Perfectly Imperfect: Reflections of a Newly Qualified Clinical Psychologist in using CAT to Explore the Relational Contribution to Binge Eating

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Introduction

As a newly qualified Clinical Psychologist my training granted me opportunities to work within a range of clinical placements, and CAT was my model of choice throughout my placements. However, my relationship with CAT is not a simple one; I have often felt that I was taking 'two steps forward and then one backwards'. Determined to escape this trap, I chose to complete my specialist placement in an eating disorder service with a focus upon using CAT. Being surrounded by CAT practitioners on this placement, receiving supervision from a Clinical Psychologist who was CAT trained (Dr. Uma Patel) and participating in a CAT group for eating difficulties immersed me in its concepts and I finally started to really 'get it'.

One of my clients within this service was 'Lenia', a twenty eight year old woman with binge eating difficulties. I did not know if there was an evidence base for CAT and binge eating difficulties. This uncertainty made me question my competence to help Lenia; did I have the knowledge and skills to be able to help her? I wanted to reduce this uncertainty and to learn all that I could, but the literature did not provide me with answers. I was stuck.

Literature review

Despite the debate surrounding the usefulness of psychiatric diagnosis in the context of mental health problems (Frances and Widiger, 2012), clinical diagnoses continue to be used within mental health services and the literature. The category of binge eating disorder (BED) was introduced in The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013) and is characterised by recurrent periods of eating significantly large amounts of food, in short periods of time, whilst feeling out of control. This is associated with distress and occurs at least once a week over three months. These episodes may be followed by feelings of guilt, embarrassment or disgust.

While the literature is limited surrounding CAT and eating disorders, CAT has recently been recommended by the National Institute for Health and Care Excellence (NICE) for use with people with a diagnosis of anorexia nervosa (NICE, 2004). Denman (1995) first described using individual CAT with two women; one with a diagnosis of anorexia nervosa and the other with a diagnosis of bulimia nervosa. Following CAT, both clients were believed to have made significant behavioural and psychological improvements despite not having 'recovered'. Other case studies have also shown improved psychological functioning and weight gain for participants with anorexia nervosa (Fiorani and Poggiolo, 2005).

Treasure et al. (1995) compared CAT and educational treatment; participants who received CAT reported significantly higher subjective improvement, however no differences were found on objective measures. Dare, et al., (2001) compared CAT to focal psychoanalytic psychotherapy, family therapy and 'routine treatment'. In a third of cases CAT led to improvements to the extent that the individuals no longer met the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000) criteria for anorexia nervosa, and was comparable to both psychoanalytic psychotherapy and family therapy.

The sole focus on eating difficulties alone was argued to be insufficient in a review of CAT interventions and it was concluded that it was vital to address the interpersonal problems commonly experienced by people with eating disorders (Bell, 1999). Despite CAT not being a current recommended intervention for BED, there is an argument that the current NICE (2004) guidance is limited, due to the lack of comprehensive research (Wilson and Shafran, 2005). Given the suggested transdiagnostic difficulties encountered by people with eating disorders (Wade, et al., 2006), CAT could be appropriate for use with people with a diagnosis of BED, due to the encouraging findings for those that meet other the criteria for other eating disorders diagnoses.

Introduction to Lenia

Lenia and I have now completed 16 sessions of CAT together. She has taught me many lessons and I decided to write this article to share those lessons and perhaps help

those whom, like me, question their ability to help using the CAT model with somebody with binge eating difficulties. Lenia, who is Italian, was referred to the eating disorders service due to historical difficulties with controlling her food intake and "comfort eating". Lenia met the criteria for BED and had a Body Mass Index (BMI) of 73.9, which placed her in the obese clinical range. Consequently, this had led to health difficulties and feelings of self-consciousness when she was out in public. Despite Lenia agreeing to me writing this paper, I have changed her name, and any identifying information, for anonymity reasons.

Our initial meeting

I felt nervous about meeting Lenia; I felt I did not know what I was doing. I was conscious of my status as a 'trainee' and was aware that I had never worked with someone with binge eating difficulties using CAT before. Lenia later told me that she was anxious about my trainee status, and doubted the therapy was going to work. Lenia was visibly overweight, and she also questioned how someone with normal weight could understand her. Lenia also incorrectly assumed that I was younger than her; she was aware that I was educated to a higher standard. Lenia also used a bariatric chair, which, again, emphasised our differences. Despite this, I instantly warmed to Lenia, which further reinforced my wish to help her.

Assessment

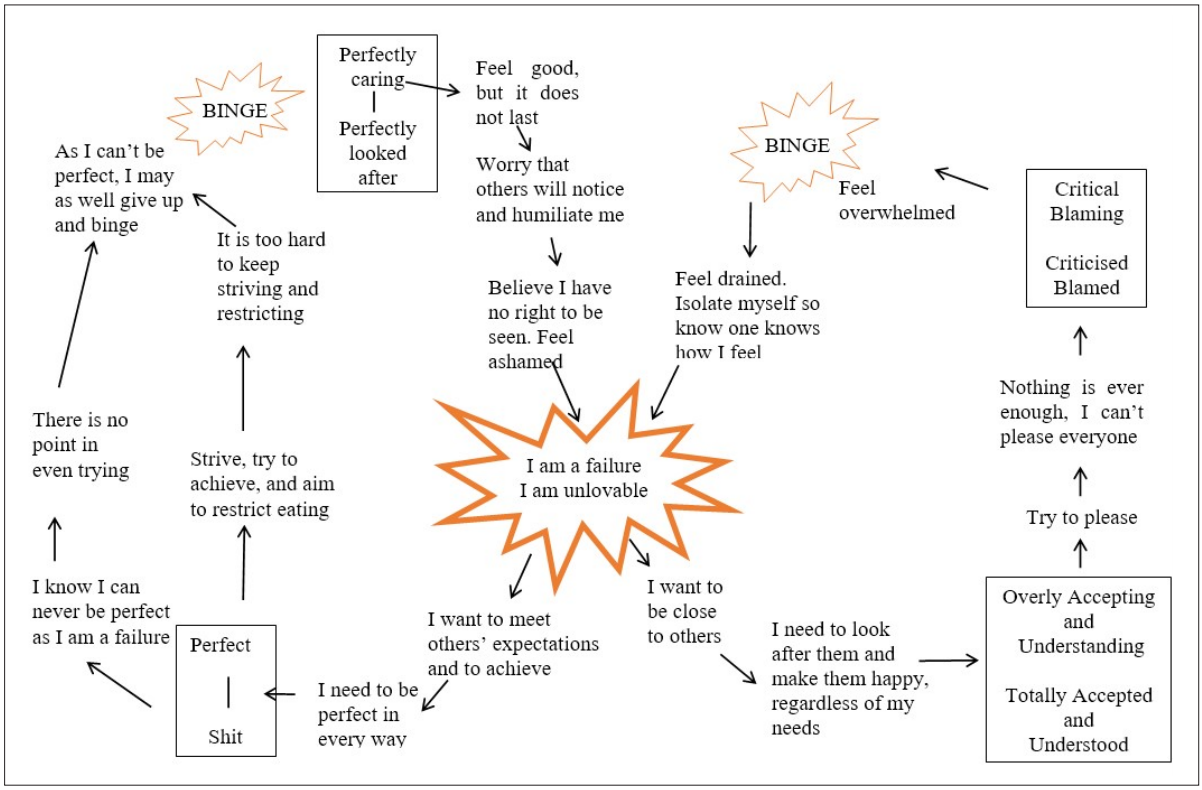
Whilst reformulating Lenia's difficulties, I often felt that she was holding back and she later confirmed that sometimes this was true. She was 'guarded' due to multiple experiences of being bullied and judged due to her weight and I was aware of wanting to prove to Lenia that she could trust me.

Lenia came to therapy in an attempt to please her mother (which was an example of her placatory behaviours) as at the time Lenia minimized her difficulties. However despite Lenia's reservations, her aim, during therapy, was to reduce her need to use food as a reward, and to lose 10 kg in weight to be eligible for bariatric surgery.

During our initial sessions Lenia was vague about some aspects of her life, whilst very detailed about others. When I asked her to complete a life chart she brought back an intricately typed ten page document detailing important life events, however, I still struggled to gain a sense of how these experiences were impacting on her life and relationships. Lenia described feeling close to her family, despite experiencing her family as critical and blaming. Lenia was aware that her mother had been sexually abused as a child, and throughout her life it seemed that Lenia's mother's needs were prioritised, over and above Lenia's. Therefore, Lenia believed that her own needs were less important, and should be kept hidden, as she "had not had it as bad as others". Many of Lenia's early memories were associated with eating, both in terms of enjoyment and distress. Lenia remembered large family meals, treats for "being good" and feeling closer to others, especially her mother, through eating. She also described participating in secret binge eating with her mother, which indicated a 'perfectly caring' to 'perfectly looked after' role, which was enmeshed with food. Throughout all conversations Lenia described chronic and pervasive experiences of feeling a "failure" and of being "unlovable".

Reformulation

We identified that Lenia's feelings of being a failure and unlovable



underpinned her compulsion to binge, and that in turn her bingeing and obesity reinforced her feelings of being unacceptable to herself and to others.

Lenia desperately wanted to achieve and 'be perfect'. She described feeling that if she, or things in her life, were not 'perfect' they were 'shit'. Lenia strived to be "the best" and to achieve, or felt that she was so awful that there was no point in attempting anything. This RR of 'perfect' to 'shit' arose from when she was either praised and rewarded for being successful, or chastised and criticised for not achieving, by her mother. This role was frequently re-enacted in the early sessions, for example I remember being impressed with how she seemed to have thrived in so many ways, despite the early difficulties she reported in her life. She had moved to England independently as a young adult, taught herself to speak fluent English, and received a scholarship to a prestigious art college. Lenia later dropped out, however, as her perfectionistic striving impeded her studies. It was acknowledged that in therapy sometimes Lenia would place me in the 'perfect and idealised' role, commenting that my reflections in therapy were "mindblowing" or asking for my 'expert' opinion on topics that I had no more knowledge about than her. As with her scholarship, Lenia believed that pleasurable activities had 'no point or value' unless she could be perfect. When she failed to 'be perfect' she felt a failure and as if she should 'give up' and subsequently binged, both as a punishment and for comfort.

Within the family Lenia 'learnt' that to be loved by others she was required to placate, please, and take care of others at the expense of her own needs. Her procedure of 'overly accepting' and 'overly understanding' to striving to be 'totally accepted' and 'totally understood' led to her trying her best to please everyone, failing, and in turn, being critical and blaming of herself, and others. This led to her feeling overwhelmed. She would then isolate herself, binge for comfort as her mother had done, and feel more unlovable and a failure.

Recognition

During our fifth session together, after sharing Lenia's reformulation letter and developing her SDR together, I noticed a 'shift' in Lenia. Lenia began to recognize that she had the choice of continuing to reenact her procedures, or that she could work towards change. She cautiously shared more about her family, whilst highlighting her reservations that I might be overwhelmed by this information. It seemed that Lenia was trying to protect me, as she had often protected her mother. Through this process, Lenia experienced being listened to and not being criticised, in a way she had not been previously. We both became aware that the more detailed account of her difficult family narratives were explained predicted by her SDR.

In time, Lenia became less preoccupied with perceiving me as different. What was important was that our conversations had allowed her to make sense of her past experiences. This coincided with my developing confidence in the model, and belief that CAT could work for Lenia despite the lack of previous literature with respect to BED. I was constantly developing my knowledge and became aware of the concepts of 'outsideness' (Bakhtin, 1990) and 'insideness' (Pollard, 2011). The process of developing an outside perspective of life events helped Lenia to develop an 'observing eye'. Through the process of 'insideness' (sharing a common humanity), this helped her develop the understanding that the difficult experiences she had encountered were not 'of her making'.

Lenia developed an observing eye (Ryle and Kerr, 2002), and from a more 'distanced position' she was able to recognize, and make further insights, into her ambivalence with respect to her relationship with food. Her feelings of being either 'perfect' or 'shit' became the focus of many of our conversations and Lenia recognised how this played out in many areas of her life, both inside and outside of therapy. The concept of working towards a position of only needing to be 'good enough' was difficult for Lenia to comprehend - but it was an area we agreed to work upon.

Revision

We collaboratively developed exits from Lenia's procedures, utilising specific techniques such as mindful eating (Kristeller and Wolever, 2010). Lenia's belief that she had to keep her feelings hidden altered as she became to believe that her feelings were as valid as others, including her mother's, and she learned to begin to manage difficult feelings more effectively. An example of this was when a stranger made a hurtful comment about her weight (activating her 'critical' to 'criticised' RR), while she found this upsetting, she did not binge as a means of regulating her mood.

Lenia was also encouraged to be less neglectful of her own needs. She bought herself a gift and discovered the enjoyment she gained from this. She began doing her "own thing" in relation to her family, for example not intervening, or attempting to placate, during arguments and therefore altering the usual course of events. Lenia developed a new understanding of how she related to others, reflecting that "I cannot look after others if I do not look after myself first". Within the therapeutic relationship Lenia also became less preoccupied with having to 'be perfect' and 'getting things right', she started pursuing her art again and began to take risks in learning, and trying out new activities that she would have previously avoided for fear of failure.

Saying goodbye

The process of sharing our goodbye letters was difficult for me. I felt competent in writing reformulation letters but goodbye letters had always challenged me; once more my own anxieties about not being good enough were triggered. I found it difficult to say goodbye, especially to someone that I had learnt so much about and who had been so willing to share her story with me. I was aware that our 16 sessions together had felt like an incredible journey and that so much had happened and changed in the process, how could I encapsulate this in one letter? How could I share my experiences of this process without making the letter about me? I recognised that Lenia had allowed me to share the process with her; together we had gone on a journey. Despite my reservations our goodbye went well. After we had shared our letters we reflected how similar the content of the two letters had been. Lenia's letter was reflective of our sessions, and I was pleased to notice how honest she was, for example stating that initially she was apprehensive about working with a trainee. Lenia expressed more compassion for herself and it was clear that she had gained in recognition and was beginning to make positive change and recognised that her standards for herself were impossibly high, and that she now accepted the importance of being "OK with being OK". Lenia signed off her letter with "your perfectly imperfect patient", encapsulating this shift from only being able to feel either 'perfect' or' shit'.

Evaluation

Lenia's scores on the Hospital Anxiety and Depression Scale (HADS; Zigmond and Snaith, 1983) reduced from the clinical range at assessment and start of therapy to subclinical on discharge. The Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM; Evans et al., 2002) demonstrated that Lenia's distress levels reduced from moderate/severe at assessment, moderate at start of therapy to subclinical at discharge. The change on both these measures are clinically significant thus mirroring Lenia's self-reporting of positive change. Lenia achieved her weight loss goal, having lost 14 kilograms. Lenia no longer met the criteria for BED, and over a three month period she had only binged once. Subjectively, Lenia reported improvements in her relationships with others and she also reported that she no longer used food to reward herself, or to manage her emotions. The combination of these factors meant that she was now eligible for bariatric surgery.

Discussion

The procedures and subsequent exits we identified led to a reduction in Lenia's weight and an improvement in her mood, self-image and in relationships with others. Lenia's ability to be satisfied with being 'good enough' for herself and others, rather than only ever feeling 'perfect' or 'shit' was vital to the change process both within and outside of therapy. Her understanding of being "perfectly imperfect" was particularly important, as individuals who have 'recovered' from eating disorders have been shown to have significantly lower levels of perfectionism than those who remain eating disordered (Bardone-Cone, Sturm, Lawson, Robinson, and Smith, 2010). Lenia's recognition and increased understanding of her use of food to regulate her emotions helped her to make positive change. This is seen as clinically very relevant as emotional regulation has been found to mediate the relationship between attachment insecurity and binge eating in bariatric surgery patients (Shakory et al., 2015).

When we met to discuss this article, approximately three months following the end of therapy, Lenia reported that she had continued to utilise her exits. She had lost a further three kilograms and had dropped three dress sizes. She was also on the waiting list for bariatric surgery. However, more importantly, she seemed visibly different to me and I noticed she was wearing make-up. Lenia had hardly worn make up in years, as in the past she thought this would attract attention that she did not deserve. Lenia told me she now felt free to do whatever she chose. This confirmed to me that she really had 'got' CAT, just like I had.

When reflecting on our sessions Lenia was surprised by how little we spoke about food in therapy. This was in stark contrast to her expectations based on her previous experience of receiving CBT and family therapy. Lenia described feeling detached in CBT believing she had to be 'perfect' whilst completing homework but entered the 'shit' role when she left therapy. Lenia experienced CAT as different – which focused on working together collaboratively whilst sharing and understanding Lenia's narrative. During therapy I acknowledged Lenia's tendency to strive to be the 'perfect patient', and while also acknowledging that I was not, and did not need to be the 'perfect therapist' and that it was ok not always 'to know everything'.

When we reflected on other changes she had made, Lenia described herself as a different person. She explained that she 'carries her reformulation around in her head', which helps her to recognise when she is feeling or thinking in an unhelpful way. By the end of therapy Lenia reported that her relationships had improved dramatically, she was more honest with people and with herself, and that she is more able to ask for help and support.

More importantly, Lenia came to understand that her eating and bingeing was driven and maintained by emotional and psychological distress and that she had the choice of doing things differently. It seems that CAT

made a difference where her previous therapies had not; thereforemore research in this area seems indicated. Lenia taught me about the power of the therapeutic relationship, and I am privileged that she trusted me enough to grant me this opportunity.

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Table 1. Outcome Measures at Assessment Start of Therapy and Discharge

	Assessment	Start of therapy	Discharge	Reliable Change Index
HADS Depression	19	11	1	-4.81*
HADS Anxiety	12	12	5	-3.14*
CORE-OM	78	55	24	-37.80*
BMI	71.6	73.9	69.7	-

*Note: * represents clinical significant change, from start of therapy to discharge, in accordance with Jacobson and Truax's (1991) criteria.*