

**Dear Me: Exploring the Experience of Generating Self-Compassion through Letter  
Writing In Adults with Eating Disorders**

Submitted in partial fulfilment of the degree of  
Doctorate in Clinical Psychology  
University Of Leicester

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## **Declaration**

This thesis is an original piece of work that has been submitted in partial fulfilment of the degree of Doctorate in Clinical Psychology. The literature review and research report contained within this thesis have not been submitted for any other degree, or to any other institution.

## **Thesis Abstract**

### **Dear Me: Exploring the Experience of Generating Self-Compassion through Letter Writing In Adults with Eating Disorders**

**Lorna Showell**

#### ***Literature Review***

The aim of the current literature review was to examine the evidence for expressive writing as an effective intervention in reducing symptoms in those presenting with eating disorders. A systematic search identified eight articles that met the selection criteria and were included in the review. The results suggested that the expressive writing task employed, and the subsequent findings of studies are variable. The review argued that further research is beneficial to determine the effectiveness of writing interventions for individuals with eating disorders and the mechanisms by which they may work.

#### ***Research Report***

Despite previous research acknowledging the prevalence of eating disorders and the difficulties associated with effective interventions, there is currently limited research investigating alternative treatments across eating disorder diagnoses. The aim of the research report was to explore the experiences of adults with eating disorders in generating self compassion through letter writing. Interpretative Phenomenological Analysis was used to analyse the transcripts from seven participant interviews. Three overarching themes emerged: the alien concept; leaving familiarity, letter writing as a journey and finding self compassion. Implications for eating disorder services were made based on the experiences of these participants. Future research regarding the use of self compassion is advocated, as well as the suggestion for a transdiagnostic approach.

#### ***Critical Appraisal***

The critical appraisal provides an account of the researcher's journey and reflections on the research process.

## **Acknowledgements**

I would like to thank the participants who contributed their time to share their stories with me, without them this would not have been possible.

I would like to thank Dr Steve Allan and Dr Ken Goss, for their support, guidance and giving me a nudge in the right direction when I needed it.

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## **Literature Review**

Is there Evidence for the Effectiveness of Expressive Writing in Reducing Eating  
Disorder Symptomatology?

Prepared for submission to the British Journal of Clinical Psychology

(See Appendix A for guidelines for contributors)



## **Abstract**

### **Is there Evidence for the Effectiveness of Expressive Writing in Reducing Eating Disorder Symptomatology?**

**Lorna Showell**

#### *Objective*

To date, there has been little research conducted on expressive writing and psychological distress, particularly concerning eating disorders. The current review provides an overview of current research into the area, establishing if there is evidence for the effectiveness of expressive writing in reducing eating disorder symptomatology.

#### *Method*

A systematic literature review of expressive writing interventions that used Pennebaker's writing task (Pennebaker & Beall, 1986) with eating disorder populations was conducted using PsychInfo, Medline, Scopus and Web of Science. Eight articles were found to meet the selection criteria and were included in the review.

#### *Results*

The review identified four studies with non-significant results. Three studies reported that expressive writing may be effective in reducing eating disorder symptomatology. One study reported a significant finding for the control condition over that of the expressive writing task condition.

#### *Conclusions*

Despite the inconsistency in findings, all studies reported that expressive writing may be of therapeutic benefit and that additional therapeutic contact may enhance efficacy. Further research however is needed to determine the effectiveness of expressive writing. Limitations of the current review are discussed and possible directions for future research include the use of clinical populations and the use of a comparator, such as CBT, rather than neutral writing.

## **Introduction**

The current review focused on the evidence for the efficacy of expressive writing in reducing eating disorder symptomatology. The review introduces the field of eating disorders, associated psychological interventions, expressive writing as an intervention and relevant theoretical underpinnings. The reviewed literature is presented and discussed.

### ***Eating Disorders***

Eating disorders encompass physical, social and psychological features. They are regarded as chronic and recurrent and are often associated with other psychological difficulties, such as depression, generalised anxiety disorder, alcoholism, phobias and post-traumatic stress disorder (National Collaborating Centre for Mental Health, 2004). In addition, eating disorders are often associated with physical complications (Stice, Marti, Spoor, Presnell, & Shaw, 2008). These problems can place considerable demand on education, employment, social and health services (National Collaborating Centre for Mental Health, 2004). Prevalence rates are estimated at 1 in 250 females and 1 in 2000 males for anorexia nervosa. Approximately five times that number suffer from bulimia nervosa. Other eating disorders such as binge eating disorder and eating disorder not otherwise specified may be more prevalent, however many of these individuals will not receive treatment (National Collaborating Centre for Mental Health, 2004). This may be due to individuals not approaching or engaging with services or not meeting service referral criteria. Eating disorder symptoms have been described as transdiagnostic (Fairburn et al., 2003), suggesting that an individual's difficulties may be fluid and dynamic across the different eating disorder diagnostic categories. This

would propose exploring eating disorder symptomatology, rather than discrete diagnostic categories and developing a treatment available for all individuals with an eating disorder, incorporating those who may not currently receive services. This is of particular significance due to the prevalence of eating disorder related difficulties and the associated severity of physical and psychological risks, for a population of individuals for whom it has been suggested there are difficulties engaging with an effective, appropriate intervention (Schmidt, Bone, Hems, Lessem, & Treasure, 2002).

### ***Psychological Interventions for Eating Disorders***

The treatment of eating disorders continues to present a significant clinical challenge and the lack of effective interventions suggests a need for additional research concerning treatments for these disorders (East, Startup, Roberts, & Schmidt, 2010). Reviews of evidence based treatments for eating disorders (Roth & Fonagy, 1996 and National Collaborating Centre for Mental Health, 2004) identified major methodological weaknesses in available research. It was suggested by the reviews that there was a lack of 'systemic investigation' of behavioural and cognitive behavioural methods for those diagnosed with anorexia nervosa. The treatment of choice for bulimia nervosa (National Collaborating Centre for Mental Health, 2004), has indicated that cognitive behavioural therapy (CBT) reduces symptoms in two thirds of patients, however only one third were symptom free at the end of the follow up period. Other psychological therapies such as interpersonal therapy and cognitive analytic therapy were comparable to the effects demonstrated with CBT. Conclusions were that there was a lack of research into effective treatments for those diagnosed with an eating disorder.

The evolution of a transdiagnostic approach has attempted to acknowledge the absence of interventions and poor remission rates for eating disorders (Fairburn et al., 2009). This approach promotes working with individuals offering similar interventions, regardless of eating disorder diagnosis. It is argued (Fairburn, Cooper, & Shafran, 2003) that this approach extends the CBT model of eating disorders, which is suggested to address dysfunctional concerns with body and shape that maintains weight control behaviours in which individuals engage (Fairburn, Marcus, & Wilson, 1993), by being inclusive of additional maintaining mechanisms, such as shame, pride, perfectionism, self esteem, mood intolerance and interpersonal difficulties this acknowledges the transition of individuals across eating disorder diagnoses and that there are shared maintaining psychopathological features. However, it is reported that treatments using a transdiagnostic CBT approach have still only achieved remission for approximately 50% of individuals after a 60 week follow up period (Goss & Allan, 2010).

### ***Expressive Writing as an Intervention for Eating Disorders***

Currently it appears that there is limited research into the effectiveness of treatments across eating disorder diagnoses. Research appears to be focused on a particular intervention for a specific diagnosis, for instance CBT for bulimia nervosa, or research has not demonstrated prolonged remission rates for those across diagnoses. The development of an intervention that will be appropriate and effective for individuals with an eating disorder is acknowledged to be challenging due to high attrition rates from therapy (Schmidt & Treasure, 2006).

In the literature, therapeutic writing tasks, also described as expressive writing or written emotional disclosure, are well researched in evaluating the psychological and physical wellbeing of individuals in non clinical populations (Frattaroli, 2006). Research reveals that writing about experiences has positive effects on physical and

psychological health, such as: decreased levels of distress in those who have suffered a trauma or loss (Kuiken, Dunn, & LoVerso, 2008); decreased depression, anxiety, and stress (Graf, Gaudiano, & Geller, 2008); and improved working memory capacity (Klein & Boals, 2001). Writing tasks have the additional advantages of being cheap, easily understood by individuals and are an intervention that can be continued to be used once formal therapy has ended (Smyth & Pennebaker, 2008).

Therapeutic writing tasks have been advocated as an adjunct to treatment in eating disorders (Schmidt et al., 2002), suggesting that standard therapeutic techniques may not transfer well to those presenting with eating disorder symptoms because of clients' pervasive experiential avoidance. There are reports that the use of expressive writing may target the cognitive, affective and interpersonal difficulties often associated with a diagnosis of an eating disorder (Treasure, Tchanturia, & Schmidt, 2005). For instance, it has been suggested that individuals with anorexia nervosa often display rigid thinking styles which can inhibit treatment outcomes, therefore an intervention which has been argued to encourage cognitive change, such as writing would be of benefit (Tchanturia et al., 2004). It is also suggested that those with an eating disorder may experience difficulties expressing feelings, needs and experiences (Geller, Hewitt, Goldner, & Flett, 2000), and that expressive writing may address this by facilitating disinhibition (Lepore, Greenberg, Bruno, & Smyth, 2002). Finally, expressive writing may work to address interpersonal aspects of eating disorders by allowing the individual to reflect on experiences from different perspectives (Campbell & Pennebaker, 2003).

### ***Theoretical Underpinnings of Expressive Writing***

Over 20 years ago, the first expressive writing study was conducted (Pennebaker & Beall, 1986) in which individuals were assigned to one of four writing conditions and

would write for 15 minutes on four consecutive days. Individuals would write either regarding: facts surrounding their trauma; emotions surrounding their trauma; facts and emotions surrounding their trauma; or a neutral event. Results revealed that, for several weeks after writing, the individuals who wrote regarding facts and emotions surrounding their trauma demonstrated a reduction in illness-related visits to the doctor. The findings suggested that written disclosure of a traumatic event could lead to an objectively measurable health improvement. Theoretical consensus has yet to be reached in relation to the mechanisms that might explain why written emotional disclosure has worked. Four main theories have been suggested. Firstly, inhibition theory suggests that disclosure of inhibited thoughts and feelings can improve physical and psychological health (Lepore & Smyth, 2002). Secondly, cognitive processing theory (Pennebaker, 1993) which involves challenging dysfunctional automatic thoughts and generating new meanings around misperceived ideas about a traumatic or stressful event. Thirdly, self-regulation theory (Lepore & Smyth, 2002) through learning self-regulation of emotional responses to traumatic stimuli. Writing expressively has been found to mediate the potential for mastery over one's self and over the intensity, duration and frequency of emotional responses to a traumatic or life stressor. The fourth theory is habituation (Foa & Riggs, 1995) through repetition and exposure to negative stimuli which eventually leads to extinction of thoughts and feelings relating to a distressing experience. Finally, disclosure through writing has also been found to stimulate greater social openness in people who have been exposed to traumas and stressful events and that this broadening of social networks can also have a mediating effect on adverse symptoms (Pennebaker & Graybeal, 2001).

### ***Why conduct the current review?***

At the time of writing no previous reviews were found to have been conducted regarding the effects of expressive writing on eating disorder symptomatology. In a meta-analysis of 146 studies on written emotional disclosure, Frattaroli (2006) noted that very little research examined the effects of expressive writing on populations with psychological or psychiatric complaints. Indeed, only four such studies were identified by Frattaroli (2006): Batten *et al.* (2002); Brown & Heimberg (2001); Gidron, Peri, Connolley, & Shalev (1996); Koopman, Ismailji, Holmes, Classen, Palesh, & Wales (2005).

Whilst expressive writing, as based on that developed by Pennebaker (1986) has been researched extensively, its use as an intervention for eating disorder symptomatology has been less widely investigated. However, the potential for an intervention that has been designed to facilitate psychological recovery and foster resilience is cost-effective and follows an easy to administer protocol that has generated growing interest in the approach.

### ***Rationale***

Individuals with a diagnosis of an eating disorder experience difficulties that encompass social, psychological and physical features. Existing research to date regarding effective treatments has identified the risks associated with the disorder and poor remission rates. However, there is little evidence of interventions that are proven to be effective for those across diagnostic categories. The development of a transdiagnostic approach is promising, as it improves the accessibility of potential interventions to individuals. However to date, the only research available is regarding

CBT. The use of expressive writing has been suggested to be effective for individuals with psychopathological features that are also prevalent in eating disorders.

### ***Review Aims***

The aim of the current review was to systematically review, critique and synthesise the literature regarding the effectiveness of expressive writing interventions in reducing eating disorder symptoms. Key areas that were addressed were:

1. What is the evidence of effectiveness for expressive writing as an intervention for adults with eating disorders?
2. What are the limitations and implications of the existing literature for expressive writing as an intervention for adults with eating disorders and how could future research address these?



## **Method**

### ***Development of Search Terms***

A scoping review of the literature was conducted which informed the review question and search terms. Initial searching of the literature revealed that studies conducted on the effectiveness of expressive writing for psychological difficulties more broadly, returned studies that were widely varied and therefore difficult to compare. The current search therefore focused on eating disorder symptomatology and the impact of expressive writing as an intervention. A combination of search terms was used: expressive writing, written emotional disclosure, experimental disclosure, therapeutic writing, and eating disorders. The accuracy of the search criteria was verified by checking whether previously identified papers were found using the search terms and inclusion criteria.

### ***Inclusion Criteria***

#### ***Studies***

To achieve the current review objective, only quantitative English language studies were included. Studies using individuals or groups that compared expressive writing with a control group were eligible for inclusion. Those that used therapeutic letter writing, which entailed a therapist writing the letter, were not included or those studies employing qualitative analyses. The study must have presented new data and not be a review or discussion of the literature.

### ***Participants***

Studies were included that recruited clinical or non-clinical populations of adults exhibiting eating disorder symptoms. For the purpose of the current review, eating disorder symptoms were defined as those that would meet the criteria for Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, Eating Disorder Not Otherwise Specified and individuals who do not have a diagnosis of an eating disorder, but are experiencing symptoms that are consistent with eating disorder symptomatology such as body image disturbance.

### ***Interventions***

Eligible studies were required to include a variation of the original written emotional disclosure task (Pennebaker & Beall, 1986). This task involved writing about a significant life event or personal topic.

### ***Procedure for the Identification of Studies***

Literature searches were conducted to identify relevant studies. Electronic databases: Medline, Psychinfo, Web of Science and Scopus were searched to include articles published between 1986, the year that the original expressive writing study was published (Pennebaker & Beall, 1986), and December 2011. In addition, the Cochrane Database of Systematic reviews was searched, which yielded no relevant studies. An outline of the resultant studies is detailed in Table 1, below. Once the relevant papers had been obtained, a backwards search was conducted, from which papers were located from reference lists and citations in studies already obtained. The titles and abstracts of studies were screened, with 18 identified that potentially met the inclusion criteria. Full text articles were retrieved for these references.

**Table 1. Database Search – December 2011**

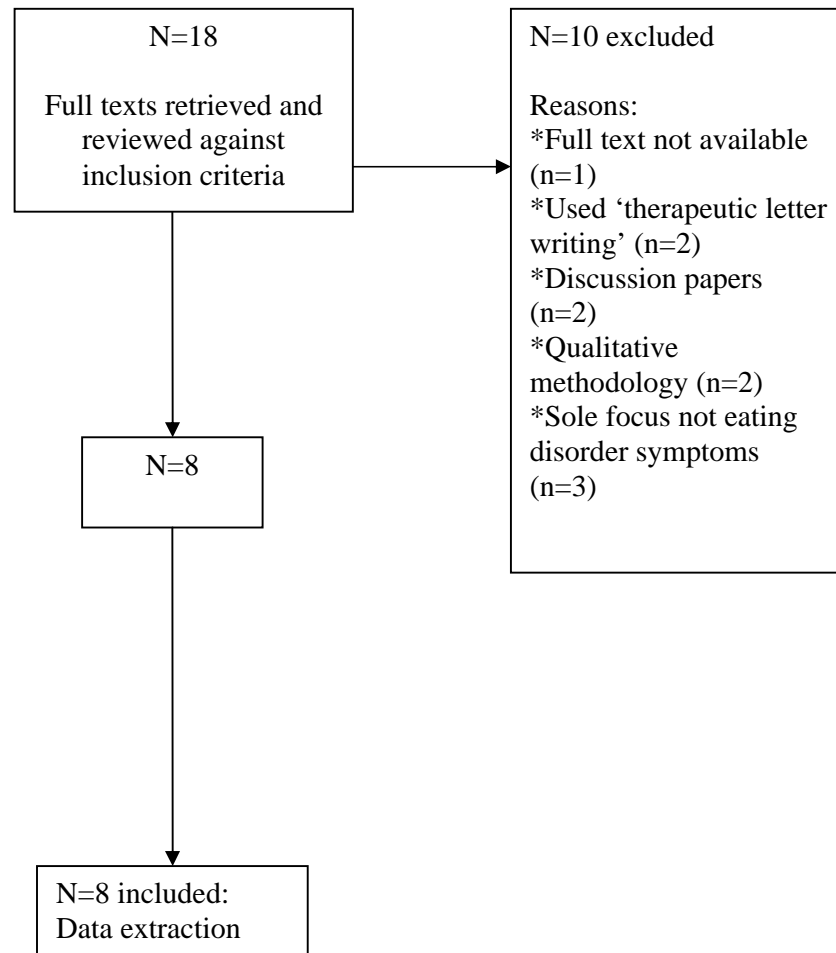
<b>Search Terms</b>	<b>Results Returned</b>			
	<b>Scopus</b>	<b>Medline</b>	<b>Psychinfo</b>	<b>Web of Science</b>
Therapeutic writing AND eating disorder*	54	7	27	45
Written emotional disclosure AND eating disorder*	3	0	1	4
Experimental disclosure and eating disorder*	8	16	65	1
Expressive writing AND eating disorder*	6	21	8	6

\*Truncation specific to each database used to maximise search results

### ***Full Text Retrieval***

Eighteen full text articles were evaluated against the inclusion criteria. Eight articles were included in the review, the selection process and reasons for exclusions are highlighted in Figure 1 below.

**Figure 1. Flow Chart of Full Text Screening**



### ***Data Extraction and Management***

The eight selected articles were further screened using data extraction variables (Appendix F). The data extraction form facilitated assessment of the quality of each article and its relevance to the current review. The extraction categories were informed by the Centre for Reviews and Dissemination guidance (Centre for Reviews and Dissemination, 2009), these were; author and date, study characteristics, study design,

participants characteristics, intervention and setting, methodological factors and results.

Each study was given an identification code from 1 to 8.

### ***Assessment of Methodological Quality of Included Studies***

Studies were assessed by applying a checklist based on that developed by (Downs & Black, 1998). The checklist assessed study quality, alerting the reviewer to particular strengths and weaknesses. Ratings are given to each statement on the checklist as 'yes' or 'no' to indicate whether they are present within the study. The quality assessment of the included studies is shown in Appendix G.

## **Results**

Eight articles were found to meet the selection criteria and were included in the current review. The synthesis process included details of participants, the intervention, outcomes and study design. Comparisons between studies involved examination of clinical and methodological heterogeneity. A summary of the study designs is detailed in Table 2 (page 19) and a summary of the results of the interventions in Table 3 (page 20). A summary of the main outcome measures used, relevant to eating disorder symptomatology is presented in Table 4 (page 21).

### ***Included Studies***

Eight studies with a total of 776 participants were identified. Two studies were dissertations (Grasso, 2007; Lafont, 2011); all others were published between 2002 and 2011 in peer reviewed journals.

### ***Study Designs***

The study designs were all appropriate to the present review question, therefore investigating the effectiveness of expressive writing as an intervention in reducing eating disorder symptomatology. Studies included in the present review involved randomised, minimum two group, parallel trials based on an expressive writing task (Pennebaker, 1989). In all studies, participants were assigned to write emotionally regarding eating disorder symptomatology or neutrally about a trivial topic, such as their room. Sample size varied from 22 (East et al, 2010) to 181 (Grasso, 2007).

### ***Participants***

Four studies (Johnston et al, 2010; East et al, 2010; O'Connor et al, 2011; Robinson & Serfaty, 2008) were conducted in the UK, three were conducted in the USA, and one was conducted in Australia (Frayne & Wade, 2006). Four studies recruited females only (Earnhardt et al, 2002; O'Connor et al, 2011; Frayne & Wade, 2006; Lafont, 2011). Each of the eight studies recruited participants from universities and colleges, with all studies excluding individuals from participation if they were in active treatment for a diagnosis of an eating disorder. One study also recruited participants from eating disorder websites (Johnston et al., 2010). Two studies investigated the effects of expressive writing on individuals reporting bulimic symptomatology, with Johnston et al. (2010) only recruiting those who scored within the medium range cut off for bulimia symptoms. East et al. (2010) and Robinson et al. (2008) recruited participants presenting with a range of eating disorder symptomatology including, bulimia, binge eating disorder and eating disorder not otherwise specified. Four studies recruited those who reported difficulties with body image.

### ***Interventions***

The present review considered studies that included the use of expressive writing based on that by Pennebaker (1986) with individuals experiencing difficulties in relation to eating disorder symptoms. The writing task involved writing about a significant life event or topic for 15 to 30 minutes for three consecutive days. All included studies evaluated against a control group. The maximum follow up period reported in the studies was 12 weeks.

Four studies (Johnston et al., 2010; Earnhardt et al., 2002; Grasso, 2007; Frayne & Wade, 2006) employed two group repeated measures designs evaluating the therapeutic writing task against a control condition. The remaining studies had two experimental conditions and a control condition. For example, O'Connor et al. (2011) asked participants to write regarding body image success stories and East et al. (2010) used a perspective shift writing task condition. Robinson et al. (2008) primarily investigated the efficacy of 'email bulimia therapy' against a therapeutic writing task and a control condition.

### ***Outcomes***

All eight studies in the present review used valid and reliable self-report measures for eating disorder or body image symptoms as a primary outcome. There was variability in the outcome measures used however, with little consistency across studies. A range of secondary measures were included in these studies primarily for depression and anxiety. Length of follow-up ranged from four weeks to 12 weeks. Measures used are listed in Table 4 (page 21).

### ***Representative Sampling***

In the majority of studies, recruitment appeared adequate to ensure representative sampling although this was unclear in two studies how samples were selected (Earnhardt et al., 2008; Frayne & Wade, 2006). All studies, with the exception of Earnhardt et al. (2008) indicated participants had been randomly assigned with the randomisation procedure clearly described.



### ***Allocation Concealment and Blinding***

It was implicit in the design of most studies how allocation concealment was assured. It was unclear in most studies however, if blinding of outcome assessors occurred, with the exception of East et al. (2010). All studies reported characteristics of participants lost to follow up.

### ***Effects of Expressive Writing Task***

Most studies only reported completer results. There were no significant differences in outcomes between treatment and control condition in four studies (Johnston et al., 2010; Earnhardt et al., 2002; Grasso., 2007; O'Connor et al., 2011). Statistically significant differences between comparison groups were found in the remaining four studies. However, Frayne and Wade (2006), reported that the significant difference was only notable for the control group. East et al. (2010) discussed that there were significant findings, with the effect only notable for the experimental tasks in reducing inhibited self expression and reducing concerns with eating, weight and shape. Robinson et al. (2008) reported that significantly fewer participants fulfilled the criteria for an eating disorder following the expressive writing task. Lafont (2011) reported significant findings for participants in the high symptomatology body image group. All studies concluded that, in isolation, therapeutic writing tasks may be of limited clinical significant outcome and that additional therapeutic contact may be necessary.

**Table 2. Summary of study designs included in review**

<b>Study ID, First Author &amp; Year</b>	<b>Aims</b>	<b>Design</b>	<b>Inclusion criteria</b>	<b>Exclusion criteria</b>	<b>Sample (female)</b>	<b>Diagnosis/ Symptoms</b>	<b>Sample selection</b>	<b>Follow-up</b>
1. Johnston (2010)	Effects on bulimic symptomatology of a writing task intended to reduce emotional avoidance.	Mixed between (writing)/within (time).	Score 10 or above on BITE Above 18 years old UK resident	In treatment for ED. Risk of self harm Serious physical illness Substance misuse BMI below 18.5	80 (71)	Bulimia symptoms	UK universities and colleges. Eating disorder websites.	8 weeks
2. East (2010)	Impact of 3 writing tasks on cognitive, affective & interpersonal factors associated with ED	2 experimental tasks, 1 control task.			22 (gender ratio 2:9)	Eating Disorder symptoms	UK university	4 weeks 8 weeks
3. Earnhardt (2002)	Initial increase in distress in experimental group, long term decrease in distress.	2 group repeated measures			48(48)	Body Image	USA university	4 weeks
4. Grasso (2007)	Web-based expressive writing intervention to improve body image	2 group repeated measures	Above 18 years old Self-reported body image difficulties.		181(89.5%)	Body Image	USA university	4 weeks
5. O'Connor (2011)	Efficacy of writing intervention on self esteem, body image and psychological distress	2 experimental tasks, 1 control task.	Female Aged 18-21 English as first language		158(158)	Body Image	UK university	4 weeks
6. Frayne (2006)	Effectiveness of therapeutic writing on disordered eating	Mixed between (writing)/within (time).			98(98)	Bulimia symptoms	Australian university	10 weeks
7. Robinson (2008)	Effect of email therapy in eating disorders	2 experimental tasks, 1 control task.	Diagnosis of BN,BED, EDNOS. Written English College email Staff or student	BMI below 17.5 Substance misuse Self harm Pregnant In treatment for ED	97(93)	Bulimia Nervosa Binge Eating Disorder EDNOS	UK university	12 weeks
8. Lafont (2011)	Effects of writing task interventions on eating disorder symptomatology.	2 experimental tasks, 1 control task.			92(92)	Body Image	USA university	4 weeks

**Table 3. Summary of results of interventions in review**

Study ID, First Author & Year	Intervention. Primary comparison	p value	Summary of impact on eating disorder symptomatology	Conclusions	Limitations
1. Johnston (2010)	Therapeutic and writing control task	p< .001	Symptom decreases statistically but not clinically significant. Control task led to reductions equal to writing task condition.	Used in isolation therapeutic writing tasks of limited benefit	No no-treatment control group. Self-selection bias?
2. East (2010)	1. Therapeutic writing task 2. Perspective shift writing 3. Control writing task	p<.063	Significant findings, effect only notable for experimental tasks	Writing tasks may address a number of ED symptoms. Experimental tasks more engaging on emotional level.	Non-clinical population –generalisability? Small sample size Low uptake and high attrition
3. Earnhardt (2002)	Therapeutic and writing control task	p>0.5	No significant differences over time for experimental or control condition. Participation in study, regardless of condition, related to improvements in body image and mood	Placebo, sensitisation effects, and regression to the mean explored as explanations for findings.	Narrow small sample. Only 1 month for follow up
4. Grasso (2007)	Therapeutic and writing control task	p>0.5	No significant differences over time for experimental or control condition.	No objective evidence for hypotheses. Solely web based, additional therapeutic contact may be beneficial.	Narrow sample Self selection bias Non-clinical
5. O'Connor (2011)	1. Therapeutic writing task 2. Body image success stories 3. Control writing task	p>0.5	No significant differences over time for experimental or control condition.	Therapeutic writing had beneficial effect on implicit self esteem. Supports that writing beneficial for those who self disclose.	Non-clinical More detailed measures of body image and self-esteem
6. Frayne (2006)	Therapeutic and writing control task	p<0.22	No significant findings for disordered eating or associated psychopathology. Significant finding in 'control' condition.	Use of therapeutic writing as an adjunct to therapy.	Student population Self report measures for ED No 'true' control group
7. Robinson (2008)	1. Email bulimia therapy 2. therapeutic writing 3. Control writing task	P<0.02	Significantly fewer participants fulfilled criteria for eating disorder. Significant findings over waiting list control. BDI and BITE scores no significant change.	Applicability of treating ED via email therapy. Usefulness of therapeutic writing.	Measures (QEDD not EDE-Q) Small sample
8. Lafont (2011)	1. Therapeutic writing task 2. Body image writing task 3. Control writing task		Significant findings for participants in high symptomatology group	Writing beneficial for those with ED symptoms	Small sample size Self report measures –social desirability Student population

**Table 4. Summary of main outcome measures relevant to eating disorder symptomatology**

<b>Main Outcome Measures</b>	<b>Johnston</b>	<b>East</b>	<b>Earnhardt</b>	<b>Grasso</b>	<b>O'Connor</b>	<b>Frayne</b>	<b>Robinson</b>	<b>Lafont</b>
BITE Bulimic Investigatory Test-Edinburgh	*						*	
HADS Hospital Anxiety and Depression Scale	*	*						
Emotional Approach Coping scales	*							
EDE-Q		*				*		
CBDS Cognitive Behavioural Dieting Scale			*					
Body Esteem Scale			*					
EDI-II Eating Disorder Inventory-II			*					
The Multidimensional Body-Self Relations Questionnaire				*				
Situational Inventory of Body-Image Dysphoria Short Form				*				
Body Image Disturbance Questionnaire				*				
Eating Attitudes Test-26				*				*
BIAQ Body Image Avoidance Questionnaire					*			
Body Checking Questionnaire					*			
Body Parts Satisfaction Scale								
QEDD Questionnaire for Eating Disorders							*	
Body Image Questionnaire								*

## Discussion

The aim of the current review was to review the strength of the evidence regarding the effectiveness of expressive writing as an intervention in reducing eating disorder symptomatology. Eight studies were identified that met the inclusion criteria, with a total of 776 participants, with sample sizes ranging from 22 to 181. Studies were conducted in the UK, USA and Australia. This section addresses the key areas that were to be identified in the review, the evidence for expressive writing as an intervention for individuals with eating disorders, the limitations and implications of the existing literature for clinical practice and future research.

### *Expressive Writing as Intervention for Eating Disorders*

Only a handful of researchers had used expressive writing as an intervention for eating disorder symptomatology. Of these, only one study in the current review used a non-student population (Johnston, Startup, Lavender, Godfrey, & Schmidt, 2010). Although most researchers used both a control group and an experimental group, their writing tasks differed. Frayne and Wade (2006) devised an experimental group that wrote about past trauma and a control group wrote about future planning; (Earnhardt, Martz, Ballard, & Curtin, 2002) had the experimental group write about body image and the control group write about their room.

Significant findings were found for the expressive writing condition in three of the studies reviewed (East et al., 2010; Lafont, 2011; Robinson & Serfaty, 2008). Eating disorder symptoms were reported to decrease statistically, but were not of clinical significance in one study (Johnston et al., 2010). Despite the inconsistency in findings, all studies reported that expressive writing may be of therapeutic benefit and that additional therapeutic contact may enhance efficacy.

Whilst research has shown expressive writing to be of greater therapeutic effectiveness than factual writing for individuals with a variety of physical and psychological problems (Kuiken et al., 2008); (Graf et al., 2008), the current literature does not suggest that the same is consistently true for eating disorder symptoms. In particular, researchers found that both of their writing groups experienced an equivalent increase in mood, improvement in body image and decrease in disordered eating (Earnhardt et al., 2002); (Grasso, 2007). It was also reported that there were no significant differences over time for the control or expressive writing condition, however, both groups experienced a beneficial effect on implicit self esteem (O'Connor et al., 2011). Frayne & Wade (2006) found that the control group who wrote about future planning experienced greater reduction in disordered eating and ineffectiveness (feelings of inadequacy, insecurity, worthlessness, and lack of control) at the 10-week follow up than the experimental group who wrote about a traumatic event. These reductions were attributed to the idea that the individuals who wrote about future planning possibly felt a greater sense of control over valued outcomes and that future planning may aid in the development of future coping tasks. These results are contradictory to what would be expected based on past expressive writing research, but still suggest that a writing intervention may be of use for individuals.

An assessment of the methodological quality of included studies was conducted using a checklist based on that developed by Downs and Black (1998). The quality assessment of the studies included in the current review is shown in Appendix G. From the assessment of the quality of the studies, those conducted by East et al. (2010), Robinson et al. (2007) and Lafont (2011) demonstrated the highest ratings. These studies scored positively, in comparison to the other included studies, on the quality checklist for the following items: participants were representative of the entire

population from which they were recruited; participants were randomised to intervention groups; adverse events as a consequence of the intervention were reported; and the studies had sufficient power to detect a clinically important effect. The studies that demonstrated the highest ratings on the quality checklist (East et al., 2010; Lafont, 2011; Robinson & Serfaty, 2008), were the studies that reported significant findings for the effectiveness of expressive writing as an intervention for adults with eating disorder symptomatology. A commonality in the designs of these studies is the inclusion of two experimental tasks: a therapeutic writing task and an expressive writing task focussed on eating disorder related difficulties; and a control writing task. The significant findings from the studies, which were only notable for the expressive writing task, suggested that expressive writing may be more emotionally engaging for participants, with a significant reduction in the number of participants experiencing eating disorder symptomatology (East et al., 2010; Lafont, 2011) and fulfilling the criteria for an eating disorder (Robinson & Serfaty, 2008).

### ***Limitations***

There were eight available studies that met the inclusion criteria for the current review. The inclusion criteria was defined to only include those studies that used the Pennebaker expressive writing paradigm, to enable a review of the possible mechanisms that expressive writing may be effective by. The criteria were also refined to include only those concerning eating disorder symptomatology. The justification for this was that previous research regarding expressive writing had excluded those with eating disorder symptomatology, focussing on post-traumatic stress disorder, depression, anxiety and non-clinical populations. The refinement of the selection criteria, although justified and reflective of the available literature for the current review, therefore produced interesting findings, resulted in few studies available for synthesis. It should

also be acknowledged that research had been conducted on the effectiveness and experiences of therapeutic letter writing, which entails the writing of letters by the therapist to the client and linguistic analysis studies. These studies were not included in the current review, and further investigation in to the findings and merit of these studies to the field would be beneficial due to the different constructs being measured.

As studies to date have used student populations and non-clinical samples, it is difficult to determine the generalisability of these findings to clinical populations. In addition, the vast variation of measures used across studies illustrates difficulties with the determination of and comparison of participants' eating disorder symptomatology. Therefore, it was difficult to draw conclusions as to the overall effectiveness of expressive writing.

A further limitation suggested with the studies included in the current review, was the maximum follow up period of 12 weeks. Previous research has argued that the engagement of individuals with an eating disorder is often difficult (U. Schmidt et al., 2002). It may be that an extended period of time is required for individuals to engage with expressive writing and for the intervention to be associated with improved outcomes.

### ***Implications and Future Research***

Given the prevalence and severity of the nature of eating disorders, there is increasing research into the effectiveness of alternative treatments. An approach that addresses the core underlying psychopathology has demonstrated the most effective results currently available in the literature. The use of expressive writing has been advocated as a useful adjunct to treatment, in particularly, addressing difficulties with experiential avoidance (U. Schmidt et al., 2002). Further research investigating the experiences of those completing expressive writing tasks may also provide an insight as



to the possible mechanisms that explain why expressive writing may be effective for some individuals and the difficulties it may be present for others. This may also provide evidence for the different theories presented as to how written disclosure may be effective: inhibition theory (Lepore & Smyth, 2002); cognitive processing theory (Pennebaker, 1993); self regulation theory (Lepore et al., 2002) and its effects on social openness (Pennebaker & Graybeal, 2001). Studies defined samples on eating disorder diagnostic categories and specific symptoms, for instance bulimia nervosa and body image. Further research that investigates a transdiagnostic approach to expressive writing, as proposed by Fairburn (2003), may be of use in addressing the core psychopathological features that underlie eating disorder diagnoses. This would also address the absence of research that has focused on populations of individuals who experience difficulties associated with a diagnosis of anorexia nervosa and eating disorder not otherwise specified.

### ***Conclusions***

Research regarding writing interventions for body image and eating disorder symptomatology suggested mixed evidence regarding expressive writing interventions for people with psychological and physical problems. There is evidence that groups, regardless of whether they engaged in expressive or factual writing, showed improvements related to negative body image and low mood (Earnhardt et al., 2002), similar findings were reported by (Frayne & Wade, 2006; Grasso, 2007) However, the research reviewed was limited and many different methods were used. The majority of research solely recruited university students and a variety of different outcome measures were used. From the present review, there appeared to be insufficient evidence to reach a firm conclusion as to the effectiveness of expressive writing as an intervention for

reducing eating disorder symptomatology. However, there were promising results, as significant findings were found for the effect of expressive writing in three studies (East et al., 2010; Lafont, 2011; Robinson & Serfaty, 2008) for reducing eating disorder symptoms. A review of these studies against those that did not report significant findings, suggests that the methodological quality of the studies that reported that expressive writing is an effective intervention for adults with eating disorder symptomatology is greater. There were also findings for the beneficial impact on self esteem, mood and that it may facilitate engagement and emotional expression over time. Further research on clinical populations may demonstrate further positive outcomes. Additionally, future research may be beneficial on evaluating expressive writing against existing eating disorder interventions.

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## **Research Report**

Dear Me: Exploring the Experience of Generating Self-Compassion through Letter  
Writing In Adults with Eating Disorders



## **Abstract**

### **Dear Me: Exploring the Experience of Generating Self-Compassion through Letter Writing In Adults with Eating Disorders**

**Lorna Showell**

#### ***Introduction***

There has been considerable acknowledgement within research into eating disorders that they are distressing for the individual experiencing the disorder, presenting psychological and physical risks posing a challenge to clinicians and services. The aim of the study was to explore the felt experience of compassionate letter writing by adults diagnosed with an eating disorder. It was hypothesised that the findings of the study would contribute to developing clinical practice in the new therapeutic approach of compassion focussed therapy and may elicit processes operating in compassionate letter writing interventions. A qualitative approach was adopted to describe these experiences and what they meant to individuals in overcoming an eating disorder.

#### ***Method***

Seven interviews were conducted with participants attending an outpatient eating disorders service. Interviews were transcribed, then analysed using interpretative phenomenological analysis (IPA).

#### ***Results***

Three superordinate themes and ten subordinate themes emerged from the analysis of the interview transcripts. The superordinate themes reflected the process that an individual embarked upon throughout the course of generating self compassion through letter writing; approaching the task as ‘the alien concept: leaving familiarity’, ‘letter writing as a journey’ and the identification of and ‘finding self-compassion’.

#### ***Conclusions***

The experience of generating self compassion through letter writing appeared to be not only a valued personal experience for individuals with an eating disorder, but it also appeared to be an effective intervention for targeting some of the core psychopathological features of eating disorders. The current lack of evidence available on effective treatments for eating disorders is of significant concern. Compassion focused therapy is a developing approach within the field of eating disorders, providing an alternative treatment for those who may not benefit from existing approaches. Limitations of the current study, clinical implications and suggestions for further research are discussed.

## **Introduction**

### ***Eating Disorders***

It is currently estimated that there are 1.6million people in the UK affected by an eating disorder, of which 11% are male (Beat, 2010). However, these statistics may not include those who have not presented to services for treatment or not received a formal diagnosis of an eating disorder. Recent research suggests that up to 6.4% of adults experienced difficulties consistent with a diagnosis of an eating disorder (McManus, Meltzer, Brugha, Bebbington, & Jenkins, 2009). The current Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR) (American Psychiatric Association, 2000), which is used in practice in the UK, establishes three categories for eating disorders: Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Eating Disorder Not Otherwise Specified (EDNOS). It is estimated that of those with eating disorders, 10% are diagnosed with AN, 40% BN, and the rest fall into the EDNOS category, including those with binge eating disorder (Beat, 2010). Due to the prevalence of associated factors individuals may experience alongside a diagnosis of an eating disorder, such as physical and psychosocial issues, it is often regarded as one of the most difficult psychiatric conditions to treat (Crow et al., 2009). It is also reported that individuals with eating disorders have the highest mortality rates of all psychiatric conditions (Crow et al., 2009).

The current evidence suggests that eating disorders are of serious concern to not only those diagnosed with a disorder, but also to clinicians and services. With this in mind it is considered of importance to explore the difficulties that those diagnosed with an eating disorder experience, existing approaches and treatments and how new approaches to eating disorders may aid recovery.

### ***Eating Disorders Treatment Approaches: Previous Research***

To date, the majority of research has focused on identifying separate features of eating disorders according to each diagnostic category. Research has described how those with a diagnosis of BN and those diagnosed with AN experienced emotions. It has been suggested that mood intolerance is significant in the aetiology and maintenance of BN (Fairburn, Cooper, & Shafran, 2003), affecting behaviours such as binge eating to avoid or minimise emotional distress. There have also been reports of individuals with BN experiencing alexithymia (Bydlowski et al., 2005). The experiences of women with BN were investigated before and after a mindfulness based eating disorder treatment group (Prolux, 2007). Individuals described an experience of moving from a position of loneliness, self-loathing and a disconnected, idealised image of self to the development of an inner connection with themselves, acceptance and compassion, resulting in reduced emotional distress and improved abilities to manage stress. It was reported that being a member of the group facilitated the development of individuals due to their experience of mutual vulnerability.

It has been described that those with AN are experientially avoidant (Schmidt, Bone, Hems, Lessem, & Treasure, 2002), thus detaching from personal, psychological, physical and interpersonal experiences. In addition, individuals may have difficulties verbalising their feelings, needs and experiences. It has been suggested that this is more apparent when such verbalisation may be perceived to result in interpersonal loss or discord (Geller, Hewitt, Goldner, & Flett, 2000), therefore engagement with their own difficulties, social relationships and services may be challenging.

Similar to research regarding the pathology of eating disorders according to diagnosis, historically, treatments for eating disorders have also been focussed on an

individual's diagnosis. Perhaps surprisingly given the severity of AN, there is very little research available into the effectiveness of treatments. Possibilities for this may be due to the recruitment of individuals as there is a low incidence of the disorder compared to BN and EDNOS, there is also a high attrition rate from outpatient therapy (Agras, Brandt, Bulik, Dolanswell, & Fairburn, 2004) and the disorder often requires long term management.

The EDNOS category of eating disorders encompasses difficulties that do not reach all of the diagnostic criteria for BN or AN. It is reported (McManus et al., 2009) that EDNOS can typically account for half of all eating disorder diagnoses. The NICE guidelines (National Collaborating Centre for Mental Health, 2004) suggest that as there is no evidence for the management of EDNOS, the clinician should follow the guidance for the eating disorder that most closely represents the individual's eating difficulties.

Currently the treatment of choice for individuals diagnosed with BN is cognitive behavioural therapy (CBT), as to date, it is the most empirically supported intervention (National Collaborating Centre for Mental Health, 2004). Manual based CBT (Fairburn, Marcus, & Wilson, 1993) is based on the notion that the core feature of BN behaviours is the dysfunctional concern with body and shape that maintain the weight control behaviours in which individuals engage. The manualised CBT approach was revised (Fairburn et al., 2003), enhancing the treatment not only for BN but for other eating disorders. The enhanced approach included the addition of low self esteem, clinical perfectionism, mood intolerance and interpersonal difficulties as maintaining mechanisms. However, despite the empirical support for this treatment, it is argued that too many patients do not respond sufficiently to this approach (Wilson, 2005).

The difficulties associated with the engagement and effective treatment for those with eating disorders has been reported in the research literature (East, Startup, Roberts, & Schmidt, 2010; Johnston, Startup, Lavender, Godfrey, & Schmidt, 2010; Schmidt et al., 2002; Stice, Marti, Spoor, Presnell, & Shaw, 2008). Roth & Fonagy (1996) and the National Collaborating Centre for Mental Health (2004) have provided major reviews of evidence based treatments for eating disorders. Major methodological weaknesses were identified (Roth & Fonagy, 1996) in studies and it was concluded that there was a significant lack of investigation into the effectiveness of behavioural and cognitive behavioural methods for eating disorders. Evidence of the effectiveness for other psychological therapies such as interpersonal therapy and cognitive analytic therapy were comparable to the findings demonstrated with cognitive behavioural therapy.

The research to date, conducted on the psychopathology of eating disorders has been focussed on separate diagnostic categories. This has led to a somewhat linear pathway of intervention for those individuals, according to their particular eating disorder presentation. However, there does appear to be similarities in the research regarding the avoidance of emotional experiences in those across the diagnostic categories and this may be transferrable to the more recent research that is now being conducted in the field of eating disorders.

### ***Eating Disorders: Recent Research***

Recent research has suggested a commonality of features across eating disorder diagnostic categories. To date, there has been limited research into the role of symptoms across eating disorder diagnoses, however it has been proposed that treatment for underlying psychological distress may be at least as effective as treating

specific eating disorder behaviours (Steele & Wade, 2008). Using a phenomenological approach, the personal meaning for individuals experiencing a range of eating difficulties was explored (Fox, Larkin, & Leung, 2011). Three overarching themes were identified: the experience of the eating disorder as functional; the negative effects of having difficulties; and ambivalence towards eating difficulties. The finding that their difficulties were functional was explored and how individuals exhibited 'exaggerated adolescent egocentricity'. It was suggested that once the adolescent stage of development was negotiated with individuals through the development of relationships, self identity and regulation of experiences, this may reduce the functionality of the eating disorder and therefore the frequency of symptoms. Despite participants having different symptoms, there was considerable overlap of their experiences. In a study analysing the language of individuals with an eating disorder, it was reported that the cognitive style of individuals, reflected through their writing was ruminative, past orientated, negativistic, self-focused and avoidant (Wolf, Sedway, Bulik, & Kordy, 2007).

The absence of research into effective treatments that contribute to the evidence base is of significant concern, specifically for those individuals diagnosed with AN or EDNOS. The development of a transdiagnostic approach, shown to be of use with BN, could be more widely applied in treating those with an eating disorder. This approach may be able to reach all those experiencing difficulties associated with disordered eating behaviours and psychological distress where current evidence based treatments are failing to offer empirically supported research.

### *Compassion Focussed Therapy*

Compassion focussed therapy (CFT) for eating disorders (Goss & Allan, 2010) encompasses a transdiagnostic approach, addressing factors such as shame, pride, self-directed hostility and self-criticism. CFT offers a promising approach by combining cognitive restructuring with the development of self-compassion. Self-compassion is the ability to treat oneself kindly rather than being harshly self critical, not to be overwhelmed by distress and to see one's problems as part of human experience (Neff, 2003). This approach attempts to address the difficulties that individuals with a diagnosis of an eating disorder may experience with standard cognitive therapies. It is suggested that individuals generating alternative cognitions can see the logic, but do not feel emotionally reassured by the alternative cognitions, with the inability to "feel" the intervention as supportive and helpful (Gilbert, 2000).

CFT for eating disorders has been developed over the past five years, combining elements of cognitive behavioural therapy and other eating disorder treatments (Goss & Allan, 2010). A CFT approach for overcoming shame has proved effective in clinical studies of its use in the treatment of eating disorders (Goss & Gilbert, 2002). It also included techniques to help individuals address distressing thoughts, feelings and behaviours and help to normalise their eating and weight.

There has been relatively little research into self-compassion and CFT. Research that has so far been conducted leaves uncertainty as to how well the findings generalise to clinical populations.

## *Self Compassion*

Self compassion has been conceptualised as involving three interrelated components that are demonstrated at times of distress: self kindness; holding thoughts and feelings in mindful awareness; and understanding one's own fallibility. These components are described as "being touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering and to heal oneself with kindness" (Neff, 2003, p.87). In a qualitative study, the meaning and experience of compassion for individuals with depression and anxiety was explored. The findings are encouraging as participants described positive experiences of self compassion and connected with the concept meaningfully (Pauley & McPherson, 2010). Self compassion has been reported to be negatively associated with depression and anxiety, rumination, thought suppression and avoidance in another study, which focussed on young adults and adolescents (Neff, 2003).

Self compassion has a growing evidence base for its potential clinical usefulness. The barriers to the development of self compassion have also been explored. It is suggested that individuals may perceive it to be difficult, as it can feel especially challenging due to their psychological disorder and how this has negatively impacted on their ability to be self compassionate (Pauley & McPherson, 2010). A recent investigation into the fears of self compassion (Gilbert, McEwan, Matos, & Rivis, 2011) has suggested that it is not only the absence of compassion that is of importance but the fear that an individual may have of holding compassion. This may mean that compassionate behaviours or experiences are resisted. In clinical practice this needs to be considered as, if the fears of generating compassion are left unaddressed, then it may be that individuals are not able to experience feelings of kindness and



compassion, with the therapy then potentially having limited impact. The development of ways of facilitating compassion is advocated as important. Previous research (Gilbert, Baldwin, Irons, Baccus, & Palmer, 2006) concerning the fears of self compassion found that individuals experienced doubt, fear and resistance. These feelings were linked to an unfamiliarity with compassion, not considering its value and an unresolved feeling of grief of wanting kindness but experiencing rejection. In a more recent study, Gilbert et al. (2011) reported that fears of compassion for the self were linked to self-coldness, self-criticism and depression.

Only one study has focussed on eating behaviours and self compassion (Adams & Leary, 2007). A study investigating individuals with rigid restrictive eating attitudes found that those who received a self compassion induction reported increased positive affect, without increased negative affect. They could keep their eating goals in mind and did not ruminate on diet breaking behaviours. In addition, it was suggested that by inducing self compassion, personal responsibility was increased, with individuals reportedly not feeling overwhelmed by negative emotions, thus increasing potential future emotional regulation abilities.

### ***Compassionate Letter Writing***

Compassionate letter writing is an important component of CFT for eating disorders; it is based on expressive writing tasks that have primarily been used to help clients communicate about distressing events and process emotions (Smyth & Pennebaker, 2008). It is not yet known however which variables impact on the effectiveness of expressive writing interventions. In the literature there are four proposed theories that suggest how expressive writing may be beneficial to individuals: Inhibition theory (Lepore & Smyth, 2002) suggested that physical and psychological

health can be improved through the written disclosure of thoughts and feelings. Secondly, cognitive processing theory (Pennebaker, 1993) suggested that writing enables the challenging of dysfunctional automatic thoughts and facilitates the individual to produce new meanings about a traumatic or stressful event: Thirdly, self-regulation theory (Lepore & Smyth, 2002) proposed that writing enables an individual to learn emotional self-regulation. Finally, the theory of habituation (Foa & Riggs, 1995) suggested that through exposure and repetition, the thoughts and feelings relating to a distressing experience are diminished. Disclosure through writing has also been found to encourage greater social openness in individuals who have been exposed to traumas and stressful events and this broadening of social networks can also have a mediating effect on symptoms (Pennebaker & Graybeal, 2001).

It has been suggested that current therapeutic techniques may not transfer well to those experiencing eating disorder symptoms due to an exhibited pervasive experiential avoidance (Schmidt et al., 2002) and that therapeutic writing tasks are an appropriate addition to current therapeutic techniques. The effectiveness of expressive writing has been attributed to its ability to address the cognitive, affective and interpersonal difficulties often associated with a diagnosis of an eating disorder (Treasure, Tchanturia, & Schmidt, 2005). This is of particular interest when regarding the research that has suggested that individuals with anorexia nervosa can display rigid thinking styles that may impact on treatment outcomes, therefore an intervention that has been argued to encourage cognitive change, such as writing, may be of benefit (Tchanturia et al., 2004). In addition it has been proposed expressive writing may facilitate the disclosure of emotions, experiences and needs (Geller et al., 2000) through disinhibition (Lepore, Greenberg, Bruno, & Smyth, 2002). Finally, expressive writing can encourage an individual to reflect on experiences from different perspectives (Campbell &

Pennebaker, 2003), which may alleviate distress associated with interpersonal difficulties. Research that has investigated the effectiveness of writing interventions for those diagnosed with eating disorders has found that there were significant findings in reducing inhibited self expression and concerns with eating, weight and shape (East, Startup, Roberts, & Schmidt, 2010). Significantly fewer participants fulfilled the criteria for an eating disorder following an expressive writing task (Robinson & Serfaty, 2008) and significant findings were reported for participants in a high symptomatology body image group (Lafont, 2011).

It is argued that outcome results for writing tasks are impressive, given the brevity of the treatment and its flexibility in individual or group interventions. Writing tasks have the additional advantages of being cost effective, easily understood by clients and are an intervention that individuals can continue to use after formal therapy has ended (Schmidt et al., 2002).

It has been suggested (Gilbert et al., 2006) that using a standard paradigm of writing freely about a negative experience may lead to individuals writing letters which are implicitly self critical with more authoritarian than compassionate suggestions, therefore compassionate letter writing has been developed. Compassionate letter writing is an integral part of CFT and is not a stand alone treatment. It is a task where the theory and techniques taught in compassion focused therapy are drawn together. Individuals practise writing self-compassionate letters to themselves, expressing warmth and understanding of the problems they are experiencing. Letters may be read aloud, alone or to a group using a warm and sympathetic tone of voice in order to enrich the felt experience of self compassion. The goal of compassionate letter writing is to generate experiences of kindness and self-warmth. Further aims of compassionate letter

writing are for the individual to practise thinking about the self from a caring point of view, generating alternative thoughts and directing attention to different aspects of the self, therefore reducing high levels of shame, self directed hostility and self-criticism.

The only available research to date investigating the induction of self compassion through writing suggested that self reported self compassion can be increased in individuals, with individuals reporting lower negative affect and an adoption of a position of personal responsibility (Leary, Tate, Adams, C.E., Allen, & Hancock, 2007). Leary et al. (2007) utilised a student population comparing individuals in a self compassion induction condition, a self esteem induction condition, a writing control and a control condition. Leary et al. (2007) suggest the value of further research investigating the processes operating in self compassion and research conducted in clinical settings. To date there has been no research on the ‘insider perspective’ of developing self-compassion or expressive letter writing which generates a compassionate focus with individuals diagnosed with an eating disorder.

### ***Rationale for the Current Study***

There has been considerable acknowledgement within research into eating disorders that they are distressing for the individual experiencing the disorder, presenting psychological and physical risks posing, a challenge to clinicians and services. The majority of research conducted has divided the treatment of eating disorders into the separate diagnostic categories of AN, BN and EDNOS. Although there has been effectiveness demonstrated regarding the treatment of BN, this is limited and the lack of evidence available on effective treatments for AN and EDNOS is of significant concern due to the severity of AN symptoms and the high prevalence of EDNOS.

The development of a transdiagnostic approach suggests considering the core aetiological and maintaining features across diagnostic categories. Consideration of these features in developing interventions enables the development of treatments applicable to all those experiencing eating disorder difficulties and may help to address the difficulties currently associated with the engagement of individuals with treatment and its subsequent effectiveness. Particular features that have been identified are those of avoidance, rumination, past orientation, negativity, self criticism, with the eating disorder behaviours viewed as functional to cope with current difficulties.

The generation of self compassion was hypothesised by the researcher in the current study as a valuable experience to be investigated for individuals with eating disorders. The aim of the current study was to explore the felt experience of compassionate letter writing by adults who had been diagnosed with an eating disorder. It was hypothesised that the findings of the current study would contribute to developing clinical practice in the new therapeutic approach of compassion focussed therapy and may elicit processes operating in compassionate letter writing interventions. The cognitive, affective and interpersonal impacts associated with the features across eating disorders were considered in the current study. A qualitative approach was adopted to describe these experiences and what they meant to individuals in overcoming an eating disorder.

Questions that were explored in the study were: what are the thoughts, emotions, behaviours and physical responses of clients when writing their letters and when reading them out to the group; their reflections later; how this experience altered over time by comparing their first letter with their last; and the differences (if any) when

writing alone. The answers may be helpful in understanding how the individual's relationship with the self alters and how interactions with others affect this process.

### *Aims*

The aim of the current study was to explore the experience of generating self compassion for individuals diagnosed with an eating disorder. The following key areas were addressed:

1. What is the experience of adults with eating disorders when they try to generate self-compassion through letter writing?
2. What does the experience of writing a self-compassionate letter mean to an individual in their struggle to overcome an eating disorder?
3. What are the difficulties or problems experienced when using compassionate letter writing?
4. Are there strategies that help individuals overcome any difficulties that they experience with compassionate letter writing?
5. How does an individual's experience of compassionate letter writing develop over the course of therapy?
6. What components of the compassionate letter writing process seem to have most effect and what are these effects?

## **Method**

This section details the design and rationale for the chosen methodology, describes participant recruitment, data collection and analysis procedures.

### ***Design***

The aims of the study and the research questions were exploratory and emphasised the meaning and understanding an individual had of their personal and social experiences of writing compassionate letters, which led to the choice of a qualitative methodology. Semi-structured interviews were chosen as a means of data collection as they would ensure that the interview was conducted in a systematic, comprehensive and replicable manner (Widiger & Coker, 2002), whilst being open-ended, flexible and modifiable in light of any issues arising. Modifications to the interview enabled the interviewer to ask prompt questions, seek clarification from the participants and explore the participant's account more thoroughly. The interview format enabled an encouraging yet neutral stance of the interviewer who could facilitate both positive and negative aspects of the individual's experience to be discussed. Interpretative Phenomenological Analysis (IPA) was deemed to be consistent with the research aims in that it explored the experiences of the individuals diagnosed with an eating disorder, providing an enriched account of their process of compassionate letter writing. This approach was deemed to be favourable above other qualitative methodologies such as Discourse Analysis, which focuses on the language an individual uses or Grounded Theory, which focuses on developing a theoretical narrative from the participant's account.

## ***Participants***

The sample consisted of seven individuals diagnosed with an eating disorder, who attended a specialist outpatient adult eating disorders service. IPA guidelines suggest that a sample size between 4-10 participants provides adequate data to examine similarities and differences between participants but not so many so that there is an overwhelming amount of data (Smith, 2006). Participant demographics are detailed in Table 1. All participants were interviewed within 6 weeks of finishing the treatment programme at the eating disorders service. Some individuals declined to participate in the research, expressing a reluctance to discuss and revisit potentially distressing information. Some individuals expressed that they had devoted a lot of time to the therapeutic programme and did not wish to take further time off from work or their studies. For others, it was deemed inappropriate to participate in the research by clinicians due to ongoing difficulties they were experiencing.

**Table 1.** Participant Demographics

<b>Participant*</b>	<b>Age</b>	<b>Gender</b>	<b>Ethnicity</b>	<b>Diagnosis at beginning of treatment</b>	<b>Length of eating disorder</b>
1. Krystyna	28	Female	White-Polish	Bulimia Nervosa	11 years
2. Saskia	25	Female	White-British	Bulimia Nervosa	18 months
3. Jane	37	Female	White-British	Bulimia Nervosa	15 years
4. Eve	21	Female	White-British	Anorexia Nervosa	4 years
5. Adam	19	Male	White and Black Caribbean	Bulimia Nervosa	2 years
6. Heather	27	Female	White-British	Bulimia Nervosa	15 years
7. Mandy	25	Female	White-British	Bulimia Nervosa	11 years

\*All participants names have been changed to ensure confidentiality.



***Inclusion criteria.***

Participants were required to have completed the eating disorders therapy programme. The study inclusion criteria therefore followed those of the eating disorder service. These were:

- Aged 18-65
- Diagnosis of anorexia nervosa, bulimia nervosa, or eating disorder not otherwise specified.
- Suitability for outpatient treatment (being able to attend weekly sessions).

An additional inclusion criterion specific to the study was that participants had attended at least two group sessions in which they had written compassionate letters.

***Exclusion criteria.***

Consistent with the eating disorders service exclusion criteria, the exclusion criteria were:

- A body mass index of 15 or less
- A recent history of self harm (Self injurious behaviours in the preceding 6 months)
- Suicidal ideation, planning or intent
- Illegal drug use; alcohol misuse
- Diagnosis of psychosis
- History of aggressive behaviour
- Intellectual disability.

### ***The Treatment Programme***

The group treatment programme at the eating disorders service consisted of three phases: psychoeducation; recovery; and maintenance. The psychoeducation group programme consisted of two hour sessions weekly, for four weeks. The aim of the psychoeducation programme was to provide individuals with information regarding the physical, psychological and social consequences of an eating disorder. The second phase of the treatment programme was a 20 session group based recovery programme. This took place over 16 weeks, with two sessions a week for the first four weeks, followed by weekly sessions for 12 weeks. There was telephone and face to face support available between group sessions. Each group session lasted for 2.5 hours, with homework tasks each week. The main focus of the recovery phase of the programme was for individuals to develop skills in understanding the nature and value of compassion and to practise using these skills. The content of the programme included: crisis management techniques; using thought, behaviour and eating diaries; meal planning; completing a compassionate formulation; using compassionate imagery and breathing techniques; compassionate letter writing; and finally the development of a relapse prevention plan. The third phase of the group treatment programme consisted of monthly maintenance group sessions for three months. Compassionate letter writing was introduced in session 11 of the recovery phase of the programme and subsequently would feature in the remaining nine sessions of the group programme. On average half of a group session may be devoted to compassionate letter writing. Compassionate letters would be written in sessions and for homework, individuals would read their own letters out to the group or another group member would read their letter out if the individual chose to do this.

### ***Ethical Approval***

Ethical approval for the study was granted by a local Research Ethics Committee and the host NHS trust Research and Development Department. The study had previously been granted ethical approval in June 2009, however due to the study not commencing at this time, amendments were requested to reflect the new researchers conducting the study. See Appendix E for ethical approval documentation.

### ***Materials***

- Information Sheet (Appendix D)
- Consent Form (Appendix H)
- Digital recorder for interviews which were transcribed
- Semi-structured interview (Appendix I)

The semi-structured interview was devised in collaboration with clinicians working within the eating disorders service. The semi-structured format of the interview enabled the interviews to be participant led, with additional questions asked based on participant responses. The key areas of the interview were focussed on individual's experience of:

- Compassionate Letter Writing (CLW) in the therapeutic group programme
- CLW outside of the therapeutic group programme
- Developing self compassion

### ***Procedure***

Participants were drawn from a purposive sample of clients from the targetted eating disorders service who were approaching the end of therapy or who were in the eating disorders service maintenance programme, in which their Body Mass Index

(BMI) and psychological state continued to be monitored by an allocated service clinician. Recruiting participants who were in therapy or on the maintenance programme ensured that individuals still met the study inclusion criteria at the time of their interview. Clinicians within the eating disorders service identified potential participants who met the study inclusion criteria and informed them of the research towards the end of their therapy. Information was given to potential participants by the clinician that their decision to participate or not in the study would not affect their treatment. The clinician gave an Information Sheet (Appendix D) and answered any initial questions. If individuals agreed to be approached, their contact details were forwarded to the researcher. After a delay of at least 24 hours to allow the potential participant to consider their initial decision, they were contacted by telephone by the researcher to provide a further opportunity to ask questions, confirm that they want to participate and to arrange an appointment for the research interview at the eating disorder service where they attended for treatment. All individuals were informed that they were entitled to leave the study at any time without giving a reason, in which case their data would be destroyed.

Prior to the commencement of the interview, individuals were guided through the completion of a Consent Form (Appendix H). Each interview lasted approximately 35 to 60 minutes and was digitally recorded. Participants were debriefed following the end of the interview, which was not recorded. The researcher made notes regarding thoughts and observations of the process of the interviews immediately after each interview.

## ***Analysis***

The initial interview was transcribed verbatim by the principal researcher and due to time constraints, the remaining interviews by a paid administrator who signed a confidentiality agreement. For those interviews that were not transcribed by the principal researcher, each audio recording was played back in conjunction with reading the transcript not only to edit each interview, but also to become familiar with the content (see Appendix J for example transcript extract).

The data was analysed using IPA. Each transcript was read a number of times by the researcher, and initial notes made regarding interesting or significant material. Following this, each interview was examined looking at the descriptive, linguistic and conceptual content of the interview (Smith, Flowers, & Larkin, 2009). This process relied on how the researcher made sense of what had been said and was not prescriptive regarding what was commented on. Once this process had been completed for each transcript, emerging themes were developed. A chronological list of themes was developed for each transcript. Themes were clustered in terms of the strongest and most significant concepts to the less significant concepts. During this process, certain themes were excluded from the research, for instance those with limited data in the transcripts to support them. From the development of superordinate themes for each individual transcript, the themes were then re examined across the seven transcripts for similarities and differences. This led to the final superordinate and subordinate themes.

## ***Position of the Researcher***

The interviews and data analysis were conducted by the principal researcher who was a 30-year old female, White-British trainee clinical psychologist.

The researcher was also on placement in an eating disorder service and therefore had clinical experience to draw upon. With respect to clinical experience, the researcher may have had a preconceived view of the experiences of individuals writing compassionate letters in the eating disorder service. It was therefore ensured that the researcher did not interview individuals for whom they had been the lead clinician in the service. Assumptions, expectations or biases that the researcher may have had were discussed: in clinical supervision with a clinician working within the eating disorders service; in research supervision; and in a reflective journal. The researcher took on a predominantly contextual constructionist epistemological position, assuming that there is not one reality that can be assumed. The impact of both the researcher and the participants was considered and how both interpret and act upon the world around them. The position that knowledge is local, provisional and situation dependent (Jaeger & Rosnow, 1988), reflected the researcher's stance in the analysis and interpretation of the data. The philosophy of IPA appeared to be consistent with this stance in that the production of knowledge may be effected by participants' own understandings and the researcher's interpretations (Pidgeon & Henwood, 1997).

### ***Quality Issues***

Due to the reflexive process of qualitative research, different criteria for assessing the quality of the current research are needed to that used in quantitative studies. Smith et al. (2009) recommended the use of the guidelines proposed by Yardley (2000), and have described how they can be applied to IPA research. Therefore the current study was assessed with regards to quality issues using the four principles outlined by Yardley (2000): sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance.

### ***Sensitivity to context.***

Sensitivity to context can be established by the demonstration of sensitivity to the existing literature and theory, the socio-cultural setting of the study (Yardley, 1999) and the material obtained from the participants (Smith et al., 2009). The current research addressed this issue through the attention to relevant theoretical knowledge and literature, detailed description of the study process and the in-depth analysis of the data.

### ***Commitment and rigour.***

The quality issue of commitment and rigour is described as an in-depth engagement with the topic and a competence and skill in the method used (Yardley, 2000). Smith et al. (2009) suggested that this may be demonstrated through attentiveness to participants during data collection and a detailed analysis.

### ***Transparency and coherence.***

Smith et al. (2009) stated that transparency refers to how clearly the stages of the research process are described and that there should be coherence between the research that has been carried out and the underlying theoretical assumptions of the approach being utilised.

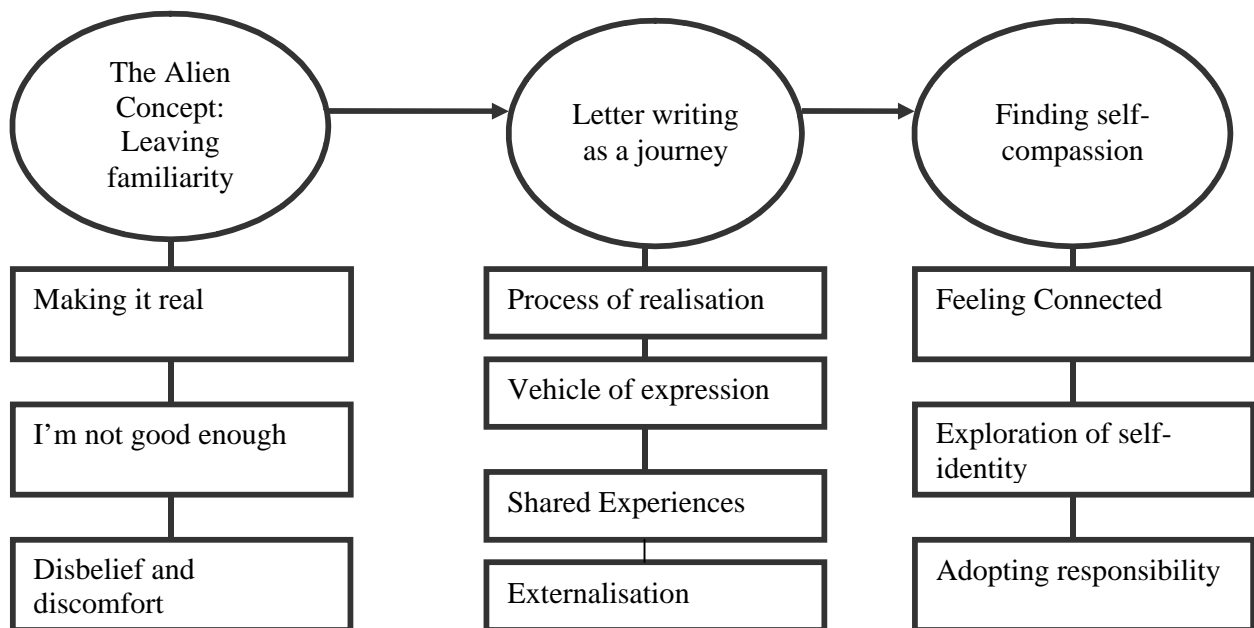
### ***Impact and importance.***

This final principle reflects that however well or sensitively a piece of research is conducted, the most decisive way it may be evaluated is if it has impact and importance for its intended audience. The findings and clinical implications of the research are contained within the Discussion section.

## Results

Three superordinate themes and 10 subordinate themes emerged from the analysis of the interview transcripts, illustrated in Figure 1. The superordinate themes reflected the process that an individual embarked upon throughout the course of generating self compassion through letter writing: approaching the task as ‘the alien concept: leaving familiarity’; ‘letter writing as a journey’ that an individual embarks upon; and the identification of and ‘finding self-compassion’. Each of the themes illustrated the participants’ experiences and was related to the research questions. As suggested by Smith (2011), the narrative of each theme is detailed in the Results section and the interpretation is presented in the Discussion section. An overview of each superordinate theme with subordinate themes follows, with verbatim participant extracts.

**Figure 1.** Superordinate and subordinate themes.





## ***The Alien Concept: Leaving Familiarity***

### ***Overview***

This theme aims to reflect the unfamiliarity of being introduced to the concept of generating self-compassion through letter writing and approaching change. For over half of the participants interviewed, they discussed how the act of writing would make their experiences and their difficulties real. This triggered thoughts associated with disbelief that writing compassionately would work and feelings of discomfort at the prospect of discussing their difficulties. It was apparent that participants had not previously discussed experiences that were causing them significant distress; to do this was an alien concept and completely unfamiliar. All participants discussed feelings of not being good enough, a bad person and feelings of being useless when approaching compassionate letter writing.

### ***Making it real***

All participants spoke of initially approaching the concept of compassionate letter writing as being confronted with having to deal with emotions, rather than a reluctance to write. Participants spoke of past and present difficulties and experiences and how now writing these on paper would make them real:

*‘My first letter I didn’t write everything, I held quite a, quite a bit back so I didn’t have to deal with it’ (Mandy/7/5/103)*

*‘understanding the emotions and being prepared to deal with putting them down on paper because it was more of a barrier at the first sort of session, rather than not wanting to do it, proper writing’ (Jane/3/7/148)*

Heather spoke of her thoughts about talking about experiences and the negative affect this would cause her. It seemed that what was familiar to participants was to not acknowledge or think about their past experiences or difficulties:

*'we're voicing about what, like I said that, I kept in for so long and, and seeing it on papers almost an admission that they happened. Well it is an admission that they happened erm and I don't know how to deal with that so its kind of like dredging up all these feelings that I can't really handle'* (Heather/6/19/456)

### ***I'm not good enough***

The theme of not being good enough was apparent for all participants when they reflected on their thoughts of when compassionate letter writing was first introduced. For some, they related their thoughts of not being good enough to their experiences with relationships:

*'the bad person erm, I just felt that erm I'm not good enough erm to have er friends I have cos I know they care about me and, and me as a bad person was pushing them away'* (Krystyna/1/19/467)

Saskia and Mandy spoke of feeling that there was no point in trying anything new as they believed they would not succeed, these thoughts were also ascribed to what they believed others thought of them too:

*'before the smallest thing would manifest into I'm useless. I'm no good. This is just rubbish. What's the point?'* (Saskia/2/14/327)

*'They were more like you're useless. The whole beating things up, well you're fat. No one loves you and no one wants to be with you, you're no good at what you do'*  
(Mandy/7/12/294)

During letter writing, two participants spoke of the difficulties they experienced in the process of trying to generate self compassion, as their focus was on others and their beliefs and if they thought that they were good enough. This appeared to be a barrier for participants to initially be able to understand and attend to the meaning of the content of their letters:

*'When I was reading my letter out I was more concerned with what everyone else was thinking cos I wasn't really listening to the words. I was saying them and thinking I wonder if this is any good'* (Eve/4/10/232)

### ***Disbelief and Discomfort***

The theme of disbelief and discomfort emerged across all participants when they spoke of their initial reactions towards writing letters. Saskia described feeling dismissive due to her disbelief that letter writing could help her with her difficulties:

*'the first one was how is this going to help? Really? Erm and it was quite bizarre the thought of writing a letter saying I'm lovely and you are wonderful and da, da, da please be ok, erm so initially when it was described to me it was kind of like this isn't going to help at all'* (Saskia/2/7/156)

The disbelief that letter writing would work seemed to make the engagement with the task harder:

*'I wasn't too receptive to the idea to start with, you know it made it harder, and this is stupid and you know its not going to work erm so it was, it was very hard erm and like I said all the you know the first letters came out attacking'* (Eve/4/17/398)

*'mainly I thought it would be hard to have to actually write down what was going through my head and I thought I'd just dredge up old feelings and get me upset, so hard'*(Mandy/7/4/86)

The theme of discomfort emerged as participants described how uncomfortable they felt with letter writing as they did not believe that it would alleviate their difficulties, this experience was hard for individuals and was expressed not only in their letters as described above, but also this was experienced physically for one participant:

*'It made me feel quite sick. Erm and I suppose it made me feel anxious because I wasn't sure what to write'* (Saskia/2/8/192)

Adam shared how he continues to struggle with letter writing, finding it difficult to complete alone:

*'it seemed a little strange writing to yourself in third person, well it, it just seemed like an odd procedure, but erm I think that's mainly why I haven't been able to take it home'* (Adam/5/3/69)

## ***Letter Writing as a Journey***

### ***Overview***

The theme of letter writing as a journey developed as participants shared their experiences of generating self compassion. The journey for participants encompassed a process of realisation and acceptance of their eating disorder and the potential value for them of compassionate letter writing. The importance for participants of shared experiences and how letter writing acted as a means of externalisation and a vehicle of expression emerged within the superordinate theme of letter writing as ‘a journey’.

### ***Process of realisation and acceptance***

Participants spoke of developing an understanding of their difficulties and experiences, past and present. This was a shift from the theme that emerged relating to ‘making it real’. Participants now appeared to be in a position of accepting the reality of reflecting on and realising their experiences of having an eating disorder. Eve spoke of how the process of realisation evolved for her:

*‘So if you feel sad about something erm and you start to get I don’t know, you think oh God, why am I feeling sad about this blah, blah, it was about erm understanding why you feel sad. You kind of explore, I feel sad because x, y and z has happened and then you kind of think well no wonder I feel sad’* (Eve/4/14/328)

Saskia found that understanding her difficulties enabled her to have capacity to consider change:

*'a better understanding of it and why it was here and, and knowing why it was here could make you think well what can I change to help get over it'* (Saskia/2/16/379)

Krystyna spoke specifically about her eating disorder and the realisation of the impact that her difficulties were having on her life. The acceptance of her eating disorder seemed to allow her to think about herself without an eating disorder:

*'I kind of er discovered that my eating disorder, it's not me that makes me feel bad or makes me feel angry at that person. It's my eating disorder that does it. So it's kind of like I've got two personalities. Like my eating disorder is, is the one and, and me without can show that how a different person I am'* (Krystyna/1/12/294)

### ***Vehicle of expression***

The theme of compassionate letter writing as a vehicle of expression reflected different experiences participants articulated with regards to using their letters as a means of overcoming barriers to express their difficulties to others. Krystyna spoke of the relationship between her and her mother and how she had not been able to talk to her mother about her difficulties. She felt that her letter enabled her to talk to her mother:

*'we were talking and I said to her that I want to show her something. So I, I gave her my letter to read it'* (Krystyna/1/9/204)

Mandy spoke of how she was able to use her letters to express what she was feeling within the group treatment programme:

*'I found it a lot easier to write in my letter and then read out in my group than I would be able to tell others outside of the group session what actually was going on'*  
(Mandy/7/17/403)

Other participants spoke of how letters acted as a vehicle of expression, as the letters facilitated clarity of thoughts and how these could then subsequently be viewed and changed:

*'you know you've written down probably so you can just look at that and turn it round, rather than in your head just being all eurgh. You can look at that and just think right, flip that and change that to that and do it just makes thinking an easier process, so yeah that was good'* (Adam/5/11/267)

### ***Value of shared experiences***

All participants spoke of how they valued sharing their experiences with other group members in the treatment programme. This shared experience appeared to facilitate the generation of self compassion. Adam spoke of how hearing another person talk compassionately was easier than initially trying to generate self compassion:

*'talking to someone else in there you know rather than trying to think of how you know you can make things better yourself, have someone else say it. It's just as easy for that to come, quite easy from another person'* (Adam/5/13/304)

All participants spoke of the value of shared experiences through mutual understanding of experiencing the difficulties associated with a diagnosis of an eating disorder:

*'I did feel relief that some, I wasn't doing it on my own. It meant that someone knew what I was going through and I knew what they were going through'* (Mandy/7/8/192)

Heather spoke of her sharing experiences with others. In comparison with other participants, although expressing that she valued the feedback from others on her compassionate letter, hearing what others thought was different to what others described:

*'I found it, found it a bit shocking actually. I suppose I'm not used to it so it was nice to have that kind of feedback on something so personal anyway, cos its something I kept to myself for a very long time so, yeah it was quite nice really, in a weird way'* (Heather/6/10/240)

### ***Externalisation***

The theme of externalisation arose as participants spoke of the writing of compassionate letters as letting out experiences, thoughts and feelings, which they had not talked about before:

*'The things that I hadn't spoken to anybody about erm that's what upset me I think, actually saying those words and it's a bit of a relief really I think more than anything.'*



*Its almost like if someone close to you is going tick, tick, tick er and all of a sudden out it comes and I do, I think its more of a release than anything' (Jane/3/12/290)*

Krystyna talked about writing a letter to her mother, similar to other participants who had written letters to members of their family. Participants spoke of this as a paradoxical experience, of the relief of talking about their difficulties but that this was also emotionally difficult:

*'I think it was the hardest letter I've ever wrote, so er a positive, positive erm how would I describe my letter in words now; um positive feelings about writing a letter but also, also erm kind of making me feel upset as well but at the end I feel it's so good that I've finally get out of myself' (Krystyna/1/5/119)*

Throughout the journey of developing self compassion, the externalisation of a participant's eating disorder was also evident, as in Saskia's account:

*'I hate you Bernard, I've written I hate you Bernard. You know I'm reading it out I'm like I hate you it did make a difference saying it' (Saskia/2/22/527)*

Closely linked to the theme of the value shared experiences, is the idea of how individuals valued the experience of hearing others read their letters out. However, as Eve describes below, this experience is fitting with the theme of externalisation as, unlike the value of shared experiences, this is concerned not with sharing an experience and having a mutual understanding, but hearing the words read out loud, rather than this being a purely internal process:

*'When someone reads it to you, you could listen a lot more and not worry, not have to worry about reading it out and erm so you could listen to the words and what you'd written more and obviously take more of it in and I definitely think that was a better way of doing it even though it was slightly scarier, you got more out of it that way I think'*  
(Eve/4/10/234)

### ***Finding Self-Compassion***

#### ***Overview***

All participants spoke of reaching an understanding of the meaning of self-compassion. Five of the seven participants described finding self compassion and feeling it for themselves. Previously participants had spoken of the feeling of compassion towards others, but had not connected with this feeling for their own difficulties. The process of finding self compassion encompassed feeling connected, establishing a connection that was linked to participants exploring their self identity without an eating disorder and beginning to adopt a position of responsibility for their self care.

#### ***Feeling connected***

The theme of feeling connected arose as participants spoke of their discovery of self compassion as a process of making links. Krystyna spoke of making links and re-establishing connections with significant people in her life. Participants had previously spoken of their feelings of not being good enough, often pushing people away as they did not feel worthy of those relationships. As Krystyna developed self compassion, she found that this impacted positively on this:

*'I kind of separate from, from all the friends and people erm who I trust er inside so yeah I think that my connection with er, with er friends and people are picking up slowly but, but I'm making more effort to go and see someone' (Krystyna/1/18/425)*

Participants spoke of their development of understanding their feelings and emotional responses to experiences. This was described as a gradual process for all participants, with individuals being at different points in their journey. This appeared to be achieved through the affirmation that events were not necessarily the individuals' fault, the removal of self blame and feeling connected to a range of possible emotional responses to difficult situations. Saskia discussed feeling connected to past experiences and how these impacted on her life currently:

*'associate something that was happening now with something that had happened in the past and that's why I felt the way I did, and its ok, I'm moving through it' (Saskia/2/24/570)*

Eve described her journey as progressing from a position of disbelief leading to her dismissing the possibility of letter writing being effective to a position of acceptance for her difficulties and connecting with the salient feelings of what was written in her letters. This was achieved, as with other participants, through repetition and practice:

*'Like the whole understanding your feelings, I was like er but you know I'd write something but not really feel it and I'd be like well that's just stupid, why you know and not really explore it properly I guess. Erm and it just, after a lot of practice it came to*

*me that you know how, how you should understand it. How it is acceptable that you feel that way and I think that came from just writing lots more of something and once you got used to them the realisation came'* (Eve/4/15/350)

### ***Exploration of self identity***

As participants' journey through the development of generating self compassion continued, it became apparent that individuals questioned their self identity and were exploring who they were as a person, without an eating disorder. The integration of new experiences into the individual's identity appeared to be pivotal. Saskia spoke of exploring herself as an individual who could feel emotions, and how she could regulate those without her previous, often harmful eating disorder and impulsive behaviours:

*'My favourite saying I've adopted is I'm not a robot. I'm a human. I'm designed to feel a range of emotions. Its just about how long you stick with one erm and that, that's the biggest thought pattern change for me'* (Saskia/2/14/335)

Eve summarised how there was a shift from a preoccupation with what others thought and behaving in ways that were believed to satisfy the expectations of others. She began to explore who she wanted to be, based on an understanding of how she had been previously and the impact that had upon her life:

*'you can't spend your life caring about what other people think of you when, and you know doing things that other people; I mean that's not even the person I want to be so it kind of gave me something to aim for, erm to work on'* (Eve/4/27/658)

For one participant, the process of exploring their self identity revealed different sides to their character. Although this was described as a useful process, they did not describe, as other participants had, exploring how their self identity had changed since generating self compassion through letter writing, they were feeling uncomfortable with feelings and thoughts of compassion towards themselves. She later described that the ‘unusual feeling’ was attributable to the belief that in order to feel self compassion, this would mean changing the habit of a lifetime:

*‘It was like developing a whole new side to your character. A useful side but, but one that I’m going to have to get used to still. Yeah, quite an unusual feeling’*  
(Heather/6/22/540)

### ***Adopting responsibility for self care***

The theme of adopting responsibility for self care emerged when considering participants’ experiences in relation to finding self compassion. It seemed evident that for five of the seven participants, there was a change from a position of non-acknowledgement of the impact of their eating disorder symptoms or diagnosis, or a significant difficulty in being able to see how their current strategies of dealing with negative experiences could be dealt with any differently. This changed to a position of recognising and understanding their own needs and caring for the self with compassion. This occurred alongside the aforementioned themes discussed of participants feeling connected to experiences, emotions and others and exploring their self identity.

One way in which adopting responsibility for self care was expressed, was by Saskia, who described how she previously felt when her eating disorder diagnosis was given to her. At the end of treatment, her diagnosis had changed and her symptoms

were consistent with a diagnosis of eating disorder not otherwise specified (EDNOS), Saskia spoke of how she felt that she was now EDNOS, indicating a level of responsibility for her difficulties where previously, it was described as though she had no control over these difficulties and that they were given to her:

*'I was given multi impulsive bulimia nervosa. I'm now EDNOS'* (Saskia/2/1/21)

Saskia also talked of how the responsibility for her own self care came through a realisation that by no longer endeavouring to fix her difficulties, her mood and wellbeing was improved by being compassionate towards herself:

*'I wanted to be happy and I thought that if I just fixed everything I'd be happy but I have to make myself happy erm and being mean to myself isn't really going to make me very happy, it's just going to make me more and more depressed so being compassionate to yourself is important, for your wellbeing I guess'* (Saskia/2/35/865)

Mandy and Adam discussed how the generation of self compassion directly impacted on their eating disorder behaviours and how letter writing was effective as an intervention. Letter writing appeared to offer an alternative strategy for individuals to deal with situations and experiences that they had previously struggled to think of coping with without their eating disorder behaviours. Adam discussed how his initial response to a difficulty may still be the same; however his way of coping with the difficulty had now changed:

*'I think in that way it helped cos erm there was a time where I, you know I'd just be you know I'd just dive straight in the fridge but these days you know that might be my response but I've come away from it. I find it a lot easier to just walk away and think I'll not go now' (Adam/5/27/651)*

Mandy described how writing compassionate letters facilitated her to focus on her strengths and achievements. The finding of compassion appeared to enable her to move away from a position of not being good enough, or intolerant of discomfort and being able to soothe herself through letter writing rather than punishment through restriction:

*'little things like even if I was having a bad day, write what I've done even if I'd just got up, got dressed and had breakfast. I'd feel better than what I was, erm and I used to before my letter writing I used to just not eat, now I'd start writing a letter' (Mandy/7/13/306)*

## Discussion

The current study aimed to investigate the experience of generating self compassion through letter writing in adults with eating disorders. Seven interviews were conducted with participants attending an outpatient eating disorders service. Interviews were transcribed, then analysed using interpretative phenomenological analysis (IPA). The main findings of the research are presented below. Each of the three super-ordinate themes are interpreted, with discussion of how these findings relate to the research questions. The three super-ordinate themes were: ‘the alien concept: leaving familiarity’, ‘letter writing as a journey’ and ‘finding self compassion’. The limitations, suggestions for future research and clinical implications of the current study with appropriate interpretation to relevant theory and clinical practice will also be discussed.

### *The Alien Concept: Leaving Familiarity*

Across all participants that were interviewed, when the concept of compassionate letter writing was first introduced it was met with a reaction of disbelief that it would be an effective intervention accompanied by feelings of discomfort to write the letters. One participant spoke of her physical feelings of discomfort, of feeling nauseous and anxious. The disbelief and discomfort appeared to be related to the described experiences that engaging in letter writing would mean leaving coping strategies and therefore their eating disordered behaviours that they had potentially engaged in for a number of years. The idea of having to remember and then write about experiences and emotions was described as leaving something familiar and therefore was met with reluctance. It was found in a previous IPA study on the personal meaning of eating disorder symptoms that individuals experienced ambivalence towards their



eating difficulties (Fox et al., 2011). The present study found that this was also true with participants, demonstrating an acknowledgement of their current difficulties through engagement with the treatment programme, but an initial reluctance to actively change their eating disorder behaviours. It has been suggested that the functionality of eating disorder behaviours can hinder an individual's progress through therapy (Fox et al., 2011), therefore by negotiating this stage with individuals may help in addressing these difficulties.

The theme of 'making it real' emerged as participants explored their experiences of an admission of past and present experiences and difficulties. One participant described how writing emotions on paper and being prepared to deal with them was a real barrier for her. This was a common experience described across participants. It appeared that the difficulty with initially writing emerged from a fear of not knowing how to deal with negative emotions if they should arise, therefore initial attempts at letter writing were approached in a guarded manner in order to protect the individual from an experience they felt that they were not able to cope with. Previous research has suggested that those with eating disorders are experientially avoidant: detaching from personal, psychological, physical and interpersonal experiences (Schmidt et al., 2002).

Feelings of 'I'm not good enough' were evoked for participants and therefore this theme emerged. This reflected participants' characteristics of self criticism and perfectionism, and thus completing an unfamiliar task could potentially lead to failure, an intolerable concept. For some, the feelings of inadequacy were related to their feelings of failure with interpersonal relationships. It also appeared that the focus of participants prior to commencing letter writing was on the thoughts, feelings and behaviours of others, and their self worth and value was based upon this. There appeared to be little strength within the sense of self for participants.

The experiences of participants supported the transdiagnostic approach (Fairburn et al., 2003) and the notion that there are shared maintaining features across eating disorder diagnoses, which are: low self esteem, clinical perfectionism, mood intolerance and interpersonal difficulties. Low self esteem was expressed within the theme of 'I'm not good enough' and the participants' desire for perfectionism, which contributed to their reluctance to initially engage in compassionate letter writing. The themes of 'disbelief and discomfort' and 'making it real' could be linked to the suggestions of individuals of mood intolerance. Research that has been conducted into Compassion Focussed Therapy for eating disorders has identified that individuals experienced high levels of shame, pride, self directed hostility and self criticism (Goss & Allan, 2010), providing further evidence for the emerging themes from the current study. An investigation into the fears of compassion has proposed that not only should the absence of compassion be considered, but the fear that the individual may have of holding compassion (P. Gilbert et al., 2011). An individual's doubt, fear and resistance of compassion were evident in the present study, when considering making their feelings and experiences 'concrete', visible and therefore initiating a process of acknowledging difficulties.

### ***Letter Writing as a Journey***

The theme of 'letter writing as a journey' emerged as participants discussed their experiences of moving from a position of being introduced to self compassion to beginning to generate self compassion. This appeared to be a transitional point for individuals, where they spoke of what personal meaning this held for them and the strategies they used to overcome their difficulties and the components of letter writing which had the most effect on them and what these effects were. When participants spoke of their experiences of beginning to write compassionate letters, they reflected on

a ‘process of realisation’. The process of realisation held meaning for individuals from their experience of beginning to understand their difficulties relating to their experiences both past and present. For some at this point in their journey, they found difficulty in moving past this and moving towards understanding. For others, they progressed to a position of accepting the reality of their experiences and how these had impacted upon them. This process enabled individuals to consider and employ strategies to undergo change, a difficult emotional experience for participants. This experience provides support for the suggestion that individuals may not initially consider the value of compassion and have an unresolved feeling of grief of wanting kindness, but have had experienced rejection within their lives (P. Gilbert et al., 2006). This grief and a realisation of missed experiences and the development of feelings of sadness that participants had missed out on compassionate and self compassionate experiences was evident.

It appeared that the mechanisms by which compassionate letter writing facilitated the generation of self compassion and those that were discussed by participants, were evident in the emergent themes: ‘vehicle of expression’; ‘shared experiences’; and ‘externalisation’. As previous research has described, those diagnosed with an eating disorder can experience difficulties with emotional expression (Geller et al., 2000). The current study supports the theory that writing may facilitate disinhibition (Lepore & Smyth, 2002). The physical act of letter writing appeared to provide a way for people to organise what were described as confused and chaotic thoughts. The letters then enabled participants to view how and where potential change could occur. This supports cognitive processing theory (Pennebaker, 1993) that writing may be effective through the challenging of thoughts and generating new meanings. The letters also provided a way to overcome barriers in expression to others. The value

of shared experiences with a group of people who were also experiencing difficulties associated with an eating disorder, was expressed by all participants. Participants spoke of how they felt that they would not be judged or criticised and they were not alone, that not only did someone know what they were going through, but they knew what the others were going through too. The development of self compassion appeared to be a process that began with initially receiving feedback from others, on which great value was placed as others also had an eating disorder, to a gradual growth of the ability to integrate the feedback and generate self compassion. Pennebaker and Graybeal (2001) also found that disclosure through writing was found to encourage greater social openness and broaden social networks.

The theme of ‘externalisation’ emerged as participants described the writing of compassionate letters as letting out experiences, thoughts and feelings, which they had not talked about before, and were reluctant to do so before letter writing. This was a paradoxical experience; the relief of talking about their difficulties but this was an intensely emotionally difficult process. One participant spoke of how she externalised her eating disorder, naming it and therefore giving it a separate identity to herself. The group of which participants were a member during their treatment programme at the eating disorders service also featured as a means of how individuals found externalisation helpful in their development of self compassion. It appeared to be important, although uncomfortable and anxiety provoking, for individuals to ‘hear’ their letters read out. The reading out of letters by others enabled participants to focus on and attend to the content of their letters and its meaning, as opposed to being concerned with their performance of reading their own letters out.

### *Finding Self Compassion*

It appeared that through compassionate letter writing, participants were able to find self compassion. For five of the participants, this meant that they could not only understand, but generate and feel self compassion. Others appeared to have developed an understanding of self compassion, appreciating its value, but still needed support to generate and therefore feel compassion. The experiences of the participants in the current study suggested a journey from a position of unfamiliarity with compassion, providing support for the work of Gilbert (2006). For five participants, there was a significant expression of a move to a position of 'feeling connected', 'exploring their self identity' and 'adopting responsibility'.

'Feeling connected' held many meanings for participants. For some it appeared to be a process of making links between past and present experiences and understanding their emotional responses to situations. The generation of self compassion facilitated individuals to experience the removal of self blame and feeling connected to a range of possible emotional responses to difficult situations, giving a space to the sadness that they may not have felt previously. Re-engagement with emotional experiences has been advocated as an important process in facilitating recovery from an eating disorder (East et al., 2010). Participants also spoke of improvements in interpersonal relationships; feeling connected to others in their life and understanding why interpersonally they may have had or continue to experience times of difficulty. There was also a connection that evolved for participants in their relationship with the compassionate letters. There appeared to be a parallel process for individuals of engaging and accepting letter writing to engaging and accepting feelings.

Through the space that was given to understanding participants' difficulties and the processing of these, there appeared to be a developing 'exploration of self identity'. One participant described how a whole new side of her character was developing and that without her eating disorder, there was space for 'her' to develop. Participants spoke of integrating emotional experiences into their identity and how these could now be tolerated, and the control that they did not think that they could achieve over their emotions without their eating disorder, was in fact becoming a reality. A self compassion induction study, found that individuals with rigid restrictive eating attitudes were also able to experience feelings of increased positive affect without increased negative mood (Adams & Leary, 2007). It was also found that individuals did not ruminate on past diet breaking behaviours.

The final theme that emerged within the superordinate theme of 'finding self compassion' was 'adopting responsibility for self care'. This theme reflected the development of participants' acknowledgement of the impact of their eating disorder behaviours and associated difficulties on their life and self identity. The expression of how letter writing had assisted individuals to achieve this was described explicitly by two participants. They reflected on how their focus had shifted to their strengths and an ability to tolerate difficulties, without needing to use eating disordered behaviours. Therefore illustrating how for these participants they had successfully generated and transferred the ability to be self compassionate to deal with situations that they had previously struggled to cope with without behaviours such as dietary restriction, bingeing and purging behaviours. This finding concurs with that of Leary et al. (2007), who suggested that by inducing self compassion, personal responsibility was increased, with individuals not feeling overwhelmed by negative emotions and this increased their potential ability to regulate emotions in the future.

The theme of ‘finding self compassion’ appeared to reflect the components of self compassion conceptualised by Neff (2003). For some participants, they described how they had moved towards self kindness in their adoption of responsibility for their own self care; they were holding thoughts and feelings in mindful awareness, in that they described feeling connected to emotions and experiences and understood their own fallibility as a person, in their exploration of self identity. These findings also concur with those of (Pauley & McPherson, 2010), who reported that the meaning and experience of compassion for individuals with depression and anxiety, was one of feeling connected to self compassion.

The journey that participants embarked upon throughout their experiences of generating self compassion through letter writing in the current study, has similarities to the findings from a study that explored the experiences of women with BN before and after a mindfulness based group (Prolux, 2007). The findings suggested a shift from a position of self-loathing, loneliness and a disconnected, idealised image of the self to an inner connection with themselves and compassion, resulting in reduced emotional distress and improved abilities to manage stress. The importance of being part of a group and the experience of mutual vulnerability was also suggested as a factor in this process.

### ***What do these Findings Mean?***

The findings from the current study are summarised below and presented in relation to the research questions:

1. The initial experience of adults with eating disorders when trying to generate self compassion through letter writing is one of feeling exposed, vulnerable and imperfect. The experience of making their experiences visible on paper and

therefore real, evoked feelings of not being good enough, discomfort and disbelief that it would work.

2. In their struggle to overcome their eating disorder, the experience of writing a self compassionate letter appeared to be an unfamiliar concept to individuals and they realised that they had not experienced self compassion before and now desired to experience it for themselves. The realisation that their eating disorder was contradictory to feelings of self compassion was discovered through letter writing. It provided an alternative coping strategy through the act of writing about difficulties and not acting immediately upon distress with eating disordered thoughts and behaviours, therefore facilitating an understanding of their self identity without an eating disorder.
3. The difficulties that were experienced when using compassionate letters related to the individuals' feelings when trying to generate self compassion. Individuals also had personal preferences to writing with others, or alone. Individuals expressed how initial letters were self attacking, critical and distinctly lacking in self compassion.
4. The strategies that appeared to be most helpful for individuals in overcoming difficulties they experienced with compassionate letter writing appeared to encompass the value placed on shared experiences and a mutual understanding with other group members. Feedback from others and hearing others' experiences seemed to foster self compassion. In addition, by externalising difficulties such as reading letters out loud or others reading the letters out, enabled individuals to have a different perspective on their difficulties.
5. The participants' experience of compassionate letter writing gradually developed over the course of therapy; from a position of disbelief, discomfort,



reluctance, to a process of understanding and a realisation of difficulties past and present. Individuals began to externalise their difficulties, then expressing a position of feeling connected emotionally, physically and interpersonally. Individuals began to explore their self identity without an eating disorder, adopting responsibility for their own self care.

6. The components of letter writing that seemed to have the most effect on individuals were the shared experiences with others and the gradual development of self compassion. In addition that letter writing is revisited, revised and repeated. The writing of letters appeared to dissolve a barrier for individuals in expressing emotions and experiences that they had not discussed before. The letters facilitated the generation of self compassion, perhaps as they enabled confused thoughts and feelings to achieve clarity.

### ***Clinical Implications***

The current study has provided an interesting insight into the individual experience of generating self compassion for adults with eating disorders. The current treatment of choice for eating disorders is an enhanced CBT approach, however it is argued that many patients do not respond sufficiently to this approach (Wilson, 2005). Previous research has argued that individuals may not feel emotionally reassured by alternative cognitions, not valuing the interventions as supportive and helpful (P. Gilbert, 2000). The generation of self compassion in individuals and a CFT approach may address these difficulties that individuals with an eating disorder may experience with standard cognitive therapies. Writing tasks appear to have additional advantages for some individuals, in that they can continue to use them once formal therapy has ended (Schmidt et al., 2002).

It is interesting that eating disorder symptomatology was not largely referred to by participants; this may reflect the importance of underlying features of eating disorders and by addressing these, there is an impact on the eating disordered behaviours. Previous research has suggested that expressive writing may target the cognitive, affective and interpersonal difficulties associated with an eating disorder (Treasure et al., 2005). The current study provides support for this research, suggesting that through the experience of writing compassionate letters, it was not only the eating disorder that concerned participants but the aetiological and maintaining factors, such as their thoughts, feelings and relationships with others.

There appeared to be considerable value placed on being a member of a group, from the described experiences of the participants from the current study. Clinically, this may be of relevance in engaging a population of individuals who present with difficulties in generating self compassion. The current study has also highlighted difficulties and the potential resistance that individuals may experience when trying to generate self compassion and how for some, this may be overcome through habituation and practice of writing letters. It may also be through support of others and the externalisation of their difficulties, through the physical act of writing rather than verbalisation.

### ***Limitations of the Current Study***

The current study used a participant sample who were attending an outpatient eating disorders treatment programme. Compassionate letter writing was a central process in the programme, which endeavoured to facilitate individuals to generate self compassion, however it is important to note that it was not a stand alone treatment and other factors may also have impacted on participants' experiences. Individuals attended

weekly group treatment sessions, with three group facilitators. Participants also received support from a dietician regarding meal planning and their weight was regularly monitored. Individuals also engaged in additional compassionate imagery and breathing exercises.

The use of IPA, which is idiographic, means that it is not possible to generalise the findings to wider populations. Despite this, the findings of the current study have achieved its initial aims of investigating the experiences of adults with eating disorders in generating self compassion and the personal meaning this process held.

A further limitation of the current study was that the researcher was on placement within the service in which the research was conducted. Even though the researcher was not the lead clinician for any of the participants interviewed, participants were aware that the researcher was based in the service. This may have had implications for the responses that participants gave, potentially wanting to express that the treatment was effective. This was considered due to high levels of shame, perfectionism and wanting to please others that individuals with eating disorders can exhibit.

### ***Future Research***

The current study was focussed on the generation of self compassion in adults with eating disorders, however, given the promising findings, it is suggested that further research into this field would be beneficial with groups of adolescents. This may give an insight to potential differences between the two groups and contribute to preventative work in the field of eating disorders. Additional populations of whom it would be of interest to research with regards to the generation of self compassion,

would be inpatient eating disorder service users, those with a diagnosis of binge eating disorder (who were not included in the current study), and a non clinical sample.

The current study only focused on one time point, when individuals had finished treatment. Interviewing individuals at different time points throughout the generation of self compassion may give a different account of their experiences and generate additional findings. There may also be value in a follow up study, which investigates if there are continued effects of compassionate letter writing. As the current study did only focus on those who completed the treatment programme, additional research using qualitative methods investigating those who do not complete the treatment programme would be valuable. In addition, exploring the experiences for those who do not develop self compassion using a qualitative phenomenological approach to potentially compare the experiences with those of the individuals from the current study who did predominantly develop self compassion. This may illustrate aspects that individuals find difficult and how the process is not able to meet their needs.

Finally, the current study employed a qualitative methodology. It is therefore difficult to ascertain the impact on eating disorder symptoms, other than the expressed experiences of individuals. Further research adopting quantitative measures, may give an insight to the impact of compassionate letter writing on eating disorder symptomatology. Suggestions are for the use of a self compassion measure, such as the Self-Compassion Scale developed by Neff (2003), the Fear of Compassion Scale (Gilbert et al., 2011) and a valid, reliable measure for eating disorder symptoms, such as the Eating Disorder Examination Questionnaire (Fairburn & Beglin, 1994).

## ***Conclusion***

The experience of generating self compassion through letter writing appeared to be not only a valued personal experience for individuals with an eating disorder, but it also appeared to be an effective intervention for targeting some of the core psychopathological features of eating disorders. The current lack of evidence available on effective treatments for eating disorders is of significant concern, particularly for those diagnosed with AN and EDNOS. Compassion focused therapy is a developing approach within the field of eating disorders, providing an alternative treatment for those who may not benefit from existing approaches.

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## **Critical Appraisal**

The research process, for me, is best described as a journey. One which has, at times been difficult, frustrating, rewarding and ultimately a journey of not only professional but personal growth.

### ***The Initial Research Idea***

I initially considered the idea of conducting my research project in the field of eating disorders, as it is an area that has interested me since I completed my undergraduate psychology degree. I had worked for a year on an inpatient eating disorders unit. At this time I began to realise the risks associated with an eating disorder diagnosis, for the individual, their families and services. It was at times, distressing to work with so many young people who were experiencing such great distress, requiring often long term, involuntary admissions to the unit. With those experiences behind me, when I encountered the possibility of conducting research into eating disorders as part of my training, I was immediately interested. After extensive discussions with supervisors in the field, a project began to take form. A project was offered through the university which would combine a year long second year placement with the research process. This was particularly attractive to me as it would mean the research would be embedded within clinical practice, and I would be able to familiarise myself with the client group and approaches used. This critical appraisal is an account of conducting the research project, my reflections on this process, with consideration given to limitations of the research project.

### ***The Research Project***

The current study was in its infancy in terms of a developed project. The project had gained ethical approval some two years previous, however it had not developed past this point. My initial concerns that conducting a project that was already defined, and would therefore restrict my ability to ‘make it my own’ were unfounded. I met with my field supervisor and the clinicians in the eating disorders service where recruitment was to take place, to discuss the proposed interview schedule. This provided me with the experience and insight of their knowledge, understanding of working using a compassion focused therapy approach and using compassionate letter writing with individuals. Using this information and thinking about what the research hoped to achieve in terms of individuals’ experiences of generating self compassion through letter writing helped shaped what felt to be a valid interview schedule.

Although the initial idea remained largely unchanged, the development of the research proposal and revisiting the previously submitted ethics documentation meant that I was able to be fully influential in the project from the start. Having been through the ethics process in previous roles prior to commencing clinical training, this was a process that felt familiar and I felt that this prior knowledge and understanding made this process somewhat easier. After submitting requested amended documentation to the relevant ethics and local research and development committees, recruitment could commence.

## ***Recruitment***

Being on placement within the service had considerable advantages in terms of recruiting participants. Firstly, it meant that all clinicians in the service were aware of the research project, understood and agreed with the aims of the research from previous meetings regarding the development of the interview schedule. Secondly, it meant that I was able to meet with participants and clinicians at short notice to discuss any queries or concerns. Despite the advantages, there were a few difficulties that I encountered in recruiting participants. Participants were approached as they were finishing the treatment programme at the eating disorders service; this meant that they would have a common experience of letter writing in terms of the opportunities of writing compassionate letters. However, recruitment of participants had to be timed accurately as the treatment programme lasted for 20 weeks. There were three programmes scheduled to finish within the available time frame for interviewing, with an average of five participants per programme. Some individuals declined to participate in the research, expressing a reluctance to discuss and revisit potentially distressing information. Some individuals expressed that they had devoted a lot of time to the therapeutic programme and did not wish to take further time off from work or their studies. For others, it was deemed inappropriate to participate in the research by clinicians due to ongoing difficulties they were experiencing.

## ***Interviewing***

Throughout the interview process, I was aware that participants knew of my role as a clinician based in the service. This raised questions for me as to how honest participants would be on their experiences of letter writing; would they want to give positive accounts? I also considered the impact of me being a 30 year old, white female

and if this would influence their responses. I also wondered if conducting the interviews within the service where they attended for treatment would impact on their responses. As the interviews progressed it became clear that individuals appeared to describe their genuine experiences of compassionate letter writing. I felt honoured that people were sharing such difficult experiences with me. This was reinforced when individuals spoke of how difficult they found it initially to share their difficulties or even acknowledge them personally. To hear how individuals had used compassionate letter writing to understand their difficulties and their progression through the treatment programme was truly rewarding. Not all participants had reached a point where they were able to generate self compassion. When they spoke of their difficulties it was difficult for me to separate my role as a clinician and that of a researcher. I found myself wanting to offer support and step into a therapist role, which would lead me away from the aims of the research project. This conflict of roles was managed as I defined my role as a researcher to participants, containing any concerns or difficulties that they had and directing them to their named clinician within the service.

### *Analysis*

Although prepared for the potential time consuming nature of conducting qualitative analysis, this still at times presented challenges. The transcribing of transcripts, was incredibly time consuming, resulting in a paid administrator transcribing interviews. I felt that having conducted the interviews and editing the transcribed transcripts still enabled me to fully engage with the interview data. The choice of interpretative phenomenological analysis (IPA) seemed an appropriate choice of methodology. As it not only fit with the aims of the research to investigate the experiences of generating self compassion for individuals, but also my position in

acknowledging not only the importance of individuals' experiences but the interpretations that I made of these. I personally and professionally, found it interesting to investigate the experiences of individuals with eating disorders who had undergone a treatment process that could potentially inform future clinical practice.

The analysis process was at times overwhelming. In order to follow the principles of IPA, I found it necessary to have a 'break' between each level of analysis and the analysis of each transcript. This way it was felt that I would give adequate attention to the content of what was being said. Inevitably there would be influence from the analysis of previous interviews, this was considered and managed through taking a break between analyses, therefore adding to the analysis without unduly taking away from each individual's experiences. I found it helpful to keep a diary throughout the research process; this helped in ensuring I stayed grounded in the data without jumping to themes. I was then able to revisit and revise if necessary at a later stage. This also ensured that I was mindful of potential influences from other theoretical models, as at times I felt that I was offering psychodynamic interpretations from the data. This entailed me frequently revisiting the principles of IPA. The sheer number of possible themes was also at times overwhelming. Trying to encapsulate the differences and similarities that emerged from the data whilst doing justice to individuals' experiences and not being distracted to so many other fascinating themes that could potentially emerge, but were not necessarily of relevance to the current project. This opened my eyes to the potential cascading nature of research and how the process of conducting research informs further research.

The committal to what would be the final themes was difficult, as it felt as though I was potentially excluding aspects of participants' experiences. However, I felt



comfortable with the final themes in that they described the participants' experiences throughout the process of generating self compassion through letter writing. As a novice to IPA it was difficult to trust my judgement and that my interpretations were 'right'. Through supervision and reconnecting with my epistemological position I was able to distinguish that the value of the findings was in the subjectivity and appreciation of novel experiences. My position of contextual constructionism shaped the research process, in that my interpretations were dependant not only on the participants' experiences but my personal and professional interpretations. The discussions in supervision surrounding the notion that there is no ultimate truth to be found in the data, and that analysis may take many forms dependant upon the researcher improved my confidence in this process.

Throughout the research process I was aware of my frustrations at not solely being able to focus on the research project. There were also considerable demands from placement, academic assignments and personal life. I considered how I wanted to be fully immersed in the experience of the research process, to just have one focus and how juggling different experiences impacted upon my confidence to complete everything to the best of my ability. I felt that there were parallels with what I was experiencing and the journey that participants described regarding their experiences. The fear, frustrations and rumination they experienced regarding letter writing, through to an acknowledgement and sharing of experiences to a position of clarity and self confidence.

### ***Limitations and Implications***

I felt that the research project has provided an interesting account of participants' experiences of generating self compassion through letter writing. Upon

completion of the research, I have questioned the value of a quantitative study in assessing the impact of a compassionate letter writing intervention on arguably objectively measurable constructs. In addition, perhaps the use of an alternative qualitative methodology such as grounded theory and how this would have differed to the findings in the current study. I was also intrigued when thinking about the application of this approach to different populations, such as adolescents, inpatients, those with binge eating disorder and those who may not meet the criteria for a diagnosis of an eating disorder, but experience distressing difficulties related to eating. I also considered those who did participate in the study and those who did not, are there different experiences of generating self compassion and letter writing for these individuals and if so what are these? I think that it would also have been an interesting and valuable experience to share the findings with participants, to gain their feedback if they felt that the manner in which I had interpreted and represented their experiences was one which made sense to them.

### ***Concluding Thoughts***

Reflections on the research process has highlighted to me the importance of keeping in mind the aims of the research project and my defined role as a researcher and not that of a therapist. In addition, the demands of juggling simultaneous tasks, at different stages, whilst also trying to meet deadlines to keep on track. The supervision process enabled me to have a space to think about both the practicalities of my research and share ideas and concerns. The collaborative setting of deadlines and targets enabled me to be focussed on how to achieve what at times felt like an impossibly huge task. Conducting this research project has reinforced for me how I value the importance of the individual and how we make sense of our experiences. I have really appreciated the

experience of being able to conduct my research within a service where I was on placement. I feel that this process has given me an insight to the demands of conducting research within a clinical setting. I have valued the knowledge that I have gained of compassion focused therapy and I am excited about the potential benefits this approach may have for individuals. Overall, I think that this process has taught me many skills that I shall continue to use throughout my career.

## **Mandatory Appendices**

### **Appendix A**

#### **Guidelines for Contributors to the *British Journal of Clinical Psychology***

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

- Papers reporting original empirical investigations
- Theoretical papers, provided that these are sufficiently related to the empirical data
- Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications
- Brief reports and comments

#### **1. Circulation**

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

#### **2. Length**

Papers should normally be no more than 5000 words (excluding abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

#### **3. Submission and reviewing**

All manuscripts must be submitted via <http://www.editorialmanager.com/bjcp/>. The Journal operates a policy of anonymous peer review. Before submitting, please read the [terms and conditions of submission](#) and the [declaration of competing interests](#).

#### 4. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded from [here](#).
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.
- All papers must include a structured abstract of up to 250 words under the headings: Objectives, Methods, Results, Conclusions. Articles which report original scientific research should also include a heading 'Design' before 'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.
- All Articles must include Practitioner Points – these are 2–4 bullet points to detail the positive clinical implications of the work, with a further 2–4 bullet points outlining cautions or limitations of the study. They should be placed below the abstract, with the heading 'Practitioner Points'.
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.

- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright. For guidelines on editorial style, please consult the [APA Publication Manual](#) published by the American Psychological Association.

## 5. Brief reports and comments

These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective, Method, Results, Conclusions. There should be no more than one table or figure, which should only be included if it conveys information more efficiently than the text. Title, author name and address are not included in the word limit.

## 6. Supporting Information

BJC is happy to accept articles with supporting information supplied for online only publication. This may include appendices, supplementary figures, sound files, videoclips etc. These will be posted on Wiley Online Library with the article. The print version will have a note indicating that extra material is available online. Please indicate clearly on submission which material is for online only publication. Please note that extra online only material is published as supplied by the author in the same file format and is not copyedited or typeset. Further information about this service can be found at <http://authorservices.wiley.com/bauthor/suppmat.asp>

## 7. Copyright

Authors will be required to assign copyright to The British Psychological Society. Copyright assignment is a condition of publication and papers will not be passed to the publisher for production unless copyright has been assigned. To assist authors an appropriate copyright assignment form will be supplied by the editorial office and is also available on the journal's website at [http://www.blackwellpublishing.com/pdf/CTA\\_BPS.pdf](http://www.blackwellpublishing.com/pdf/CTA_BPS.pdf). Government employees in both the US and the UK need to complete the Author Warranty sections, although copyright in such cases does not need to be assigned.

## 8. Colour illustrations

Colour illustrations can be accepted for publication online. These would be reproduced in greyscale in the print version. If authors would like these figures to be reproduced in colour in print at their expense they should request this by completing a Colour Work Agreement form upon acceptance of the paper. A copy of the Colour Work Agreement form can be downloaded [here](#).

## 9. Pre-submission English-language editing

Authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. A list of independent suppliers of editing services can be found at

[http://authorservices.wiley.com/bauthor/english\\_language.asp](http://authorservices.wiley.com/bauthor/english_language.asp). All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

## 10. OnlineOpen

OnlineOpen is available to authors of primary research articles who wish to make their article available to non-subscribers on publication, or whose funding agency requires grantees to archive the final version of their article. With OnlineOpen, the author, the author's funding agency, or the author's institution pays a fee to ensure that the article is made available to non-subscribers upon publication via Wiley Online Library, as well as deposited in the funding agency's preferred archive. For the full list of terms and conditions, see [http://wileyonlinelibrary.com/onlineopen#OnlineOpen\\_Terms](http://wileyonlinelibrary.com/onlineopen#OnlineOpen_Terms)

Any authors wishing to send their paper OnlineOpen will be required to complete the payment form available from our website at:

<https://onlinelibrary.wiley.com/onlineOpenOrder>

Prior to acceptance there is no requirement to inform an Editorial Office that you intend to publish your paper OnlineOpen if you do not wish to. All OnlineOpen articles are treated in the same way as any other article. They go through the journal's standard peer-review process and will be accepted or rejected based on their own merit.

## 11. Author Services

Author Services enables authors to track their article – once it has been accepted – through the production process to publication online and in print. Authors can check the status of their articles online and choose to receive automated e-mails at key stages of production. The author will receive an e-mail with a unique link that enables them to register and have their article automatically added to the system. Please ensure that a complete e-mail address is provided when submitting the manuscript. Visit <http://authorservices.wiley.com/bauthor/> for more details on online production tracking and for a wealth of resources including FAQs and tips on article preparation, submission and more.

## 12. The Later Stages

The corresponding author will receive an email alert containing a link to a web site. A working e-mail address must therefore be provided for the corresponding author. The proof can be downloaded as a PDF (portable document format) file from this site.

Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following web site:

<http://www.adobe.com/products/acrobat/readstep2.html>.

This will enable the file to be opened, read on screen and annotated direct in the PDF. Corrections can also be supplied by hard copy if preferred. Further instructions will be sent with the proof. Hard copy proofs will be posted if no e-mail address is available. Excessive changes made by the author in the proofs, excluding typesetting errors, will be charged separately.

### 13. Early View

British Journal of Clinical Psychology is covered by the Early View service on Wiley Online Library. Early View articles are complete full-text articles published online in advance of their publication in a printed issue. Articles are therefore available as soon as they are ready, rather than having to wait for the next scheduled print issue. Early View articles are complete and final. They have been fully reviewed, revised and edited for publication, and the authors' final corrections have been incorporated. Because they are in final form, no changes can be made after online publication. The nature of Early View articles means that they do not yet have volume, issue or page numbers, so they cannot be cited in the traditional way. They are cited using their Digital Object Identifier (DOI) with no volume and issue or pagination information. E.g., Jones, A.B. (2010). Human rights Issues. Human Rights Journal. Advance online publication. doi:10.1111/j.1467-9299.2010.00300.x



## **Appendix B**

### ***Statement of Epistemological Position***

The principal researcher was a 30-year old female, White-British trainee clinical psychologist. The researcher was also on placement in an eating disorder service and therefore had clinical experience to draw upon. With respect to clinical experience the principal researcher may have had a preconceived view of the experiences of individuals writing compassionate letters in the eating disorder service. It was therefore ensured that the researcher did not interview individuals who they had been the lead clinician for in the service. Assumptions, expectations or biases that the researcher may have had were discussed in clinical supervision with a clinician working within the eating disorders service, research supervision and a reflective journal. The principal researcher took on a predominantly contextual constructionist epistemological position, assuming that there is not one reality that can be assumed. The impact of both the researcher and the participants was considered and how both interpret and act upon the world around them. The position that knowledge is local, provisional and situation dependent (Jaeger & Rosnow, 1988), reflected the researchers stance in the analysis and interpretation of the data. The philosophy of IPA appeared to be consistent with this stance in that the production of knowledge may be effected by participants own understandings and researchers interpretations (Pidgeon & Henwood, 1997).

## Appendix C

### Chronology of Research Process

Date	Stage of Research
July 2010	First draft of research proposal reviewed by university research panel.
January 2011	Redrafted proposal submitted for peer review.
February 2011	Submission to ethics and R&D
April 2011	Favourable opinion received from ethics and R&D
April – August 2011	Recruitment and participant interviews
August – December 2011	Transcription
August – December 2011	Literature Review
January – February 2012	Analysis
January – April 2012	Writing
27th April 2012	Submission

## **Appendix D**

### **Participant Information Sheet**

#### ***Title of Study: Dear Me: Exploring the Experience of Generating Self-Compassion through Letter Writing In Adults with Eating Disorders***

I would like to invite you to take part in a research study. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish.

Please ask if there is anything that is not clear or if you would like more information. Take time to consider whether or not you wish to take part.

#### **What is the purpose of the study?**

There are two reasons for my carrying out this study.

As you may remember from your treatment with the Eating Disorder Service, the purpose of writing self-compassionate letters is to practise a less critical, more sympathetic way of thinking about yourself and your problems. Although there has been research into measuring self-compassion, there has been little which describes it from the viewpoint of the people trying to develop self-compassion, and none into writing letters which focus on it. One reason for this study is to find out what writing self-compassionate letters was like for you and what the experiences meant to you. This is important information that only you can know. Your help will be valuable whether the letter writing went well or not as well as you hoped. In either case, your information could help improve treatment in the future.

The other reason for my carrying out this study is that research is a required part of my work towards a Doctorate in Clinical Psychology through the University of Leicester.

#### **Why have I been invited?**

Because you are completing treatment with the Eating Disorders Service or you are on their maintenance programme, and you wrote at least two self-compassionate letters during treatment. I expect to invite about another 5 people to join the study.

#### **Do I have to take part?**

It's up to you to decide. I will telephone you to describe the study, answer your questions and go through this information sheet which you can keep. I will ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.

#### **What will happen if I take part?**

I will inform your GP and therapist that you will be taking part in the research.

You will have one individual interview with me, lasting about 1 to 1½ hours, in a room at the Eating Disorders Service. Before we start, you will be welcome to ask questions about the study. I will ask you some background questions: your age, marital status, level of education, job, and type and duration of your eating disorder.

In the interview, I will ask you briefly about how you came to join the group and then about your thoughts and feelings before, during and after writing self-compassionate letters, and what you feel you gained from them. I will audiotape the interview so that it can be typed up later.

There are no “right” or “wrong” answers to the questions because they are about your experiences. I would also appreciate any thoughts you might have about improving compassionate letter writing. During the interview, you can say as little or as much as you wish and it will not be a therapy session. After we have finished, there will again be time for you to ask questions.

I will be interviewing some other people in the same way. I will then read the typed interview records to identify the similarities and differences of individual’s experiences and meanings, before writing a report of the whole study and an article for publication in a professional journal. This may take about 9 months to complete. The report and article will contain direct quotations from participants but your real name will not appear anywhere in them. The information will be kept confidential.

**What are the possible disadvantages and risks of taking part?**

You will be asked to give up about 1 to 1½ hours of your time for the interview. Although you decide what information you wish to give, it is possible that you may become distressed in which case I will contact your therapist to make sure that you have support available.

**What are the possible benefits of taking part?**

You may find it a useful opportunity to think about this part of your treatment and gain further insight into it. The information we get from this study will contribute to the knowledge base of the treatment of people with eating disorders.

**What if there is a problem?**

If you have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions. The following people are involved in this research study:

Lorna Showell, Trainee Clinical Psychologist  
Researcher  
02576 521130

Dr Steve Allan  
Academic Supervisor, University of Leicester  
0116 223 1648

**Will my taking part be kept confidential?**

Yes. I will follow legal and ethical practice and all information about you will be handled in confidence.

**What will happen to any information I give?**

The information will be used to write a report on the study but your name will not appear anywhere in it. Quotations from the interview may be used but if they contain any information which could identify you, I will change the details so that you cannot be recognised.

In order to keep your information confidential, only a master file will contain your real name and details. This file will be kept separate from audiotapes, written records and computer back-up disks which will be anonymised. All items will be kept in locked storage at the Eating Disorders Service. The archived storage and destruction (after 30 years) of these materials will be according to the data protection policies of the host NHS Trust.

The study report will be put in the Leicester University library for future use and will be summarised for publication in a professional journal.

If you join the study, some parts of your data may be looked at by people authorised to check that the study is being carried out correctly. They may be from the University of Leicester, from regulatory authorities and from the host NHS Trust. All will have a duty of confidentiality to you as a research participant and will do their best to meet this duty.

**What will happen if I don't want to carry on with the study?**

You are entitled to withdraw from the study at any point before publication without giving a reason, and all your interview data and written records will be destroyed. Your withdrawing would not affect your current or future treatment or your relationship with clinicians.

**Will anyone else know I'm doing this?**

I will keep your information in confidence. This means I will only tell those who have a need or right to know. This will include your therapist and your GP.

**Who is organising and funding the research?**

There is no funding for the research. The training course for the Doctorate in Clinical Psychology makes some funds available to cover expenses.

**Who has reviewed the study?**

Before any research goes ahead it has to be checked by a Research Ethics Committee to protect your safety, rights, well-being and dignity. They make sure the research is fair. This project has been reviewed and been given favourable opinion by (REC) Ethics Committee.

**Thank you for reading this – please ask any questions you may have.**

Lorna Showell  
Trainee Clinical Psychologist

## Appendix E



**National Research Ethics Service  
Coventry & Warwickshire Research Ethics Committee**

Prospect House  
Fishing Line Road  
Enfield  
Redditch  
B97 6EW

Tel: 01527 582532  
Fax: 01527 582540

19 January 2011

Dr Kenneth Goss  
Consultant Clinical Psychologist  
James Brindley House  
Coventry Canal Basin  
St. Nicholas Street  
Coventry  
CV1 4LY

RECEIVED  
21 JAN 2011

Dear Dr Goss

<b>Study title:</b>	<b>Dear Me: Exploring the Experience of Generating Self-Compassion through Letter Writing in Adults with Eating Disorders</b>
<b>REC reference:</b>	<b>09/H1211/64</b>
<b>Amendment number:</b>	<b>AM01 (minor)</b>
<b>Amendment date:</b>	<b>19 January 2011</b>

Thank you for notifying the Committee of the above amendment.

The Committee does not consider this to be a "substantial amendment" as defined in the Standard Operating Procedures for Research Ethics Committees. The amendment does not therefore require an ethical opinion from the Committee and may be implemented immediately, provided that it does not affect the approval for the research given by the R&D office for the relevant NHS care organisation.

### Documents received

The documents received were as follows:

Document	Version	Date
email from Lorna Showell		19 January 2011

### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

This Research Ethics Committee is an advisory committee to West Midlands Strategic Health Authority  
The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient  
Safety Agency and Research Ethics Committees in England

RE: Delayed commencement of research. REC reference number:  
09/H1211/64

Sent: 19 January 2011 15:36

To: Showell, Lorna J. [ljs41@leicester.ac.uk]

---

Dear Lorna,

Many Thanks for these details. I will forward these on to the Chair of the Committee.

Please note that the Chief Investigator will need to explain the reasons of why this study did not start earlier when they submit their first Annual Progress Report for the study next year. There will be a section on the form to do this.

Kind Regards and best wishes for the study.

  
**West Midlands Research Ethics Centre**  
**Prospect House**  
**Fishing Line Road**  
**Enfield**  
**Redditch B97 6EW**

**Tel: 01527 582531**

From: Showell, Lorna J. [mailto:ljs41@leicester.ac.uk]


Sent: 19 January 2011 14:29

To: 

Subject: Delayed commencement of research. REC reference number: 09/H1211/64

Further to our telephone conversation regarding delayed commencement of research following ethical approval, I have detailed additional information below.

REC reference number: 09/H1211/64

I am a Trainee Clinical Psychologist from Leicester University, currently on placement within  Eating Disorders Service. As part of my doctorate in clinical psychology I am undertaking a research project whilst I am placement in Coventry. Dr Ken Goss had previously submitted the project for ethical approval and obtained a favourable opinion in June 2009, unfortunately the individual who was going to conduct the research at that time was unable to do so. I am now planning to take on this project and as you have confirmed ethical approval is still valid for this study. Dr Ken Goss is still the Chief Investigator on the project and none of the details of the research itself have changed, just that I am now involved. The proposed end date for the study will now be April 2012.

Many Thanks

Lorna Showell

Trainee Clinical Psychologist

## Non-Mandatory Appendices

### Appendix F

#### Data Extraction Variables

Author(s) and Date:
Study Characteristics: <i>Aims of the study/Research questions</i> <i>Study design</i> <i>Study inclusion and exclusion criteria</i> <i>Recruitment procedures used</i>
Participant Characteristics: <i>Eating Disorder diagnosis</i> <i>Gender</i> <i>Age</i> <i>Ethnicity</i>
Intervention and Setting: <i>Setting in which the intervention is delivered</i> <i>Intervention(s) used and control(s)</i>
Methodological Factors: <i>Key variables and measures used</i> <i>Measures</i> <i>Procedure</i> <i>Statistical analyses</i>
Results: <i>Significant differences in target outcome variables</i> <i>Areas with no significant difference in target outcome variables</i> <i>Key evaluations</i> <i>Conclusions</i> <i>Limitations</i>



## Appendix G

**Table 4. Checklist for Measuring Study Quality**

	1. Johnstone et al (2010)	2. East et al (2010)	3. Earnhardt et al (2008)	4. Grasso (2007)	5. O'Connor et al (2011)	6. Frayne et al (2006)	7. Robinson et al (2007)	8. Lafont (2011)
Is the hypothesis/aim of the study clearly described?	Y	Y	Y	Y	Y	Y	Y	Y
Are the main outcomes to be measured described in the Introduction or Methods?	Y	Y	Y	Y	Y	Y	Y	Y
Are the participants characteristics described?	Y	Y	Y	Y	Y	Y	Y	Y
Are the interventions of interest clearly described?	Y	Y	Y	Y	Y	Y	Y	Y
Are the principal confounders described?							Y	Y
Are the main findings of the study clearly described?	Y	Y	Y	Y	Y	Y	Y	Y
Does the study provide estimates of the random variability in the data for the main outcomes?	Y	Y	Y	Y	Y	Y	Y	Y
Adverse events as a consequence of the intervention reported?	Y	Y		Y			Y	Y
Characteristics of participants lost to follow-up reported?	Y	Y	Y	Y	Y	Y	Y	Y
Actual probability values reported?	Y	Y	Y	Y	Y	Y	Y	Y
Participants representative of the entire population from which they were recruited?	Y	Y		Y	Y		Y	Y
Attempt made to blind participants to the intervention?	Y	Y		Y	Y	Y	Y	Y
Attempt to blind those measuring main outcomes of intervention?		Y						Y
Results of study based on “data dredging” made clear?	Y	Y	Y	Y	Y	Y	Y	Y
Differences in follow-up adjusted for?	Y	Y	Y	Y	Y	Y	Y	Y
Statistical tests appropriate?	Y	Y	Y	Y	Y	Y	Y	Y
Compliance with the interventions reliable?	Y	Y	Y	Y	Y	Y	Y	Y
Were the main outcome measures used accurate, valid and reliable?	Y	Y	Y	Y	Y	Y	Y	Y
Participants randomised to intervention groups?	Y	Y		Y	Y	Y	Y	Y
Was there adequate adjustment for confounding in analyses from which main findings were drawn?	Y	Y		Y	Y	Y	Y	Y
Did the study have sufficient power to detect a clinically important effect?	Y	Y		Y	Y	Y	Y	Y

## Appendix H

### CONSENT FORM

***Title of Study: Dear Me: Exploring the Experience of Generating Self-Compassion through Letter Writing In Adults with Eating Disorders***

*Name of Researcher: Lorna Showell*

Please initial box

I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my care or legal rights being affected.

☐

I understand that relevant sections of data collected during this study may be looked at by individuals from the University of Leicester, from regulatory authorities or from the NHS Trust where it is relevant to my taking part in this research.

☐

I agree to my GP being informed of my participation in this study.

☐

I agree to take part in the above study.

☐

I understand that any information I give will be treated as confidential

☐

\_\_\_\_\_  
Name of client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of person taking  
consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

When completed: 1 copy for client; 1 for researcher site file;  
1 (original) to be kept in client notes.

## **Appendix I**

### **Interview Question Schedule**

***Title of Study: Dear Me: Exploring the Experience of Generating Self-Compassion through Letter Writing In Adults with Eating Disorders***

#### **Background**

Just to get some background and to get to know something about you, can you tell me about how you came to be in the group?

#### **CLW in group sessions**

How many letters did you write in group sessions?

What was the usual procedure for writing them? (Prompt: when during the session, how long to write, when were they read out, who read them)

If you think back to when CLW was first described to you, what was your reaction?

Thinking of the very first letter you wrote in a group session – can you tell me what that was like for you? (Prompts: subject (if willing to disclose), thoughts, feelings, physical reactions, behaviour, what helped)

Did you read your letter out to the group?

If no, was there some reason why you didn't?

What about later letters?

If yes, can you tell me about that? (Prompts: were you the first, the last, your thoughts, feelings, physical reactions, behaviour?)

What do you think was the reaction of the other people in the group to your letter?

How did that affect you?

What about a bit later, after that session was over – how did you feel about the experience (of writing/ reading aloud)?

#### **After you'd had more practice of writing self-compassionate letters in the group**

What was writing later letters like compared with writing that first letter?

What kinds of difficulties or events did you tend to write about?

How easy was it to be warm and understanding towards yourself in your letters?

- what other kinds of thoughts would come into your mind? (Prompts: thoughts about yourself, your ED or others?)

- how did you deal with them?

- was there anything that helped you write with self-compassion? (Prompt: any ideas or images from the therapy sessions?)
- how did they help?

### **Homework CLW**

Part of the therapy was to write letters at home. Were you able to do that?

If not - what do you think stopped you?

If yes,

- when did you write (for homework for the sessions or at other times?)
- did you write about the same types of things at home as in therapy? (examples)
- how did writing at home compare with writing letters in session? (Prompts: motivation, techniques used, ability to be self-compassionate by yourself, to generate warmth)

Was there anything you'd tried in therapy that didn't work or was more difficult when you were writing letters by yourself?

- What do you think was the reason for that?
- Anything that was easier when writing at home?
- What do you think made it easier?

### **Self-compassion**

Looking back over writing letters in session and at home

- what did these experiences of being compassionate to yourself mean to you?
- what did the letters tell you about how you felt about yourself? (examples?)
- what did you think about that?
- what did they tell you about your relationships with other people? (examples?)

What kind of compassionate self did you imagine was writing?

One of the aims of CLW is to develop warmth towards yourself

- how did that go?
- what did you do to help develop warmth?
- can you still feel that warmth – if so, what does it feel like?

### **Overall opinion**

Looking back, what experience of CLW had the most effect on you?

What do you think about the idea of being compassionate towards yourself?

How helpful or believable were the alternative thoughts you wrote about yourself?

We need your input to help improve the therapy

- what would you like to change about CLW?
- how could we make it better?

Which part of the CLW process do you think has been most beneficial?

-why?

## Appendix J

### Transcript Extract

I: Ok. Thinking back to the first time that letter writing was described to you

P: Mm hm

I: Can you remember what your initial reaction was? (Pause) Did you have any thoughts or feelings about it?

P: Erm (pause) it was more, the first one was how is this going to help? (Laughs)

Really? (Laughs) Erm and it was quite bizarre the thought of writing a letter saying I'm lovely and you are wonderful and da, da, da please be ok erm so initially when it was described to me it was kind of like this isn't going to help at all. Erm but then the more it was explained

I: Mm

P: The more I could kind of see how from a compassionate point of view it was going to help make me, make me think more about it

I: Yeah

P: Think about being kind to yourself if that makes sense?

I: Mm, yeah definitely. The first letter that you wrote in group

P: Mm hm

I: Can you remember what that experience was like; the very first one?

P: Erm (pause) it was hard erm but we were given the opportunity to kind of write just a few things down erm about the struggles we were having just in that week, or in general or something. Erm we were told to think about something that we would like to write about

I: Mm

P: And then when we went into our breathing and, and safe place and things you know we kind of talked about that a bit more erm but the safe places are quite easy

I: Mm

P: But then coming out of that and then thinking right ok I've got to write now erm but normally once you get the first sentence started its quite easy

I: Yeah. Did you have any new kind of physical feelings or thoughts or anything going through your mind writing that letter?

P: It made me feel quite sick.

I: Yeah

P: Made me feel quite sick

I: Mm hm

P: Erm and (pause) I suppose it made me feel anxious because I wasn't sure what to write. Erm and I was anxious that I wasn't going to write the right thing. Erm and it was, it was quite a negative first letter really

I: Mm

P: Erm although once I read it out there were some compassionate elements to it pointed out to me

I: Mm

P: Erm but no, I thought it was quite a (pause) it was quite an anxious kind of thing to do.