

Counsellors in the crossfire

For counsellors working with young people, the outcome of the current consultation is perhaps of more immediate concern. Clearly, for most, if not all, counsellors, a young person disclosing involvement in underage sexual activity would raise real concerns about their welfare and the potential for abuse. However, to frame the issue as one of simple illegality, or as a necessary indicator of abuse, is too simplistic a response. For some young people, engaging in sex under 13, or even under 16, may well point to abuse or exploitation. Yet reporting such activity automatically to the authorities is unlikely to produce much more than a denial or a retraction of the statement by the young person concerned. It seems highly unlikely to produce the kind of evidence which will guarantee either a successful prosecution of a predatory adult perpetrator, or even to produce effective and lasting child protection arrangements. What it does seem likely to achieve is to deepen the young person's mistrust of helping agencies, and for counsellors to be caught in the crossfire. ■

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References

- 1 Department for Education and Skills. Working together to safeguard children: consultation draft. London: DfES; 2005. www.dfes.gov.uk/consultations
- 2 Brook Advisory Centres. Under 16s: the law and public policy on sex, contraception and abortion in the UK. London: Brook Advisory Centres; 2005.
- 3 Department of Health. Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health. DoH: London 2004 (www.doh.gov.uk)

Resources

- www.brook.org.uk
www.bma.org.uk

For information on the BACP response to the consultation on Working together, go to www.bacp.co.uk/notice_board

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Eating disorder

Clients suffering from an eating disorder are often a clinical criteria for a number of eating disorders, and

When I began to write this article I thought about those typical images of someone suffering from an eating disorder; you know the type of thing, one of those shots of a skeletal teenager looking as though they would be more at home in some famine ridden region of the world. In reality intense starvation is only one of the characteristics of this range of illnesses. Often someone with an eating disorder is able to maintain a normal or near-normal body weight and for this reason, among others, the condition may often go undiagnosed. When I refer to individuals who have acquired an illness of this nature as 'sufferers', I do so intentionally, to highlight the reality of living with an eating disorder; make no mistake, this client group suffers. They may

suffer emotional and psychological pain along with physical pain and discomfort, inner turmoil, anger, fear and distress and the difficulties that one would associated with having an illness that on one hand provides them with the so called 'control' they so badly desire, while in extreme cases, ultimately becoming a victim of the control the illness wields over them.

In this series I will provide theoretical and clinical information, an overview of the different approaches to treating and working with individuals with an eating disorder and case studies from clients who have been kind enough to confide in me their experiences of seeking help, both good and bad.

What is an eating disorder?'

The Eating Disorders Association UK website (www.edauk.com) describes it as follows:

- Eating disorders develop as outward signs of inner emotional or psychological distress or problems.
- They become the way that people cope with difficulties in their life.
- Eating, or not eating, is used to help block out painful feelings. Without appropriate help and treatment, eating problems may persist throughout life.
- Eating disorders are complex illnesses where both the disturbed eating pattern as well as the psychological aspects need to be treated.
- Restoring a regular eating pattern plus a balanced diet is needed for balanced nutrition.
- Helping someone come to terms with the underlying emotional issue enables them to cope with difficulties in a way that is not harmful to them.

DSM IV diagnostic criteria

Anorexia nervosa

- Refusal to maintain body weight over minimum normal weight for age/height, eg weight loss leading to maintenance of body weight 15 per cent below that expected; or failure to make expected weight gain during period of growth, leading to a body weight 15 per cent below that expected.
- Intense fear of gaining weight or becoming fat, even though underweight.
- Disturbance in the way in which one's body weight, size of shape is experienced; eg the person claims to 'feel fat' even when emaciated, believes that one area of the body is 'too fat' even when obviously underweight.
- In females, absence of at least three consecutive menstrual cycles.

Bulimia nervosa

- Recurrent patterns of binge eating (rapid consumption of a large amount of food over a discrete period of time).
- A feeling of lack of control over eating behaviour during the eating binges.
- Regular self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain.
- A minimum average of two binge-eating episodes a week for at least three months.
- Persistent over-concerns with body shape and weight.

Multi-impulsive bulimia

- Bulimia associated with one or more of:

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This client group suffers emotional and psychological pain along with physical pain and discomfort, inner turmoil, anger, fear and distress

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ders: a body to die for?

challenge for counsellors. In the first article of a new series, Jo Hunt looks at definitions and shares a case study of a client presenting with the symptoms of anorexia nervosa

- Eating disorders are not about food, they are about feelings.
- Eating disorders are a way of coping with feelings that are making people unhappy or depressed. It may be difficult to face up to, and talk about feelings like anger, sadness, guilt, loss or fear.
- An eating disorder is a sign that he/she needs help in coping with life, and sorting out personal problems.
- People with eating disorders have very low self esteem.

An eating disorder, while being an outward physical manifestation is in reality associated with inner emotional and psychological distress.

- ◆ alcohol abuse
- ◆ 'street' drug abuse
- ◆ multiple overdosing
- ◆ repeated mutilation
- ◆ sexual disinhibition
- ◆ shoplifting
- Each behaviour is associated with a similar sense of being out of control.
- Behaviours may fluctuate, are interchangeable and impulsive.
- The sufferer is affected by depression and intense anger, which are declared when the behaviours are controlled.
- There is low self esteem (this applies to all eating disorders).

Binge eating disorder

- Recurrent episodes of binge eating.
- Binge eating episodes associated with at least three of the following:
 - ◆ eating more rapidly than normal
 - ◆ eating until uncomfortably full
 - ◆ eating large amounts of food when not physically hungry
 - ◆ eating alone because embarrassed by amount being eaten
 - ◆ feeling disgusted with self, depressed or very guilty after over eating
- Marked distress regarding binge eating
- The binge occurs, on average, at least two days a week for six months.
- The disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa

Eating disorder not otherwise specified

- All the criteria of AN met, except the individual has regular periods or, despite significant weight loss, current weight is still normal range.
- All the criteria of BN are met except binges occur at a frequency less than twice per week or for less than three months.
- Individual is of normal weight but regularly engages in inappropriate compensatory behaviour after eating small amounts of food (eg self-induced vomiting after eating two biscuits).
- An individual who repeatedly chews and spits out, without swallowing, large amounts of food.

Applying clinical criteria is not always straightforward and there are many similarities between disorders. For example, a sufferer of bulimia may starve themselves for a period of time in the way that someone with anorexia would. There is also a high frequency of crossover of symptoms: an anorexic may use laxatives to rid him/herself of any ingested food. An estimated 50 per cent of individuals move between diagnoses over time. ■

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Case study: Anne

Having gradually put on weight and developed a more mature body over a period 12-18 months, Anne (14) had become unhappy with her weight and body shape. She had much preferred herself when she was thinner, more like her friends and less 'curvy'.

Anne had never been overweight but by the time she entered counselling 15 months after she began losing weight she had lost nearly two stone. Equally importantly she had failed to achieve the weight gain and growth expected of someone of her age and height.

What started as a 28-day diet and fitness plan from a book her Mum had bought had fast become a challenge between Anne and her poor self view. She described initially sticking to the diet of low-fat food such as chicken, fish and lots of fruit and veg. Her Mum was encouraged by her daughter's desire to eat what appeared to be a healthy diet. However, Anne had become extremely clever identifying low-fat food and calculating the calorific value of what she ate. She began cutting out all carbohydrates like bread, pasta, rice and potatoes. Once she had begun to successfully lose weight the desire to continue to be successful had become too great a challenge for her to refuse. In order to maintain continued weight loss, Anne had had to increasingly restrict her food intake and increase her exercise. The story of her home life became typical of someone with anorexia – a tale of lying to her parents, not eating unless forced to, in order to maintain the facade of being 'fine' and wherever possible hiding the food and disposing of it later.

Anne's parents had begun to express their concern for their daughter's ever-decreasing weight. Anne defended herself saying she just wasn't hungry or she felt ill or had a virus but she refused to go to her doctor. When she became too exhausted to attend school her parents insisted that they consult their GP who immediately instigated a referral to an out-patient eating disorder service within her local NHS primary care trust. Anne and her parents were advised by her GP that she could expect a three-month wait for assessment and acceptance onto their education and recovery programme. Her mother, endeavouring to stay calm and 'strong' for her daughter, quietly said to the counsellor 'I'm not sure she'll be here in three months'.

On entering counselling it was explained to Anne and her parents that the therapist would fully support her accessing the eating disorder service. Her counsellor would be happy to work with Anne either until such time as she entered the eating disorder service programme or, with

approval of the service, would continue to work with Anne alongside the psychological education and recovery programme that the service offered.

It was explained to the client that although well trained and qualified as a counsellor, and while having considerable experience of working with clients with a disordered pattern of eating, her counsellor could not provide a medical diagnosis of her illness. The job of diagnosis would be covered by the psychiatry/psychotherapy team at the eating disorder service once she had been for a full clinical assessment.

Due to the Anne's frail physical condition her counsellor added one additional proviso to the usual counselling contract. She asked that, until such time as Anne was being monitored by the eating disorder service, she agree to see her GP on a weekly basis (or a frequency deemed appropriate by her GP) in order to have her health monitored. This was requested in order to ensure that Anne's counsellor did not collude with any belief that Anne may have that her current condition was a healthy one. It would also allow the counsellor to be fully present for Anne rather than being distracted by any fears for her client's health. Responsibility for that aspect of Anne's care would now be taken by the GP. Had Anne presented in her current frail condition without having had a referral to a specialist service, or had she not already approached her GP, her counsellor would have added the proviso that counselling take place alongside medical monitoring/intervention. Anorexia nervosa continues to have the highest mortality rate of any mental illness (estimated to be approximately 10 per cent). In this instance Anne's therapist did not feel that counselling alone was sufficient to ensure the wellbeing of the client.

When asked to describe herself and her situation Anne said she was 'relatively intelligent'. She had been brought up and driven by the philosophy of 'if a job's worth doing it's worth doing well'. She felt the need to be the best she could in all aspects while always feeling that in some way she was never quite good enough. When exploring this need to be the best Anne explained that it wasn't driven by any arrogance on her part or a need to be better or ahead of others, but was instead about simply staying level and not falling behind. She was terrified that if she stopped being ahead academically she would quickly fall behind her peer group. Likewise, the need to be thin wasn't about being more attractive but about trying to fit in and be accepted and as good as her friends compared to whom she had always felt big and unattractive and by whom she felt somehow excluded.

When asked how she applied the need to be good at everything and her inability to forgive herself mistakes or imperfections to others, it became evident that she was far kinder to others than to herself. Anne was capable of offering a level of acceptance and forgiveness to others that she felt she didn't deserve herself.

Exploring her situation with her therapist and gaining more understanding of her illness was a great comfort to Anne. Time and again she said she was relieved to hear that it wasn't just her who experienced certain thoughts

and feeling about her illness.

Anne's need to be perfect had transferred itself to her eating and she was striving to be the perfect dieter. She accepted that she would almost certainly be diagnosed with anorexia nervosa and if that was the case then she was going to do a good job of that too. However, as is typical with a sufferer of anorexia there were many contradictions in what Anne said. On one hand the 'well' part of Anne acknowledged that she had eating problems but the 'unwell' part of her was pleased about it and didn't want to give it up. But it was more than that – Anne was terrified of giving it up. If she gave it up she would have failed. While one part of her loved the sense of being worried about by others, being cared for and of generally being considered 'ill', another part was incredibly distressed by the worry she was causing family and friends.

Anne also described herself as a 'fraud'. She was very fearful of being rejected by the eating disorder service and determined to lose more weight in order to justify her place should she be offered one. This sense of being fraudulent permeated other aspects of Anne's life. She described feeling that she wasn't really academically bright; instead she had just been lucky with her marks. She lived in fear of being 'found out'; with the referral to the eating disorder service the fear of being found to be a fraudulent sufferer of anorexia nervosa was ever present.

Research has found consistencies in the personalities of people who acquire anorexia. They are typically introverted, conscientious and well-behaved children who seldom present problems at home or school. Many surveys note high intelligence, and superior scholastic performance, but the two personality traits consistently found are perfectionism and obsessive behaviour. It is when these last two are combined with a general dissatisfaction with life, or life presents an individual with events with which they feel unable to cope, that anorexia becomes a viable alternative. It may be seen as a coping mechanism.

Anne's approach to life mirrors many of these aspects. Far from presenting as a selfish young woman who wanted to control those around her (sadly a not uncommon description of a sufferer of anorexia) Anne was struggling, as she always had, to control herself and her place in the world.

So, what could Anne's counsellor offer her? As a humanistic therapist she could offer the core conditions – empathy, congruence and unconditional positive regard. She could offer Anne a safe place to be who she was at that time. She would have the opportunity to explore her thoughts and feelings around having acquired an eating disorder. If Anne wanted to say she was fine about being ill and enjoyed the attention while at the same time loathing herself for doing so, she could say it without fear of rejection. In counselling she did not need to be perfect, she just needed to be Anne, whoever Anne was. Knowing that Anne's physical condition was being monitored by a medical professional freed Anne and her therapist to focus on distress and emotion of being who she was at that time.