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CASE REPORT Open Access

"We went fishing in the dark": a case report highlighting one therapeutic process in an out-patient comorbid anorexia nervosa (AN) and complex post-traumatic stress disorder (C-PTSD) treatment

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Abstract

Background There has been little research into effective treatment of comorbid AN and C-PTSD. This group of patients may show severe and enduring illness histories, often needing repeated hospitalisation and periods of outpatient treatment, adversely affecting their lives. Presently, there is no single recommended treatment for patients with comorbid AN and C-PTSD.

Case presentation This article presents a case report of one therapeutic process through two stories; the patient's and the therapist's. The therapeutic approach in this case of comorbid AN and C-PTSD was symptomatic-, person- and process-oriented, with an eclectic choice of therapeutic methods including enhanced cognitive behavioural therapy for eating disorders (EDs) (CBT-E), mentalisation based therapy for EDs (MBT-ED), compassion focused therapy for EDs (CFT-E), emotionally focused therapy (EFT), and narrative exposure therapy (NET), aiming to provide personalised care; tailoring the interventions to the patient. The therapeutic relationship and treatment are analysed, with the aim of highlighting what influenced the therapeutic process.

Conclusion The authors are not aware of other studies addressing the stories of patient and therapist in a therapeutic relationship, used to better understand factors relevant to the therapeutic process, in treating comorbid AN and C-PTSD. This case report provides insight into one therapeutic process treating these psychiatric illnesses in combination. The overall goal in therapy proved to be minimising the distances within the patient, between patient and therapist, between patient and society, and between the patient's past and present, through a personalised approach. Further research should elaborate on the dyadic perspective unfolding from these two stories; addressing specifically the emotional-relational processes within the therapeutic relationship, to help broaden the understanding of treatment for comorbid AN and C-PTSD. We call for further research into personalised therapeutic interventions for

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these patients, suggesting a 'toolkit' of interventions, tailored to the patient. It should not be the patient's job to fit the method, but our job to make sure the method fits the patient.

Plain English summary

There has been little research into effective treatment of comorbid AN and C-PTSD. This article presents a case report of one therapeutic process through two stories; the patient's and the therapist's. The therapeutic approach in this case of comorbid AN and C-PTSD was symptomatic-, person- and process-oriented, with an eclectic choice of therapeutic methods, aiming to provide personalised care; tailoring the interventions to the patient. The therapeutic relationship and treatment are analysed, with the aim of highlighting what influenced the therapeutic process. The overall goal in therapy proved to be minimising the distances within the patient, between patient and therapist, between patient and society, and between the patient's past and present, through a personalised approach. Further research should elaborate on the dyadic perspective unfolding from these two stories; addressing specifically the emotional-relational processes within the therapeutic relationship, to help broaden the understanding of treatment for comorbid AN and C-PTSD. We call for further research into personalised therapeutic interventions for these patients, suggesting a 'toolkit' of interventions, tailored to the patient.

Keywords Eating disorders, Anorexia nervosa, Complex PTSD, Case report, Personalised care

Background

AN is a mental disorder affecting especially young women [1, 2]. It is essential to continue developing treatment methods targeting this vulnerable group of patients with one of the highest mortality risks among psychiatric disorders [2], high dropout rates [3], and, often, the need for repeated hospitalisation and years of treatment [4, 5].

Comorbid psychiatric disorders have been shown to be more rule than exception in patients with AN [6]. For instance, studies show that childhood trauma is more prevalent in ED populations than in other psychiatric disorders and healthy populations [7, 8]. One assessment study of PTSD in patients with AN, found the most common traumatic events reported by those with PTSD diagnosis were sexual related traumas during childhood, and the odds of meeting criteria for PTSD were significantly lower in individuals with restricting AN than individuals with purging AN without binge eating [9]. A systematic review of the literature on comorbid PTSD in patients with ED found that difficulties in emotional regulation may be a common mechanism in both disorders, and comorbid PTSD was associated with more severe ED symptoms [10]. A recent prevalence study of ED patients, using ICD-11 criteria, reports C-PTSD being significantly more prevalent than PTSD [11]. The symptoms added to the core PTSD symptoms in C-PTSD are difficulties in emotion regulation, self-concept and relational capacity [12], evidenced by individuals with C-PTSD having greater functional impairment, and benefitting from different treatments, as compared to individuals with PTSD [13].

The Norwegian national guidelines for treating EDs recommend individual psychotherapy for adults with AN, while not recommending any specific psychotherapy [14]. NICE Guidelines in Britain recommend clinicians to consider one of three treatment methods for AN in adults; CBT-E, Maudsley anorexia treatment for adults (MANTRA) or specialist supportive clinical management (SSCM) [15]. The guidelines point out that there is little evidence for which treatment works best for people with an ED and a comorbidity, suggesting a need to deviate from recommended methods if needed [14, 15].

A much-researched treatment method for EDs is CBT-E, a transdiagnostic, manualised, symptomatic method, focusing on psychoeducation, modification of eating habits, weight-control behavior, and cognitive concerns about eating, weight and shape [16]. One recent systematic review found that CBT-E can be an effective treatment method for adult patients with an ED such as bulimia nervosa or binge eating disorder, but for AN, results have been inconsistent [17].

Other treatment methods targeting patients with an ED, such as MBT-ED [18–20], CFT-E [21–23] and EFT [24–26] have been proposed and researched. Common to these seem to be that they target various maintenance and relapse risk factors associated with the ED. MBT-ED has been developed with the idea that patients with an ED have shown low mentalising capacity and reflective functioning compared to healthy controls [27, 28]. It focuses on the therapeutic alliance, aiming to restore general mentalising and, ultimately, reduce ED symptoms [18]. CFT-E aims to address shame and self-criticism, which are associated with increased ED pathology, and to assist patients in developing greater self-compassion [21, 29]. EFT targets emotional avoidance, emotional dysregulation and social anhedonia, shown to be maintaining factors in ED pathology: the aim being to transform maladaptive emotions by activating adaptive emotions, to be better able to connect with oneself and others [26]. These methods combined bring a focus on emotion regulation, self-compassion, self-construction and working within

the therapeutic relationship, and can be seen as important additions to CBT-E.

Trauma focused CBT or Eye Movement Desensitisation and Reprocessing (EMDR) are usually recommended for adults with PTSD, but evidence is limited with respect to interventions for C-PTSD [30]. A recent meta-analysis found that patients with childhood trauma had less beneficial outcomes from recommended treatments, than those without [31]. International Society for Traumatic Stress Studies' (ISTSS) guidelines on C-PTSD in adults [32] suggests that as C-PTSD comprises a greater number and range of symptoms than PTSD, its treatment may involve more diversity of treatment interventions and/or longer duration. NET is conditionally recommended, among other therapies, by the American Psychological Association (APA) clinical practice guideline for the treatment of PTSD, particularly in those suffering from complex and multiple trauma [33].

Research into the understanding and treatment of comorbid ED and C-PTSD is scarce, the literature calling for further research into both existing and new treatments for C-PTSD, without and with comorbid ED [31, 32, 34]. A recent systematic review suggests that when childhood trauma is present, the ED may have a different function than in classical ED, serving as a survival mechanism with a protective function in avoiding the emotional confrontation with the trauma experience [35]. A resent qualitative study provides insight into how six inpatients with an ED and late effects of childhood trauma, experienced in-session therapeutic processes post-treatment [36]. The three main core teams emerging from the interviews were covert strategies of self-effacement, preferring either therapist closeness or distance to open up, and adhering to reflective rather than experimental interventions. The authors addressed the importance of the awareness around patients' characteristics to be able to explicitly address inter- and intrapersonal processes potentially impeding treatment progress. For instance, the therapist may risk patients engaging in covert experiential avoidance, pretending to participate or withdrawing self-assertion.

Current evidence from a systematic review and meta-analysis [37], indicates that personalisation is an effective strategy for improving outcomes of psychological therapy. In recent research into personalising treatment for EDs [38], the authors point out that part of the reason treatment might not work in a subset of individuals with ED, is the high heterogeneity of this group. Conducting an open series trial of network-informed personalised treatment for EDs, personalised based on idiographic network models of ED cognitions, behaviors, affect and co-occurring symptoms, their research suggested that network-informed personalised treatment has high acceptability and feasibility, and can decrease ED and related pathology [38]. The clinical significance of this is that it can be used to identify top therapeutic targets in individuals with EDs and co-occurring psychiatric disorders [39].

Another important source of information for understanding and treating PTSD, both with and without ED, comes directly from trauma survivor's life and therapy experiences, offering insight into their primary concerns and treatment preferences. Cloitre [40] calls for research evaluating the role of patient preference in enhancing treatment engagement, adherence and outcome, and suggest a "toolkit" of interventions in therapy from which patient and therapist can select. In an article providing personal and professional perspectives of lived experiences with ED and PTSD, written by a doctor and two patients [41], shared key elements when evaluating and treating patients with ED and trauma, by putting the patient's treatment experiences in the context of ongoing clinical research. They point out that their stories can guide professionals towards improved, more integrated trauma-informed care and practice. Some important themes emerging from their perspectives were that symptoms of PTSD that can be overlooked in therapy or interpreted as something else, that emotional avoidance and dysregulating with ED pathology can function as ways of handling trauma and pain, and that shame and self-criticism can increase ED pathology. The authors also highlighted the importance of combining different treatment methods to fit the patient in question, trust between patient and therapist as more important than the method itself, widening the gaze and being curious as essential for solid treatment, and the patients' need for help from the therapist in providing a language and an understanding in order to be able to start getting better and reconnect with an authentic self.

The authors of this case report are not aware of any studies addressing the stories of a patient and a therapist in one therapeutic relationship, to try and better understand which factors are relevant to the therapeutic process in treating comorbid AN and C-PTSD. The case report aims to highlight what influenced, and had an effect on, the therapeutic process in one patient-therapist dyad.

Method

Study context

The initiative to write this case report came from a patient, Barbara, asking her therapist, Kathrine, to cooperate in writing stories of their shared therapy process, with the aim of publishing an article.

Barbara, is a 38-year-old woman with a history of childhood trauma, including sexual, emotional and physical trauma, and AN. She has been in both in- and outpatient care numerous times from childhood. Starting

this latest treatment, she met the criteria for AN, purging subtype, and C-PTSD. She was out of employment and had a restricted social life, feeling alone and of little use to society. Presently, she works in hospital as a peer support worker. The main symptoms of Barbara's AN were restrictive eating and exercise, combined with periods of eating and purging. The most common C-PTSD symptoms in this case were flashback's and nightmares, avoidance in various forms, sleep disturbance, overwhelming emotions and difficulties regulating them, panic attacks, negative self-view, relational challenges and difficulties connecting with herself and others.

Kathrine, is a 45-year-old woman working in an outpatient clinic specialising in complex cases of ED, often in combination with comorbid disorders such as C-PTSD. She has worked as a licensed psychologist for 16 years, specialised in adult psychology. She is a CBT-E therapist, and trained in MBT and EFT. She has worked with EDs and comorbidities for eight years and has a special interest in ED and C-PTSD. Her general view on ED treatment is that personalisation and timing are more important than the method itself. She is committed to working within the therapeutic alliance, following the patient, being aware of the emotional regulation in the therapy room and to help patients find their own voice and strength. She strives to create a space for transparency and a mutual ground where working with change is possible, by keeping in mind the asymmetrical relationship between patient and therapist, and by challenging avoidance within the therapeutic space.

General, eating-related and post-traumatic symptoms were assessed in beginning of therapy using interviews and self-report questionnaires such as MINI International Neuropsychiatric Interview (MINI 6.0), SEDI (Structured Eating Disorder Interview), EDE-Q (Eating Disorder Questionnaire), CIA (Clinical Impairment Assessment Questionnaire) 3.0, and IES-R (Impact of Event Scale-Revised).

The therapeutic interventions took a symptomatic-, person- and process-oriented approach, with an eclectic choice of methods such as CBT-E, MBT-ED, CFT-E, EFT, and NET.

Barbara received out-patient care over a period of three years, usually one session per week. She gave notice if she could not, on occasion, attend, and had the possibility of contacting Kathrine between sessions if needed. Kathrine, sometimes, offered extra sessions, if she had the impression that Barbara needed more support.

The writing process

Barbara and Kathrine each wrote their story about the therapeutic process. Kathrine conducted a literature search and wrote the remainder of the article. A professor and qualitative researcher, Berit, not part of the therapy sessions, joined the research meetings, supervising, guiding and collaborating in the research and writing process. The stories started out long and with several themes. Initially there was a process of comparing the stories on several occasions over a period of two years; approximately 15 meetings of 1–2 h. The three parties worked together to narrow both stories down to something comparable, trying to find the main shared themes seeming important to both Barbara and Kathrine. There were thorough discussions on what Barbara would feel comfortable sharing in this article, parts of the stories not be shared publicly being omitted. Those parts including third parties and details of traumatic experiences were not included. Some parts considered unnecessarily detailed, were left out, as were parts not relevant to this therapeutic process. These elisions are not believed to have impacted the transparency of the stories but are believed, rather, to have made them more 'to the point'. Barbara expressed a feeling of increased autonomy and more room to find and express her own voice throughout the therapeutic process, which contributed to her initiating this project. She described the writing process as therapeutic. For her, it was important to own her story and not be ashamed of it, but to grow from the process and, hopefully, provide a meaningful voice in the debate on treatment for patients with the same comorbid disorders as she hers.

Ethical considerations

The idea of writing this case study was the patient`s. The therapist made sure to remind her that she could choose to end the process at any point. What felt right to share publicly in the stories, and what would be kept in the therapy room, were discussed on several occasions. Third parties were not involved in the stories. The therapist was mindful her role and responsibility for the patient and gave room for debriefing after meetings. The patient looked at this cooperation as a professional relationship between co-authors, where she was able to own her own life story, and to do as she wished with it.

The project was considered by the Regional Committees of Medical and Health Research Ethics (REK) as not requiring submission and was approved by the data protection officer at the Nordland Hospital Trust, Norway. For the record, the patient provided a written consent to have the article published in full.

Results

Case presentation

Barbara's story

Throughout my life, I have learned that humans are amazingly complicated creatures designed so that the brain can automatically shut off parts, or all, of traumatic experiences to protect itself. Looking back on my life, there were many signals that something was wrong, but I

did not understand them—flashbacks, nightmares, panic, anxiety and feeling disconnected from myself and others. Sometimes, I felt grown up and in control, but often, I felt like a small child who was scared and alone. I did not know what was happening, why, or how to fix it. I could not handle the fact that I was not in control. I thought something was wrong with me and I did everything I could to avoid it and hide it from the world. The solution was to become perfect and overcompensate to show the world everything was fine. I decided to change myself.

I started exercising, and for the first time, I experienced a sense of accomplishment, the huge endorphin rushes that exercise gave me, and I received praise and recognition from others. I was suddenly a person who was good at something. First, I discovered the treadmill, where I could run for hours and feel free, no one could catch me. Then, it was strength training. The most incredible feeling of accomplishment came when I managed to go without food for a whole day and exercise simultaneously. I have always had a hard time with relationships. I filled the void where friends were supposed to be with exercise. I was strong, I was in control, and I was good at something. When my past caught up with me, and I did not know how to deal with that, I felt disgust towards myself, and I could not handle my own body. I would also eat and throw up. It gave me a sense of relief there and then, a break from everything that was pressing from my inside, that I was struggling to understand.

At some point, people around me started to react. I was diagnosed with an ED, and eventually, with C-PTSD. I received treatment and was hospitalised several times. I was offered CBT-E, among other things. I was used to doing what others told me to do, so that's what I did in therapy. I was keen to say and do what I thought therapists expected of me. I was afraid of not being good enough in treatment and afraid that they would give up on me. I learned to do 'the right thing', especially when it came to eating more regularly and interpreting my own weight. Even if I managed to meet some goals in therapy, it felt as if it did not quite hit the mark. I could not stick with it, relapsed and needed new rounds of treatment. I was also offered EMDR to try and help me process my traumatic experiences, a treatment that did not feel quite right and safe enough for me.

One day, I moved away from everything familiar and safe and sought treatment for my ED again. I was receiving disability benefits and had no role in society. The only thing that remained was my best friend - my ED, something that could not be taken away from me. How wrong I was - I thought I had prepared for anything that might come my way, but this caught me completely unprepared. I met someone I thought I could keep my distance from, say what I thought she expected and get away with it. But this person did not tell me what to do. She stood beside me, not in front of me. She was interested in what I had to say and was curious without me feeling that she had expectations of how I should be. She spoke to me in a way that I understood, and that made me feel understood. I realised after some testing that she recognised when I was avoidant, that there was more to the story than I could express, but she did not punish me for it or overlook it. This person was my new psychologist, Kathrine, who would become one of the most influential people in my journey towards becoming healthier.

If I do not allow it, I do not show emotions, but when I realised I had a chance, there was a complete crisis. After so many years, a tiny seed of hope sprouted, as if by magic, and shattered the picture I had painted of my future. I felt split in three - the ED that had been my best friend for so many years was screaming so loudly and was afraid of being thrown out, afraid that I would lose control again. The little child in me was rocking back and forth, waiting for punishment; I saw her crying but did not hear her. Even without a voice, she takes up enormous space because she is so scared and needs care. Then, the 'adult me' sits with Kathrine. In her, I see a person who listens, understands and does not condemn me. She saw what was under 'my mask' and still accepted me for who I was. I decided to give therapy a try.

I realised that to move forward, we had to start at the bottom and work our way up. We had to start in my deepest darkness, where breathing was almost impossible. We had to find where the 'little child' lives, the part of me that was never allowed to grow up and was too young to understand what happened back then. Kathrine and I went down there together to try to find this little child, lift her up, and give her a voice.

My journey from being severely ill to being healthier has been my most challenging journey. At some point, I saw that I would never be completely free, free in the sense that I was before everything happened to me, but I could work towards something better. There have been many ups, but there have been even more downs. I have been so far down in my darkness that it is a wonder I am not gone. However, having someone who sees your needs before you do, is patient and willing to give you the control you need is unique. The humility, genuine care, cooperation and respect I have encountered in my sessions have given me the strength to find my voice; I have been allowed to speak up to the person who has sat there with more knowledge and power than me when something was not okay for me. I did not have to follow a specific treatment method but was allowed to help decide how to work together.

Part of getting better for me was no longer only about being able to eat everything, get my mind on other things than food and body, or just focusing on gaining weight. It was about gaining more knowledge to understand what

happens when I feel that enormous loneliness and insecurity, listening inside myself to get answers to what I need. One of Kathrine's most frequently asked questions has been, "What do you need now?". At first, I could not find an answer, but in time it became clearer to me. It allowed me to learn more about what felt right for me, not just do what I thought others expected of me, which is how I have basically lived my whole life. I was also encouraged to work, to find a place in society and not just focus on illness. I was no longer just seen as a sick person. I have learned to say that it is okay to be in pain and that it is okay to be allowed to contribute to society even if I do not always meet the expectations of others.

Treatment was like fishing with a thin line. You throw out the line and hope that today is the day you get something, and if you do not get anything, you have learned that you try something different next time. If you get a bite on something meaningful, you have to reel in a little and then give a little more line, reel in, and give more line. In the same way that a fish gets tired at some point and gives up, I became confident enough not to fight so much and give more access to what felt painful and unsafe. I needed Kathrine to handle the fishing technique, so I dared to hold on to the line.

Kathrine's story

I remember my first meeting with Barbara very well. She had two wishes. First, she wanted me to be open and honest with her. Second, she wanted me to share something of myself when it was natural. The central theme that emerged from the first meeting was that our relationship and an open and mutual cooperation would be the foundation of the treatment.

I knew that Barbara had received years of treatment for AN and, eventually, C-PTSD. I felt tremendous respect for everything she had been through and that she was willing to give treatment another chance. I sat in our first meetings and tried to understand what Barbara needed and what it would take to dare to take new steps in treatment this time. I understood that taking control of food, body, and weight had a function. It seemed to create a distance from the pain from the past, and gave her a sense of mastering something here and now.

Barbara's initial wishes for treatment were help to tolerate being of normal weight and to have a more relaxed and healthy relationship with food and body. With a symptom-oriented approach, psychoeducation and a mentalising and empathic stance as a foundation in our meetings, we worked on exposure to increased weight and food intake and on reducing excessive exercise and purging. After achieving normal weight, I noticed that Barbara became ambivalent about being in treatment, and she expressed this herself. She wanted to tolerate her weight and body but also strongly expressed wanting to lose weight. She described how she sometimes 'wore a mask' in sessions and underreported how she felt, answering what she thought I expected of her. Her C-PTSD symptoms worsened, and the eating disorder tightened its grip on her, she became more reluctant to 'keep doing the right thing' in therapy. I tried to imagine what it might be like to feel 'trapped' in illness for many years on the one hand and what an image of life without illness would look like on the other. I imagined that the distance could feel huge and perhaps even insurmountable. It was as if the important steps she had taken in treatment so far were making her feel unsafe and creating more distance and confusion, within herself and between us. I was worried that she would drop out of treatment, and she expressed her worries that I would give up on her.

At this point I wanted to try and understand and help to minimise this distance between us. I was keen to show her that I believed she would be able to take new steps in treatment, that I had no intention of giving up on her, and that we would figure out the way forward together. I experienced that my most important 'tools' in this phase were to be patient, show support and empathy and follow her lead, while at the same time be curious and creating space to explore what did not quite make sense, by also leading the process. I did not have a ready-made answer to what would be right for Barbara going forward in treatment, although I had some ideas for methodological approach and focus, and used an eclectic approach, picking what I thought would meet her needs at any particular time, from a 'toolkit' acquired over the years. We worked on trying to better understand what she needed and what felt right for her, through working with self-compassion, here-and-now focus, exploring her narrative and trying to make sense of her own emotions and reactions, within herself and between us.

For me, it also seemed of importance to work on trying to minimise the distance between Barbara and others, by showing her support and expectations in that she could be part of society. She was young and reliant on a disability pension but wanted to contribute. She started volunteering, and later got a part-time job, and studied at university. She expressed pride in being a person who accomplished more than just showing up for treatment sessions. She made friends and collegial relationships. In this period, she described how she felt like two people: one who was successful and equal at work and university and another who felt alone, worthless and 'damaged', especially when she was on her own. This distance became apparent within herself, when she described parts of her not functioning on the same 'wavelength', and that confused her. She could feel small and scared on the one side, but often found it easier to 'put on a mask' and be as she thought others expected of her. She felt an

overwhelming need of control over what did not make quite sense within herself, and described a rigid and critical part of herself where there was no room for mistakes. Here is where the ED seemed to take its place.

Barbara also described a distance between her past and the present, and she struggled to reconcile these. With psychoeducation and narrative exposure, we worked on trying to understand her reactions to previous traumatic life events. We worked to increase her understanding and acceptance of her reactions, which have had a function and are part of her story. Barbara gained more access to her feelings and was better able to be present in the here and now.

What stood out as the most important theme in treatment was that Barbara would eventually be the one at the helm and that I would follow her lead, providing support and guidance. The treatment plan became more and more something Barbara owned herself, not a plan she felt she had to live up to, but something that gave her direction and met her needs. I had the opportunity to be a few steps ahead of her with a professional understanding of some of the processes she would need to go through, by also leading the process. Barbara did the heavy lifting, taking necessary steps in a manageable order, working on the distances within herself, between us and in society, and between the past and the present.

Discussion

If you try to catch a fish with your hands, it will only slip away.

The patient's metaphor describing therapy as going fishing, says it all. Therapy is not simply getting the patient on board; it's about the process. In the therapy room, there are multiple factors that can both challenge the process and create space for healing and change.

Starting therapy, CBT-E, as one of the NICE guidelines' recommended treatment methods for AN [15], formed the frame of the therapy sessions. The patient reported an effect in helping her to learn 'to do the right thing' around food intake, regular eating, reducing exercise and purging, and to interpret her own weight changes. Nonetheless, it appeared that these interventions were not quite sufficient. As the patient said herself: "…it did not quite hit the mark. I could not stick with it, relapsed and needed new rounds of treatment." This was also the therapist's impression, that when getting to a point of normal weight, the patient 'became ambivalent about being in therapy' and that she "became more reluctant to 'keep doing the right thing'". Therapy is ultimately about healing and change, and when patients do not respond well to some therapies and seem to get 'stuck', we need to consider options.

As Norwegian and British guidelines for treating EDs suggest, there might be a need to deviate from the guidelines in choosing methods, focus and duration in therapy when treating ED and a comorbidity, it being the patient as a whole to be treated, not only the specific diagnosis [14, 15]. In this case, the patient met the criteria for AN, purging subtype, and comorbid C-PTSD, as a consequence of sexual, emotional and physical trauma in childhood. As abovementioned assessment and prevalence studies report, childhood sexual trauma and purging AN has been shown to be prevalent in AN patients with comorbid PTSD [9], and C-PTSD to be significantly more prevalent than PTSD in ED patients [11]. Patients with C-PTSD benefitting from different treatments as compared to individuals with PTSD [13], and patients with childhood trauma shown to have less beneficial outcomes from recommended treatments, than those without [31], gives insight into the complexity of treating PTSD/C-PTSD, challenging the 'one-size-fits-all' approach to treating complex psychiatric disorders.

At one critical point in therapy where the therapist wrote: "I was worried that she would drop out of treatment, and she was worried that I would give up on her", it was the therapist's job to try and understand what the patient would need to commit further to treatment. Knowing that many patients end up dropping out, relapsing and needing several rounds of treatment [3–5], we need to try to isolate which maintaining symptoms from the individual patient's psychiatric disorder are more dominant and focus on them.

This patient's ambivalence regarding weight gain seemed to be one maintaining symptom which made commitment to therapy challenging. The systematic review of mediating factors between childhood traumatic experiences and ED development highlighted normalisation of weight for patients with AN as needing to be managed carefully, as it may provoke a strong confrontation with the memories and emotions related to the traumatic past [35]. The patient wrote; "I have learned that humans are amazingly complicated creatures designed so that the brain can automatically shut off parts or all of the traumatic experiences to protect itself … there were many signals that something was wrong, but I did not understand them … I did everything I could to avoid it and hide it from the world … I decided to change myself… I started exercising… I would also eat and throw up. It gave me a sense of relief there and then, a break from everything that was pressing from my inside, that I was struggling to understand …. " The therapist's perspective was: "I understood that taking control of food, body and weight had a function. It seemed to create a distance from the pain from the past and gave her a sense of mastering something here and now." This provided an understanding on how AN in this case could be a coping mechanism for the C-PTSD symptoms of intrusion, avoidance, emotional dysregulation and negative

self-concept. The patient distanced herself from the traumatic pain, by trying to disconnect from herself and her surroundings, change herself and take control, regulating with food, body and weight. The representation of the ED for the patient can be looked at as being of an ego-syntonic nature as she wrote: "The only thing that remained was my best friend - my ED, something that could not be taken away from me". Struggling with this ambivalence, the patient sought treatment for the ED, but at the same time seemed reluctant to let the ED be 'taken away'.

The therapist had to manage this position of trying to help the patient 'take away' the symptoms of ED, an essential part of therapy and, at the same time, be aware of, and take into consideration, the patient's ambivalence and reluctance. Confrontation with the traumatic past through reduction of ED symptoms, seemed to push the patient into a corner, challenging her relational capacity and ability to trust and connect in therapy sessions; another common C-PTSD symptom [12]. The patient's attitude initially was: "I met someone I thought I could keep my distance from, say what I thought she expected and get away with it." While also feeling that "I was afraid of not being good enough in treatment and afraid that they would give up on me". The therapist wrote that: "It was as if the important steps she (the patient) had taken in treatment so far were making her feel unsafe and creating more distance and confusion within herself and between us." This is in line with the interpersonal process recall study by Olofsson et al. [36], where patients managed interactions with therapists through self-effacing and submissive behaviors, engaging in covert experimental avoidance, pretending to participate in therapy. In this case, the therapeutic alliance and trust seemed to be on the line, with the patient trying to keep her distance from the therapist, and the therapist feeling distance and confusion emerging. It seemed as if the patient needed to regulate emotionally by maintaining a distance and withdrawing self-assertion, by 'wearing a mask' as a way of being in control. Both patient and therapist expressed worries that the therapeutic relationship could end.

What seemed to be a turning point in therapy was the patient saying: "After so many years, a tiny seed of hope sprouted, as if by magic, and shattered the picture I had painted of my future…". "I realised after some testing that she recognised when I was avoidant, that there was more to the story than I could express, but she did not punish me for it or overlook it." And "I see a person who listens, understands and does not condemn me. She saw what was under 'my mask' and still accepted me for who I was. I decided to give therapy a try." It is as if the patient realised that she was within a frame where change might be possible. The frame proved to be a therapeutic relationship based on transparency and trust, where the patient's autonomy and the therapist's attitude towards her was of the essence. The patient started by giving the therapist access to her inner struggles of finding within herself what 'felt right for me', and not simply doing 'what I thought therapists expected of me'. They had to work from the 'bottom-up', as the patient herself wrote: "We had to start in my deepest darkness…".

The therapist picked interventions from her 'toolkit', to try and meet the patient's needs to create the necessary change in therapy. The patient wrote: "Kathrine and I went down there together to try to find this little child, lift her up, and give her a voice" and: "One of Kathrine's most frequently asked questions has been, 'What do you need now?'". Working with elements from EFT, as suggested in previous research on ED and EFT [24–26], they tried to get to 'the little child's' primary emotions and needs, the therapist leading the process but also following the patient, with empathic interventions. It seemed to help the therapist get a broader perspective of the patients own experience, helping her to find healthier ways to managing avoidance and emotional dysregulation, rather than ED behavior.

Shame and self-criticism seemed to accentuate the patient's ED pathology. The patient wrote: "I thought something was wrong with me and I did everything I could to avoid it and hide it from the world. The solution was to become perfect and overcompensate to show the world everything was fine." The therapist wrote that the patient could feel 'worthless' and 'damaged' and "… described a rigid and critical part of herself where there were no room for mistakes. Here is where the ED seemed to take its place". It made sense in keeping with previous research on CFT-E and ED, where shame and self-criticism are associated with elevated ED pathology, where the aim of therapy is to assist patients in developing greater self-compassion [21, 29, 41]. Working with elements from CFT-E, especially addressing the critical part of the patient, increased awareness and compassion for her own struggles.

In conformity with research into MBT-ED [18, 27, 28], the therapist attempted to maintain a mentalising stance, in which the therapeutic relationship was core, working with the dynamics between the patient and the therapist. As the patient put it: "She stood beside me, not in front of me. She was interested in what I had to say and was curious without me feeling that she had expectations of how I should be. She spoke to me in a way that I understood, and that made me feel understood." The therapist wrote: "I experienced that my most important 'tools' in this phase were patience, show support and empathy and following her lead, while at the same time be curious and creating space to explore what did not quite make sense, by also leading the process". The therapist strove after a mentalising and empathic stance; both following and leading the process, with interventions in line with both

MBT and EFT, as a foundation for a therapeutic style and dynamic in the therapy room. Overall, the therapist tried to follow the patient's cues, responding to them moment by moment. As the patient put it: "I needed Kathrine to handle the fishing technique, so I dared to hold on to the line."

The patient had been offered EMDR-treatment before, aiming to treat her C-PTSD, but experienced that: "Any of the changes I tried to make in therapy did not feel quite right or safe enough for me." According to NICE and ISTSS guidelines for PTSD [30, 32], evidence for treatment methods for C-PTSD is limited, suggesting greater diversity of treatment interventions. As APA clinical guidelines [33] conditionally recommend, the patient and the therapist went through the patient's lifeline with elements from NET, establishing a narrative, concentrating on traumatic experiences, but also incorporating positive events. Making sense of the past helped the patient make more sense of the present. She wrote: "We had to find where the 'little child' lives, the part of me that was never allowed to grow up and was too young to understand what happened back then." And: "….part of getting better. It was about gaining more knowledge to understand what happens when I feel that enormous loneliness and insecurity, listening inside myself to get answers to what I need." She had needed to make sense of the past to have a clearer view of what she needs in the present. Trauma-informed care was an essential part of the therapeutic process in this case, in line with the lived experience perspectives in Brewerton et al. [41]. They pointed out that patients lacking the capacity to come to term with their traumas, need someone to give them a language and understanding, to be able to start getting better and reconnecting with an authentic self.

Being in treatment for many years had given the patient a sense of self entailing mainly being a person with a psychiatric illness, but wanting more. As the therapist wrote, starting therapy: "She was young and reliant on disability benefits but wanted to contribute." One important focus in therapy was to help the patient get back to functioning in society, accepting her own limitations not as excluding her from taking part in society, but as something to continue working on. As she wrote: "I have learned to say that it is okay to be in pain and that it is okay to be allowed to contribute to society even if I do not always meet the expectations of others."

The heterogeneity in this group of patients has been proposed as explaining why treatment might not work in a subset of individuals with ED [38], leading to important recent research of data-driven network-informed personalised treatment [38, 39], in which one has begun to identify top therapeutic targets in individuals with ED, tailoring interventions individually. In addition, abovementioned authors point out the importance of health professionals listening to people with lived experience of trauma and EDs [40, 41]. Suggestions of a 'toolkit' of interventions from which patient and therapist can select, combining different therapeutic methods to fit the patient [40, 41], corresponds to the therapeutic process presented in this case report.

The goal was for the patient to get to a point of this 'feels right' instead of this is 'the right thing to do'. An important path towards this goal was via the emotional-relational dyadic process within the therapeutic relationship, where trust, transparency and timing were of the essence. Matching therapeutic interventions to the patient was seen by this patient as "going fishing", not a straight forward and manualised approach, but a personalized approach where both parties had to engage, be patient and adjust to one another, minimising the distances within the patient, between patient and therapist, between patient and society, and between the patient's past and present.

Limitations and strengths

One obvious limitation of this case report is the subjective description of the therapeutic process from two people in a single therapeutic relationship. The findings cannot generate any information on incidence, prevalence or causality, and cannot be generalised.

The patient initiated the study, the impulse coming from her positive view of the therapeutic relationship and process. One needs to be aware of the asymmetrical relationship between patient and therapist. This case report does not address this asymmetry, not offering insight into more challenging aspects of a therapeutic relationship and process, equally as important to explore.

One strength is the dyadic perspective of the two stories from patient and therapist, providing an in-depth understanding from their descriptions of the therapy process. This case report can have an educational value for therapists treating patients with AN and C-PTSD, provide more interest, discussion and a greater understanding on what processes in a therapeutic relationship can play out, and be important for patients with AN and C-PTSD, possibly contributing to change in clinical practice and research.

Recommendations for further research

Further research should elaborate on what has shown to be the true strength of this case report, the dyadic perspective derived from the two stories. More specifically, the emotional-relational processes and therapeutic alliance in the therapy room: how they unfold can help broaden the understanding of treatment for AN and comorbid C-PTSD. We believe this dyadic perspective provides increased transparency within the therapeutic space, often seen as closed and hidden. Further,

we believe that transparency can help reduce asymmetry between patient and therapist, and increasing trust within the therapeutic space, where the patient can allow the therapist access to the inner struggles, essential in being able to work with ambivalence, avoidance and relational challenges, common in comorbid AN and C-PTSD.

In this case, patient and therapist had a similar understanding on how the process unfolded. The patient's agenda for publishing an article was to share which important aspect of therapy was central to her ability to work towards increased autonomy and better health. Further research should also address aspects of therapeutic dyads where patients dropped out of treatment or there was none or limited treatment effect.

Future research should also explore the potential of multicomponent intervention treatment, focusing on personalised treatment methods, tailored to the patient. This will be essential not only for people seeking therapy, but also in enabling mental healthcare institutions to provide more cost-effective treatment, reaching patients who do not respond to, or drop out from, recommended treatment methods. We want to challenge the 'one-size-fits-all' approach to treating complex mental health disorders, choosing one or another treatment method, without tailoring the intervention to the particular patient in treatment. It should not be the patient's job to fit the method, but our job to make sure the method fits the patient.

Conclusion

Research into effective treatment for AN and C-PTSD has been limited. This group of patients may show severe and enduring illness histories and often need several hospitalisations and periods of outpatient treatment, affecting many important areas of their lives. We need more research and ultimately guidelines on how to treat the complexity of AN and C-PTSD in combination. One place to start is to listen to stories from the therapy room.

This case report presents one out-patient therapeutic process through two stories; from patient and therapist. The therapeutic approach was symptomatic-, person- and process-oriented, with an eclectic choice of methods such as CBT-E, MBT-ED, CFT-E, EFT, and NET. Addressing ED pathology through offering CBT-E, working with behavioral change and cognitive reconstruction, proved insufficient in this case. It seemed that the ED symptoms had a role in managing, take control of and avoid what was difficult to deal with and make sense of within the patient, between patient and therapist, and within the patients lived experiences. Offering personalised treatment, tailoring interventions to the patient, added focus to the patient's narrative, emotion regulation, self-compassion, self-construction and working within the therapeutic relationship.

In this case, therapy was not only about getting the patient on board, it was about the process. Within the therapeutic space, there were multiple factors both challenging the therapeutic process, and creating space for healing and change. The patient gave the therapist access to her inner struggles through the emotional-relational process in the therapy room, where, ultimately, timing, transparency and trust were proven to be more important than the method itself. As the patient put it herself: "therapy was like fishing with a thin line", where she needed the therapist to "handle the fishing technique", so that she "dared to hold on to the line".

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Author contributions
KRM contributed to the study design and wrote the therapist's story. She was responsible for the literature review and wrote the first draft of the article. She read and approved the final manuscript. BJS initiated the article and contributed to the study design. She wrote the patient's story, read and commented on the article, and read and approved the final manuscript. BSB contributed to the study design. She joined all research meetings, supervised, guided and cooperated in the research and writing process. She read and commented on the article for important intellectual content, read and approved the final manuscript.

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No datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent to participate
The project was considered not required to be submitted by the Regional Committee of Medical and Health Research Ethics (REK). It is approved by the data protection officer at the Nordland Hospital Trust. For the record, the patient provided a written consent to have the article published in full.

Consent for publication
As a co-author of this case report, the patient provided consent to have the article published in full.

Competing interests
The authors declare no competing interests.

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