
Yes	0 (0.0)	1 (1.6)	30 (36.1)	0	31 (3.2)	
No	32 (100.0)	61 (98.4)	53 (63.9)	778 (100.0)	924 (96.8)	

Note. ED = Eating Disorder

12.5.2 Descriptive statistics. The means, standard deviations, minimum and maximum values for the Eating Disorder Diagnostic Scale, the vulnerable narcissism scale, and the Grandiose Narcissism scale, including its 3 factors derived from Study 1, can be found in Table 20. The mean score of vulnerable narcissism for the control group matched the mean score in the psychometric testing of the Hypersensitive Narcissism Scale (HSNS; $M = 29$). The eating disorder groups approached high scores as defined by the HSNS (>35). The means of grandiose narcissism were all below the means identified in the original development of the scale ($M = 15.55$), except for the eating disorder therapists who had the equivalent mean. All scales demonstrated good internal consistency ranging from .70 to .84. These figures were consistent with prior research findings.

Table 20

Study 3 Descriptive Statistics of the Eating Symptomatology, Vulnerable Narcissism and Grandiose Narcissism

		<i>n</i>	<i>M</i> [#]	<i>SD</i>	Min	Max	Statistic
Eating symptomatology (EDDS; $\alpha = .82$)	ED Therapist	32	22.19 ^{ab}	12.38	3	38	$F(3, 935) = 25.68, p < .01, \eta_p^2 = .08$
	Non ED	62	25.02 ^{cd}	13.34	0	59	
	Therapist						
	Clients	83	42.17 ^{bde}	9.05	13	76	
	Control	778	31.57 ^{ace}	14.23	6	85	
Vulnerable Narcissism (HSNS; $\alpha = .75$)	ED Therapist	32	30.91	4.80	25	39	$F(3, 935) = 7.00, p < .01, \eta_p^2 = .02$
	Non ED	62	29.81 ^a	6.73	18	47	
	Therapist						
	Clients	80	32.78 ^{ab}	6.26	16	50	
	Control	765	29.63 ^b	5.91	10	50	
Grandiose Narcissism (NPI; $\alpha = .84$)	ED Therapist	32	15.97 ^{abc}	6.96	4	29	$F(3, 935) = 7.34, p < .01, \eta_p^2 = .02$
	Non ED	62	9.98 ^a	5.95	1	25	
	Therapist						
	Clients	81	10.70 ^b	6.41	1	30	
	Control	778	12.03 ^c	6.34	0	34	
Authority, Self-Sufficiency (NPI Factor 1; $\alpha = .70$)	ED Therapist	32	5.44 ^{abc}	2.49	1	10	$F(3, 935) = 6.10, p < .01, \eta_p^2 = .02$
	Non ED	62	3.69 ^a	2.41	0	9	
	Therapist						
	Clients	81	3.40 ^{bd}	2.72	0	9	
	Control	778	4.25 ^{cd}	2.53	0	11	
Entitlement, Exhibitionism, Exploitativeness (NPI Factor 2; $\alpha = .71$)	ED Therapist	32	5.03 ^{ab}	3.37	1	11	$F(3, 935) = 7.14, p < .01, \eta_p^2 = .02$
	Non ED	62	2.48 ^{ac}	2.46	0	11	
	Therapist						
	Clients	81	3.73 ^c	2.78	0	10	
	Control	778	3.26 ^b	2.65	0	12	
Superiority, Vanity (NPI Factor 3; $\alpha = .74$)	ED Therapist	32	3.34 ^a	2.39	0	8	$F(3, 935) = 5.20, p < .01, \eta_p^2 = .02$
	Non ED	62	2.15	2.22	0	9	

Therapist					
Clients	81	1.85 ^{ab}	2.39	0	9
Control	778	2.75 ^b	2.42	0	11

Note. EDDS = Eating Disorder Diagnostic Scale; HSNS = Hypersensitive Narcissism Scale; NPI = Narcissistic Personality Inventory; ED = Eating Disorder; # Arabic letters mark significantly different pairs.

12.5.3 Correlations. A Pearson's r bivariate correlation was conducted on the eating disorder therapist's data with Eating Disorder Diagnostic Scale (EDDS), HSNS (Hypersensitive Narcissism Scale) and Narcissistic Personality Inventory (NPI) as the variables in question (see Table 21). As expected, the grandiose and vulnerable narcissism scales were unrelated. The EDDS had no relationship with the grandiose narcissism scale; however, was significantly related to the vulnerable narcissism scale such that the higher the eating disorder symptomatology the higher the level of vulnerable narcissism in an individual. As expected the grandiose narcissism factors had strong significant relationships with the overall NPI score.

Table 21

Study 3 Correlations amongst Grandiose Narcissism Vulnerable Narcissism and Eating Symptomatology in Eating Disorder Therapist Group

	EDDS	HSNS	NPI	NPI Factor 1	NPI Factor 2	NPI Factor 3
EDDS	1					
HSNS	.64**	1				
NPI	.07	-.07	1			
NPI Factor 1	-.07	-.31	.69**	1		
NPI Factor 2	.14	.06	.87**	.34	1	
NPI Factor 3	-.08	.02	.88**	.48**	.70**	1

Note. EDDS = Eating Disorder Diagnostic Scale; HSNS = Hypersensitive Narcissism Scale; NPI = Narcissistic Personality Inventory; Factor 1 = Authority and Self-Sufficiency; Factor 2 = Entitlement, Exhibitionism and Exploitativeness; Factor 3 = Superiority and Vanity; * $p < .05$, ** $p < .01$

12.5.4 Eating Symptomatology. An independent groups ANCOVA compared groups (eating disorder therapists, non-eating disorder therapists, eating disorder clients, control) on eating symptomatology, controlling for relationship status and education level. Results indicated that there was a significant difference between groups on eating symptomatology, $F(3, 901) = 11.63$, $p < .01$, $\eta_p^2 = .56$. Post hoc comparisons using the

Tukey HSD test indicated that the mean score for the control group ($M = 31.57$, $SD = 14.23$) was significantly higher than the eating disorder therapists ($M = 22.19$, $SD = 12.38$), $p < .01$, $d = .70$, and non-eating disorder therapists ($M = 25.02$, $SD = 13.34$), $p < .01$, $d = .48$, however there was no significant difference between the therapist groups, $p = .78$, $d = .22$. The mean score for the client group ($M = 42.17$, $SD = 9.05$) was significantly higher than the eating disorder therapist group, $p < .01$, $d = 1.84$, the non-eating disorder therapists, $p < .01$, $d = 1.51$, and the control group, $p < .01$, $d = .89$. Whilst the eating disorder therapist group scored significantly lower than the eating disorder group and the community sample, 12 respondents (37.5%) in the eating disorder therapist group met criteria of undue influence on body weight or shape on self-evaluation, and a fear of weight gain or becoming fat.

12.5.5 Vulnerable narcissism. An ANCOVA compared groups (eating disorder therapists, non-eating disorder therapists, eating disorder clients, control) on vulnerable narcissism, controlling for relationship status and education level. Results indicated that there was a significant difference between groups on vulnerable narcissism, $F(3, 885) = 7.30$, $p < .01$, $\eta_p^2 = .27$. Post hoc comparisons using the Tukey HSD test indicated that there was no significant difference between eating disorder therapists ($M = 30.91$, $SD = 4.80$) and eating disorder clients ($M = 32.78$, $SD = 6.26$), $p = .44$, $d = .34$, eating disorder therapists and non-eating disorder therapists ($M = 29.81$, $SD = 6.73$), $p = .83$, $d = .19$, eating disorder therapists and the control group ($M = 29.63$, $SD = 5.91$), $p = .64$, $d = .24$, and non-eating disorder therapists and the control group, $p = .99$, $d = .03$. However, the eating disorder client group scored significantly higher than the non-eating disorder therapist group, $p < .01$, $d = .46$, and the control group, $p < .01$, $d = .52$.

12.5.6 Grandiose narcissism. An independent groups ANOVA compared groups (eating disorder therapists, non-eating disorder therapists, eating disorder clients, control) on grandiose narcissism. Results indicated that there was a significant difference between groups on grandiose narcissism ($F(3, 935) = 7.34, p < .01, \eta_p^2 = .02$). Post hoc comparisons using the Tukey HSD test indicated that the mean score for eating disorder therapists ($M = 15.97, SD = 6.96$) was significantly higher than the non-eating disorder therapists ($M = 9.98, SD = 5.95$), $p < .01, d = .93$, the control group mean score ($M = 12.01, SD = 6.34$), $p < .01, d = .60$, and the eating disorder group mean score ($M = 10.70, SD = 6.41$), $p < .01, d = .79$. However, the mean score for non-eating disorder therapists was not significantly different from the mean score of the eating disorder group, $p = .91, d = .12$, or the control group, $p = .07, d = .35$, and the mean score for the control group was not significantly different from the eating disorder group, $p = .28, d = .22$.

12.5.6.1 Factor 1. An independent groups ANOVA compared groups (eating disorder therapists, non-eating disorder therapists, eating disorder clients, control) on Factor 1, measuring authority and self-sufficiency. Results indicated that there was a significant difference between groups on Factor 1 ($F(3, 935) = 6.10, p < .01, \eta_p^2 = .02$). Post hoc comparisons using the Tukey HSD test indicated that the mean score for non-eating disorder therapists ($M = 3.69, SD = 2.41$), $p < .01, d = .71$, the control group mean score ($M = 4.25, SD = 2.53$), $p < .01, d = .47$, and the eating disorder group mean score ($M = 3.40, SD = 2.72$), $p < .01, d = .78$, were all significantly lower than the eating disorder therapists ($M = 5.44, SD = 2.49$). Additionally, the eating disorder group scored significantly lower than the control group, $p < .01, d = .32$. However, there was no significant difference between the other groups. The non-eating disorder therapists did

not score significantly different from the control group, $p = .35$, $d = .23$, or the eating disorder group, $p = .90$, $d = .71$.

12.5.6.2 Factor 2. An independent groups ANOVA compared groups (eating disorder therapists, non-eating disorder therapists, eating disorder clients, control) on Factor 2 of grandiose narcissism, measuring entitlement, exhibitionism and exploitativeness. Results indicated that there was a significant difference between groups on Factor 2 ($F(3, 935) = 7.14$, $p < .01$, $\eta_p^2 = .02$). Post hoc comparisons using the Tukey HSD test indicated that the mean score for the eating disorder therapist group ($M = 5.03$, $SD = 3.37$) was significantly higher than the non-eating disorder therapist group ($M = 2.48$, $SD = 2.46$) $p < .01$, $d = .86$, and the control group ($M = 3.26$, $SD = 2.65$) $p < .01$, $d = .58$. However, there was no significant difference between the eating disorder therapist and the eating disorder groups ($M = 3.73$, $SD = 2.78$) $p = .09$, $d = .42$, between the non-eating disorder therapist and the eating disorder groups, $p = .03$, $d = .48$, between the control and the eating disorder groups, $p = .45$, $d = .17$, and between the control and non-eating disorder therapist groups, $p = .13$, $d = .31$.

12.5.6.3 Factor 3. An independent groups ANOVA compared groups (eating disorder therapists, non-eating disorder therapists, eating disorder clients, control) on Factor 3, measuring superiority and vanity. Results indicated that there was a significant difference between groups on Factor 3 ($F(3, 935) = 5.20$, $p < .01$, $\eta_p^2 = .02$). Post hoc comparisons using the Tukey HSD test indicated that the mean score for eating disorder group ($M = 1.85$, $SD = 2.39$) was significantly lower than the eating disorder therapist group mean score ($M = 3.34$, $SD = 2.39$), $p < .01$, $d = .59$, and the control group mean score ($M = 2.75$, $SD = 2.42$), $p < .01$, $d = .37$, however there was no significant difference between the eating disorder group and the non-eating disorder therapists (M

= 2.15, $SD = 2.22$), $p = .89$, $d = .13$. There was no significant difference between the eating disorder therapist group and non-eating disorder therapist group, $p = .10$, $d = .52$, between the control group and the non-eating disorder therapist group, $p = .27$, $d = .26$, and between the control group and eating disorder therapist group, $p = .52$, $d = .25$.

12.6 Discussion

This research provides preliminary cross-sectional data on factors pertaining to the eating disorder therapist that may contribute to treatment resistance in individuals with eating disorders. A key aim of this study was to investigate eating disorder symptomatology and narcissism in therapists who treat eating disordered clients. This study determines whether these factors are in fact elevated in therapists before future research, beyond the scope of this thesis, can explore the influence these factors have on countertransference and treatment resistance. Contrary to predictions, yet unsurprisingly, therapists had lower levels of eating symptomatology than individuals with eating disorders. Moreover, both therapist groups had lower eating symptomatology than the community sample. The result that therapists reported less eating symptomatology than a community sample is surprising and difficult to explain. Perhaps therapists have low eating disorder symptoms compared to the community sample due to the high frequency of undiagnosed eating disorders and subthreshold eating disorders in the general population (Paxton et al., 2012). Alternatively, therapists may have a healthy relationship with food, weight and shape due to their exposure to eating disorder treatment (i.e., using clients' therapy for their own purposes) or from previous treatment of an eating disorder, if it was present (as up to one third of eating disorder therapists have an eating disorder history; Barbarich, 2002; Bloomgarden et al., 2003; Johnston et al., 2005). Alternatively, the result that eating disorder therapists have

lower eating symptomatology compared to a community sample may be influenced by therapists providing socially desirable responses to the questionnaire, despite anonymity, due to the controversy in the field regarding mental health in therapists (Bloomgarden et al., 2003). Contrary to hypotheses, there were no differences in eating symptomatology between eating disorder therapists and non-eating disorder therapists. In fact, only individuals from the group of non-eating disorder therapists reported an eating disorder diagnosis; one individual reported an anorexia nervosa diagnosis and another three reported a bulimia nervosa diagnosis. However, 37.5% of eating disorder therapists met criteria of undue influence on body weight or shape on self-evaluation, and a fear of weight gain or becoming fat. Therefore, the current study does suggest some reason to consider eating symptomatology in eating disorder therapists.

Unexpectedly, eating disorder therapists did not score differently to non-eating disorder therapists and the community sample on vulnerable narcissism. However, as expected, levels of vulnerable narcissism did not differ between eating disorder therapists and eating disorder clients. Thus, when eating disorder therapists treat individuals with eating disorders there will likely be difficulties within the therapeutic relationship including avoidance of addressing challenging issues (Pincus & Lukowitsky, 2010) or therapist inability to maintain an empathic position, rather hastily validating the client's vulnerable narcissism characteristics to allay their own anxieties relating to these shared characteristics (Seligson, 1992). Contrary to predictions, eating disorder therapists had higher levels of grandiose narcissism compared to eating disorder clients but, as expected, were also higher than other therapists and the community sample. The elevated level of grandiose narcissism in eating disorder therapists seems concerning at face value; however, the average for this sample is

equivalent to the mean score of the scale as identified in earlier psychometric research (Terry & Raskin, 1988). Given the mean score from previous research is higher than the score of the community sample in the current study which included 778 participants, the result may indicate problems with psychometric properties of the grandiose narcissism measure, the NPI, as previously noted (Kubarych et al., 2004). Alternatively, underreporting may have influenced the results such that participants in the current study did not complete the survey honestly. Interpretation of these results are challenged, likely unreliable, due to the inconsistencies. Evidence of others perception of grandiose narcissism in therapists should be sought.

For grandiose narcissism, investigation of Factor 1, authority and self-sufficiency, reflected the same results as the overall grandiose narcissism score such that eating disorder therapists scored significantly higher than the other three groups. It is likely eating disorder therapists may be inclined to take authority over client's treatment therefore therapists are warned to be mindful of this and consider an empathic stance. However, unlike the overall grandiose narcissism score, due to the preliminary nature of the factors from the factor analysis in Study 1, there is no normative data with which to compare the results. The analyses on Factor 2, entitlement, exhibitionism and exploitativeness, revealed that eating disorder therapists did not score different to the eating disorder group, but still scored higher than the control group and non-eating disorder therapist group. The similarity between eating disorder therapists and eating disorder clients on entitlement, exhibitionism and exploitativeness warns that the therapist could preserve their own sense of narcissism whilst validating the patient's narcissistic injury (Seligson, 1992). Entitlement, exhibitionism and exploitativeness may be tolerated or condoned (Seligson, 1992). On Factor 3, superiority and vanity, the

eating disorder therapist group scored significantly higher than the eating disorder group but not significantly different to the control group, suggesting that therapists are unlikely to collude with the client or act in ways which intensify the pathology related to this factor. However, they may reinforce an already present sense of inferiority in individuals with eating disorders (Perry et al., 2008).

The role of the therapist is fundamental to successful treatment in self psychology due to therapist's empathic enquiry acting as treatment. Fortunately, the results suggest there is little concern in relation to therapists treating individuals with eating disorders with regards to therapists own eating behaviours. The low level of eating symptomatology in eating disorder therapists minimises the risk of over-identification with clients, enmeshment and boundary violations, and unique countertransferential reactions to clients (Bloomgarden et al., 2003; Costin & Johnson, 2002; Hughes, 1997; Jacobs & Nye, 2010; Johnston et al., 2005; Kaplan & Garfinkel, 1999; Satir et al., 2009). Given the similarities between eating disorder patients and eating disorder therapists on vulnerable narcissism, it is important to note Seligson's (1992) argument that when a patient with narcissism meets a therapist with narcissism the pathology is intensified. Both patient and therapist collude to maintain therapist's narcissism and indulge the patient's narcissistic injury. Therapists are warned against countertransference including over-identifying with and making assumptions based on own experiences. Therapists must be aware of both their own and their client's hypersensitivity, insecurity (Pincus & Lukowitsky, 2010; Ronningstam, 2005) and underlying grandiose expectations and entitlement (Dickinson & Pincus, 2003; Pincus & Lukowitsky, 2010), including how this plays out in the therapeutic relationship. When individuals with vulnerable narcissism perceive threats to their self they are likely

to withdraw in an attempt to manage self-esteem (Dickinson & Pincus, 2003; Pincus & Lukowitsky, 2010). Therefore, eating disorder therapists need to be aware that they themselves may avoid issues due to their own perceptions of how this may affect their sense of self. For example, eating disorder therapists may not interpret a defense identified in the client if the therapist perceives the client may reciprocate in a way which creates narcissistic injury in therapist. This dynamic reflects the intensification of pathology as discussed regarding Factor 2 of grandiose narcissism. It is apparent that grandiose narcissism, being elevated above the community sample, may influence the therapeutic relationship in other unidentified ways. For example, many of the characteristics of grandiose narcissism prevent effective relationships. Treatment providers require supervision and consultation on a regular basis as well as professional development to ensure they maintain competent and ethical practice.

12.6.1 Limitations of the present study. A number of factors may have influenced the results. The sample comprised predominantly females, therefore the results cannot be generalised to male therapists or male clients with eating disorders. Whilst a strict *p* value was used to control for Type 1 error due to the sample size, replication of results is required in a larger population of therapists who treat individuals with eating disorders. Whilst the snowballing approach of data collection was utilised, it cannot be certain that the results would generalise to other samples. Although participation in this study was anonymous and the design of the research limited the effect of social desirability, this effect might still exist. Specifically, therapists are likely to be able to respond in socially desirable ways. The EDDS, the NPI and the HSNS contain sensitive questions and participants may have been influenced by factors such as concern for researcher's perception of the participant, employment security and

confidentiality. Like all studies using self-reported data, this data may be limited by inaccurate reporting and/ or low insight into participants' own behaviour and experience. This limitation was managed via the use of standardised questionnaires but cannot be totally discounted. Matched pairs (i.e., the client group includes individuals who are treated by the therapists in the therapist group) was not employed in this study therefore we cannot make direct comparisons between the groups including whether transference was involved. This study was designed only as a starting point. Whilst it does not prove that narcissism and eating pathology in therapists causes poor therapeutic outcome, this study provides preliminary evidence to support investigation of this hypothesis. Due to the preliminary nature of the current study and the small sample pool to run analyses on (due to the difficulty recruiting participants who specialise in treating eating disordered individuals), a number of therapist factors that could impact experiences working with these patients (i.e., personal history of therapy, severity of illness, length of time recovered, personal definitions of recovery) and patterns of responding based on professional credentials, theoretical orientations, and the level of care therapists provide (e.g. inpatient versus outpatient) were not examined in this research. Furthermore, normative data on the three factors of grandiose narcissism does not exist for comparison purpose. Therefore, interpretation of the current findings must be treated with these in mind.

12.7 Summary

The current study examined the levels of eating symptomatology and the two facets of narcissism (grandiose and vulnerable) in therapists who treat individuals with eating disorders. Research suggests that a relatively large percentage of therapists who treat patients with eating disorders have a personal history of eating pathology (Warren

et al., 2013), but this current study demonstrated that none of these individuals have current eating symptomatology at a clinical level. However, 12 participants endorsed undue influence on body weight or shape on self-evaluation, and a fear of weight gain or becoming fat. Additionally, eating disorder therapists had comparable levels of vulnerable narcissism to the eating disorder group. Moreover, they had higher levels of grandiose narcissism (including Factor 1) compared to a community sample however this was not at a clinical level. The results indicate the importance of containing the influence of the therapists own vulnerable narcissism characteristics from clients with eating disorders and that future research, beyond the scope of this thesis, could explore countertransference and therapeutic outcomes for those therapists who reported high levels of vulnerable narcissism.

Chapter 13

Study 4: Exploring Narcissism in Eating Disorder Patients Using Interviews

13.1 Purpose of the Study

The purpose of the fourth study was to use a qualitative approach to further explore narcissism, trait-like and state-like resistance in individuals with eating disorders, and to examine their perceptions of their treatment providers' eating behaviour and levels of narcissism. Using a qualitative approach as the final study of the program of research also permitted the results of the previous questionnaire phases to be examined in an in-depth manner. More specifically, because of the poor reliability of the seven components of the grandiose narcissism scale (NPI), the role of these individual components in eating disorders was unable to be explored in Study 2. Rather, the seven characteristics were extracted into just three factors in Study 1 for use in Study 2 and Study 3. Thus, it was difficult to explain the unexpected finding that grandiose narcissism was not elevated in individuals with eating disorders. Study 4 allows the seven components of the grandiose narcissism scale, which may provide meaningful theoretical direction to be appraised. Further, Study 4 enables exploration of the role that narcissism plays in treatment resistance in the eating disorder population. As Study 2 was unable to determine whether grandiose narcissism or vulnerable narcissism predicted trait-like resistance in the anorexia nervosa group, whether grandiose narcissism (and its 3 factors) predicted state-like resistance (stage of change) or trait-like resistance (somatisation of conflict) in the anorexia nervosa group, and whether grandiose narcissism (and its 3 factors) or vulnerable narcissism predicted trait-like resistance (problems in relationship formation, low expectation of benefit,

somatisation of conflict, self-orientation/ narcissism, lack of environmental support) in the bulimia nervosa group. Study 4 aimed to address these gaps. Study 4 expanded on Study 2 and Study 3 by examining the perspectives of individuals with either anorexia nervosa or bulimia nervosa on treatment and their response to excerpts on the seven characteristics of grandiose narcissism presented in the interview. Whether and how participants ascribe these seven characteristics of grandiose narcissism to themselves or their therapist, and the effect these characteristics (either in them or therapist) have on treatment resistance was investigated. This qualitative study also permitted confirmation that vulnerable narcissism was present in eating disorder individuals by exploring whether respondents identified with this facet and how they perceived it influenced treatment resistance.

13.2 Brief Introduction

There is considerable treatment resistance amongst eating disordered clients and low motivation to engage in treatment (M. Cooper, 2005; Fassino & Abbate-Daga, 2013; Vitousek & Watson, 1998). Much research has explored factors to explain this phenomenon to little avail. Although self psychology posits that narcissism can account for treatment resistance, in eating disordered patients, narcissism has been excluded from explanations of treatment resistance. The exclusion of narcissism is likely due to its associated stigma and past associations between eating disorders and ‘attention seeking’. It is argued that attempting to understand anorexia nervosa and bulimia nervosa using theoretical frameworks that underestimate or ignore the role of narcissism limits the development of appropriate treatments. This is in the context of links between eating disorders and narcissism, and the documented role of narcissism in poor treatment outcome. To effectively and holistically include narcissism in the

conceptualisation of eating disorders, it is important to explore narcissism in its two facets, grandiose narcissism and vulnerable narcissism, as well as the role of therapists' narcissism and how this may influence treatment outcome. Exploring eating disordered individuals' perceptions of the presence of eating pathology and narcissism in therapists will provide insight into its influence on the therapeutic alliance and outcomes as it is noted that clients' perceptions of the therapist are more relevant for positive therapeutic outcome than the reality of the therapist (Duncan & Moynihan, 1994).

Study 4 aims to draw together the findings of Study 2 and 3 by confirming whether participants demonstrate state- and trait-like resistance to treatment, and whether and how participants identify with the characteristics of grandiose and vulnerable narcissism and how these characteristics may hinder or facilitate engagement in treatment. Additionally, Study 4 aims to explore whether participants observed eating disorder behaviours and narcissism in treatment providers and whether this impacted the eating disordered individual's engagement in treatment.

13.3 Method

As described in detail in Chapter 9, a sample of adults ($N = 14$) aged between 18 and 46 years old was recruited from a private eating disorder clinic in Queensland and were interviewed about factors associated with grandiose and vulnerable narcissism, the therapeutic relationship and the way in which these features might predict engagement in treatment in eating disorders. See Chapter 9 for in-depth methodology.

13.4 Results

A summary of the demographic characteristics of the sample is presented in Table 22.

Table 22

Study 4 Participant's Characteristics

Participant	Gender	Education	Marital Status	Living Area	Ethnic Background	Diagnosis	Treatment
1	Female	Trade/technical/vocational training	Single	Metro	Anglo/Caucasian	AN	Inpatient
2	Female	Postgraduate degree	Single	Metro	Anglo/Caucasian	AN	Outpatient
3	Female	Did not complete high school	Married	Rural	Anglo/Caucasian	AN	Inpatient
4	Female	High School	Single	Metro	Anglo/Caucasian	AN	Inpatient
5	Female	Undergraduate degree	Single	Metro	Anglo/Caucasian	AN	Inpatient
6	Female	High School	Single	Rural	Anglo/Caucasian	AN	Inpatient
7	Female	Undergraduate degree	Single	Metro	Anglo/Caucasian	AN	Outpatient
8	Female	Undergraduate degree	Married	Metro	Hispanic	BN	Outpatient
9	Female	Undergraduate degree	Defacto	Metro	Anglo/Caucasian	BN	Outpatient
10	Female	Undergraduate degree	Defacto	Metro	Anglo/Caucasian	BN	Outpatient
11	Female	Did not complete high school	Single	Metro	Anglo/Caucasian	AN	Outpatient
12	Female	Undergraduate degree	Defacto	Metro	Anglo/Caucasian	AN	Outpatient
13	Female	High School	Single	Metro	Anglo/Caucasian	BN	Inpatient
14	Female	High School	Married	Metro	Anglo/Caucasian	BN	Inpatient

As per the aims of this study, the results are presented in a number of sections. Firstly, evidence of state- and trait-like resistance to treatment as described by interviewees is provided. Second, respondents' comments about the excerpts from the literature identifying narcissism in individuals with an eating disorder in addition to other themes related to narcissism that emerged from these discussions are presented. Thirdly, the observation of eating disorder behaviours and narcissism in treatment providers are detailed. While the data are separated in this way for ease of reading, the data were interconnected. For example, participants provided information corresponding to a number of interview questions at various points throughout the interview. Although the overarching research focuses on resistance to treatment and narcissism, additional data driven themes were considered and are included in Appendix Z.

13.4.1 State-like resistance. State-like resistance suggests that resistance is situational and specific to the behaviour of focus (Beutler et al., 1991). State-like resistance is best captured by an interviewee's motivation to engage in treatment (Perry, 2009). As detailed in Chapter 4, motivation to engage with treatment was considered from a Stage of Change model. Participant responses indicated that, even though in treatment, five interviewees were clearly in precontemplation in terms of motivation to change eating disordered behaviours. For example, participants stated "I don't think my eating disorder is that bad that I need treatment" (Participant 3, Anorexia Nervosa) and "I'm very much still in denial" (Participant 14, Bulimia Nervosa). A number of participants described their engagement in treatment as being due to others' orders or wishes; personally they either did not believe they had a problem or did not want to recover. Some of these respondents reported that others were forcing treatment onto them against their wishes. Consequently, they would overtly or covertly disengage with

treatment. One respondent stated, “I’m under an [Involuntary Treatment Order]” (Participant 3, Anorexia Nervosa). Some respondents stated they would participate in treatment because of pressure from their treatment team, family or friends to participate. For example, one outpatient respondent stated “I’m just kind of doing it because that’s what I have to do...makes people think I’m trying to get better” (Participant 2, Anorexia Nervosa). But once some respondents left treatment, they intended to (or anticipated that they would) revert back to eating disordered behaviours. This return to eating disordered behaviours was hidden by some participants but not by others. Several respondents stated they would act in ways to make staff and family believe they were engaging in treatment; however they were covertly engaging in eating disordered behaviours and had no intention of regaining weight. There were also more subtle non-committals to recovery. For example, one participant (Participant 1, Anorexia Nervosa) reported she was engaged with three psychiatrists, two group therapists and a dietician. However, with further probing this participant revealed that she did not feel comfortable to discuss her eating disorder or underlying concerns with any of these treatment providers.

Five participants appeared to be in the contemplation stage of change. One outpatient stated that leading up to her latest inpatient admission she “wanted to try and sort of fix this” but “then obviously slipped again” (Participant 12, Anorexia Nervosa). Even her wording “try and sort of” demonstrates her ambivalence towards change. Perhaps unsurprisingly, participants were committed to treatment of unwanted aspects of the eating disorder (e.g. bingeing or purging) but were not committed to recovery from other aspects (e.g. restriction). For example, one respondent stated, “I just want to be skinny and not purge” (Participant 9, Bulimia Nervosa).

Three participants appeared to be in the preparation stage of motivation to change eating disordered behaviours. One client revealed she had “kind of accepted I have an eating disorder which is the first step” (Participant 8, Bulimia Nervosa).

Another interviewee shared her experience of accepting her situation.

I think it's really hard to treat eating disorders successfully...It really depends on the state of mind that you're in. Like, early on in my treatment I didn't want to be helped...I guess realising that recovery doesn't mean that I'm gonna feel good about my body or that it's gonna be easy to eat. But that I have to put up with the discomfort and just accept that that's the way it has to be...I'm finally accepting [eating disorder behaviours are] not realistic (Participant 6, Anorexia Nervosa).

Despite all interviewees being in either inpatient or outpatient treatment, only one of them appeared to be in action stage of change evident from their statement about themselves, “your weight's 15 kilos heavier... you know when you have to eat, what you eat, it's just there's no mental help” (Participant 7, Anorexia Nervosa). However, it appeared that even this respondent was at risk of relapse as they stated, “you're freaking out. You're kind of screwed. You can't adjust. That's what I'm finding, anyway”.

Respondents discussed uncertainty about their ability to recover from their eating disorder, even when in treatment. One respondent stated, ““once you recover’...well you can't promise me that” (Participant 2, Anorexia Nervosa), also highlighting her distrust in therapists. Other respondents who had more treatment attempts than the previous respondent stated, “I'm unhelp-able” (Participant 3, Anorexia Nervosa), “Sometimes I'm like, ‘Oh, I'll never get, I'll never like recover”” (Participant 13,

Bulimia Nervosa) and “I feel so hopeless sometimes. I don’t know if [recovery’s] even possible...I have been here for quite a while now and ... I still have got a long way to go” (Participant 4, Anorexia Nervosa). These three responses highlight the possibility that the longer the duration of treatment or the increased number of treatment attempts, the lower the self-efficacy to recover. The notion of not recovering was reinforced for one interviewee who stated “I’ve had psychologists say to me ‘you’re never going to get better’” (Participant 7, Anorexia Nervosa). Despite the low-self efficacy to recover, some of these respondents reported that they still wanted to try to recover. For example, one respondent stated “I do, I do want to get better. I want to get better so bad but it’s just so extremely difficult” (Participant 4, Anorexia Nervosa). None of the respondents were in maintenance stage of change, which was expected given respondents were recruited from either inpatient or outpatient treatment.

13.4.2 Trait-like resistance. Trait like-resistance refers to particular psychological characteristics (e.g., inconsistent responding, closed mindedness, problems in relationship formation, low expectations of benefit, perceived lack of environment support) which are manifestations of psychological resistance. A number of these characteristics were evident from responses across the interviews, suggesting trait-like resistance is prominent in individuals with eating disorders.

13.4.2.1 Inconsistent responding. One manifestation of resistance, inconsistent responding, refers to answering similar questions in different ways, or presenting conflicting themes in the interview (Butcher, 2004). Some participants demonstrated inconsistency in responses. For example, it was noticeable there was conflict between what interviewees said and their overt behaviours. One respondent stated “I put my layers on” (Participant 7, Anorexia Nervosa) to hide her body however she presented at

the interview wearing a revealing dress. Similarly, another respondent stated “Yeah, like I’m wearing baggier clothes than I ever have before” (Participant 2, Anorexia Nervosa) yet was wearing a form fitting singlet and short skirt. This was a manifestation of resistance; it seemed the client was hiding the truth about how she felt about her appearance or possibly her need to clamour for attention, or for some unspecified reason did not want the interviewer to explore her self-perception. Another example of inconsistent responding was the conflicting thoughts that many of the interviewees had regarding independence. For example, one respondent stated “I’m responsible and independent...” yet she also stated “I just want to be a child... I just wish I could never grow up... I did love being cared for and people looking after me” (Participant 4, Anorexia Nervosa). The inconsistency in responses questions the client’s truthfulness and cooperativeness in treatment. Alternatively, inconsistency of responses may be a manifestation of the vertical split (see *13.4.4.1 Narcissistic behaviour disorders: vertical split*).

13.4.2.2 Closed mindedness. Closed mindedness refers to the lack of openness to new ideas or ways of behaving and represents people who prefer not talking about themselves to others and have a reluctance to divulge personal information to anyone including therapists (Butcher, 2004). There was evidence that some participants were not open to new ideas or ways of behaving. For example, one participant was resistant to suggested techniques provided by their treatment team, stating, “I don’t agree with their advice” (Participant 2, Anorexia Nervosa). It appeared that because the focus of therapy for individuals with bulimia nervosa was on reducing the binge-purge cycle, bulimic respondents were more open to treatment. However, individuals with anorexia nervosa were less likely to be open to the advice of therapists due to the focus on weight

gain. The majority of the respondents who demonstrated closed-mindedness were open in discussing this in interviews. There was one respondent however, who was closed-minded regarding some of the excerpts read to her responding only with “No” (Participant 3, Anorexia Nervosa) to many excerpts and was not open to further prompting.

There was evidence of closed mindedness in terms of being reluctant to divulge personal information. For example, one respondent stated, “I never really talk, even when I've been in treatment. There's not been many times that I've talked about my illness with people” (Participant 6, Anorexia Nervosa). Another participant stated, “I'm a bit standoffish toward [the therapists]... I trust them, but I wouldn't necessarily go to them if I had a problem” (Participant 8, Bulimia Nervosa). Another respondent appeared to be avoiding talking as evidenced by her statement, “I know I probably also need to speak more... [My therapist is] a man. I find it very hard to talk to men in general...” yet then she also stated, “it'd be silly to have a female because, you'd never, that's part of like the problem, you'd never conquer the fear if you only dealt with females” (Participant 1, Anorexia Nervosa). Another respondent stated, I usually don't really open up. I still don't really” (Participant 7, Bulimia Nervosa).

13.4.2.3 Problems in relationship formation. Respondents demonstrated problems in relationship formation thus providing further evidence of trait-like resistance. Self-reclusion was common. For example, one respondent stated, “I get invited to things, and I'm like kind of like, ‘I'm already doing stuff’, isolating myself...and then they don't invite you, and you feel rejected” (Participant 2, Anorexia Nervosa). For some respondents, their relationship with their mother seemed to be their only close relationship. Many of these relationships between participants and their

mothers appeared to imitate the dependent relationship of a younger child. For example, one interviewee in her late twenties stated, “at home my mum makes up my lunch” (Participant 1, Anorexia Nervosa). Some respondents conveyed difficulty interpersonally, as if they found it difficult to trust friends. For example, one respondent stated that she had said to her friend “if you want to look thin, stand next to me” (Participant 2, Anorexia Nervosa) highlighting her distrust of her friend’s motives; she believed her friends would only be friends with her to make themselves feel better. Alternatively, she may have wanted to emphasise that she was actually slimmer than her friend, which could be perceived negatively by the friend.

Despite interpersonal problems in other relationships, indicating that they may have problems in relationship formation with their therapist, it appeared that respondents, mostly individuals with bulimia nervosa, seemed to view the therapeutic relationship as a friendship. Common words used to describe therapists were “friendly” and “lovely”. One respondent said about her doctor, “she’s more like a really knowledgeable friend rather than a doctor” (Participant 13, Bulimia Nervosa). Another respondent stated “If they weren’t my therapists, I could be their friend” (Participant 9, Bulimia Nervosa), and another stated, “she’s the kind of therapist that I would want to invite to my birthday party” (Participant 14, Bulimia Nervosa). Another respondent noted her therapist was “very easy to talk to like a friend” (Participant 12, Anorexia Nervosa). Moreover, at least one respondent “like[d] that therapists open up the door a little bit on a personal level”, and that “she’s closer to my age so she’s more relatable” (Participant 14, Bulimia Nervosa). This last comment also reflects the importance respondents placed on the therapist being relatable, if not friends. Respondents also stated engaging in group therapy made them “feel less alone” (Participant 8, Bulimia

Nervosa). Overall participants felt that to be able to recover they had “to trust them [the treating team] and go with what they say” (Participant 3, Anorexia Nervosa) but conveyed this could be difficult to do.

Despite sound relationships with therapists, and consistent with the notion that individuals with narcissistic characteristics are able to form but are less able to maintain relationships, some participants did end relationship with therapists. For example, one respondent stated about her psychologist, “she was a bit into yoga ... let’s like sit here and like breathe and ... I just didn’t ... like some of those things” (Participant 10, Bulimia Nervosa). Another patient stated that despite not having complaints against her group psychologist, she was “trying to stick at it for a bit but finding it really confronting” (Participant 12, Anorexia Nervosa) highlighting her struggle to stay engaged in treatment. Interviewees’ willingness to terminate therapist relationship appeared unhealthy due to termination being in the context of disagreement regarding treatment.

13.4.2.4 Low expectations of benefit. Respondents conveyed that they believed therapy was unlikely to help them recover from their illness, highlighting further psychological resistance. One respondent stated, “the GP has a really obvious job and the psychiatrist has ... that’s like the medication side ... but the psychologist sometimes, you feel like you’re not getting anywhere... I felt like with all my supports that was the one I could do without” (Participant 10, Bulimia Nervosa). Other participants conveyed that therapy was only beneficial when they were in crisis and needed a one off appointment. For example, one respondent stated, “I might make an appointment... [when] ‘I’ve got to see you’ ... usually at crisis” (Participant 2, Anorexia

Nervosa). Another participant stated, “I hate [treatment], it's a total farce. There's nothing worked on for your behaviours” (Participant 3, Anorexia Nervosa).

Some participants had already had unsuccessful treatment which minimised their hope of future successful treatment. It appeared the ongoing cycle of admission and discharge from hospital heightened participants' feelings that intervention would not be effective. For example, one respondent stated, “I've been in and out of here many times... majority of the time was probably spent in hospitals... I can't count the number of admission I've had over the years...still unwell” (Participant 6, Anorexia Nervosa). Another participant noted, “there's chronic cases and you see them come back year after year, and, yeah, I guess I definitely feel that helplessness” (Participant 10, Bulimia Nervosa).

Some participants identified the lack of benefit they felt when they had reached the weight criteria for recovery, thus leading them to relapse. For example, one respondent stated that she was informed “if you reach this weight then you will feel so good about yourself, and people will like you and everything will be good...and you reach the weight and, obviously, that doesn't happen” (Participant 6, Anorexia Nervosa). The lack of perceived benefit of treatment was conveyed by other respondents such as one respondent stating, “[the eating disorder] is the only thing you've got going for you” (Participant 13, Bulimia Nervosa) and another stating, “what's your motivation to recover then? Your whole identity and everything you feel good about goes into your eating disorder and then you're being told or forced to do the opposite...you don't feel like you have anything” (Participant 11, Anorexia Nervosa).

13.4.2.5 Perceived lack of environmental support. Despite acknowledging the importance of taking responsibility to recover, participants noted environmental support

in the form of family and friends was important in facilitating contact with treatment. For example, one respondent shared that she did not seek support, rather her parents organised it for her. She stated, “then once [the eating disorder] escalated my parents became involved and they fairly quickly got like a little team together so within about six weeks they organized GP, a dietician, a psychiatrist then a psychologist” (Participant 8, Bulimia Nervosa). This respondent appeared pleased with the support received. However, other respondents perceived they did not have environmental support. For example, one respondent agreed they felt “isolated and alone ... don’t get help from friends or family members... anyone” (Participant 1, Anorexia Nervosa). It appeared that for participants to feel supported they required this support from people whom they felt were acceptable supports. For example, one respondent stated, “I think it's sad that a psychiatrist is more involved in your life than your own family because they're selfish” (Participant 11, Anorexia Nervosa). This statement highlights that the respondent felt family was the most acceptable form of support. Whilst another respondent highlighted the expectation of support from therapists by stating,

I hardly ever see [my doctor]....like every morning when he's in the, um, courtyard all these people are lined up to see him, all his patients and it's like, I'm not gonna sit there, why should I have to sit there like a fucking idiot looking needy like these people... I don’t need to see him to tell him I feel like shit...It’s like I don’t matter, because, I must be alright because I’m not chasing him
(Participant 3, Anorexia Nervosa).

The statement also demonstrates that individuals with eating disorders believe they know what they need but that they should not have to ask for it, that others should

anticipate their needs but not take their control away. They feel that resources should be freely available to them. They do not want (what they perceive as) ‘production line’ support.

13.4.2.6 Receptivity to the therapeutic process and an examinee’s willingness to change. Participants described treatment as an active process whereby it was their responsibility to get results from treatment. This was reflected in the responses “to really recover, in my experience you have to take the wheel and take responsibility” (Participant 6, Anorexia Nervosa) and “the latest admission was most helpful because I chose to come in....it's really come from me and not external sources” (Participant 12, Anorexia Nervosa), demonstrating authority over the treatment process. Another respondent stated, “You sort of have to be with this program at a point where you're ready to take responsibility ...” (Participant 5, Anorexia Nervosa). This statement not only reflects the importance of timing treatment with the individual’s state of mind but could also represent the letting go of the young, dependent identity that individuals with eating disorders often have. Another respondent stated, “it feels good to be responsible for my own treatment and to be choosing to be here rather than them forcing me to stay ...You have to choose to be here and to choose recovery” (Participant 4, Anorexia Nervosa). This comment highlights the close relationship between taking responsibility and choosing recovery. Another respondent highlighted the need of not relying solely on others to be able to recover. She stated, “I think clinically, you need to determine whether they rely on people too much... [people with eating disorders] need to take responsibility for themselves” (Participant 10, Bulimia Nervosa).

The point was raised that eating disordered individuals were not always able to see the importance of treatment and recovery without this support. One respondent

exemplified this in the statement, “sometimes you need that [treatment forced on you], when you have people who are critically ill. If they're not willing to take responsibility, somebody has to” (Participant 6, Anorexia Nervosa). This also highlights the acknowledgment by the participant that individuals at significant risk of health complications should not be able to avoid treatment, even if they are not able to see the importance of treatment for themselves.

13.4.2.7 Self-oriented/narcissism. Given narcissism is the focus of the interview it is discussed in depth in the next section rather than under trait-like resistance.

13.4.3 Summary. Responses clearly demonstrated that individuals with anorexia nervosa and bulimia nervosa exhibit both state- and trait-like resistance. Most participants were in the precontemplation or contemplation stage of change and whilst some demonstrated preparation for change they were reluctant to engage in treatment that addressed restrictive eating behaviours. Additionally, participants demonstrated particular psychological characteristics including inconsistent responding, closed mindedness, problems in relationship formation, low expectations of benefit and perceived lack of environment support suggesting they were resistant to psychological intervention.

13.4.4 Narcissism. In addition to confirming resistance in individuals with eating disorders, confirmation of narcissism was required. Excerpts relating narcissism to eating disorders were read to participants. Respondents provided feedback about the excerpts which confirmed the presence of narcissism in the eating disorder population and that a number of themes related to narcissism were considered unhelpful to treatment.

13.4.4.1 Narcissistic behaviour disorders: vertical split. The respondents described having what seemed like a split sense of self consistent with those present in individuals with narcissism; a parallel and coexisting other (Goldberg, 1999), evident from a conflicting identity. For example, one respondent stated, “I’m getting better...but I also feel like my illness is getting a lot stronger as well...and they’re fighting each other” (Participant 4, Anorexia Nervosa). Another stated it was like having “two conflicting personalities inside”, adding that she wanted to get better but also did not want to get better, and that she could not resolve the indecision (Participant 8, Bulimia Nervosa). Another respondent stated, “I feel like there are different versions of myself” (Participant 14, Bulimia Nervosa).

Furthermore, some respondents had difficulties identifying with aspects of themselves. Some participants described their eating disorder as an unintentional and subconscious illness; when unwell they were unaware of how unwell they were. To be able to engage in treatment participants noted that first they have to acknowledge that they have a problem. As evident from these descriptions, a split sense of self seems to exist in eating disordered individuals; this lends some support for self psychology’s proposition that eating disorders are narcissistic behaviour disorders.

13.4.4.2 Vulnerable narcissism. The following excerpt, a description of individuals with vulnerable narcissism, was read to interviewees and all of them identified with this facet of narcissism.

Hypersensitivity to the opinions of others, insecure, having an intense desire for approval, and poor self-image. Presenting with shyness, constraint, and even the appearance of empathy.

However also wanting to be thought of as the best and have high

expectations for themselves. Being mismatched in this way results in the experience of shame and depression. Individuals are unable to consistently maintain a grandiose sense of self and lack self-enhancement strategies to modify self-esteem, often relying upon external support. They can withdraw in an attempt to manage self-esteem.

When this definition was read to participants they responded with statements including “pretty much could write the same thing about myself” (Participant 12, Anorexia Nervosa), “it’s like looking into a mirror” (Participant 13, Bulimia Nervosa), and “yes, absolutely, very much so [me]” (Participant 11, Anorexia Nervosa). One respondent stated, “You want to be thought of as the best and you have high expectations for yourself but ...I was only ever good and I still am only good if someone tells me” The respondent continued, “[you] withdraw to manage self-esteem [if you do not get told by someone you’re good] because if you’re not getting that positive feedback ... withdrawal because it’s just a way to like self-preserve” (Participant 10, Bulimia Nervosa). This respondent’s quote highlighted their identification with vulnerable narcissism. One bulimic individual stated, “when I’m depressed, I will go out of my way to get affection. Or admiration” (Participant 7, Bulimia Nervosa).

Individuals with vulnerable narcissism are avoidant and they present explicitly with fears of relating to others, lacking confidence in their interpersonal abilities. This way of relating was demonstrated in a number of responses. For example, one respondent stated, “even before I had an eating disorder, I think the reason I withdrew socially was just my hypersensitivity ... to the opinions of others” (Participant 6,

Anorexia Nervosa). Individuals with vulnerable narcissism also fear being disappointed or are ashamed of their needs within relationships. This was evidenced from the confusion about what support participants wanted. For example, one client was angry when her mother was not going to visit her, but refused a visit when her mother offered to visit (Participant 4, Anorexia Nervosa).

Some of the interviewees described that vulnerable narcissism would create a barrier to engaging in treatment due to “you want to hide” (Participant 5, Anorexia Nervosa) and the inherent need to be the best which interviewees directed towards eating disordered behaviours. Some respondents shared the shame they felt. Specifically, respondents stated that they were “ashamed of behaviours” (Participant 3, Anorexia Nervosa) and “ashamed of my past” (Participant 6, Anorexia Nervosa). In contrast, it seemed the other characteristics of vulnerable narcissism which participants identified with, such as feeling “worthless”, “unimportant”, “invisible”, “self-loathing” and “self-hatred” would be reasons to engage in treatment. However, this would require admitting to struggling which appears challenging for those with high expectations for themselves.

13.4.4.3. Grandiose narcissism. The following excerpt, a description of individuals with grandiose narcissism, was read to interviewees to determine whether they believed it related to eating disordered individuals or themselves.

These individuals can have a belief that one is special, denial of weaknesses, a requirement for excessive admiration, a sense of entitlement, a lack of empathy, a tendency to envy others and a belief that one is envied and presenting with what could be perceived as arrogant behaviour, consistent anger in unmet

expectations and the devaluation of people that threaten self-esteem.

When this definition was read to participants the majority were able to identify with all aspects except for the lack of empathy. One respondent stated,

Like every word, it's so true. Especially the, um, like because it's like a huge thing, especially with girls is that ... We all hate each other because we all see each other as a threat to our self-esteem ... People who I think are hotter than me, I'll be like "Oh, but they're this or they're that" ... consistent anger in unmet expectations, yeah, yeah, angry at people for not being perfect or not meeting ... So it's easier to just not deal with people...just like what could be same as arrogant behaviour, definitely you try to act like, you know, I think I'm the best or like ... definitely a tendency to envy others and also, you know, a belief that, yeah, someone's looking at you and be like "God, I wish that I had that kind of like ... I've got this ..." but you're still, you're not satisfied with it. You're only satisfied if you believe that you're subject to someone's envy because you envy people... a lack of empathy. That's interesting ... Actually, ... I don't agree with that...I think it comes across as a lack of empathy but I ... dissociate...I've ... I've definitely been accused of not being, you know, empathetic and I think that's definitely what it appears like ... Sense of entitlement, definitely...Requirement for excessive admiration, definitely (Participant 10, Bulimia Nervosa).

Thus, exhibitionism (a requirement for excessive admiration), entitlement (consistent anger in unmet expectations), vanity (a belief that one is envied) and superiority (devaluation of people that threaten self-esteem) were strongly supported by respondents. Although lack of empathy was explicitly denied by many of the participants at the time of discussing grandiose narcissism, at other times during the interviews, respondents indicated that they lacked the ability for empathy because they were so focused on themselves. The presence of both vulnerable narcissism and grandiose narcissism in respondents supports eating disorders as narcissistic behaviour disorders which comprise both grandiose and vulnerable narcissism (Kohut, 1977).

13.4.4.4 Exhibitionism. Exhibitionism, a factor of grandiose narcissism, is described as sensation seeking, extraversion and impulsivity (Raskin & Terry, 1988). An exhibitionist person requires constant attention and admiration (Ronningstam, 2010). Individuals with bulimia nervosa described themselves as "...silly, fun" (Participant 9, Bulimia Nervosa), "pretty outgoing" (Participant 10, Bulimia Nervosa) and "eccentric" (Participant 14, Bulimia Nervosa). One respondent stated, "I did become so reckless but because I had these [eating related] rules that let me know I was okay" (Participant 10, Bulimia Nervosa). The paradox of control is profound; individuals feel in control of their lives through control of eating, yet it is this control of eating which indicates they are dangerously out of control. However, the participants with anorexia nervosa denied being exhibitionistic. For example, one respondent stated "anorexics are not outgoing...parties you would avoid" (Participant 2, Anorexia Nervosa).

13.4.4.5 Authority. Authority is described as dominance, assertiveness, leadership, criticality, and self-confidence (Raskin & Terry, 1988). There was consistent

feedback from respondents that individuals with eating disorders were not authoritative. For example, one respondent stated “I’m not sure many people with an eating disorder would be leading others” (Participant 1, Anorexia Nervosa). Half of the participants comprising both bulimic and anorexic patients, used the words “closed-off”, “standoffish” and “quiet” to describe themselves. They reportedly found it difficult to open up to others let alone have authority over them. Yet some participants said they could be leaders to help others. For example, I can definitely relate to that because I’d love being the leader and being a helper (Participant 4, Anorexia Nervosa) and another stated, “Trying to help others...and leading them to recovery” (Participant 8).

13.4.4.6 Vanity. Vanity was described as an individual believing that they are physically attractive and are perceived this way by others and who want approval from others (Raskin & Terry, 1988). Moreover, it related to self-absorption and self-admiration. Interviewees described attention seeking and vanity as prevalent in the eating disorder population. For example, one respondent stated “[they] wear things for attention, they may not want to say it but they feel hot” (Participant 9, Bulimia Nervosa), another stated “people are anorexic and proud of it...they’d stand out the front and flirt with guys across the road and try and get their attention...” (Participant 13, Bulimia Nervosa). Some respondents could only name this as others’ experience, as exemplified by the previous comments, whilst other respondents were able to identify this as their own experience. For example, one patient identified with this theme when she stated, “Without it, what are you? Like a normal person, you don’t get noticed... so you make yourself noticeable” (Participant 2, Anorexia Nervosa). This participant noted attention seeking extended to social media such that “to get more followers...you share accounts...for validation, like, because you don’t really fake an eating disorder but ...

the reason behind it is more from that kind of attention thing” (Participant 2, Anorexia Nervosa).

Respondents conveyed that there are two types of people with eating disorders – those who intentionally show off and make it really obvious vs. those who hide their symptoms. For example, one respondent stated, “I know people who, with eating disorders, the only way they get attention is by flaunting their figure...” whilst others “that hide it, we’re ashamed” (Participant 7, Anorexia Nervosa). However, even those respondents that conveyed that they hid their disorder also presented wearing tight fitted clothing and appeared proud of their appearance. However, interviewees recognised that despite the appearance of vanity, underlying concerns were the cause. For example, one interviewee stated “some people gain confidence from it...probably something going on underneath” (Participant 6, Anorexia Nervosa) whilst another stated “but it’s an insecurity thing” (Participant 13, Bulimia Nervosa).

High levels of self-absorption were evident. One participant even explicitly stated this, responding “people with eating disorders tend to focus on themselves” (Participant 1, Anorexia Nervosa). This self-focus appeared to be at the cost of interpersonal relationships and normal functioning. One respondent demonstrated the inability to focus on anyone else but yourself, stating, “it might appear the [eating disordered] person is empathic when really they're self-involved ... inside their own head” (Participant 12, Anorexia Nervosa). Some clients liked knowing that they were the focus of other people’s attention. For example, one client stated “It is great because ... you can tell they've talked about me” (Participant 7, Anorexia Nervosa) when she was reiterating the importance of her treatment team communicating to one another about her.

Some clients recognised the obsessiveness of self-involved behaviours. When discussing her exercise routine, one respondent stated, “it would be really distressing if it ever had, like had to be interrupted ... for others” (Participant 12, Anorexia Nervosa) demonstrating both the importance of self over other and the obsessive nature of this symptom. It appeared obsessiveness was not specific to eating disorder behaviours for some individuals. For example, one client stated, “I’m OCD [obsessive compulsive disorder] ... My husband reckons we can rent out our spare rooms as operating theatres” (Participant 3, Anorexia Nervosa) in relation to her cleaning behaviours. However, with a diagnosis of OCD, this client’s response may be an anomaly.

13.4.4.7 Self-sufficiency. Self-sufficiency was described as assertiveness, independence, self-confidence, and achievement need (Raskin & Terry, 1988). Respondents seemed to struggle with assertiveness, self-confidence and independence. For example, one respondent stated, “it’s such a sheltered environment where you have no responsibilities, like everything is done for you. You’re basically babied. So the transition to home is always really hard” (Participant 12, Anorexia Nervosa).

Whilst lacking self-confidence, assertiveness and independence, there was a clear achievement need amongst participants. Participants reported a sense of achievement when they achieved a goal (e.g. lost weight, engaged in excessive exercise, or engaged in other eating disorder behaviours) and when they improved on their own eating disorder behaviours (e.g. ate less calories than the previous day). For example, one respondent stated, “when you start purging it’s so hard and then ... that breakthrough day where you’d get everything out and you’re like, “I have gotten ... I’m good at this” (Participant 10, Bulimia Nervosa). Another respondent highlighted the need to improve on previous achievements stating, “I’ve had a lot of trouble with

excessive exercising... I kept records” (Participant 12, Anorexia Nervosa). For example, respondents stated “something drives you so you can really achieve” (Participant 5, Anorexia Nervosa) and “if it can be done, I can do it, I should be doing it” (Participant 7, Anorexia Nervosa). Respondents identified that these standards were true for their eating disorder also. For example, one interviewee said “if somebody my height and thinner than me, it’s like well they did it, I should be able to do it” (Participant 6, Anorexia Nervosa). Another respondent stated her father had said “you know, pretty impossible, you know, one percent of the population can survive on, you know, this many calories or can actually become underweight” and her response was “Challenge accepted” (Participant 10, Bulimia Nervosa). Some interviewees shared that they would have a better chance at recovery from the eating disorder if they were able to redirect high standards onto recovery. “If I could though that’d be good. If I could recover, that’s the impossible, but I also think not eating a lot is difficult, so that wins?” (Participant 9, Bulimia Nervosa).

Many respondents reported that they had been high achievers before. One client stated “... in my life, I have kind of been good at everything” (Participant 10, Bulimia Nervosa). Moreover she stated, “my parents ... putting pressure on me to do everything, like, “You can, you could be the president if you wanted. You could do this. You could do that” because I was always really good at school and everything...”. This quote demonstrated her lifelong achievement orientation which now extended to her eating behaviours.

On the other hand, some respondents seemed to harness their achievement orientation to assist with their recovery. One respondent stated that wanting to achieve in other areas of her life was motivating her to recover. She explained, “there are things

I want to achieve and [that] like pushes me to want to get better” (Participant 13, Bulimia Nervosa). Another respondent also identified that achievement orientation could assist with recovery. She stated, “if eating more was like more of an achievement, which it probably is because it’s actually harder for people with eating disorders to do, and more glorified then it would be easier to reach our goal” (Participant 5, Anorexia Nervosa).

13.4.4.8 Entitlement. Entitlement is a shared characteristic of grandiose and vulnerable narcissism. Entitlement was described as ambitiousness, need for power, dominance, hostility, toughness, intolerance of others, and lack of self-control (Raskin & Terry, 1988). Respondents did not seem to chase power or dominance but could come across as dominant and hostile toward others. For example, one respondent stated that whilst “[she] would probably appear shy... when [she] do[es] speak up it's generally pretty abrupt and forceful (Participant 8, Bulimia Nervosa). Some respondents demonstrated consistent anger to unmet expectations. For example, one respondent stated “I’m always wanting so much from everyone around me... I want my mum to come in every day ... Just yesterday she said, ‘Oh, it’s going to be really hard to make it in today but I can still come if you want me to’ and I said, I got really angry,... ‘why are you offering to come?’” (Participant 4, Anorexia Nervosa). Another stated, “the world revolves around ... me. Like, if my mum can't do something for me, if she's busy, I might get angry” (Participant 2, Anorexia Nervosa). Some respondents demonstrated an insistence about how the world should be, anger about how they have suffered, and the unwavering belief that only they have been hurt and that they are deserving of more than what is given them. For example, the respondent who stated “I think it's sad that a psychiatrist is more involved in your life than your own family because they're selfish”

(Participant 11, Anorexia Nervosa) disclosed a 16 year history of intensive support from her family and what some might view as a privileged life. Most respondents believed individuals with eating disorders were entitled. One respondent stated, “Bit like self-righteous... there’s definitely people like that [in treatment]...not all people with eating disorders, but a lot of them... they feel like that they’re in charge ... like everyone should be helping them (Participant 13, Bulimia Nervosa).

13.4.4.9 Exploitativeness. Exploitativeness was described as rebelliousness, nonconformity, hostility, and inconsiderate and intolerance of others (Raskin & Terry, 1988). Whilst some respondents made statements like “I do feel a lot of empathy for everybody” (Participant 4, Anorexia Nervosa), it appeared that others were intolerant of others and inconsiderate. For example, one respondent stated, “[I get] angry at people for not being perfect ... So it’s easier to just not deal with people (Participant 10, Bulimia Nervosa) whilst another said, “I pretend to care [for others], I mean of course I care, but sometimes I just want to feel good you know?” (Participant 9, Bulimia Nervosa).

Whilst some respondents conformed to societal expectations, as evidenced by the response, “I find that a lot of the people that I’ve met who have eating disorders ... don't want to do things wrong ... [and] follow rules” (Participant 8, Bulimia Nervosa), other participants described not conforming to and rebelliousness with regard to treatment. Some participants described their lack of engagement in treatment as though they were purposefully defying the treatment and the treatment team’s expectations. For example, one interviewee stated “[I] only do what I want to do anyway” (Participant 2, Anorexia Nervosa) and another stated, with a big smile on her face, “my eating wasn't monitored so it was very easy to get away with things” (Participant 8, Bulimia

Nervosa). Another, also smirking, proudly reported “you had to restrict the exercise so I paced around ... And then I’d stand all the time because it burns more calories” (Participant 1, Anorexia Nervosa). Moreover, participants were particularly devious about this defiance. Another respondent stated “they could only get me to a certain place...after that I avoided treatment [laughs]” (Participant 11, Anorexia Nervosa). Another participant exemplified her intentional defiance and deviousness as per the quote below.

I walk for like two or three hours a day. I just do laps around the block every day. And they note it. But because my weight’s okay ...but my weight is completely fluid loaded, so it’s like, ‘we know you’re fluid loading’ but they can’t get me on it...and they took me off the table (where eating is monitored) because I caused too many riots... that was good to be taken off because then I just get away with everything I want (Participant 3, Anorexia Nervosa).

Another demonstrated her rebelliousness by stating that when her doctor roused at her for illegally parking her response was, “sorry (laughs) see ya. And I drove home” (laughing) (Participant 11, Anorexia Nervosa). Similarly, three of the fourteen participants, including both anorexic and bulimic participants, used the words “deceitful” and “stubborn” to describe themselves in the context of their eating disorder and treatment. As evident from these descriptions, defiance may be similar to being uncommitted to recovery as they both comprise resistance to treatment, however, defiance encapsulates the boldness of this resistance.

13.4.4.10 Superiority. Superiority is a shared characteristic of grandiose and vulnerable narcissism. Superiority was described as concern for status, social presence,

and self-confidence (Raskin & Terry, 1988). Individuals with eating disorders have been described as having an inflated sense of specialness, flaunting achievement, making comparisons to others and being aware of rank in relation to appearance, and devaluing others who threaten self-esteem. One participant stated “sometimes I tell my friends ... I’m good at everything, and they’re like I’m being sarcastic but like in my life, I have kind of been good at everything” (Participant 10, Bulimia Nervosa).

Respondents also described a sense of superiority due to their eating disorder. Superiority of specialness was conveyed through participant’s own behaviour or knowledge, or their associations with others. For example, one respondent stated they “...feel superior, the ability, the power, almost, to withhold” (Participant 4, Anorexia Nervosa). During one interview, the participant was excited to share with the interviewer that she had only eaten 200 calories that day. She clearly felt superior based on the researcher’s observations of her sitting up in her chair, her eyes lighting up, her voice becoming stronger and a smirk on her face. However, this comment could also be regarding a sense of achievement. Another participant demonstrated her superiority by stating, “I had to educate the nurses [about eating disorders]”. A sense of superiority was also conveyed in comments such as “my dietician’s like, she’s pretty renowned” (Participant 7, Anorexia Nervosa), whereby the client expressed superiority by association. This statement highlights this participant’s need to idealise her dietician, supporting the archaic need of the individual for selfobject experiences.

Superiority was evident across the majority of respondents. There was a clear disdain for being “normal” and “average”. Respondents wanted to be better than others. This was summarised in the following quote.

[Normal] like the worst thing ever. Like when my psychiatrist like, ‘You know, don’t you just, you know, want to be normal?’ and I’m like ‘That’s like a death sentence to me’. Like I don’t even want to be, coz to me that’s mediocre. And she’s like ‘normal people can be, you know, happy and successful’... I’m like normal is just like, pft ... Low, it means low expectations. It means, you know, I don’t know, just disastrous ... (Participant 10, Bulimia Nervosa).

This quote also demonstrated how superiority was unhelpful to treatment engagement.

In order to maintain a sense of superiority participants had a heightened awareness of those around them. The most common theme to emerge from the interviews was the comparisons that participants made between themselves and others (e.g. “I envy other people...wish I was like them” (Participant 12, Anorexia Nervosa) and “the illness breeds competition” (Participant 11, Anorexia Nervosa). One participant discussed the use of devaluing those who threatened their self-esteem when comparing herself to them. She stated, “People who I think are hotter than me, I’ll be like ‘Oh, but they’re this or they’re that [something negative]’” (Participant 10, Bulimia nervosa). Each participant highlighted comparisons as an issue standing in the way of recovery.

I think being with, probably, around a lot of other people with eating disorders it’s helpful in some ways but it’s sort of like I said a bit triggering and makes you want to compare and be thinner or eat less... I know I compare myself to others and it affects how I think about myself...[change] behaviours, weight

and stuff... that gets in the way of recovery...um, because like that's just like you wanting to be sicker (Participant 5, Anorexia Nervosa).

Being with other eating disordered individuals in treatment also provided participants with opportunities to learn new eating disordered behaviours from other patients. One example included "I didn't tend to talk to the other eating disorder people but I tend to kind of observe a couple of them and sort of subconsciously learn habits...take on some of those behaviours" (Participant 8, Bulimia Nervosa).

13.4.5 Therapists. There was little evidence to support narcissism in therapists. However, there was evidence to support possible eating pathology in some therapists. Moreover, some therapists appeared to collude and have countertransference with clients. The data discussed in this section could also be explained by clients' obsession with appearance and seeing other's motives and behaviours through their own lens.

13.4.5.1 Therapist eating pathology. There was evidence to suggest that therapists have eating pathology from respondents' accounts. One interviewee stated "one nurse I suspected might have an eating disorder" (Participant 14, Bulimia Nervosa). Interviewees also reported that treating professionals may also compare themselves with the patients. Two interviewees reported that they had a previous therapist disclose about their own eating disorder history. One stated, "an old therapist told me that she used to have an eating disorder and she would often bring that up... made me feel like I should be helping her rather than her helping me" (Participant 13, Bulimia Nervosa). The second stated, "one nurse...brought up the fact that she had an eating disorder". Unlike the previous respondent, this interviewee stated she found that the nurse's disclosure "wasn't helpful or unhelpful" (Participant 8, Bulimia Nervosa).

Only one respondent discussed that competition was explicitly evident from therapists, although she had not experienced this for herself. She stated, “I’ve heard how [eating disordered] people don’t trust their psychologist or psychiatrist because they’ve told them they are jealous of how they look...I would probably go out of my way to stay thin...competitive, hell yeah” (Participant 9, Bulimia Nervosa). In terms of comparisons between therapists and patients, interviewees believed that men would not make these comparisons; “males don’t compare” (Participant 1, Anorexia Nervosa). Also, interviewees believed that having a male therapist prevented them from making comparisons based on weight and beauty; there is “less emphasis on body image and eating attitudes with men than there are female” (Participant 11, Anorexia Nervosa).

13.4.5.2 Therapist narcissism. Only one respondent highlighted narcissistic traits in their therapist. The respondent stated, “He is a complete wanker. He has belief that he can fix everyone and he's got so many patients and he's like, ‘I can never find you’ and I said, ‘the nurses know exactly where I sit and smoke or go and do my crosswords’...he is so unprofessional and uncourteous” (Participant 3, Anorexia Nervosa). However, it is unclear whether this respondent felt uncared for and was therefore exaggerating her therapist’s presentation.

13.4.5.3 Collusion. There was evidence that therapist’s did not always have an empathic stance and contributed to the respondents’ presenting issues. For example, one interviewee stated “one nurse said “I’d love to be as skinny as you are, what’s your secret?” (Participant 11, Anorexia Nervosa). However, this participant felt the nurse’s comment did not have a long term negative impact on treatment. Rather, it just resulted in frustration at the time. Another respondent stated “it's not helpful when they're too like overly nice, because you still kind of need to hear the truth (Participant 2, Anorexia

Nervosa). Another respondent stated, “[group therapists are] happy to like joke around, they’re always joking around in group and stuff (Participant 13, Bulimia Nervosa) questioning the appropriateness of the treatment of the issue at hand.

13.5 Discussion

This study used a qualitative design to capture the respondents’ point of view about narcissism, trait- and state-like resistance, and client-perceived disordered eating and narcissism in treatment providers. Using a qualitative approach as the final study of the research also permitted the results of the previous questionnaire phases to be extended and re-examined. Due to the poor reliability of the seven components of the grandiose narcissism scale (NPI), yet the important theoretical information provided by these components, Study 2 was unable to capture information these components separately. Instead, a three-factor solution of the NPI, identified Study 1, enabled exploration of these factors, but information was still lost due to the grouping of the seven components (e.g., Factor 1 grouped authority with self-sufficiency).

Further clarification of the presence of grandiose narcissism was provided by the current study. This qualitative study also permitted confirmation that vulnerable narcissism, and state- and trait-like resistance was present in individuals with eating disorders and whether resistance was predicted by narcissism by exploring whether respondents identified with the two factors of narcissism and how they perceived it influenced engagement in treatment. As a result, a broader depiction of narcissism in eating disorders was obtained which supports that vulnerable narcissism and some facets of grandiose narcissism should be included in the conceptualisation of anorexia nervosa and bulimia nervosa. Discussion of the results of the interview phase follow,

whilst comparisons across studies and implications will be discussed in the overall discussion (Chapter 14).

Interviewees reflected low motivation to change (state-like resistance) from their eating disordered behaviours. Participants ranged from the precontemplation through to preparation phases of treatment. Some individuals were in the action phase of change for those eating disorder symptoms which were not wanted by participants (e.g., binge eating) whilst simultaneously being in the precontemplation or contemplation phase with regards to important aspects of their treatment (e.g., weight gain). Given stage of change is employed as a measure of state-like resistance (Perry, 2009) and that individuals with eating disorders are considered resistant to treatment (M. Cooper, 2005; Fassino & Abbate-Daga, 2013; Vitousek & Watson, 1998), it is surprising that interviewees spanned the stages of change. The endorsement by some responses of stages of change above low stages (i.e., above precontemplation and contemplation stages) likely reflects that interviewees were already engaged in treatment. The endorsement of higher stages of change were often in the context of aspects of the eating disorder that were considered negative such as purging, similar to previous findings (Fassino & Abbate-Daga, 2013; Serpell et al., 1999; Williams & Reid, 2010). Even those respondents who acknowledged their eating disorder was a problem and were taking responsibility for recovery described low self-efficacy to recover and felt conflicted about receiving treatment. Additionally, the ambivalence which often occurs when considering recovery from the eating disorder (Williams & Reid, 2010), as supported by responses regarding the pained chronic ambivalence that is wishing to comply with treatment whilst also rebelling against it, suggests the presence of the

vertical split whereby the eating disorder identity and the healthy identity chronically clamour for attention (Goldberg, 1999).

There was also evidence of trait-like resistance from respondents, including inconsistent responding, closed mindedness, low expectations of benefit and low willingness to change. Inconsistent responding was also reflective of the vertical split (Goldberg, 1999). There was a noticeable conflict between what interviewees said and their overt behaviours. It appeared participants were unable to identify the striking split in their personality. On the one hand, it appeared respondents genuinely felt hidden away (e.g., stating they wore baggy clothing), yet, on the other hand, they were clamouring for attention (e.g., wearing form-fitting clothes). The inconsistency in responding can be likened to the defenses, such as splitting (as with the vertical split) and repression. Repression refers to blocking unacceptable ideas or impulses from entering consciousness (Gabbard, 2005). Having needs from others causes a deep sense of shame for individuals with disorders of self like eating disorders (Jacoby, 1999). Therefore, these individuals may have repressed their needs (of attention, for example) yet continue to unconsciously elicit a response from others without the experience of shame.

Recall closed mindedness refers to the lack of openness to new ideas or ways of behaving and represents people who prefer not talking about themselves to others and have a reluctance to divulge personal information to anyone including therapists (Butcher, 2004). The presence of closed mindedness evident from responses may be an attempt to defend against a repeat of failed selfobject experiences by avoiding or denying the selfobject experience with others such as therapists (Kohut & Wolf, 1978). These failed selfobject experiences may also have been in the form of treatment with a

previous therapist given a number of respondents noted a succession of failed treatments. For some respondents, evidence of closed mindedness was cognitively self-identified but not *felt*. Intellectual insight was not the same as emotional insight (Shedler, 2010). That is, whilst respondents identified with not “open(ing) up”, they could not resolve this and engage in treatment. For this type of presentation it is important that treatment, like that underpinned by self psychology, focuses on client’s affective understanding of experience, rather than just a cognitive understanding (Siegel, 1996). Participants identified low expectations of benefit and low willingness to change. Common responses were reflected in the statement “your whole identity and everything you feel good about goes into your eating disorder and then you’re being told or forced to do the opposite...you don’t feel like you have anything”. Such responses reflected the work of Hilde Bruch (1981), pioneer in the field of eating disorders and self-identified as practicing closest to self psychology, who proposed that the eating disorder acts in lieu of a clear identity.

Trait-like resistance in the form of difficulties in relationship formation and perceived lack of environmental support was not present for all respondents. Whilst there was evidence of difficulties in relationship formation in every day settings, most participants reported what they perceived as strong therapeutic relationships. In fact, based on the apparent idealisation of therapists by some respondents, it may be that an idealising selfobject experience was already occurring in treatment for respondents; a connection to an admired other for a sense of calming, safety, soothing, strength and inspiration (Kohut, 1984). This would need to be explored in future research. A number of participants noted enough environmental support in the form of family and friends that their support aided contact with treatment. Those respondents who did perceive a

lack of environmental support demonstrated the struggle of individuals with disorders of self who perceive they are different and alone (Kohut, 1971).

Individuals consistently and most closely identified with the excerpt which was a definition of vulnerable narcissism. However, respondents were unclear whether vulnerable narcissism would facilitate or hinder recovery. Respondents also identified with grandiose narcissism. Of all the excerpts read to participants, respondents identified more strongly with vanity (including attention seeking, self-focus and obsession), superiority (including making comparisons with others to maintain a sense of superiority) and entitlement. Furthermore, the rebellious and non-conforming qualities of exploitativeness were present in individuals with eating disorders. However, it appeared these characteristics were mostly in relation to their eating disorder; respondents were obsessed with eating disorder behaviours thus self-focused, respondents drew comparisons with other eating disorder patients based on eating disorder related behaviours and thoughts, and respondents rebelled against treatment and took satisfaction in this rebellion. Of concern, respondents identified that these characteristics of grandiose narcissism (entitlement, exploitativeness, superiority and vanity) were most likely to stand in the way of treatment as it was these characteristics that reinforced the eating disorder. The eating disorder appears effective in meeting selfobject needs.

A split sense of self was evident throughout and across interviews. Respondents were exhibitionistic at times yet also were withdrawn and hidden; they seemed conflicted about whether they wanted to be noticed or not. These individuals saw others' needs as more important than their own, while simultaneously resenting that their own needs were not being met. They wanted to recover but also did not want to

recover from their eating disorder. This split was representative of the vertical split characteristic of individuals with narcissistic behaviour disorders (Goldberg, 1999). Thus, this study provided further evidence to support the self psychology conceptualisation of eating disorders as narcissistic behaviour disorders.

The present study explored whether eating disordered individuals recognised eating pathology in therapists, which might influence the therapist's ability for empathic immersion and interpretation, thus treatment outcomes. Respondents highlighted that some, not all, therapists did demonstrate disordered eating. Responses demonstrated that interviewees were hyperaware of the eating and weight-related behaviours of treatment providers, particularly those staff who monitored participants' own eating. Therefore, although some respondents identified disordered eating in their therapist it remains unclear whether this identification was an exaggeration of even the smallest eating behaviour in the mind of the eating disordered individual. More clarity is provided whereby some respondents disclosed that they were aware that their therapist had a past eating disorder. However, it was less clear what influence a therapist's disclosure had on an eating disordered individual and their treatment outcome; some respondents were not affected by these sorts of disclosures, whilst others became competitive in response, striving to be thinner. This differing response from respondents further complicates the controversy surrounding past eating disordered therapists treating these individuals (Barbarich, 2002; Costin & Johnson, 2002; Johnston et al., 2005). Moreover, the competitive response of respondents further supports the need for future research to explore therapy outcomes in individuals who have therapists who make disclosures related to eating pathology. Some respondents used the therapists eating behaviours as an excuse to not engage in healthy eating themselves. The responses of interviews in

this study suggested that eating disorder treatment providers were not perceived as having elevated levels of narcissism, even despite being idealised by some respondents. Therefore, the risk of intensified narcissistic pathology (Seligson, 1992) seems low.

13.5.1 Clinical implications. The responses in the interviews support that individuals with eating disorders are treatment resistant. Additionally, responses support the inclusion of vulnerable narcissism and aspects of grandiose narcissism in the conceptualisation of eating disorders, supporting an approach which addresses both these aspects of narcissism; corresponding treatment may be the key to overcoming resistance in eating disorders which was identified by participants as being predicted by grandiose narcissism, superiority, vanity, entitlement and exploitativeness. It is important in clinical practice to address the narcissistic characteristics in therapy, even if the client does not explicitly reveal these characteristics. When narcissistic characteristics were conveyed to interviewees as being understood and empathised by the interviewer, interviewees were honest and forthcoming in their discussion about how they relate to these characteristics. Thus, an empathic approach of the therapist may be required in therapy for client to admit to their own narcissistic characteristics. Whilst incorporated in a number of approaches (e.g., Rogers, 1957), empathy acts as the treatment in self psychology, thus self psychology seems an effective treatment approach for eating disordered individuals. Further research is required, however, to support this proposition.

The presence of narcissism in the anorexic and bulimic population can be addressed in therapy by exploring sense of self. Many of the participants had more years of being eating disordered than not eating disordered, with participants describing eating disordered behaviours starting in their early adolescence or late childhood. It is

unsurprising then that the eating disorder can become a substitute identity whereby food, weight and its control meets the individual's needs (Kohut, 1977; S. Sands, 1989). To understand the eating disorder identity, it is suggested that the client's invalidating environment and narcissistic aspects are explored. Additionally, a new identity, based on eliciting likes and dislikes and considering oneself as an autonomous individual, can be equally as important. Integration of the split self should also be a focus of treatment. Integration of the split self can occur by acknowledging and accepting both sides of the split self and to take insight from it as a product of the eating disordered mind (Goldberg, 1999). The deviousness of some respondents, for example saying they have eaten when they have not, needs to be acknowledged and interpreted without confrontation and blame (Kohut, 1977).

Given the aspects of grandiose narcissism in this population, including competition and comparisons, the impact of patients living in close proximity or engaging in therapy with others seems problematic. Reservations are made regarding whether particularly ill patients should be treated with patients nearer to recovery and discharge. Additionally, therapists need to be mindful of the influence they have on the individuals that they are treating. Supervision and self-reflection, even therapy, seems necessary. Therapists are also cautioned regarding self-disclosure of eating disorders, past or present, given the eating disordered clients hypersensitivity to disclosures around eating and weight behaviours and the possibility of it contributing to treatment resistance.

13.5.2 Limitations. The present study was based upon interviews conducted with 14 women, 9 diagnosed with anorexia nervosa and 5 diagnosed with bulimia nervosa. These participants were in varied stages of treatment; some were inpatient,

some were re-feeding, some were outpatient. Males and those who have never engaged in any treatment were not included in the interviews. Therefore, the interviews do not reflect the views of males and untreated individuals. Additionally, participants were recruited from an organisation which provides inpatient and outpatient treatment which also has associations with other specific organisations and private practitioners therefore the treatment providers (i.e., psychologists, psychiatrists and dieticians) are shared. As a result, the perceptions of a narrow group of treatment providers limit the generalisability of results.

13.6 Summary

The current study examined whether individuals with either anorexia nervosa or bulimia nervosa identified with vulnerable narcissism, grandiose narcissism or the seven characteristics of grandiose narcissism. These eating disordered individuals, regardless of diagnosis, exhibited the characteristics of vulnerable narcissism. Additionally, although respondents did not identify with all aspects of grandiose narcissism, they did in fact identify with entitlement, exploitativeness, superiority and vanity. Moreover, it was these grandiose narcissism factors and characteristics that contributed to resistance. Responses were mixed regarding whether therapists had or were perceived to have past or present eating disorders. Respondents did not describe their therapists as having any narcissistic attributes. The contributions of the results in the context of the results of Study 1, Study 2 and Study 3 will be discussed in the following chapter (Chapter 14).

Chapter 14

General Discussion

14.1 Purpose and Overview of the Research

This program of research addressed the need to extend current understandings of anorexia nervosa and bulimia nervosa in order to effect treatments that offset poor prognosis (Agras et al., 2009; Byrne et al., 2011; Dalle Grave, Calugi, Conti, et al., 2013; Dalle Grave, Calugi, Doll, et al., 2013; Fairburn et al., 2009; Galsworthy-Francis & Allan, 2014; Keel & Brown, 2010; Lampard & Sharbanee, 2015; McFarlane et al., 2008; C. Miller & Golden, 2010; Wonderlich et al., 2014). This program of research extended current mainstream understandings by exploring theoretical contributions provided by self psychology. Self psychology considers eating disorders as a particular type of disorder of self, a narcissistic behaviour disorder, which results from unmet needs during development by selfobjects (Kohut, 1971, 1977, 1984). Individuals with narcissistic behaviour disorders have an archaic need for selfobject experiences denied in their childhood. Self psychology treatment is the empathic enquiry and empathic interpretation from the therapist (Kohut, 1959). A rationale for resistance in the eating disorder population is presented by self psychology; the eating disorder acts as a selfobject substitute which meets narcissistic needs (Bachar, 1998; Barth, 1988; Bruch, 1978, 1982; Fassino & Abbate-Daga, 2013; Geist, 1989; Kohut, 1977; S. Sands, 1989), and the absence of therapist empathic enquiry and interpretation (Bienenfeld, 2005; Kohut, 1959; Lessem, 2005), in the form of countertransference, perpetuates already present resistance (Plakun, 2012; Strober, 2004). To empirically test the suitability of self psychology understandings of eating disorders, further research into narcissism and

the role of therapist, and their effect on treatment resistance in individuals with eating disorders was required.

The current research project had four overarching aims. The first aim was to verify the factors of the grandiose narcissism measure, the Narcissistic Personality Inventory (NPI), for use in the subsequent studies. The second aim was to examine the role of various facets of narcissism in eating disorders. The third aim was to explore the role of narcissism in treatment resistance in eating disorders. The fourth aim was to explore narcissism and eating disorder symptoms in eating disorder therapists as these factors may inhibit therapists' effectiveness at treatment.

The overarching research aims were addressed through four studies using a mixed-method approach. In Study 1, a quantitative study, 905 adults completed the grandiose narcissism scale, the NPI, to determine its factor structure. In previous research the established seven factor structure (Raskin & Terry, 1988) was deemed inconsistent or unreliable (del Rosario & White, 2005; Emmons, 1984; Kubarych et al., 2004). However, other proposed two-, three- and four-factor models of the NPI still comprised unreliable psychometric properties (Ackerman et al., 2011; Corry, Merritt, Mrug, & Pamp, 2008; Emmons, 1984, 1987; Kubarych, Deary, & Austin, 2004). Clarification of the factor structure in Study 1 enabled the subsequent studies to capture a deeper understanding of the role of grandiose narcissism in eating disorders by employing the factors extracted in Study 1. Study 2 examined grandiose narcissism (including its 3 factors identified in Study 1), vulnerable narcissism and state- and trait-like resistance in the eating disorder population. Self-report measures were completed by 180 adults, 40 with an anorexia nervosa diagnosis, 43 with bulimia nervosa diagnosis, 41 with a mental health diagnosis commonly comorbid with eating disorders

and 56 community members without a mental health diagnosis. Analyses were conducted to determine whether grandiose narcissism (and its factors) and vulnerable narcissism scores were elevated in individuals with either anorexia nervosa or bulimia nervosa compared to a mental health and healthy control group, and whether there were differences between eating disorder groups on these factors. Study 3 utilised quantitative data collected from 32 eating disorder therapists, 62 non-eating disorder therapists, 83 eating disordered individuals and 778 community members to investigate whether the various facets of narcissism, in addition to eating symptomatology, were elevated in eating disorder therapists compared to non-eating disorder therapists (and the two other control groups). Moreover, Study 3 aimed to determine whether eating disorder therapists exhibited similar levels of narcissism to clients, thus, whilst not examined in this research, increasing the chance of intensified pathology in both when in treatment (Seligson, 1992). In Study 4, qualitative data obtained through semi-structured interviews with 14 individuals with eating disorders permitted insight into eating disordered individuals experience of treatment, therapists and narcissism, and how these may impede or assist engagement in treatment in addition to clarifying and extending on the findings from the previous studies.

14.2 A Summary of the Pertinent Findings

This program of research confirmed that treatment resistance is common in individuals with anorexia nervosa and bulimia nervosa. State-like resistance was endorsed in both Study 2 and Study 4 by eating disorder participants. Study 2 revealed that individuals with anorexia nervosa were, on average, in the precontemplation stage of change and individuals with bulimia nervosa were, on average, in the contemplation stage of change. Moreover, individuals with anorexia nervosa endorsed more state-like

resistance than individuals with bulimia nervosa. In Study 4, whilst interviewees ranged from being in pre-contemplation through to action stage of change, those endorsing a higher stage of change described only being interested in changing some behaviours (e.g., purging) whilst were not interested in changing others (e.g., weight gain), low self-efficacy to recover and conflicting feelings about receiving treatment.

The results relating to trait like-resistance (problems in relationship formation, low expectation of benefit, somatisation of conflict, self-orientation/ narcissism, perceived lack of environmental support) were less straightforward. In Study 2, whilst individuals with eating disorders did not score higher compared to a mental health group on problems in relationship formation, their scores were considered high compared to a normative, college and clinical sample (Butcher, 2004). Study 4 clarified that individuals with eating disorders had some problems in relationship formation, as respondents discussed isolation, self-reclusion and, whilst being more related to maintenance of relationships, a willingness of some to end even therapeutic relationships that were even positively perceived by respondents. Thus, individuals with eating disorders endorsed trait-like resistance in the form of problems in relationship formation. Study 2 found that eating disordered individuals had low expectations of benefit. This finding was supported by Study 4 as respondents conveyed that they believed therapy was unlikely to help them recover from their illness, likely due to previous unsuccessful treatment, and that if treatment were successful this would be disappointing to them given the eating disorder was relied upon to “feel good” about self. Thus, trait-like resistance in the form of low expectation of benefit was present in individuals with eating disorders. Whilst Study 2 suggested eating disordered individuals perceived they did not have environmental support at similar levels to

individuals with anxiety and depression, the responses from Study 4 interviews suggested family and friends were important in supporting respondents to commence treatment and that *who* provided support was important. Thus, there is the possibility of trait-like resistance in the form of perceived lack of environmental support for some participants. As with Study 2, there was no evidence of somatisation of conflict amongst interviewees in Study 4. Overall, respondents demonstrated some aspects of trait-like resistance. Given the understanding that eating disordered individuals are treatment resistant (M. Cooper, 2005; Fassino & Abbate-Daga, 2013; Vitousek & Watson, 1998), it appears that a measure more specific to trait-like treatment resistance in eating disorders is required.

Vulnerable narcissism was typical amongst individuals with eating disorders, regardless of diagnosis. In Study 4, interviewees consistently and most closely identified with the excerpt which was a definition of vulnerable narcissism. Their responses confirmed the results of Study 2 which demonstrated that individuals with anorexia nervosa and bulimia nervosa reported elevated levels of vulnerable narcissism compared to control groups. These results indicate that vulnerable narcissism is important to be considered in the conceptualisation of anorexia nervosa and bulimia nervosa. This supports the self psychology understanding that eating disorders are disorders of self (Kohut, 1977), comprising vulnerable narcissism.

Whilst eating disorder participants did not endorse grandiose narcissism (as measured via the Narcissistic Personality Inventory measure) in Study 2, respondents in Study 4 identified with grandiose narcissism including envy, devaluing those that threaten self-esteem, sense of entitlement, requirement for excessive admiration. In Study 4, whilst not identifying with a lack of empathy, respondents provided a number

of examples which indicated that they lacked empathy and admitted that some of the behaviour could be perceived by others as lacking empathy. The discrepancies in results between Study 2 and Study 4 could be explained by the grandiose narcissism measure capturing a variety of components of grandiose narcissism, not just the components of grandiose narcissism identified by interviewees. Alternatively, in the interview study, grandiose narcissism was discussed in the context of eating disorders therefore respondents' identification with grandiose narcissism may have been through the lens of their eating disorder. With the identification of three factors of grandiose narcissism in Study 1, which were used in Study 2 to further examine grandiose narcissism in the eating disorder population, further clarification of the role of grandiose narcissism was provided.

Study 2 demonstrated that Factor 1 (authority and self-sufficiency) was not elevated, and was in fact below the general population levels, in individuals with eating disorders. Whilst this outcome reinforced research that eating disordered individuals were non-assertive and submissive (Bruch, 1973; Troop & Baker, 2008) and insecure (Perry et al., 2008), it did not support that eating disordered individuals demonstrated characteristics of authority, dominance and criticality (M. Campbell & Waller, 2010; Hartmann et al., 2010; Raskin & Terry, 1988; Riebel, 2000), and a primary characteristic of self-sufficiency, achievement need (Goldner et al., 2002; Gunnard et al., 2012; Stice, 2002). Study 4 assisted to clarify these findings as, rather than grouping authority and self-sufficiency together, these components of grandiose narcissism could be examined separately. Study 4 confirmed that individuals with either eating disorders lacked self-confidence, assertiveness, independence, leadership and authority, and were generally not self-sufficient (in terms of independence, self-confidence and

assertiveness). This clarification of results also minimises the possibility (as suggested in Study 2 discussion) that participants were sensitive to the ideas of authority and self-sufficiency when responding. However, Study 4 demonstrated that individuals with either eating disorder had a characteristic of self-sufficiency, that is, achievement need. Achievement need was not captured in Study 2 and appeared to mostly related to the eating disorder in Study 4 (although for many participants, it was present in other arenas of life prior to the eating disorder). The result of Study 4 that eating disordered individuals did in fact have an achievement need clarified the seemingly incongruent findings of Study 2 that eating disordered individuals were likely to be ambitious (entitlement, exhibitionism and exploitativeness, discussed next) but were not self-sufficient (see Chapter 12, Study 2); the current results show they were in fact achievement oriented (one aspect of self-sufficiency), complementing ambitiousness.

Study 2 demonstrated that both eating disorder groups scored above the general population on Factor 2 of grandiose narcissism (entitlement, exhibitionism and exploitativeness), but that only individuals with anorexia nervosa scored above the mental health control group on this factor. To clarify which of the three components of Factor 2 were identified with by eating disorder respondents, and whether the two eating disorder groups identified to different components accounting for why only the anorexia nervosa group scored above the mental health control group on this factor, the three components of Factor 2 entitlement, exhibitionism and exploitativeness were separated in Study 4. Respondents, regardless of diagnosis, identified with aspects of entitlement including ambitiousness, hostility and intolerance of others (i.e., consistent anger in unmet expectations) and insistence of how the world should be, anger about how they have suffered, and believing only they have been hurt and that they are

deserving of more than what is given them. Moreover, most respondents, including those with anorexia nervosa, perceived individuals with eating disorders as entitled. It is unsurprising that entitlement was evident in individuals with eating disorders given it is a shared characteristic of grandiose narcissism and vulnerable narcissism and all eating disordered individuals identified with vulnerable narcissism. Only individuals with bulimia nervosa, however, identified with aspects of exhibitionism including extraversion and recklessness. Bulimic individuals, however, did not identify with exhibitionism in terms of showing off. This latter finding was interesting as both anorexic and bulimic individuals' responses to other excerpts read in the interview study highlighted aspects of exhibitionism including the covert need for constant attention and admiration. It appeared respondents were not aware of, or did not want to admit awareness of, this aspect of self. Respondents identified with aspects of exploitativeness including inconsideration of others, nonconformity and rebelliousness; however, these aspects mostly emerged when discussing the eating disorder and treatment.

Surprisingly, Study 2 did not reveal superiority and vanity (Factor 3) in eating disorder individuals, which was inconsistent to previous research that revealed these individuals have an inflated sense of specialness due to eating disorder behaviours (e.g., restriction in anorexic individuals and purging of binge eating in bulimic individuals; Bruch, 1973, 1978; Curry & Ray, 2010; Faer et al., 2005; A. Lock et al., 2005; Riebel, 2000; Tobin, 1993) and that eating disordered individuals are frequently making comparisons to others and are aware of rank in relation to appearance (M. Campbell & Waller, 2010; Cardi et al., 2014; Fox et al., 2005; Riebel, 2000), but consistent with results, also found when examining Factor 1, that eating disordered individuals

generally have low self-confidence (Perry et al., 2008). To explain these unexpected results, it was suggested that superiority in eating disordered individuals is based only on the narcissistic behaviour which affirms themselves and provides them the perception of omnipotence. Lingering needs for admiration remain but can only be fulfilled by the narcissistic behaviour disorder (Goldberg, 1999; Kohut, 1977). This explanation was supported by the results of Study 4. Specifically, respondents identified with the excerpt relating to superiority and described having an inflated sense of specialness, flaunting achievement, making comparisons to others, being aware of rank in relation to appearance (they made frequent comparisons to others), and devaluing others that threatened self-esteem; however, these characteristics were typically related to their eating disorder. Thus, it can be suggested that the scores of superiority were not elevated in Study 2 because these individuals do not feel superior ubiquitously, but only in the context of the eating disorder behaviour. The conclusions were further supported by the finding that vanity was present in interviewees in Study 4 in the form of wanting approval from others and self-absorption due to the focus on the eating disorder behaviours. Moreover, interviewees described attention seeking and vanity as prevalent in the eating disorder population but that it was based on underlying feelings of insecurity.

The conclusions derived from the results support a self psychology perspective of eating disorders. In explaining disorders of self, such as eating disorders, Kohut (1977) identified problems with both vulnerable and grandiose narcissism. Across the components of grandiose narcissism, entitlement, exhibitionism (in individuals with bulimia nervosa), exploitativeness, superiority and vanity were characteristics of individuals with eating disorders, whilst authority and self-sufficiency (except for

achievement need) were not characteristic. Additionally, vulnerable narcissism was a notable characteristic of individuals with eating disorders. Moreover, the results demonstrated that for eating disordered individuals it was not enough to relate to others as selfobjects (e.g., attention did not promote a pervasive sense of superiority amongst eating disordered individuals); the self, rather needed the eating disorder to avoid narcissistic embarrassment (e.g., the shame of eliciting others to meet their needs) and to promote their own narcissistic pleasure (Ulman & Paul, 2006). Thus, food and its control acted as a restitutive system in which disordered eating behaviours, not people, were the vehicles for meeting selfobject and narcissistic needs (Kohut, 1977; S. Sands, 1989). The results also demonstrate that self psychology can be used to view eating disorders and treat eating disorders without the risk of pathologising or blaming the patient as narcissism is only present in relation to the eating disorder behaviours.

It is less clear whether narcissism predicts resistance in the eating disorder population. Study 2 was unable to determine whether vulnerable narcissism predicted state- or trait-like resistance and respondents in the interview phase were unclear whether vulnerable narcissism would facilitate or hinder recovery. Replication of study 2 analyses examining the predictive power of vulnerable narcissism in a larger population is required. Additionally, a longitudinal study measuring vulnerable narcissism and treatment engagement could illuminate these relationships. Whilst Study 2 was unable to determine whether grandiose narcissism predicted state- and trait-like resistance, in the anorexia nervosa group, entitlement, exhibitionism and exploitativeness, and superiority and vanity predicted trait-like resistance. In the bulimia nervosa group, authority and self-sufficiency predicted state-like resistance. Moreover, interviewees self-identified that characteristics of grandiose narcissism (i.e., entitlement,

exhibitionism, superiority, vanity) were barriers to treatment for both eating disorder diagnoses. As discussed in Chapter 11 (Study 2), rebelliousness and nonconformity (exploitativeness), hostility and intolerance of others (entitlement) are likely to extend into anorexic individuals' attitudes towards treatment and therapeutic relationship, generating resistance. Additionally, the anorexic individuals' need for attention and admiration may prevent engagement in treatment which is perceived as an assault on the eating disorder, the vehicle which meets these needs. Alternatively, the need for attention and admiration may be enacted in treatment such that the therapeutic environment is the place for attention. The interview phase highlighted that the assault on the eating disorder, which seemingly acted as selfobject substitute, contributed to resistance in both eating disorder populations. Moreover, it highlighted the need for a measure more specific to eating disordered individuals that assesses treatment-resistance.

Study 3, which examined narcissism and weight-related behaviours in therapists, revealed that eating disorder therapists had low levels of eating symptomatology, below levels found in the general population. Despite this, interviewees' from Study 4 identified disordered eating in their therapist. Although it is unclear whether recognised disordered eating in therapists was accounted for by respondents' attentiveness to eating and weight-related behaviours, the finding clearly advises clinicians be aware of perceptions of eating disorder clients. Some respondents also disclosed that they were aware that their therapist had a past eating disorder. However, influence of these disclosures on treatment was inconsistent, only negatively affecting half of respondents who had experienced these disclosures. Therapists are warned against self-disclosures given the unpredictable effects on clients. Vulnerable narcissism was elevated to the

same level as individuals with eating disorders and grandiose narcissism was elevated beyond the eating disorder population in eating disorder therapists. Yet interviewees did not perceive that eating disorder therapists had elevated levels of narcissism. This finding was despite the idealisation of therapists that was apparent amongst many respondents which could suggest therapists could act elitist. This was not examined explicitly and cannot be confirmed. Therapists are cautioned to resist colluding with the client's narcissism, rather recognise their own and client's emotions (Plakun, 2012). This will likely be challenging given therapists must also allow the client's narcissistic behaviour to emerge to accept the clients' need for self-preservation so they develop trust of therapist as a selfobject (Barth, 1988).

There are some interesting findings across studies. In both study 2 and study 3 the eating disorder clients scored significantly lower than the control participants on superiority and vanity, reflecting reliability of these results. In Study 3 in eating disorder therapists, vulnerable narcissism was not elevated above eating disordered individuals yet grandiose narcissism (including Factors 1 and 3) was. Whilst comparisons across studies are tentative, these results combined seem an interesting finding, supporting the notion of dynamic between therapist and client possibly influencing resistance possibly based on an unidentified factor. It is recommended that further research into narcissism in therapist, therapeutic relationship between eating disorder client and eating disorder therapist and outcomes is conducted. Of concern, Study 2 revealed that entitlement, exhibitionism and exploitativeness was elevated in eating disordered individuals compared to community sample. However, in Study 3 there was no difference between the eating disorder group and the control group on these factors in a different sample. The results of Study 4, which demonstrated that both eating disorder groups identified

with entitlement and exploitativeness and that individuals with bulimia nervosa identified with aspects of exhibitionism, supported the findings of Study 2. However, further research should replicate these findings.

14.3 Implications of the Current Research

Taken together, the findings of this program of research offer support to an alternative way of conceptualising and treating anorexia nervosa and bulimia nervosa, based on self psychology. The recommendation is made to tailor assessment and clinical intervention towards narcissism in the eating disorder population as it may assist in offsetting the poor prognosis of eating disorders. Self psychology explains narcissism well, using both vulnerable and grandiose component, and treats it successfully (Kohut, 1977). Therefore, as vulnerable narcissism and aspects of grandiose narcissism were identified in individuals with eating disorders, self psychology provides a promising framework for treating these disorders.

From a self psychology perspective, empathic immersion to understand the eating disordered client's narcissistic presentation may reduce the risk of treatment drop-out and resistance. At the core of the eating disordered clients' issues is an inability to meet narcissistic needs through any other means except relying on eating disorder behaviour. Moreover, the eating disorder identity compensates for the lack of a clear identity and sense of self (Bruch, 1981, 1982; Fairburn et al., 2003; Fassino & Abbate-Daga, 2013). Therefore, from a clinical standpoint, the understanding of the adaptive value of the eating disorder to the individual is crucial. Vehicles which meet narcissistic needs cannot be overcome or discarded without psychological detriment and the healthy mental state of matured narcissism would remain unavailable. The importance of including the self psychology understanding is clear; maladaptive

cognitions are seen as the cause of the presenting issues which can be discarded in preference for something more rational; however, self psychology not only identifies the maladaptive belief but recognises it is not to be discarded but understood and explained to allow the corrective development of narcissism that would otherwise been overlooked (Kohut, 1966).

Across studies there were a number of limitations which can be addressed in future studies. Firstly, each study lacked sampling diversity in gender, age and ethnicity. There was a significant gender imbalance with a predominantly female sample in each study; therefore, the results cannot be generalised to males. Additionally, the samples mostly included young adults. There was little cultural diversity with almost all participants identifying as being Caucasian. As the sample was limited in demographic diversity, future research could compare between different cultural groups. More systematic data collection by targeting males, older adults and other cultural groups rather than using a snowballing approach could be incorporated to ensure generalisability of results to other populations.

Secondly, Study 1 highlighted the inconsistencies of the NPI, measuring grandiose narcissism, in its validity and reliability. Strengthening the psychometric properties of the NPI in future research could be achieved by modifying it into a Likert scale response questionnaire and by employing other methods, such as Velicer's Minimum Average Partial test and confirmatory factor analysis. Then this more reliable and valid measure could be employed to confirm the results of Study 2 and Study 3.

Third, alternative research designs could be utilised. Although the cross-sectional nature of Study 2 and Study 3 allowed an initial examination of the relationship between narcissism, state- and trait-like resistance, and eating disorders, it

did not allow for the examination of changes over time in these relationships. Thus, a future study could examine possible fluctuations in the relationships between variables by adopting a longitudinal design and using multiple repeated measures. Further, Study 3 could incorporate matched pairs to determine whether a therapist with elevated narcissism influences treatment engagement and/ or resistance of their client.

Whilst a strict p value was used to control for Type I error due to the small sample sizes in Study 2 and Study 3, future research requires recruitment of larger sample sizes. Larger sample sizes would allow examination of the influence of other client variables such as level of care, exposure to treatment and length of diagnosis, and therapist variables such as personal history of therapy, severity of illness, length of time recovered and personal definitions of recovery, patterns of responding based on professional credentials and theoretical orientations, and the level of care therapists provide, which were not examined in this research. Alternative avenues of research could be followed by including others' perceptions of participants so that the subjective experiences of respondents can be compared for accuracy.

It is clear that further thought and consideration, beyond the scope of this thesis, is needed to meaningfully introduce self psychology into current clinical praxis to affect positive therapeutic outcomes. Thus, the concepts are discussed based on purely theoretical grounds. Testing of the integration of self psychology into the eating disorder population will determine the capacity to open up useful lines of future research into psychotherapeutic change. This thesis predominantly argues that narcissism provides additional information for the conceptualisation of anorexia nervosa and bulimia nervosa and initial results demonstrate this may influence engagement in treatment.

It is also acknowledged that basing treatment solely on narcissism and self psychology is potentially problematic due to the exclusion of directly addressing symptoms such as restrictive eating. It will be important for clinicians to identify narcissistic traits early on in the assessment process and to conduct the assessment with narcissistic development of the individual as a guiding framework, but to also address risk associated with eating disorders. Moreover, the support of self psychology is not to say that the gold standard treatments do not have their place in intervention. The techniques of cognitive behavioural therapy including psychoeducation about the impacts of restriction (i.e., binges and cyclical dieting, health complications and disruptions of reinforcing behaviours), and challenging unhelpful beliefs and selective abstract of meaning from subjective experience are warranted, even critical for those individuals at serious medical risk. Moreover, family therapy, the gold standard treatment for anorexia nervosa, offers valuable techniques for addressing entrenched relational problems among family members and is sensible when it dictates taking responsibly over an eating disordered individual's recovery when the individual cannot do this for themselves (J. Lock et al., 2001). It is also reiterated that the focus of narcissism in self psychology is not about patient-blaming, a concept previously raised when relating narcissism to mental health disorders (J. Lock et al., 2001; Roehrig & McLean, 2010). Whilst it can be argued from the results of the program of research that individuals with eating disorders engage in attention seeking behaviours related to their eating disorder and are motivated in part by narcissism (i.e., narcissistic needs) it is not argued that eating disordered individuals are responsible for their illness. Anorexia nervosa and bulimia nervosa are considered serious illnesses for which the individual is not responsible, however, the inclusion of narcissism in the conceptualisation of these

disorders provides understandings to overcome pervasive treatment resistance in this population.

The current research also highlights the need to develop assessment measures to better reflect narcissism and treatment resistance in eating disordered individuals. The measure of grandiose narcissism employed in his program of research, the Narcissistic Personality Inventory, presented particular challenges. Specifically, a three-factor solution of the NPI with sound internal consistencies was produced in Study 1, however one of the three factors failed to provide sound internal consistency in Study 2. This result further contributed to the problems of the factor structure of the scale identified in previous research (Corry et al., 2008; del Rosario & White, 2005; Emmons, 1984, 1987; Kubarych et al., 2004). When examining the seven established factors (which had not demonstrated reliable internal consistency yet provided important theoretical information about the components of grandiose narcissism) in the qualitative study, only entitlement, exhibitionism, exploitativeness (in the bulimia nervosa population), superiority and vanity were endorsed by respondents. To this end, a measure of narcissism specific to the eating disorder population that captures the aspects of narcissism as discovered in this research (i.e., vulnerable narcissism, entitlement, exhibitionism, exploitativeness, superiority, and vanity) which are specific to the eating disorder should be developed for ease of dissemination to clinicians in real-life service delivery. By appropriating the scales used in the current research program, including the vulnerable narcissism and grandiose narcissism scale, or by the development of a new narcissism measure that is tailored to the anorexic and bulimic population, narcissism in the eating disorder population can be assessed early on in treatment and reviewed over time. This assessment measure could also be used for early intervention. Additionally,

the results of the current research provided conflicting results regarding aspects of trait-like resistance such that Study 4 confirmed aspects of trait-like resistance (e.g., problems in relationship formation) which were not identified in eating disorder participants in Study 2. Whilst Perry (2009) highlights that state-like resistance measures and the BTPI or MMPI best capture treatment resistance, it is clear that a more accurate measure of treatment resistance is required for the eating disorder population. Given the likelihood that eating disorders are narcissistic behaviour disorders, based on the current research, and narcissistic behaviour disorders are difficult to treat, it appears that a measure specific to treatment resistance in the context of narcissistic behaviour disorders is required. Similar to the narcissism measure that could be created for specific use in the eating disorder population, a measure of treatment resistance specific to narcissistic behaviour disorders (i.e., eating disorders) could be employed to assess resistance early on in treatment and to review resistance over time.

Although the focus of this research was to explore a population currently diagnosed with either anorexia nervosa or bulimia nervosa, the implications of this research for prevention are worth noting. Fostering healthy and available selfobjects for a child's development is likely to assist prevention of eating disorders. Adequate attunement between the developing person and his or her selfobject is necessary for adequate development of sense of self and identity. Allowing infant mirroring and idealising selfobject experiences is important.

14.4 Conclusion

The current program of research was conceived as a way to extend the available body of knowledge about eating disorders, by exploring the role of narcissism within

the anorexia nervosa and bulimia nervosa population and the treatment providers of these eating disorders and developing a conceptual understanding for resistance in this population. The result of this research supported a self psychology understanding of eating disorders based on narcissism. Even if self psychology is not adopted by clinicians, treatment of narcissism as an adjunct or modification to existing treatments are required. Although weight restoration clearly is vital, it is also essential that individuals' psychological needs are addressed. The proposal is that best practice standards include narcissism into the conceptualisation of eating disorders.

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Appendices

Appendix A

DSM IV Diagnostic Criteria (APA, 1994) for Anorexia Nervosa

Diagnostic Criteria for 307.1 Anorexia Nervosa

- A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).
- B. Intense fear of gaining weight or becoming fat, even though underweight.
- C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
- D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., oestrogen, administration.)

Specify type:

Restricting Type: during the current episode of anorexia nervosa, the person has not regularly engaged in binge-eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

Binge-Eating/Purging Type: during the current episode of anorexia nervosa, the person has regularly engaged in binge-eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

Appendix B

DSM IV (APA, 1994) Diagnostic Criteria for Bulimia Nervosa

Diagnostic Criteria for 307.51 Bulimia Nervosa

- A. Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following:
 - (1) eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
 - (2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)
- B. Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.
- C. The binge eating and inappropriate compensatory behaviours both occur, on average, at least twice a week for 3 months.
- D. Self-evaluation is unduly influenced by body shape and weight.
- E. The disturbance does not occur exclusively during episodes of anorexia nervosa.

Specify type:

Purging Type: during the current episode of bulimia nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas

Nonpurging Type: during the current episode of bulimia nervosa, the person has used other inappropriate compensatory behaviours, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas

Appendix C

DSM 5 (APA, 2013) Diagnostic Criteria for Anorexia Nervosa

Diagnostic Criteria for 307.1 Anorexia Nervosa

- A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, developmental trajectory, and physical health. Significantly low weight is defined as weight that is less than minimally normal, or, for children and adolescents, less than minimally expected.
- B. Intense fear of gaining weight or becoming fat, or persistent behaviours that interfere with weight gain, even though at a significantly low weight.
- C. Disturbance in the way in which 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.

Specify type:

(F50.01) Restricting Type: During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.

(F50.02) Binge Eating/Purging Type: During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Specify current severity:

The minimum level of severity is based, for adults, on current body mass index (BMI) (see below) or, for children and adolescents, on BMI percentile. The ranges below are derived from World Health Organisation categories for thinness in adults; for children and adolescents, corresponding BMI percentiles should be used. The level of severity may be increased to reflect clinical symptoms, the degree of functional disability, and the need for supervision.

Mild: BMI $\geq 17\text{kg/m}^2$

Moderate: BMI 16-16.99 kg/m^2

Severe: BMI 15-15.99 kg/m^2

Extreme: BMI $<15\text{kg/m}^2$

Appendix D

DSM 5 (APA, 2013) Diagnostic Criteria for Bulimia Nervosa

Diagnostic Criteria for 307.51 Bulimia Nervosa

- A. Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following:
 - (1) eating in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat during a similar period of time and under similar circumstances.
 - (2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- B. Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.
- C. The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for 3 months.
- D. Self-evaluation is unduly influenced by body shape and weight.
- E. The disturbance does not occur exclusively during episodes of anorexia nervosa.

Specify current severity:

The minimum level of severity is based on the frequency of inappropriate compensatory behaviours (see below). The level of severity may be increased to reflect other symptoms and the degree of functional disability.

Mild: An average of 1-3 episodes of inappropriate compensatory behaviour per week.

Moderate: An average of 4-7 episodes of inappropriate compensatory behaviour per week.

Severe: An average of 8-13 episodes of inappropriate compensatory behaviour per week.

Extreme: An average of 14 or more episodes of inappropriate compensatory behaviour per week.

Appendix E

Study 1 Email Advertisement

Hello,

I am undertaking a research project on the topic of Treatment Engagement and Eating Disorders and would like to invite you to participate in this interesting study.

To participate in this research you must be over 18 years of age. To participate, please click the following link:

<https://www.surveymonkey.com/s/TreatmentEngagementEatingDisorders>

What will participants be required to do?

- Participants will complete an online, anonymous questionnaire that will take approximately 20 to 30 minutes

Who can participate?

- Participation is voluntary and you must be aged 18 years or above
- People with or without an Eating Disorder diagnosis may participate

Further information is provided in the Participant Information Letter which you will find on the first page of the survey when you follow the link above.

The project has been approved by the Australian Catholic University Human Research Ethics Committee (Registration Approval Number 2013 242Q).

Should you require any further information, please do not hesitate to contact the Chief Investigator Eric Marx at Eric.Marx@acu.edu.au

.au

Thank you.

Helen Bailey

HDR Student, Psychology

Brisbane campus ACU

Appendix F

Study 1 Questionnaire

NB: The questionnaire in this appendix has been removed from copy due to the measure being copyrighted.

Appendix G

Study 1 Ethics Approval



Human Research Ethics Committee
Committee Approval Form

Principal Investigator/Supervisor: Dr Carina Chan

Co-Investigators: N/A

Student Researcher: : Ms Helen Bailey

Ethics approval has been granted for the following project:

Study 1 Further exploration of barriers to treatment in the Eating Disorder population

for the period: 12/02/2014-31/12/2014

Human Research Ethics Committee (HREC) Register Number: 2013 242Q

Special Condition/s of Approval

Prior to commencement of your research, the following permissions are required to be submitted to the ACU HREC:

N/A

The following standard conditions as stipulated in the *National Statement on Ethical Conduct in Research Involving Humans* (2007) apply:

- (i) that Principal Investigators / Supervisors provide, on the form supplied by the Human Research Ethics Committee, annual reports on matters such as:
 - security of records
 - compliance with approved consent procedures and documentation
 - compliance with special conditions, and
- (ii) that researchers report to the HREC immediately any matter that might affect the ethical acceptability of the protocol, such as:
 - proposed changes to the protocol
 - unforeseen circumstances or events
 - adverse effects on participants

The HREC will conduct an audit each year of all projects deemed to be of more than low risk. There will also be random audits of a sample of projects considered to be of negligible risk and low risk on all campuses each year.

Within one month of the conclusion of the project, researchers are required to complete a *Final Report Form* and submit it to the local Research Services Officer.

If the project continues for more than one year, researchers are required to complete an *Annual Progress Report Form* and submit it to the local Research Services Officer within one month of the anniversary date of the ethics approval.

K. Pashley.

Signed: Date: 24/08/2015.....

(Research Services Officer, McAuley Campus)

Appendix H

Study 1 Online Participant Information Letter



PARTICIPANT INFORMATION LETTER

PROJECT TITLE: Treatment Engagement in Eating Disorders

PRINCIPAL SUPERVISOR: Dr. Eric Marx

STUDENT RESEARCHER: Helen Bailey

PROGRAMME IN WHICH ENROLLED: Master of Psychology (Clinical)/PhD

Dear Participant,

You are invited to participate in the research project described below.

What is the project about?

The research project investigates one particular barrier to receiving treatment for eating disorders. The aim of the study is to add valuable information to the field of psychology regarding personality and treatment resistance in eating disorders. This can then inform future research and practice regarding preventative measures and treatment planning that will reduce the likelihood of dropout and treatment noncompliance.

Who is undertaking the project?

This project is being conducted by Helen Bailey and will form the basis for the degree of Doctor of Philosophy (Psychology) at Australian Catholic University under the supervision of Dr Eric Marx.

Are there any risks associated with participating in this project?

There are no foreseeable risks involved with participation in this study. However, if you have concern about the topic in general or as a result of this study, it is encouraged that you seek information and advice from your General Practitioner or Lifeline: 13 11 14. Alternatively, ACU students can also access counsellors at Student Services, who are independent of this project.

What will I be asked to do?

Participation in this research will involve completion of an online questionnaire. This questionnaire contains some questions relating to general demographic information, and personal characteristics. This questionnaire is expected to take approximately 20-30 minutes to complete.

What are the benefits of the research project?

By participating in this research, you contribute to the existing pool of knowledge of Eating Disorders and Personality. Australian Catholic University psychology students will be eligible for course credit.

Can I withdraw from the study?

Participation in this research study is voluntary. You will be free to withdraw at any stage of completing the questionnaire without giving any reason. However, it is not possible to discontinue participation in the study once the questionnaire has been submitted. Refusal or withdrawal will not result in any disadvantage for you.

Will anyone else know the results of the project?

The researchers will take every precaution to ensure confidentiality. No identifying information will be obtained. Individual participants will not be identified in any future presentation of the results; only group results will be reported. The group results will be reported in a thesis that may be published or may be provided to other researchers in a form that does not identify participants.

Will I be able to find out the results of the project?

Participants can email tb0096872@myacu.edu.au to request a copy of the results. Upon the completion of the study (expected November 2014), these participants may request a summary of the results found in the study.

Who do I contact if I have questions about the project?

Any questions regarding this project, before or after participating, should be directed to the Staff Supervisor, Doctor Eric Marx on 07 3623 7436 in the school of Psychology, McAuley Campus at the Australian Catholic University, 1100 Nudgee Road, Banyo Qld 4014. Before commencing, you will have the opportunity to ask any questions about the project. You will also have the opportunity to discuss your participation and the project in general after completing the questionnaire.

What if I have a complaint or any concerns?

This research has been reviewed by The Human Research Ethics Committee at Australian Catholic University. In the event that you have any complaint or concern about the way you have been treated during the study, or if you have any query that the Supervisor and Student Researcher have not been able to satisfy, you may write to:

Manager, Ethics
c/o Office of the Deputy Vice Chancellor (Research)
Australian Catholic University

North Sydney Campus
PO BOX 968,
NORTH SYDNEY, NSW 2059
Ph: 02 9739 2519
Fax: 02 9739 2870
Email: res.ethics@acu.edu.au

Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

I want to participate! How do I sign up?

Continuing to the next page of this survey indicates that you have read the information letter and consent to participate in the study. Following this is the start of the questionnaire.

Your support for the research project will be much appreciated.

Helen Bailey
Student Researcher

Dr. Eric Marx
Staff Supervisor

Appendix I

Study 2 Email Advertisements

Hello,

I am undertaking a research project on the topic of Treatment Engagement and Eating Disorders and would like to invite you to participate in this interesting study.

To participate in this research you must be over 18 years of age. To participate, please click the following link:

https://acu.qualtrics.com/SE/?SID=SV_e2KWBNOVjFx0P1H

What will participants be required to do?

- Participants will complete an online, anonymous questionnaire that will take approximately 30 to 60 minutes

Who can participate?

- Participation is voluntary and you must be aged 18 years or above
- People with or without an Eating Disorder diagnosis may participate

Further information is provided in the attachment in the Participant Information Letter which you will find on the first page of the survey.

The project has been approved by the Australian Catholic University Human Research Ethics Committee (Registration Approval Number 2015 297H).

Should you require any further information, please do not hesitate to contact the Chief Investigator Dr Carina Chan at Carina.Chan@acu.edu.au

.au

Thank you.

Helen Bailey

HDR Student, Psychology

Brisbane campus ACU

Appendix J

Hard Copy Advertisement for Private Practices

Participation Invited! Treatment Engagement

My name is Helen Bailey. I am currently completing my PhD in Psychology at the Australian Catholic University in Brisbane. My research is examining barriers to receiving treatment of **eating, anxiety and depressive disorders**. I am looking for volunteers at least 18 years of age to participate.

What will participants be required to do?

- Participants will complete a hardcopy (or online), anonymous questionnaire that will take approximately 30 to 60 minutes to complete

Who can participate?

- Participation is voluntary and you must be aged 18 years or above
- Participants with an **eating disorder, anxiety disorder** and/or **depression** as diagnosed by a qualified mental health professional

For further information and to participate in this research, please access the following https://acu.qualtrics.com/SE/?SID=SV_e2KWBN0VjFx0P1H or request a hard copy from reception. Alternatively email helen.bailey@myacu.edu.au

The project has been approved by the Australian Catholic University Human Research Ethics Committee (Registration Approval Number 2015 297H).

Should you require any further information, please do not hesitate to contact the Chief Investigator Dr Carina Chan at Carina.Chan@acu.edu.au
.au

Thank you.
Helen Bailey
HDR Student, Psychology
Brisbane campus ACU

Appendix K

Study 2 Questionnaire

NB: The questionnaire in this appendix has been removed from copy due to the measures being copyrighted.

Appendix L

Study 2 Ethics Approval



Human Research Ethics Committee
Committee Approval Form

Principal Investigator/Supervisor: Dr Carina Chan

Co-Investigators: Dr Cathryne Lang

Student Researcher: : Helen Bailey

Ethics approval has been granted for the following project:

Study 1 Part B: exploration of the barriers to treatment in the eating disorder population

for the period: 30/12/2016

Human Research Ethics Committee (HREC) Register Number: 2015-297H

Special Condition/s of Approval

Prior to commencement of your research, the following permissions are required to be submitted to the ACU HREC:

The data collection of your project has received ethical clearance but the decision and authority to commence may be dependent on factors beyond the remit of the ethics review process and approval is subject to ratification at the next available Committee meeting. The Chief Investigator is responsible for ensuring that outstanding permission letters are obtained, interview/survey questions, if relevant, and a copy forwarded to ACU HREC before any data collection can occur. Failure to provide outstanding documents to the ACU HREC before data collection commences is in breach of the National Statement on Ethical Conduct in Human Research and the Australian Code for the Responsible Conduct of Research. Further, this approval is only valid as long as approved procedures are followed.

Clinical Trials: You are required to register it in a publicly accessible trials registry prior to enrolment of the first participant (e.g. Australian New Zealand Clinical Trials Registry <http://www.anzctr.org.au/>) as a condition of ethics approval.

It is the Principal Investigators / Supervisors responsibility to ensure that:

1. All serious and unexpected adverse events should be reported to the HREC with 72 hours.
2. Any changes to the protocol must be reviewed by the HREC by submitting a Modification/Change to Protocol Form prior to the research commencing or continuing. <http://research.acu.edu.au/researcher-support/integrity-and-ethics/>
3. Progress reports are to be submitted on an annual basis. <http://research.acu.edu.au/researcher-support/integrity-and-ethics/>
4. All research participants are to be provided with a Participant Information Letter and consent form, unless otherwise agreed by the Committee.
5. Protocols can be extended for a maximum of five (5) years after which a new application must be submitted. (The five year limit on renewal of approvals allows the Committee to fully re-review research in an environment where legislation, guidelines and requirements are continually changing, for example, new child protection and privacy laws).

Researchers must immediately report to HREC any matter that might affect the ethical acceptability of the protocol eg: changes to protocols or unforeseen circumstances or adverse effects on participants.

K. Pashley

Signed:

..... Date: 22/07/2016.....

Appendix M

Study 2 Participant Information Letter Electronic Copy



PARTICIPANT INFORMATION LETTER

PROJECT TITLE: Treatment Engagement in Eating Disorders

PRINCIPAL SUPERVISOR: Dr. Carina Chan

SECONDARY SUPERVISOR: Dr. Cathryne Lang

STUDENT RESEARCHER: Helen Bailey

PROGRAMME IN WHICH ENROLLED: Master of Psychology (Clinical)/PhD

Dear Participant,

You are invited to participate in the research project described below.

What is the project about?

The research project investigates particular barriers to receiving treatment for eating disorders. The aim of the study is to add valuable information to the field of psychology regarding treatment resistance in eating disorders. This can then inform future research and practice regarding preventative measures and treatment planning that will reduce the likelihood of dropout and treatment noncompliance.

Who is undertaking the project?

This project is being conducted by Helen Bailey and will form the basis for the degree of Doctor of Philosophy (Psychology) at Australian Catholic University under the supervision of Dr Carina Chan and Dr Cathryne Lang. Helen Bailey is a psychologist and treats individuals with eating disorders. She has previously conducted research examining treatment engagement in eating disorders. Dr Chan has conducted research on disordered eating and Dr Lang has conducted research projects related to psychosocial factors and health.

Are there any risks associated with participating in this project?

There are no foreseeable risks involved with participation in this study. However, if you have concern about the topic in general or as a result of this study, it is encouraged

that you seek information and advice from your General Practitioner or Lifeline: 13 11 14. Alternatively, ACU students can also access counsellors at Student Services, who are independent of this project.

What will I be asked to do?

Participation in this research will involve completion of an online questionnaire. This questionnaire contains some questions relating to general demographic information, eating behaviours and attitudes, and personal characteristics. This questionnaire is expected to take approximately 30-60 minutes to complete. At the end of the questionnaire you are invited to provide a contact telephone number if you consent to be contacted at a later date to engage in a telephone interview.

What are the benefits of the research project?

By participating in this research, you contribute to the existing pool of knowledge of Eating Disorders. Australian Catholic University psychology students will be eligible for course credit.

Can I withdraw from the study?

Participation in this research study is voluntary. You will be free to withdraw at any stage of completing the questionnaire without giving any reason. However, it is not possible to discontinue participation in the study once the questionnaire has been submitted. Additionally, the data collected prior to withdrawal may be included in this research's analyses. Refusal or withdrawal will not result in any disadvantage for you.

Will anyone else know the results of the project?

The researchers will take every precaution to ensure confidentiality. No identifying information will be obtained. Individual participants will not be identified in any future presentation of the results; only group results will be reported. The group results will be reported in a thesis that may be published or may be provided to other researchers in a form that does not identify participants.

Will I be able to find out the results of the project?

Participants can email tb0096872@myacu.edu.au to request a copy of the results. Upon the completion of the study, these participants may request a summary of the results found in the study.

Who do I contact if I have questions about the project?

Any questions regarding this project, before or after participating, should be directed to the Staff Supervisor, Dr Carina Chan on 07 3623 7436 in the school of Psychology, McAuley Campus at the Australian Catholic University, 1100 Nudgee Road, Banyo Qld 4014.

What if I have a complaint or any concerns?

This research has been reviewed by The Human Research Ethics Committee at Australian Catholic University. In the event that you have any complaint or concern

about the way you have been treated during the study, or if you have any query that the Supervisor and Student Researcher have not been able to satisfy, you may write to:

Manager, Ethics
c/o Office of the Deputy Vice Chancellor (Research)
Australian Catholic University
North Sydney Campus
Po Box 968
NORTH SYDNEY, NSW 2059
Ph: 02 9739 2519
Fax: 02 9739 2870
Email: res.ethics@acu.edu.au

Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

I want to participate! How do I sign up?

All you need to do is to continue to the questionnaire. Continuing to the next page of this survey indicates that you have read the information letter and consent to participate in the study. Following this is the start of the questionnaire.

Your support for the research project will be much appreciated.

Helen Bailey
Student Researcher

Dr. Carina Chan
Staff Supervisor

Study 2 Participant Information Letter Hard Copy



PARTICIPANT INFORMATION LETTER

PROJECT TITLE: Treatment Engagement in Eating Disorders

PRINCIPAL SUPERVISOR: Dr. Carina Chan

SECONDARY SUPERVISOR: Dr. Cathryne Lang

STUDENT RESEARCHER: Helen Bailey

PROGRAMME IN WHICH ENROLLED: Master of Psychology (Clinical)/PhD

Dear Participant,

You are invited to participate in the research project described below.

What is the project about?

The research project investigates particular barriers to receiving treatment for eating disorders. The aim of the study is to add valuable information to the field of psychology regarding treatment resistance in eating disorders. This can then inform future research and practice regarding preventative measures and treatment planning that will reduce the likelihood of dropout and treatment noncompliance.

Who is undertaking the project?

This project is being conducted by Helen Bailey and will form the basis for the degree of Doctor of Philosophy (Psychology) at Australian Catholic University under the supervision of Doctor Carina Chan and Doctor Cathryne Lang.

Are there any risks associated with participating in this project?

There are no foreseeable risks involved with participation in this study. However, if you have concern about the topic in general or as a result of this study, it is encouraged that you seek information and advice from your General Practitioner or Lifeline: 13 11 14. Alternatively, students can also access counsellors at Student Services, who are independent of this project.

What will I be asked to do?

Participation in this research will involve completion of a questionnaire. This questionnaire contains some questions relating to general demographic information, eating behaviours and attitudes, and personal characteristics. This questionnaire is expected to take approximately 30-60 minutes to complete.

If you would prefer to complete the questionnaire online, you can go to the URL INSERT HERE. A copy of this information letter will be on the first web page. By continuing to the next page of the survey this will indicate you have read the information letter and consent to participate in the study. Following this is the start of the questionnaire.

What are the benefits of the research project?

By participating in this research, you contribute to the existing pool of knowledge of Eating Disorders. Australian Catholic University psychology students will be eligible for course credit.

Can I withdraw from the study?

Participation in this research study is voluntary. You will be free to withdraw at any stage of completing the questionnaire without giving any reason. However, it is not possible to discontinue participation in the study once the questionnaire has been returned. Refusal or withdrawal will not result in any disadvantage for you.

Will anyone else know the results of the project?

The researchers will take every precaution to ensure confidentiality. No identifying information will be obtained. Individual participants will not be identified in any future presentation of the results; only group results will be reported. The group results will be reported in a thesis that may be published or may be provided to other researchers in a form that does not identify participants.

Will I be able to find out the results of the project?

Participants can email tb0096872@myacu.edu.au to request a copy of the results. Upon the completion of the study, these participants may request a summary of the results found in the study.

Who do I contact if I have questions about the project?

Any questions regarding this project, before or after participating, should be directed to the Staff Supervisor, Doctor Carina Chan on 07 3623 7891 in the school of Psychology, McAuley Campus at the Australian Catholic University, 1100 Nudgee Road, Banyo Qld 4014. Before commencing, you will have the opportunity to ask any questions about the project. You will also have the opportunity to discuss your participation and the project in general after completing the questionnaire.

What if I have a complaint or any concerns?

This research has been reviewed by The Human Research Ethics Committee at Australian Catholic University. In the event that you have any complaint or concern

about the way you have been treated during the study, or if you have any query that the Supervisor and Student Researcher have not been able to satisfy, you may write to:

Manager, Ethics
c/o Office of the Deputy Vice Chancellor (Research)
Australian Catholic University
North Sydney Campus

Po Box 968
NORTH SYDNEY, NSW 2059
Ph: 02 9739 2519
Fax: 02 9739 2870
Email: res.ethics@acu.edu.au

Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

I want to participate! How do I sign up?

All you need to do is sign the two consent forms on the following page (one for you to keep and one for the researchers to keep) stating that you have read and understood the information letter and consent to participate in the study. Following this is the questionnaire.

Your support for the research project will be much appreciated.

Helen Bailey
Student Researcher

Dr. Carina Chan
Staff Supervisor

Appendix N

Study 2 Nonparametric Tests

A nonparametric Kruskal-Wallis test compared groups (anorexia nervosa, bulimia nervosa, mental health control, healthy control) on eating disorder symptomatology. Results confirmed the parametric analysis results, indicating that there was a significant difference between groups ($\chi^2(3, N = 144) = 67.75, p < .01$). A series of Mann-Whitney tests indicated that the mental health control group scored significantly lower than both the anorexia nervosa group ($U = 127.00, p < .01$) and the bulimia nervosa group ($U = 123.00, p < .01$), and the healthy control group scored significantly lower than both the anorexia nervosa group ($U = 149.50, p < .01$) and the bulimia nervosa group ($U = 135.50, p < .01$) on eating disorder symptomatology. However, there was no difference between the eating disorder groups ($U = 590.50, p = .99$) or between the mental health control and healthy control groups ($U = 611.00, p = .45$) on eating disorder symptomatology ($F(3, 140) = 41.98, p < .01$).

A nonparametric Kruskal-Wallis test compared groups (anorexia nervosa, bulimia nervosa, mental health control, healthy control) on Factor 3 of grandiose narcissism (vanity and superiority). Results confirmed the parametric analysis results, indicating that there was no significant difference between groups ($\chi^2(3, N = 174) = .47, p = .93$). A nonparametric Kruskal-Wallis test compared groups (anorexia nervosa, bulimia nervosa, mental health control) on BTPI-REL and confirmed the results of the parametric analysis. Results indicated that there was no significant difference between groups ($\chi^2(2, N = 113) = .99, p = .61$). A nonparametric Kruskal-Wallis test compared groups (anorexia nervosa, bulimia nervosa, mental health control) on BTPI-SOM and confirmed the results of the parametric analysis. Results indicated that there was a significant difference between groups ($\chi^2(2, N = 117) = 14.95, p < .01$). A series of

Mann-Whitney tests indicated the score for the mental health control group was significantly higher than the anorexia nervosa group ($U = 356.50, p < .01$) and the bulimia nervosa group ($U = 502.50, p < .01$) on BTPI-SOM, however there was no difference between the eating disorder groups ($U = 669.50, p = .38$). A nonparametric Kruskal-Wallis test compared groups (anorexia nervosa, bulimia nervosa, mental health control) on BTPI-NAR. Results indicated that there was no significant difference between groups ($\chi^2(2, N = 118) = 5.48, p = .07$). This result differed from the parametric analysis therefore results are interpreted with caution.

Appendix O

Study 2 Welch F Test

A one-way ANOVA was conducted to compare eating disorder symptomatology in the four groups of participants (anorexia nervosa, bulimia nervosa, mental health control and healthy control). Results indicated that the anorexia nervosa group ($M = 49.75$, $SD = 15.71$) and bulimia nervosa group ($M = 49.30$, $SD = 10.73$) both scored significantly higher than the mental health control group ($M = 23.74$, $SD = 16.06$) and the health control group ($M = 21.07$, $SD = 15.60$), however there were no significant difference between the eating disorder groups and between the mental health control and healthy control groups on eating disorder symptomatology (*Welch's F* (3, 73.37) = 41.98, $p < .01$).

One-way ANOVAs were conducted to compare trait-like resistance in the three groups of participants (anorexia nervosa, bulimia nervosa, mental health control). Results indicated that there was no significant difference between the anorexia nervosa group ($M = 7.97$, $SD = 3.32$), bulimia nervosa group ($M = 7.10$, $SD = 4.16$), and the mental health control group ($M = 7.17$, $SD = 2.81$) on problems in relationship formation (*Welch's F* (2, 73.05) = .71, $p = .50$). Results indicated that the mental health control group ($M = 7.10$, $SD = 3.42$) scored significantly higher than the anorexia nervosa group ($M = 4.61$, $SD = 2.60$) and the bulimia nervosa group ($M = 4.90$, $SD = 4.15$) on somatisation of conflict (*Welch's F* (2, 75.21) = 5.89, $p < .05$), however there was no difference between the eating disorder groups. Results indicated that the mental health control group ($M = 9.97$, $SD = 2.97$) scored significantly lower than the anorexia nervosa group ($M = 14.00$, $SD = 4.02$) and the bulimia nervosa group ($M = 12.60$, $SD = 5.17$) on expectation of benefit, however there was no difference between the eating

disorder groups ($F(2, 73.85) = 8.88, p < .01$). Results indicated that the anorexia nervosa group ($M = 6.78, SD = 1.94$) and the mental health control group ($M = 6.57, SD = 3.34$) both scored significantly higher than the bulimia nervosa group ($M = 4.93, SD = 2.78$) however there was no significant difference between the anorexia nervosa and mental health groups on perceived lack of environmental support ($F(2, 74.83) = 5.39, p < .05$). Results indicated that the mental health control group ($M = 6.90, SD = 3.63$) scored significantly lower than the anorexia nervosa group ($M = 9.72, SD = 4.98$) however there were no differences between these groups and the bulimia nervosa group ($M = 8.69, SD = 5.43$) on self-orientation/narcissism ($F(2, 73.28) = 3.47, p < .05$).

Appendix P

Study 3 Email Advertisement

Hello,

I am undertaking a research project on the topic of Treatment Engagement and Eating Disorders in relation to treatment providers. I would like to invite you to participate in this interesting study.

To participate in this research you must be over 18 years of age. To participate, please click the following link:

<https://www.surveymonkey.com/s/TreatmentEngagementEatingDisordersTreatmentProviderPerspective>

What will participants be required to do?

- Participants will complete an online, anonymous questionnaire that will take approximately 20 minutes

Who can participate?

- Healthcare professionals
- Participation is voluntary and you must be aged 18 years or above
- You do not have to primarily treat individuals with eating disorders to participate in this research

Further information is provided in the Participant Information Letter at the start of the survey.

The project has been reviewed by the Australian Catholic University Human Research Ethics Committee (Registration Approval Number 2013 266Q).

Should you require any further information, please do not hesitate to contact the Chief Investigator Eric Marx at Eric.Marx@acu.edu.au

Thank you.

Helen Bailey

HDR Student, Psychology

Brisbane campus ACU

To Organisation Staff who Permitted Participation

Hello,

Thank you again for allowing staff at your organisation to participate in this research. As previously discussed, I would appreciate it if you could please forward this email onto your colleagues.

I am undertaking a research project on the topic of Treatment Engagement and Eating Disorders in relation to treatment providers. I would like to invite you to participate in this interesting study.

To participate in this research you must be over 18 years of age. To participate, please click the following link:

<https://www.surveymonkey.com/s/TreatmentEngagementEatingDisordersTreatmentProviderPerspective>

What will participants be required to do?

- Participants will complete an online, anonymous questionnaire that will take approximately 20 minutes

Who can participate?

- Healthcare professionals
- Participation is voluntary and you must be aged 18 years or above
- You do not have to primarily treat individuals with eating disorders to participate in this research

Further information is provided in the Participant Information Letter at the start of the survey.

The project has been reviewed by the Australian Catholic University Human Research Ethics Committee (Registration Approval Number 2013 266Q).

Should you require any further information, please do not hesitate to contact the Chief Investigator Eric Marx at Eric.Marx@acu.edu.au

Thank you.

Helen Bailey

HDR Student, Psychology

Brisbane campus ACU

Appendix Q

Study 3 Questionnaire

NB: The questionnaire in this appendix has been removed from copy due to the measures being copyrighted.

Appendix R

Study 3 Ethics Approval



Human Research Ethics Committee
Committee Approval Form

Principal Investigator/Supervisor: Dr Eric Marx

Co-Investigators:

Student Researcher: : Ms Helen Bailey

Ethics approval has been granted for the following project:

Study 3 Further exploration of barriers to treatment in the Eating Disorder population (Treatment engagement in Eating Disorders)

for the period: 25/03/2014-31/12/2014

Human Research Ethics Committee (HREC) Register Number: 2013 273Q

Special Condition/s of Approval

Prior to commencement of your research, the following permissions are required to be submitted to the ACU HREC:

Eating disorder services

The following standard conditions as stipulated in the *National Statement on Ethical Conduct in Research Involving Humans (2007)* apply:

- (i) that Principal Investigators / Supervisors provide, on the form supplied by the Human Research Ethics Committee, annual reports on matters such as:
 - security of records
 - compliance with approved consent procedures and documentation
 - compliance with special conditions, and
- (ii) that researchers report to the HREC immediately any matter that might affect the ethical acceptability of the protocol, such as:
 - proposed changes to the protocol
 - unforeseen circumstances or events
 - adverse effects on participants

The HREC will conduct an audit each year of all projects deemed to be of more than low risk. There will also be random audits of a sample of projects considered to be of negligible risk and low risk on all campuses each year.

Within one month of the conclusion of the project, researchers are required to complete a *Final Report Form* and submit it to the local Research Services Officer.

If the project continues for more than one year, researchers are required to complete an *Annual Progress Report Form* and submit it to the local Research Services Officer within one month of the anniversary date of the ethics approval.

Signed: Date: 27/03/2014.....
 (Research Services Officer, McAuley Campus)

Appendix S

Study 3 Participant Information Letter



PARTICIPANT INFORMATION LETTER

PROJECT TITLE: Treatment Engagement in Eating Disorders

PRINCIPAL SUPERVISOR: Dr. Eric Marx

STUDENT RESEARCHER: Helen Bailey

PROGRAMME IN WHICH ENROLLED: Master of Psychology (Clinical)/PhD

Dear Participant,

You are invited to participate in the research project described below.

What is the project about?

The research project investigates therapist factors that may contribute to treatment resistance found in eating disorders. This can then inform future research and practice regarding ways to support therapists, thus reducing the likelihood of dropout and treatment noncompliance by eating disordered individuals.

Who is undertaking the project?

This project is being conducted by Helen Bailey and will form the basis for the degree of Doctor of Philosophy (Psychology) at Australian Catholic University under the supervision of Dr Eric Marx.

Are there any risks associated with participating in this project?

There are no foreseeable risks involved with participation in this study. However, if you have concern about the topic in general or as a result of this study, it is encouraged that you seek information and advice from your General Practitioner or Lifeline: 13 11 14. Alternatively, ACU students can also access counsellors at Student Services, who are independent of this project.

What will I be asked to do?

Participation in this research will involve completion of an online questionnaire. This questionnaire contains some questions relating to general demographic information,

eating behaviours and attitudes, and personal characteristics. This questionnaire is expected to take approximately 20 minutes to complete.

What are the benefits of the research project?

By participating in this research, you contribute to the existing pool of knowledge of Eating Disorders.

Can I withdraw from the study?

Participation in this research study is voluntary. You will be free to withdraw at any stage of completing the questionnaire without giving any reason. However, it is not possible to discontinue participation in the study once the questionnaire has been submitted. This is because surveys are anonymous therefore researchers are unable to identify the survey that would require deleting once it is submitted. Refusal or withdrawal will not result in any disadvantage for you.

Will anyone else know the results of the project?

The researchers will take every precaution to ensure confidentiality. No identifying information will be obtained. Individual participants will not be identified in any future presentation of the results; only group results will be reported. The group results will be reported in a thesis that may be published or may be provided to other researchers in a form that does not identify participants.

Will I be able to find out the results of the project?

Participants can email tb0096872@myacu.edu.au to request a copy of the results. Upon the completion of the study (expected November 2014), these participants will be sent a summary of the results found in the study.

Who do I contact if I have questions about the project?

Any questions regarding this project, before or after participating, should be directed to the Staff Supervisor, Doctor Eric Marx on 07 3623 7436 in the school of Psychology, McAuley Campus at the Australian Catholic University, 1100 Nudgee Road, Banyo Qld 4014. Before commencing, you will have the opportunity to ask any questions about the project. You will also have the opportunity to discuss your participation and the project in general after completing the questionnaire.

What if I have a complaint or any concerns?

The Human Research Ethics Committee at Australian Catholic University has reviewed this study. In the event that you have any complaint or concern about the way you have been treated during the study, or if you have any query that the Supervisor and Student Researcher have not been able to satisfy, you may write to:

Manager, Ethics
c/o Office of the Deputy Vice Chancellor (Research)
Australian Catholic University
North Sydney Campus

Po Box 968
NORTH SYDNEY, NSW 2059
Ph: 02 9739 2519
Fax: 02 9739 2870
Email: res.ethics@acu.edu.au

Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

I want to participate! How do I sign up?

All you need to do is continue on to the next page of this survey. Continuing to the next page of this survey indicates that you have read the information letter and consent to participate in the study. Following this is the start of the questionnaire.

Your support for the research project will be much appreciated.

Helen Bailey
Student Researcher

Dr. Eric Marx
Staff Supervisor

Appendix T

Study 3 Nonparametric Tests

A nonparametric Kruskal-Wallis test compared groups (eating disorder treatment providers, non-eating disorder treatment providers, eating disorder, healthy control) on eating symptomatology. Results indicated that there was a significant difference between groups ($\chi^2(3, N = 955) = 85.37, p < .01$). A series of Mann-Whitney tests indicated that the control group scored significantly higher than the eating disorder therapists ($U = 7993.00, p < .01$) and non-eating disorder therapists ($U = 18485.50, p < .01$), however there was no significant difference between the therapist groups ($U = 908.00, p = .50$). Additionally, the client group scored significantly higher than the eating disorder therapist group ($U = 228.50, p < .01$), the non-eating disorder therapist group ($U = 675.00, p < .01$) and the control group ($U = 15847.00, p < .01$). These results confirmed the findings of the parametric analyses.

A nonparametric Kruskal-Wallis test compared groups (eating disorder treatment providers, non-eating disorder treatment providers, eating disorder, healthy control) on grandiose narcissism. Results indicated that there was a significant difference between groups ($\chi^2(3, N = 953) = 21.49, p < .01$). A series of Mann-Whitney tests indicated that the eating disorder therapists scored significantly higher than the non-eating disorder therapists ($U = 489.50, p < .01$), the control group ($U = 8370.50, p < .01$) and the eating disorder group ($U = 720.50, p < .01$). The eating disorder group did not score significantly differently from both the control ($U = 27438.50, p = .06$) and non-eating disorder therapist ($U = 2367.50, p = .56$) groups. However, different to the parametric results, the nonparametric results revealed that the control group scored significantly higher than the non-eating disorder therapists ($U = 19134.00, p < .01$).

A nonparametric Kruskal-Wallis test compared groups (eating disorder treatment providers, non-eating disorder treatment providers, eating disorder, healthy control) on Factor 1 of grandiose narcissism. Results indicated that there was a significant difference between groups ($\chi^2(3, N = 953) = 17.99, p < .01$). A series of Mann-Whitney tests indicated that the non-eating disorder therapists ($U = 560.00, p < .01$), the control group ($U = 9343.00, p < .05$) and the eating disorder group ($U = 751.00, p < .01$) scored significantly lower than the eating disorder therapists. Additionally, the eating disorder groups scored significantly lower than the control group ($U = 25350.50, p < .01$). However, there was no significant difference between the non-eating disorder therapist group and both the eating disorder ($U = 2275.50, p = .33$) and control groups ($U = 20968.00, p = .09$).

A nonparametric Kruskal-Wallis test compared groups (eating disorder treatment providers, non-eating disorder treatment providers, eating disorder, healthy control) on Factor 2 of grandiose narcissism. Results indicated that there was a significant difference between groups ($\chi^2(3, N = 953) = 18.13, p < .01$). A series of Mann-Whitney tests indicated that the eating disorder therapist group scored significantly higher than the non-eating disorder therapist group ($U = 529.50, p < .01$) and the control group ($U = 8598.50, p < .01$). However, there was no significant difference between the eating disorder therapist group and the eating disorder group ($U = 1017.00, p = .07$). Additionally, the non-eating disorder therapist group scored significantly lower than the eating disorder group ($U = 1795.00, p < .01$) and, unlike in the parametric tests, the control group ($U = 19645.50, p < .05$). There was no significant difference between the eating disorder group and the control group ($U = 28273.50, p = .12$).

A nonparametric Kruskal-Wallis test compared groups (eating disorder treatment providers, non-eating disorder treatment providers, eating disorder, healthy control) on Factor 3 of grandiose narcissism. Results indicated that there was a significant difference between groups ($\chi^2(3, N = 953) = 22.80, p < .01$). A series of Mann-Whitney tests indicated that the eating disorder group scored significantly lower than both the eating disorder therapist ($U = 760.50, p < .01$) and control ($U = 23002.00, p < .01$) groups. However, there was no significant difference between the non-eating disorder therapist group and the eating disorder group ($U = 2151.500, p = .13$), and the eating disorder therapist group and the control group ($U = 10478.50, p = .13$). In contrast to the parametric analysis, the nonparametric Mann-Whitney test indicated that the eating disorder therapist group scored significantly higher than the non-eating disorder therapist group ($U = 691.50, p < .05$), and that the control group scored significantly higher than the non-eating disorder therapist group ($U = 20422.50, p < .05$). This result which differed from the parametric analysis results were interpreted with caution.

Appendix U

Study 3 Welch F Test

Eating Symptomatology. A one-way ANOVA compared groups (eating disorder therapists, non-eating disorder therapists, eating disorder clients, control) on eating symptomatology. Results indicated that there was a significant difference between groups on eating symptomatology (*Welch's F* (3, 95.01) = 27.77, $p < .001$). Post hoc comparisons using the Games-Howell test indicated that the mean score for the control group ($M = 31.57$, $SD = 14.23$) was significantly higher than the eating disorder therapists ($M = 22.19$, $SD = 12.38$) and non-eating disorder therapists ($M = 25.02$, $SD = 13.34$) however there was no significant difference between the therapist groups. The mean score for the client group ($M = 42.17$, $SD = 9.05$) was significantly higher than all three other groups.

Vulnerable narcissism. A one-way ANOVA compared groups (eating disorder therapists, non-eating disorder therapists, eating disorder clients, control) on vulnerable narcissism. Results indicated that there was a significant difference between groups on vulnerable narcissism (*Welch's F* (3, 91.62) = 6.99, $p < .001$). Post hoc comparisons using the Games-Howell test indicated that there was no significant difference between eating disorder therapists ($M = 30.91$, $SD = 4.80$) and eating disorder clients ($M = 32.78$, $SD = 6.26$), eating disorder therapists and non-eating disorder therapists ($M = 29.81$, $SD = 6.73$), eating disorder therapists and the control group ($M = 29.63$, $SD = 5.91$), and non-eating disorder therapists and the control group. However, the eating disorder client group scored significantly higher than the non-eating disorder therapist group and the control group.

Grandiose narcissism. An independent groups ANOVA compared groups (eating disorder therapists, non-eating disorder therapists, eating disorder clients, control) on grandiose narcissism. Results indicated that there was a significant difference between groups on grandiose narcissism (*Welch's F* (3, 90.73) = 7.40, $p < .001$). Post hoc comparisons using the Games-Howell test indicated that the mean score for non-eating disorder therapists ($M = 9.98$, $SD = 5.95$), the control group mean score ($M = 12.01$, $SD = 6.34$) and the eating disorder group mean score ($M = 10.70$, $SD = 6.41$) were all significantly lower than the eating disorder therapists ($M = 15.97$, $SD = 6.96$). However, there was no significant difference between the other groups.

Factor 1. An independent groups ANOVA compared groups (eating disorder therapists, non-eating disorder therapists, eating disorder clients, control) on Factor 1, measuring authority and self-sufficiency. Results indicated that there was a significant difference between groups on Factor 1 (*Welch's F* (3, 91.02) = 6.01, $p < .001$). Post hoc comparisons using the Games-Howell test indicated that the mean score for non-eating disorder therapists ($M = 3.69$, $SD = 2.41$), the control group mean score ($M = 4.25$, $SD = 2.53$) and the eating disorder group mean score ($M = 3.40$, $SD = 2.72$) were all significantly lower than the eating disorder therapists ($M = 5.44$, $SD = 2.49$). Additionally, the eating disorder groups scored significantly higher than the control group. However, there was no significant difference between the other groups.

Factor 2. An independent groups ANOVA compared groups (eating disorder therapists, non-eating disorder therapists, eating disorder clients, control) on Factor 2 of grandiose narcissism, measuring entitlement, exhibitionism and exploitativeness. Results indicated that there was a significant difference between groups on Factor 2 (*Welch's F* (3, 89.93) = 7.26, $p < .001$). Post hoc comparisons using the Games-Howell

test indicated that the mean score for the eating disorder therapist group ($M = 5.03$, $SD = 3.37$) was significantly higher than the non-eating disorder therapist group ($M = 2.48$, $SD = 2.46$) and the control group ($M = 3.26$, $SD = 2.65$). However, there was no significant difference between the eating disorder therapist group and the eating disorder group ($M = 3.73$, $SD = 2.78$). Additionally, the non-eating disorder therapist group mean score was significantly lower than the eating disorder group. There was no significant difference between the control group and the eating disorder and non-eating disorder therapist groups.

Factor 3. An independent groups ANOVA compared groups (eating disorder therapists, non-eating disorder therapists, eating disorder clients, control) on Factor 3, measuring superiority and vanity. Results indicated that there was a significant difference between groups on Factor 3 (*Welch's F* (3, 91.51) = 5.41, $p < .001$). Post hoc comparisons using the Games-Howell test indicated that the mean score for eating disorder group ($M = 1.85$, $SD = 2.39$) was significantly lower than the eating disorder therapist group mean score ($M = 3.34$, $SD = 2.39$) and the control group mean score ($M = 2.75$, $SD = 2.42$) however there was no significant difference between the eating disorder group and the non-eating disorder therapists ($M = 2.15$, $SD = 2.22$). There was no significant difference between the eating disorder therapist group and non-eating disorder therapist group, and between and the control group and both therapist groups.

Appendix V

Study 4 Hard Copy Advertisement

Participation Invited! Treatment Engagement in Eating Disorders

My name is Helen Bailey. I am currently completing my PhD in Psychology at the Australian Catholic University in Brisbane. My research is examining barriers to receiving treatment of an Eating Disorder. I am looking for volunteers 18 years of age to participate.

What will participants be required to do?

- Participants will meet with me at a mutually convenient location to answer some questions in person
- Meeting will take approximately 60 to 90 minutes

Who can participate?

- Participation is voluntary and you must be aged 18 years or above
- Participants need to be people with Anorexia Nervosa or Bulimia Nervosa as diagnosed by a qualified mental health professional
- You can still participate in this study even if you are currently having treatment for an eating disorder

For further information and to participate in this research, please contact Helen Bailey in the Allied Health department on 3254 9188 or contact me on email at hjbail001@myacu.edu.au

The project has been approved by the Australian Catholic University Human Research Ethics Committee (Registration Approval Number *2013 266Q*).

Should you require any further information, please do not hesitate to contact the Chief Investigator Dr Carina Chan carina.chan@acu.edu.au.
.au

Thank you.
Helen Bailey
HDR Student, Psychology
Brisbane campus ACU

Appendix W

Study 4 Interview Questions

Treatment (willingness to engage and resistance to treatment provided).

What has been your treatment history (for your eating disorder)?

Cues. What is it like to be in inpatient treatment? What other treatment have you been engaged in apart from New Farm Clinic? What do you find helpful about treatment? What do you find unhelpful about treatment? Is there anything else you can tell me about your treatment that you feel I have not covered?

Therapist relationship. What are three words that best describe you? What are three words that best describe your current therapist? What are three words that your therapist would use to describe you? What role does your current therapist play in your recovery? Tell me more about your opinion of your current treating team. How do you relate to your current therapist on a personal level? How do you relate to your current therapist on a professional level? What do you find helpful about this therapist? What do you find unhelpful about this therapist?

I have some quotes that I would like to show you, and get your opinion about. (These quotes will also be provided in writing). This first one is an excerpt about therapists who treat people with an eating disorder.

People who treat individuals with eating disorders can show feelings of fatigue and helplessness, and may compare their own eating attitudes and body image. Therapists can be more forceful in providing treatment because of this.

What do you think about what I just read? (I may need to ask more questions when I say “what do you think about what I just read” such as “how do you feel when I

was reading it out?” “what thoughts came up for you when I read that?”). What impact does this have on your recovery, if any?

This one is an excerpt from a clinician about a client with an eating disorder.

One of my clients was beautiful and knew it. Sometimes when she was depressed, she would put on a bathing suit and sunbathe in the park so people would look at her. She talked once about being “Cinderella, a princess, I get admiration. I'm special, desirable. I can do anything”.

What do you think about what I just read? (I may need to ask more questions when I say “what do you think about what I just read” such as “how do you feel when I was reading it out?” “what thoughts came up for you when I read that?”, how do you relate your own eating disorder to this excerpt?). What impact does this have on your recovery, if any?

This one is an excerpt from a clinician about a client with an eating disorder.

This client had an appetite for the difficult, the impossible, or the heroic. For leading others and taking on tasks independently. The message from the client seemed to be, “If it can be done, I should be doing it”.

What do you think about what I just read? (I may need to ask more questions when I say “what do you think about what I just read” such as “how do you feel when I was reading it out?” “what thoughts came up for you when I read that?”, how do you relate your own eating disorder to this excerpt?). What impact does this have on your recovery, if any?

This one is an excerpt about working with clients with an eating disorder.

A person who has an overly dominant pattern of relating to others may demand so much from friends or family members that the person ends up isolated and alone when others pull away. Such rejection can lead to hostility towards others.

What do you think about what I just read? (I may need to ask more questions when I say “what do you think about what I just read” such as “how do you feel when I was reading it out?” “what thoughts came up for you when I read that?”, how do you relate your own eating disorder to this excerpt?). What impact does this have on your recovery, if any?

Some people with eating disorders say that they feel superior because of their eating disorder. Here is an example of what one client of a therapist stated,

I was so good at purging. I was the best. Friends of mine got exhausted after two times. I could do it nine or ten. I could always make the food come up...it was amazing what I could do.

What do you think about this idea? What do you think about what I just read? (I may need to ask more questions when I say “what do you think about what I just read” such as “how do you feel when I was reading it out?” “what thoughts came up for you when I read that?”, how do you relate your own eating disorder to this excerpt?). What impact does this have on your recovery, if any?

This one an excerpt from a clinicians work about working with a client with an eating disorder.

Of all my clients, it is the ones who parked in the reserved spots, put their shoes on the sofa, came to group screening sessions without a cheque book saying they did not know there would be a

fee, or did not return calls after missed sessions. The message seemed to be, “That rule doesn't apply to me”.

What do you think about what I just read? (I may need to ask more questions when I say “what do you think about what I just read” such as “how do you feel when I was reading it out?” “what thoughts came up for you when I read that?”, how do you relate your own eating disorder to this excerpt?). What impact does this have on your recovery, if any?

This is an excerpt regarding what some other researchers believe reflect eating disordered patients' characteristics.

Hypersensitivity to the opinions of others, insecure, having an intense desire for approval, and poor self-image. Presenting with shyness, constraint, and even the appearance of empathy.

However also wanting to be thought of as the best and have high expectations for themselves. Being mismatched in this way results in the experience of shame and depression. Individuals are unable to consistently maintain a grandiose sense of self and lack self-enhancement strategies to modify self-esteem, often relying upon external support. They can withdraw in an attempt to manage self-esteem.

What do you think about what I just read? (I may need to ask more questions when I say “what do you think about what I just read” such as “how do you feel when I was reading it out?” “what thoughts came up for you when I read that?”, how do you

relate your own eating disorder to this excerpt?). What impact does this have on your recovery, if any?

This is an excerpt regarding what some individuals with eating disorders hear about themselves, whether they believe it or not.

These individuals can have a belief that one is “special”, denial of weaknesses, a requirement for excessive admiration, a sense of entitlement, a lack of empathy, a tendency to envy others and a belief that one is envied, and the display of what could be perceived as arrogant behaviour, consistent anger in unmet expectations, devaluation of people that threaten self-esteem.

What do you think about what I just read? (I may need to ask more questions when I say “what do you think about what I just read” such as “how do you feel when I was reading it out?” “what thoughts came up for you when I read that?”, how do you relate your own eating disorder to this excerpt?). What impact does this have on your recovery, if any?

Prompts

If they say they don't identify it say if I asked someone else what would they say? What would your therapist say?

Appendix X

Study 4 Ethics Approval



Human Research Ethics Committee Committee Approval Form

Principal Investigator/Supervisor: Dr Eric Marx

Co-Investigators:

Student Researcher: : Ms Helen Bailey

Ethics approval has been granted for the following project:
Study 2 Further exploration of barriers to treatment in the Eating Disorder population (Treatment engagement in Eating Disorders)

for the period: 25/03/2014-31/10/2014

Human Research Ethics Committee (HREC) Register Number: 2013 266Q

Special Condition/s of Approval

Prior to commencement of your research, the following permissions are required to be submitted to the ACU HREC:

Eating disorder services

The following standard conditions as stipulated in the *National Statement on Ethical Conduct in Research Involving Humans* (2007) apply:

- (i) that Principal Investigators / Supervisors provide, on the form supplied by the Human Research Ethics Committee, annual reports on matters such as:
 - security of records
 - compliance with approved consent procedures and documentation
 - compliance with special conditions, and
- (ii) that researchers report to the HREC immediately any matter that might affect the ethical acceptability of the protocol, such as:
 - proposed changes to the protocol
 - unforeseen circumstances or events
 - adverse effects on participants

The HREC will conduct an audit each year of all projects deemed to be of more than low risk. There will also be random audits of a sample of projects considered to be of negligible risk and low risk on all campuses each year.

Within one month of the conclusion of the project, researchers are required to complete a *Final Report Form* and submit it to the local Research Services Officer.

If the project continues for more than one year, researchers are required to complete an *Annual Progress Report Form* and submit it to the local Research Services Officer within one month of the anniversary date of the ethics approval.

K. Pashley

Signed: Date: 27/03/2014.....
(Research Services Officer, McAuley Campus)

2013 266Q Extension approved

MK Ms Kylie Pashley <Kylie.Pashley@acu.edu.au>
 Mon 1/12/2014 11:14 AM

To: Dr Eric Marx <Eric.Marx@acu.edu.au>; Helen Bailey; Dr Carina Chan <carina.chan@acu.edu.au>;
 Cc: Ms Kylie Pashley <Kylie.Pashley@acu.edu.au>;

Dear Carina,

Ethics Register Number : 2013 266Q
 Project Title : Study 2 Further exploration of barriers to treatment in the
 Eating Disorder population
 Data Collection Date Extended : 28/02/2015

Thank you for returning the Ethics Progress Report for your project.

The Deputy Chair of the Human Research Ethics Committee has approved your request to extend the period of data collection. The new expiry date for data collection is the 28/02/2015 .

We wish you well in this ongoing project.

Kind regards,
 Ms Kylie Pashley

Ethics Officer | Research Services
 Office of the Deputy Vice Chancellor (Research)
 Australian Catholic University
 PO Box 456, Virginia, QLD, 4014
 T: 07 3623 7429 F: 07 3623 7328

THIS IS AN AUTOMATICALLY GENERATED RESEARCHMASTER EMAIL

2013 266Q Modification

MK Ms Kylie Pashley <Kylie.Pashley@acu.edu.au>
 Mon 1/12/2014 1:36 PM

To: Dr Eric Marx <Eric.Marx@acu.edu.au>; Helen Bailey; Dr Carina Chan <carina.chan@acu.edu.au>;
 Cc: Ms Kylie Pashley <Kylie.Pashley@acu.edu.au>;

Dear Carina,

Ethics Register Number : 2013 266Q
 Project Title : Study 2 Further exploration of barriers to treatment in the
 Eating Disorder population
 End Date : 28/02/2015

Thank you for submitting the request to modify form for the above project.

The Chair of the Human Research Ethics Committee has approved the following modification(s):

1. Inclusion of new recruitment site: New Farm Clinic.
2. Participants at New Farm Clinic to be involved in 1 interview only.

We wish you well in this ongoing research project.

Kind regards,
 Ms Kylie Pashley

Ethics Officer | Research Services
 Office of the Deputy Vice Chancellor (Research)
 Australian Catholic University
 PO Box 456, Virginia, QLD, 4014
 T: 07 3623 7429 F: 07 3623 7328

THIS IS AN AUTOMATICALLY GENERATED RESEARCHMASTER EMAIL

Appendix Y

Study 4 Information Letter



PARTICIPANT INFORMATION LETTER

PROJECT TITLE: Treatment Engagement in Eating Disorders

PRINCIPAL SUPERVISOR: Dr. Carina Chan

STUDENT RESEARCHER: Helen Bailey

PROGRAMME IN WHICH ENROLLED: Master of Psychology (Clinical)/PhD

Dear Participant,

You are invited to participate in the research project described below.

What is the project about?

The research project investigates particular barriers to receiving treatment for eating disorders. The aim of the study is to add valuable information to the field of psychology regarding treatment resistance in eating disorders. This can then inform future research and practice regarding preventative measures and treatment planning that will reduce the likelihood of dropout and treatment noncompliance.

Who is undertaking the project?

This project is being conducted by Helen Bailey and will form the basis for the degree of Doctor of Philosophy (Psychology) at Australian Catholic University under the supervision of Dr Carina Chan.

Are there any risks associated with participating in this project?

There are no foreseeable risks involved with participation in this study. However, discussing personal information about your eating disorder may leave you feeling vulnerable and distressed. If you have concern about the topic in general or as a result of this study, the researcher will ensure that counselling is made available if needed or requested.

What will I be asked to do?

Participation in this research will involve meeting with the researcher at a mutually convenient location. At the meeting you will be interviewed by the researcher about eating behaviours, personal characteristics and treatment experiences. This

interviewing will take approximately 60 minutes. The interview will be audio recorded however no one except the researcher will know that you were interviewed.

What are the benefits of the research project?

By participating in this research, you may further your understanding about your eating disorder.

Can I withdraw from the study?

Participation in this research study is voluntary. You will be free to withdraw at any stage of the research. Refusal or withdrawal will not result in any disadvantage for you.

Will anyone else know the results of the project?

The researchers will take every precaution to ensure confidentiality. No identifying information will be seen by anyone except for the researcher. Individual participants will not be identified in any future presentation of the results; only group results will be reported. The group results will be reported in a thesis that may be published or may be provided to other researchers in a form that does not identify participants.

Will I be able to find out the results of the project?

At the end of the research (expected January 2015) you will be provided a summary of the research in acknowledgment of your effort and time in helping the research with the research and gaining a PhD qualification.

Who do I contact if I have questions about the project?

Any questions regarding this project, before or after participating, should be directed to the Staff Supervisor, Doctor Carina Chan on 07 3623 7891 in the school of Psychology, McAuley Campus at the Australian Catholic University, 1100 Nudgee Road, Banyo Qld 4014. Before commencing, you will have the opportunity to ask any questions about the project. You will also have the opportunity to discuss your participation and the project in general after your involvement.

What if I have a complaint or any concerns?

The Human Research Ethics Committee at Australian Catholic University has reviewed this study. In the event that you have any complaint or concern about the way you have been treated during the study, or if you have any query that the Supervisor and Student Researcher have not been able to satisfy, you may write to:

Manger, Ethics
c/o Office of the Deputy Vice Chancellor (Research)
Australian Catholic University
North Sydney Campus
Po Box 968
NORTH SYDNEY, NSW 2059
TEL: 02 9739 2519
FAX: 02 9739 2870

Email: res.ethics@acu.edu.au

Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

I want to participate! How do I sign up?

All you need to do is sign the consent form stating that you have read this information letter, asked any questions you may have, and that you choose to participate in the study.

Your support for the research project will be much appreciated.

Helen Bailey
Student Researcher

Dr. Carina Chan
Staff Supervisor



**CONSENT FORM
COPY FOR PARTICIPANTS TO KEEP**

TITLE OF PROJECT: Treatment Engagement in Eating Disorders

STAFF SUPERVISOR: Dr Carina Chan

STUDENT RESEARCHER: Helen Bailey

COURSE: Master of Psychology (Clinical)/PhD

Participants section

I (*the participant*) have read and understood the information in the information letter inviting participation in research which involves meeting at a mutually convenient location for approximately 60 – 90 minutes. I understand this further research will involve answering a number of questions relating to eating behaviours, health service use, help seeking behaviour and characteristics related to eating disorders. Any questions I have asked have been answered to my satisfaction. I realise that I can withdraw at any time without penalty. I agree that research data collected for the study may be published or provided to other researchers in a form that does not identify me in any way. I am over 18 years of age.

NAME OF PARTICIPANT:.....

SIGNATURE:

DATE

STAFF SUPERVISOR: Dr. Carina Chan

SIGNATURE:.....

DATE

STUDENT RESEARCHER: Helen Bailey

SIGNATURE:.....

DATE



**CONSENT FORM
COPY FOR RESEARCHER TO KEEP**

TITLE OF PROJECT: Treatment Engagement in Eating Disorders

STAFF SUPERVISOR: Dr Carina Chan

STUDENT RESEARCHER: Helen Bailey

COURSE: Master of Psychology (Clinical)/PhD

Participants section

I (*the participant*) have read and understood the information in the information letter inviting participation in research which involves meeting at a mutually convenient location for approximately 60 – 90 minutes. I understand this further research will involve answering a number of questions relating to eating behaviours, health service use, help seeking behaviour and characteristics related to eating disorders. Any questions I have asked have been answered to my satisfaction. I realise that I can withdraw at any time without penalty. I agree that research data collected for the study may be published or provided to other researchers in a form that does not identify me in any way. I am over 18 years of age.

NAME OF PARTICIPANT:.....

SIGNATURE: DATE

STAFF SUPERVISOR: Dr. Carina Chan

SIGNATURE:..... DATE

STUDENT RESEARCHER: Helen Bailey

SIGNATURE:..... DATE

Appendix Z

Additional Interview Themes

Follows is an account of other themes, unrelated to the current research questions, which emerged during the interviews. Firstly, the experience of treatment and helpful and unhelpful aspects of treatment as described by interviewees are provided. Second, the experience of treatment providers and helpful and unhelpful aspects of treatment providers are detailed. While the data are separated in this way for ease of reading, the data were interconnected and was revealed through questions focusing on the current research. For example, participants provided information corresponding to a number of interview questions at various points throughout the interview.

Treatment Experience: What Helps and What Does Not

Participants spoke about factors that helped them engage in treatment and challenges that stood in the way of engagement in treatment and their recovery from their eating disorder. These issues were about personal ability and willingness to engage in treatment, resourcing, as well as the focus of treatment programs.

Control. Respondents were able to describe how their need to be in control was a barrier to treatment. One respondent stated, “I’m always going to revert back to eating disorder behaviors because that’s the way I feel like I’m in control” (Participant 1, Anorexia Nervosa). Additionally, respondents spoke about the importance of their eating disorder in maintaining a sense of control in their lives. Therefore it is understandable that these individuals would not want to give up their eating disorder and to engage in treatment as this would rid them of their perception of control. One participant exemplified this dilemma, stating “I turned down [an inpatient position]...probably about control...every time I’m forced to get treatment for my

eating disorder I lose all control...so I'm less likely to recover. I need to let go, surrender control [to recover]" (Participant 11, Anorexia Nervosa). Respondents' need for control reportedly inhibited treatment as respondents were challenged to hand over some control to therapists. This dilemma highlights the difficulties faced by treatment providers in reconciling the necessity of being the authority of treatment whilst also encouraging patients to take responsibility for their own recovery.

Perfectionists. The majority of respondents identified as perfectionists both in relation to their eating disorder but also in other areas of their lives. For example,

Yeah, I'm very much a perfectionist. So ... Aiming high and taking on tasks independently and doing things -- getting things done always feels really good. And if I don't get everything done, generally I will ... Um ... Beat myself up about it (Participant 8, Bulimia Nervosa).

This statement also demonstrated the self-critical aspects of individuals' responses. However, at times participants would minimise issues which they otherwise would criticise themselves about. For example, one client stated, "I know if I really try hard I could lose weight again even though I'm off my game at the moment with purging" (Participant 8, Bulimia Nervosa). It was as if the client needed to protect herself from her own perceived flaw; not being lower weight.

Lack of resources.

Criteria of eligibility for specialised services. Interviewees identified that it was difficult to gain entry into specialised eating disorder programs due to their scarcity. This challenged recovery. For example, respondents stated "no-one really does therapy, no steady [eating disorder specific] therapy... more specialised [eating disorder]

professionals are required” (Participant 7, Anorexia Nervosa), and “Unless you’re really underweight, there’s no inpatient support” (Participant 10, Bulimia Nervosa). One respondent demonstrated that the lack of resources could even reinforce the eating disorder. She stated “I don’t qualify for inpatient treatment because I’m not medically unstable”. Consequently she explained that she would make herself more unwell in order to meet inpatient criteria for treatment “...you try to be really sick to get the help...” (Participant 2, Anorexia Nervosa). However, becoming more unwell may be a cry for help as described, or it may really reflect the individual’s drive to maintain or further their eating disorder; it may be that the individual feels safer to engage in risky eating behaviours such as restrictive eating knowing that if she becomes more unwell there will be support available.

Restricted group access and availability. Even when admitted to specialised programs, participants reported there were not enough therapy groups available to attend. One respondent highlighted this issue by stating, “one inpatient group [runs] on Thursdays but that's the extent of the therapy given. I can't even go because it clashes with my appointment that I've been keeping each week with my therapist on the outside” (Participant 6, Anorexia Nervosa). Another patient described that her inpatient therapy as only involving “being monitored eating...and you had to restrict the exercise” but that she did not receive therapy as part of this inpatient stay, rather she “went to her [external] two psychiatrists. I kept up my appointments with them” (Participant 1, Anorexia Nervosa). One participant reported that there were fewer groups to attend than there used to be on her previous hospital admissions. She stated, “there were, I think, three inpatient groups a day just for the eating disorder clinic...” (Participant 5, Anorexia Nervosa). She alluded to the reduction in programs being about

money and the business profits. Another participant noted the inconsistent availability of programs and the challenge of not having access to appropriate groups when she stated, “until [one particular group] started, because it has been on and off, being lumped with anorexics is really hard” (Participant 10, Bulimia Nervosa).

Moreover, participants reported that there could be more variety in the groups. For example, one respondent stated, “they don't have enough groups for the [Eating Disorder Program] and they don't do like any positive body image work or other ways to feel good about yourself rather than the way you look. And, um, like they could do a [Eating Disorder Program] art and craft group and ...” (Participant 3, Anorexia Nervosa). She reiterated “it's that lack of resources, they're not putting groups out there for you to go to”.

Patient to staff ratio in programs. Even when admitted to specialised programs, respondents also reported there were not enough staff members providing support. One respondent said, “I do think it would be beneficial to have a therapist for the program ...” (Participant 6, Anorexia Nervosa) whilst another said “it's impossible for one staff member to watch ten patients...” (Participant 4, Anorexia Nervosa). Respondents noted current staff members were also too busy to be able to cater to patients' needs; one respondent stated “that's what I can't stand, when you're like patient 105” (Participant 14, Bulimia Nervosa) and another stated “...only because he has so many patients... I don't even get much therapy [with] my current psychiatrist” (Participant 4, Anorexia Nervosa).

Post-treatment support. Moreover, there was reportedly a lack of post-discharge support available. This seemed to be in relation to both managing the eating disorder and managing life in general. In relation to discharge after eating disorder treatment,

one participant explained, "...You're freaking out. You've got no skills to deal with it" (Participant 7, Anorexia Nervosa). Another respondent reiterated this and said "there's not enough treatment for eating disorders... you need more when you're like phasing out of hospital...looking after yourself...residential places" (Participant 2, Anorexia Nervosa). One respondent noted the struggle she felt to be responsible for herself again post-discharge. She stated, "[Because treatment is] such a sheltered environment where you have no responsibilities, like everything is done for you. You're basically babied ...the transition to home is always really hard" (Participant 12, Anorexia Nervosa). This seemed to especially impact individuals who were in treatment for a long time. One participant who had been in hospital "for months" stated, "[when] discharged, but that didn't really end well. There were like family arguments about my eating disorder and I was having panic attacks" (Participant 14, Bulimia Nervosa). It was evident that she would have benefited from post-treatment support.

Participants provided ideas of what would be helpful when coming out of inpatient treatment. One respondent identified it would be helpful to attend an outpatient program when phasing out of inpatient treatment. Other respondents stated they were aware of programs in other countries that incorporated nutrition classes, cooking classes and more education based groups. Respondents said that incorporating these groups into programs in Australia would make the transition from inpatient treatment less challenging. Moreover, the need for ongoing support may not be required.

Non-specialised treatment experience. Provided the reported lack of both eating disorder specific programs and available positions in the few existing programs, it was not surprising that participants reported they had received non-specialised treatment. Even for those individuals who were in specialised eating disorder treatment, many

initially engaged in non-specialised treatment. Respondents reported this helped them identify they in fact had an eating disorder. However, many respondents that attended non-specialised treatment felt “they weren't really equipped to deal with it...they're not set up so there's no, like, structure or program or anything else like that” (Participant 3, Anorexia Nervosa). It was almost as if participants blamed lack of recovery on not receiving specialised treatment. For example, one respondent stated, “[my treatment history] just started this year...but [my eating disorder's] been going on since I was 14, but it's been constantly brushed aside ... by everyone from my parents ...my doctor...a different psychiatrist” (Participant 8, Bulimia Nervosa). It is questionable whether this impacted engagement in treatment. Interestingly, this comment is also at odds with participants' statements that treatment focused too much on food and weight rather than the underlying concerns.

Weight focused. Respondents spoke about there being too much focus on weight in the treatment programs that are available to individuals with eating disorders. For example, one respondent stated, “weight restoration...I feel like they all just focus on that...once your weight's up, they just kick you out” (Participant 7, Anorexia Nervosa). Moreover, respondents perceived that the treatment they had received focused on weight to the detriment of providing the therapy that they actually needed. Specifically, a number of respondents stated that the focus on weight was a barrier to treatment as it was an unreliable measure of health and because the underlying issues that required treatment were not addressed. For example, a respondent stated, “I think [to recover] I have to look at the underlying issues. Not just the food and eating” (Participant 5, Anorexia Nervosa). However, some participants identified that the focus on weight was necessary for health. For example, one respondent stated “I understand that they have to

focus on weight restoration to make sure you're at a weight that is not going to endanger yourself" (Participant 7, Anorexia Nervosa).

It is likely that treatment does focus on weight as the Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the Treatment of Eating Disorders state that the first priority in treatment is to restore nutrition (Hay et al., 2014). These guidelines show evidence that weight gain is the key prioritised treatment goal (Hay et al., 2014; Hartmann et al., 2011). However, it is questionable whether the focus on weight is just the perception of participants; individuals with eating disorders have a heightened awareness of weight, and hypersensitivity to their weight which is inherent of the disorders. Therefore, it may be that these individuals are more sensitive to the aspects of treatment where weight is a focus. Interestingly, it was just participants with anorexia nervosa who reported the focus on weight as problematic. This supports the argument that this could be reality given the likelihood of these individuals being underweight compared to their bulimic counterparts.

Expectations of treatment. There was also evidence from responses that even if resources were available, participants had unrealistic expectations of what treatment should be, usually in the form of 24/7 support, and did not make attempts to seek support. For example, the same interviewee who stated she does not even get much therapy also stated "I wish there were more [Eating Disorder Program] groups because they're the only ones I go to because I am too scared to go to the other ones" (Participant 4, Anorexia Nervosa).

Practical barriers. A number of respondents shared other barriers unrelated to the current study that served as barriers to receiving treatment. These statements related to time pressures (e.g. "depending on work"; Participant 2, Anorexia Nervosa),

competing demands (e.g. “had to break up to focus on recovery”; Participant 14, Bulimia Nervosa), the impact on physical health (e.g. “sleep deprivation” due to both increased ruminating resulting from discussing illness and attending appointments around busy schedule; Participant 14, Bulimia Nervosa), and the financial cost of therapy (e.g. “my parents are paying for my appointments”; Participant 14, Bulimia Nervosa).

Therapists: What Helps and What Does Not

Participants were specifically asked about their relationship with their therapist/s, how they would describe their therapist/s, what was helpful and what was unhelpful about their therapist/s, and what role the therapist/s played in their treatment and recovery. Three themes stood out in relation to what seemed helpful in a therapist; blunt yet caring, providing an objective view, and being a positive role model. Without these, respondents stated treatment would be unhelpful. A lack of empathy was deemed unhelpful.

Blunt yet caring. All respondents expressed that therapists needed to balance being challenging yet also conveying genuine care, empathy and commitment to their treatment. One example of this balance was “she’s challenging and compassionate” (Participant 14, Bulimia Nervosa) when describing her psychologist. Conversely, respondents found it unhelpful when therapists were inconsistent. Inconsistencies were related to facility rules, for example, “I just really can’t stand inconsistencies with staff in terms of rules and what rules are and what rules aren’t. Everything is different for everyone. We never know what to expect” (Participant 4, Anorexia Nervosa).

Providing an objective view. Respondents named the therapist’s objective viewpoint as helpful for their recovery. The following statement summarised the

responses across participants; “They alert me when it’s the eating disorder side talking...help me make the decisions which I need to make for my life....giving me the best information, non-biased advice” (Participant 5, Anorexia Nervosa). Interestingly, despite the non-biased advice they perceived they were receiving, this appeared to have limited impact on whether they were able to act on the advice or to improve treatment efficacy.

Great role models. Respondents also appeared to idealise their therapists. Of note, the therapists identified as great role models appeared to be the therapists who were slim, attractive and who ate an acceptable amount of food. This may be because these therapists represented the only way eating disordered individuals felt comfortable to recover; to eat appropriately (reportedly presumed from what therapists preached) but to also be slim. They were credible. For example, one respondent described her therapist as “inspiring” in relation to her own recovery (Participant 6, Anorexia Nervosa). The inpatient experiences and day patient groups involves nurses eating at the dining table with clients and therapists eating in the vicinity of clients, respectively. As a result, what the therapists eat is viewed by patients. One respondent stated, “if [the therapist’s] eating attitude is like, if they're saying things like, ‘this [pointing to food] is a treat to [non-eating disordered people] ...you should have just a little bit’ ... they're just healthy towards [food]... [I] try to model my behaviour off that” (Participant 5, Anorexia Nervosa). Despite this being claimed as helpful for their recovery, it may be proposed this would not be helpful for recovery. The fact that one respondent stated one of three words to describe her therapist was “pretty” (Participant 9, Bulimia Nervosa) questions the impact this would have on therapy; it may only act to reinforce comparisons. Respondents also noted these individuals as people they wanted to be friends with,

possibly blurring boundaries whereby patients are less engaged with the therapist for treatment but rather see them as an idealised peer.

Perceived lack of empathy. The only unhelpful factor related to the therapist that was commonly named by participants was the perceived lack of empathy of therapists. Respondents unanimously stated some staff conveyed empathy whilst others did not. Respondents found some staff were dismissive which was reported as unhelpful. For example, one respondent stated, “they would say, ‘You okay? Alright. See you later’, like [without saying it, conveying], ‘I’ve got another nine patients to attend to’. It was really dismissive. I personally felt like I couldn’t talk to anyone” (Participant 7, Anorexia Nervosa). Another respondent felt some staff were “acting like you’re a nuisance, kind of. Like, they’re too busy for you or just like they don’t seem very empathetic all ...” (Participant 13, Bulimia Nervosa). A few participants also reported it was unhelpful when staff made assumptions about their behaviour or labelled them as just another eating disorder patient. One respondent stated,

They jump to conclusions a bit and put you in the “that’s just what someone with an eating disorder would do”. Like maybe you’re not doing that. I was accused of hiding food in a certain way. And I have done that in the past. But on that occasion when they accused me of doing it I actually wasn’t (Participant 5, Anorexia Nervosa).

This comment also exemplifies the hypersensitivity of respondents to criticism and perceived injustice against them; they reportedly felt they had got away with these behaviours in the past. This reflects vulnerable narcissism.