

# **Not Quite This and Not Quite That: Anorexia Nervosa, Counselling Psychology, and Hermeneutic Inquiry in a Tapestry of Ambiguity**

**Emily P. Williams, Shelly Russell-Mayhew, Nancy J. Moules,  
& Gina Dimitropoulos**

## **Abstract**

As a group of researchers exploring how to best understand the complex topic of families discovering their loved one has anorexia nervosa (AN), we found that we had to weave ambiguity into our design. Embracing ambiguity allowed us to create a tapestry that acknowledges the ambiguity of AN, counselling psychology (and other helping professions), and hermeneutic inquiry. In fact, the “not quite this and not quite that” features of these three constructs emerged as the thread that holds the inquiry together. We review the topic of AN through a lens of ambiguity. Further, we position both the field of counselling psychology and the research method of hermeneutic inquiry as compatible frameworks in the study of AN, in both practice and research. By acknowledging, and at times even embracing, ambiguity, we respect the complexity of the situation we are studying.

## **Keywords**

Ambiguity, anorexia nervosa, hermeneutic inquiry, counselling psychology

Discovery is an objective of research and practice. This is also true of us; as authors, we are in the process of discovery. We seek to reveal, unveil, un-conceal a topic that is unknown, making discovery challenging and ambiguous. Central to any process of discovery is the concept of *aletheia*, a Greek term describing some act of uncovering and opening pieces of understanding, at the expense of covering and closing others (Moules, 2002). The particulars of a topic are both

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### **Corresponding Author:**

Emily P. Williams  
University of Calgary  
Werklund School of Education  
Email: emily.williams@ucalgary.ca

exposed and hidden from us at the same time. While we pursue the truth, we are always one step behind, never able to capture the whole essence in our understanding. The term *aletheia* has multiple meanings. The first means to open, or to find a portal of understanding (Moules, McCaffrey, Field, & Laing, 2015). In terms of discovery, we must look for questions that will open our understanding or opportunity to learn about the topic in its complexity. Second, *aletheia* contains the word *lethe*, referring to the mythical river of Hades that was said to cause forgetfulness when crossed (Online Etymology Dictionary, n.d.). *Aletheia* is the opposite of forgetting, thus, while discovering, we must remember what has been forgotten. The third understanding of *aletheia* comes from the opposite of the word *lethal*; it is about bringing to life what was taken for granted, what was dead, or what was assumed about the topic (Moules et al., 2015). Evidently, *aletheia* captures an ambivalence about what we have to forfeit in order to see something else; we must make a wager with what we are willing to give up in order to better understand or discover.

In this paper, we offer the argument that ambiguity is not something to be feared or fixed, but instead allows researchers and practitioners, particularly those specializing in the treatment of anorexia nervosa (AN), to be as effective as possible. Our topic of inquiry, an examination of the experience of families discovering that their child has AN, does not sit comfortably in one place. It does not have a permanent home in prevention, treatment, psycho-education, or stigma management; nor does it have a place with any single member of the family. Moreover, the discipline of psychology that we (first and second author) are from is commonly mistaken for something that it is not. The nature of counselling psychology is not recognized by many and is still in some ways (and maybe always) in development. In addition to the complexity of these factors, the research approach we will utilize is arguably difficult and abstract; hermeneutic inquiry attends to history, interrelatedness, dialogue, language, and the possibility that we will be forever changed from understanding our topic, while at the same time noting that our understanding can never be complete (Gadamer, 2013). As we explored a research topic that involved AN, counselling psychology, and hermeneutic inquiry, we came to understand that we needed first to address the concept of ambiguity to better prepare for our research.

The solution to ambiguity is to not solve it. Ambiguity is a part of the process of research and of being a practitioner, allowing us to better understand the topic or the person in front of us. This is especially true when ambiguity is deeply ingrained in our topic, field, and research method. By welcoming ambiguity into research and practice, we remain open to possibilities and differences and are able to attend to the complexities of the phenomenon.

### **Ambiguity**

Ambiguity refers to understanding a concept, word, or expression in two or more ways (Merriam-Webster, n.d.). Ever changing, shifting, unknowing, wavering, ambiguity refers to a concept with more than one meaning, and more than one interpretation. First used in the 1500s, the Latin term *ambiguus* coming from the term *ambigere* meaning “to dispute about, contend, debate” (Online Etymology Dictionary, n.d.), is made up of the prefix *ambi* meaning “both” or undecided and *agere* meaning “to drive” (Merriam-Webster, n.d.). Uncertainty, doubt, and hesitation are sewn together, closely stitched to the concept of ambiguity, all pointing to the tendency to wander, waver, and change. Ambiguous concepts are not of poorer quality nor better

than concepts that have known truths or are easy to decipher, but rather lend themselves well to interpretation through multiple lenses, perspectives, and fields of inquiry.

Throughout the paper, we argue that ambiguity does not need to be solved. Ambiguity might have something to teach us; we can grow in our understanding and be changed by the process of creating space for ambiguity. Instead of running from, fighting against, or trying to solve ambiguity, we must welcome multiplicity and constant change as concepts that will lead to better understanding. First, we will describe AN and the mystery and inconsistency that surrounds the disclosure, recognition, diagnosis, treatment, and recovery processes. It is our intention that, by synthesizing the literature, we illustrate the ambiguity and ambivalence inherent for individuals and families affected. Further, we will position our research question: *How might we understand the experiences of parents who have discovered they have a child living with anorexia nervosa?* (research question of first author's doctoral dissertation) as not having a home in one field or another; leaving us as researchers wondering how to proceed in grey areas rather than having a black and white forward moving path. Thus, as a research team preparing to embark on a novel, discovery mission, we needed to create space for the complexities and richness of experiences inherent within the topic before collecting data. This complexity and richness can be likened to a tightly woven tapestry, one made up of many strings of different understandings, experiences, perspectives, biases – essentially, a tapestry honouring ambiguity. Next, a discussion about counselling psychology within a Canadian context is provided. Within this discussion, the multiple interpretations of what this profession is and what counselling psychologists actually do are emphasized. Last, hermeneutic inquiry is introduced and described as a method that is not quite this, nor that, but rather a method that is comfortable working with topics that are in the in-between. Further, since understanding the history and tradition of a phenomenon is fundamental to hermeneutic inquiry, throughout the paper brief histories of topics will be offered.

Overall, we seek to weave the string of ambiguity throughout each section and also call attention to the spaces in between the stitches, illustrating and sewing together the ambiguity and unknown in various fields. Together, this stitch work contributes to the larger tapestry, acknowledging ambiguity as a resource for research and practice. By highlighting the ambiguous thread throughout, we are creating space for the ambiguity, creating space for the uncertainty inherent in all areas. We do so not to suggest we solve this, but rather accept all areas as not quite this and not quite that and allow ourselves to explore and understand the uncertainty rather than avoid it. Evidently, our research process is a discovery, the same way that the topic is discovered.

### **Ambiguity and Anorexia Nervosa**

The overall experience of having AN is marked with nuances, nebulosity, and ambivalence (Ryan & Callaghan, 2014; Williams & Reid, 2010). Weaving in and out of grey areas is cause for concern for many practitioners providing treatment to individuals with AN (Adlam, 2015; George, Thornton, Touyz, Waller, & Beumont, 2004) and is troublesome for those in support and caregiver roles, including family members and friends (Craigie, Hope, Tan, Stewart, & McMillan, 2013; Voriadaki, Simic, Espie, & Eisler, 2015). Evidently, ambiguity is not solely felt by the individual with AN, but also takes up space in the lives of professional helpers, care givers, and families. The ambiguous nature of AN will be illustrated through a discussion of a) the history of AN; b) the ambivalence often reported towards AN; c) when the disorder is

somehow discovered; d) the complicated recognition process, and e) the inconsistent outcomes for those with AN. At all points throughout the course of AN, ambiguity is not far away, it is not separate from the experience but rather a part of it.

### **History of Anorexia: The Hysterical Female**

We begin with a brief history of AN, the first eating syndrome to be described by physicians in the 1870s (Gull, 1874; Lasègue, 1873). Broken down, the prefix *an* translates to “without” and *orexis* means “appetite,” therefore in full translating into “lack of appetite” (Merriam-Webster, n.d.). The history of the conceptualization of AN is full of fascination and allure specific to the era, adding obscurity to the term’s construction by medical professionals of the last several centuries. Researchers examining the archives of hospitals and mental asylums from the 16<sup>th</sup> to 19<sup>th</sup> centuries established notable accounts of fasting women and varied explanations of the disorder (Habermas, 2015; Parry-Jones, 1985).

The varied conceptualizations seem to be due to nationality and era. French physician, Lasègue, introduced the term *anorexie hystérique* in 1873, then one year later the term *anorexia nervosa* was coined by British physician, Gull, in 1874 (Habermas, 2015). Differences in conceptualizations stemmed from the French tradition of paying greater attention to psychological aspects of the condition, whereas British traditions emphasized the physical and behavioural features (Habermas, 2015).

**French conceptualization.** French physician, Lasègue described the condition in terms of hysteria, noting that his female patients had afflictions of the mind, suffering from “some emotion which she avows or conceals” (1873/1997, p. 493). Lasègue described the syndrome eventually becoming the sole object of preoccupation and portrayed his patients with AN as hysterical:

what dominates in the mental condition of the hysterical patient is, above all, the state of quietude-I might almost say a condition of contentment truly pathological. Not only does she not sigh for recovery, but she is not ill-pleased with her condition, notwithstanding all the unpleasantness it is attended with. In comparing this satisfied assurance to the obstinacy of the insane, I do not think I am going too far. (p. 495)

**British conceptualization.** In 1874 (adapted and reprinted in 1997), Gull published a piece on a peculiar condition characterized by extreme emaciation, which he referred to a disease that occurred mostly in young females. Gull used phrases such as “complete anorexia for animal food, and almost complete anorexia for everything else” (p. 498) in his description of a former patient. In addition to describing his patients’ physical states in his case studies, Gull made bold remarks regarding the treatment and lack of consideration of the patient’s desires in her treatment. He made clear the dangers of continued starvation and noted that “the inclination of the patient must be in no way consulted” (p. 500). Further, Gull spoke to the destructive mental states of the women he treated, referring to young females being “specifically obnoxious to mental perversity” (p. 501) and females with this syndrome not being of sound mind to make their own choices about caloric consumption.

Since the time of these physicians' early writings of AN, others have gone beyond descriptions of lack of appetite and hysteria by describing distinctive features such as addiction to extreme thinness, referred to as a "drive towards emaciation" (Selvini Palazzoli, 1963/1974), and relentless pursuits of thinness (Bruch, 1965). Clearly, the evolution of these descriptors throughout the 19<sup>th</sup> and 20<sup>th</sup> century point to how AN has been disputed throughout history, and how many of these disputes continue in present among medical and mental health professionals.

Our understanding of AN has evolved over time. As more is understood about the development and trajectory of AN, the conceptualization will be modified to meet the time period and be congruent with modern practices and theory. Regardless of this changing and ambiguous identification process for what constitutes AN, questions still remain: What happens next for someone with AN? How do they experience AN?

### **Ambivalence to One's Experiences of Anorexia Nervosa**

Not only is the history of AN marked with contestation, but so is the experience of living with the disorder including one's will to recover and autonomous motivations regarding AN (Nordbø, Espeset, Gulliksen, Skårderud, Geller, & Holte, 2012). Anorexia nervosa is considered to involve greater ambiguity and ambivalence compared to other eating disorders (e.g., bulimia nervosa, binge eating disorder), and individuals with AN tend to appreciate their symptoms differently than other groups experiencing mental illness (Nordbø, Espeset, Gulliksen, Skårderud, & Holte, 2006). Ego-syntonicity, referring to states, thoughts, behaviours, or feelings that are congruent with one's self-concept, and ambivalence are central features of AN (Marzola, Abbate-Daga, Gramaglia, Amianto, & Fassino, 2015). According to qualitative inquiries, some individuals have little desire to make changes, as AN is a source of pride and endurance providing a sense of achievement and self-confidence (Nordbø et al., 2006; Robinson, Kukucska, Guidetti, & Leavey, 2015). Further, researchers have illustrated how individuals with AN often depict their AN as providing them with a sense of security and stability, a way to avoid negative experiences, and as a way of obtaining a sense of power and inner sense of mastery and strength (Nordbø et al., 2006). At the same time, there are also individuals who are ambivalent about the disorder, not sure whether the AN controls them or whether they are in control of it, and irresolute if they wish to recover or maintain it (Colton & Pistrang, 2004; Reid, Burr, Williams, & Hammersley, 2008; Williams & Reid, 2010). Some individuals with AN regard their symptoms as a set of behaviours that are meaningful and positive in their lives (Nordbø et al., 2006), whereas others are ambivalent, only at times wishing to rid themselves of their restrictive eating behaviours and/or weight loss routines and resume the life they once lived (Williams & Reid, 2010). Much like the ambivalence regarding one's feelings toward their AN, individuals also vary in how they wish to proceed in the course of their experience with AN. Some may decide to disclose and ask for help, whereas others might not. Evidently, the experience of AN is individual and widely varied and, as such, an ambiguous quality emerges.

### **Disclosure of Anorexia Nervosa**

Intentional and planned disclosure is the process of letting one's self be known to others (Corrigan & Rao, 2012). Individuals with AN may intentionally come forward, verbally sharing information about their eating and weight related behaviours. However, it is also possible that

disclosures happen against the will of the person with AN (i.e., those who are caught purging). Being caught is not the same as making a willful decision to share intimate details with others. Conversely, people close to the person with AN may begin to suspect ill health and perhaps disordered eating when the size of an individual's body begins to unquestionably decrease or uncharacteristic eating and exercise habits are exhibited. Individuals communicating online via websites specifically created for those with eating disorders have reported feeling "too far gone" to continue concealing their illness from others (Williams, Russell-Mayhew, & Ireland, in press). This account supports a third type of disclosure, one that is neither intentional nor accidental, but rather an act of defeat, like one has lost his or her power over the eating disorder.

Individuals struggling with AN are often hesitant to disclose they have a problem (Becker et al., 1999). Researchers have suggested that disclosing one has an eating disorder is a gateway for receiving professional help (Gilbert et al., 2012), however, it is more complex since the process of disclosure is characterized by ambiguity, for all parties involved. Disclosure unfolds over time (Williams et al., in press), opening up the possibility that it can resemble an entirely unique experience for everyone who discloses AN, and for everyone who is on the receiving end of that disclosure. Hence, perhaps a better term for this disclosure process is *discovery*, meaning to "obtain sight or knowledge of for the first time" (Merriam-Webster, n.d.). *Discover* was first used in the 1300s and meant to "divulge, reveal, disclose" (Online Etymology Dictionary, n.d.). From the Old French term *descouvrir* meaning to "uncover, unroof, unveil, reveal, betray," and from the Late Latin *discooperire*, *dis-* meaning "opposite of" and *-cooperire* meaning "to cover up," the term conveys an undertone of betrayal or malicious exposure. In the 1550s, *discoverer* originally meant "informant" (Online Etymology Dictionary, n.d.), thus the etymology of the word maps well to the experience of one's AN being discovered by others, whether this was intentional or not.

### **Ambiguity of AN Recognition**

After a discovery, sometimes a long, complicated, and ambiguous process of recognition and assessment follows. Factors contributing to this process include differentiating between other medical conditions and symptoms mimicking malnourishment (Schwarz, Ponder, & Feller, 2009), late-onset eating disorders (Santonastaso, Camporese, Caregaro, & Favaro, 2008), and atypical cases (American Psychiatric Association, 2013; Forney, Brown, Holland-Carter, Kennedy, & Keel, 2017). Recognition can be made challenging and go unnoticed for a number of reasons including unintentional denial, comprised of the individual with AN having impaired self-awareness and reality distortions (Vandereycken & Van Humbeeck, 2008). There may also be deliberate denial about symptoms and minimization that anything is wrong, which may occur as an expression of avoidance and fear of the consequences (Gray, Murray, & Eddy, 2015; Vandereycken & Van Humbeeck, 2008). Some practitioners go as far as to say that those with AN do not wish to be diagnosed or have their AN be recognized, because they do not wish to be treated (Adlam, 2015; Cooper, 2005; Halmi, 2005). Based on physicality alone, the prototypic individual with AN presents as malnourished and emaciated (Gray et al., 2015), yet just because there is a prototypic patient does not make the recognition of AN any easier as there can be multiple reasons for weight loss. Also adding to the ambiguous nature of recognition or assessment is that the behaviours and thoughts of someone with AN fall along the same spectrum

of behaviours and thoughts that the majority of Western females have, that is a preoccupation with shape and weight (Tantleff-Dunn, Barnes, & Larose, 2011).

Various practitioners including Brown and Jasper (1993), Neumark-Sztainer, Levine, Paxton, Smolak, Piran, and Wertheim (2006), Russell-Mayhew (2007), and Sundgot-Borgen and Torstveit, (2010) have argued for a continuum of weight and body preoccupation. Brown and Jasper (1993) proposed that it was not accurate to stigmatize AN as “individual pathologies or diseases, at the same time we approve, even praise, the behaviour of those women who exercise and diet to attain the culturally prescribed body ideal” (p. 54). Brown and Jasper (1993) offered that it is difficult to suggest that someone who meets the diagnostic criteria of AN is any more pathological than someone who diets and engages in a rigid exercise routine for the purpose of controlling shape and weight. Feeling negatively towards one’s body is a similar experience for women engaging in eating disorders and those dieting, as women internalize the ideal body image, recognizing that how they look will reflect how they are valued and treated (Brown & Jasper, 1993; Malson & Burns, 2009). A wide range of eating and weight related issues exist on a spectrum, ranging from negative body image and shape concerns to significantly distressing eating disorders such as AN and bulimia nervosa (Levine & Smolak, 2006; Neumark-Sztainer, 2005; Russell-Mayhew, 2007). In this vein then, the ambiguity presents itself when behaviours that are considered normal, even virtuous, go too far.

Often, individuals with AN report a sense of self-confidence and feelings of worthiness after they have lost weight (Nordbø et al., 2006). In addition, individuals reported receiving positive feedback from others related to their shape and weight upon initially losing weight (Nordbø et al., 2006). Therefore, it is not surprising that these same individuals would experience tensions between the way they feel in their bodies after having lost weight and others conveying that they are concerned for them. Hence, the ambiguity must be endured by both the individuals with AN and the practitioners who are tasked with recognition. Apparently not everyone in these situations share the same perspectives and at times might be in direct tension with the other (Vandereycken & Van Humbeeck, 2008). Hence, the string of ambiguity continues to weave through, for both individuals experiencing AN and practitioners involved. There are multiple perspectives and positions in recognizing AN, emphasizing how this process is not black or white. Clear cut ways of recognizing that one is experiencing AN are not available; we must honour the ambiguity and hold space for all these positions so the tension and contestation are visible.

### **Anorexia Nervosa Outcome Variability**

Treatment outcomes for AN are inconsistent, and of limited success for select individuals (Steinhausen, 2008). Though treatment for AN often temporarily succeeds in weight restoration, these individuals are considered to be at high risk for early relapse (Carter et al., 2012; Khalsa et al., 2017). The limited success in treating AN is not the fault of individuals with AN, rather perhaps an issue of not having yet found a treatment that works well for all. According to the most exhaustive reviews of treatment outcomes of AN to date, among surviving patients 37% reach full recovery within four years after the disorder onset, 33% improved, and 20-25% developed a chronic course of AN (Berkman, Lohr, & Bulik, 2007; Steinhausen, 2002). The crude mortality rate is reportedly 5-9%, which is accounted for by suicide or medical

complications from starvation or compensatory behaviours (Berkman et al., 2007; Steinhausen, 2002). Thus, according to our knowledge of the course of AN, particularly the course following treatment, reaching the recovery status is not cut and dry.

The sense that one has to balance or somehow operate in ambiguous territory is not unique to those with AN, their family members, or those professionally working with this group. Experiencing uncertainty or multiple ways to go about something is also inherent in various practicing professions. One of these fields is counselling psychology, where multiplicity is the norm, creating space for ambiguity to flourish. As we move throughout this process of discovery, we intend to illustrate our position and entrance into this topic by framing it in terms of the ambiguity we, and other professionals, face as we work and study with those with AN, but also the ambiguity that will be inherent in our practice because of our background. By doing so, we will illustrate using counselling psychology as an exemplar that there is another shade of grey, another realm of uncertainty, and another uneven stitch of the string of ambiguity.

We can identify that ambiguity is involved in both AN and counselling psychology separately. We must also acknowledge that the entire process that comes between AN emerging and interacting with counselling psychology professionals is ambiguous and uncertain in itself. First, families go through an ambiguous process in determining how to respond to this discovery, who to seek help from, how to interact with other family members. Families seek out counselling psychologists likely in the hopes that their ambiguity will be resolved by the counselling psychologist, only for an entirely new environment fraught with ambiguity to be presented to them. Yet, this ambiguity is necessary if we are to truly embrace and honour each individual seeking treatment. Families with children with AN seek out treatment (i.e., counselling psychologists) to avoid ambiguity, to get clear answers, to help their child get better, whereas counselling psychologists make space for ambiguity, because they do not strive to fix ambiguous states; rather, they operate within them. The profession of counselling psychology is comprised of many fixtures, and this intricate make up of responsibilities – sometimes a mixture of not quite this nor that, and/or sometimes “both this and that,” certainly does not make ambiguity go away. Hence, one door to ambiguity closes when families choose to seek professional help within a particular discipline, only for a completely new door to ambiguity to open when this same family interacts with a counselling psychologist.

### **Ambiguity and Counselling Psychology**

The contestations and uncertainty towards what exactly counselling psychology (CP) is has been well documented (Bedi et al., 2011; Bedi, Sinacore, & Chistiani, 2016). The fact that CP has been recognized in Canada as a specialized discipline within the field of applied psychology since 1987, yet only received a formal definition in 2009, speaks to the equivocality of the profession’s apparent “distinctive identity” (Bedi et al., 2011, p. 128). It is no wonder that counselling psychologists face uncertainty when positioning their training and approach to psychology as different compared to other psychology specialties and maybe even other professions, as up until nine years ago counselling psychologists were not united in their understanding of what CP stood for and its philosophical frameworks. In order to better understand the complexity, it is helpful to trace the history of CP in a Canadian context, allowing us to review its evolution and multifaceted approach. During our discussion of CP, it may be

helpful to think of the profession as comprised as *both this and that*, hovering in-between various specialties.

### **History of Counselling Psychology in Canada**

To understand CP's emergence in Canada, one also has to be cognizant of the profession's status at the same time south of the border. In the United States, CP was recognized as a distinct discipline by the American Psychological Association in 1951 (Munley, Duncan, & McDonnel, 2004). Due to this history and early recognition, CP in the United States was and is firmly embedded within professional psychology and is better understood to be a distinct specialization. Counselling psychology in Canada on the other hand, emerged years later in the late 1980s and was pioneered by professionals who were trained as either professional counsellors or psychologists (Lalande, 2004). Given this later emergence, the history of CP in Canada is intertwined with professionals who would not be considered to be part of psychology disciplines or CP in the United States.

A field that initially narrowly focused on guidance and career counselling (Robertson & Borgen, 2016) has undergone a transformation where an applied psychology specialization emerged from the roots. The evolution of CP in Canada has certainly added to the ambiguity, leaving individuals wondering if counselling psychologists primarily assist individuals with softer life transitions (e.g., career transitions), rather than more serious concerns (e.g., eating disorders), or both. Eating disorders, and AN in particular, are considered anything but soft, therefore individuals wonder if a field traditionally focused in career and guidance has a place in the treatment of the most fatal mental illness (Arcelus, Mitchell, Wales, & Nielsen, 2011; Keel et al., 2003). This tension becomes especially obvious after reviewing the history of the field. Ultimately, CP struggles to find its home. The string of ambiguity continues to be finely stitched throughout, as multiple interpretations and understandings of what CP is, act as the foundation of which the field is based.

### **Counselling Psychology and Anorexia Nervosa**

Counselling psychologists offer a broad array of services to their communities and the world beyond. Counselling psychologists across Canada focus on client strengths. An emphasis is placed on (a) respecting diversity, (b) social justice for those who are marginalized, (c) mental wellness versus psychopathology, (d) psychoeducation, (e) assisting with successful transitions throughout life, and (f) applied research (Bedi et al., 2011). It is clear that CP holds elements that are not quite this and not quite that *and* both this and that. Counselling psychology conceptualizes individuals in terms of wellness, however the same professionals may also diagnosis a client with a label indicating psychopathology (Bedi et al., 2011). This represents a tension within the field, one that is especially relevant to counselling psychologists working with individuals with AN. Dominant discourses about AN come from a psycho-medical model, suggesting AN is an internalized, traditionally female phenomenon (Botha, 2015). If a clinician working from this model assigned a diagnosis, critics would suggest that, by doing so, the individual being treated would carry around a stigmatizing label as pathological (Botha, 2015). While receiving a diagnosis of AN may lead to an individual being accepted into a specialized service, considered by some to be what that individual requires for medical reasons, other counselling psychologists may be conflicted in assigning this label as it contradicts working from

a wellness perspective. These conflicts are important to consider when honoring the ambiguity in CP, as CP welcomes strength based conceptualizations, while also valuing assessment, diagnosis, and evidenced based treatment, all of which are linked to the medical model.

Thus, the tension is not solved, nor does it have to be. Rather, we must be aware of this contestation within the field (and other helping professions). When the theme of ambiguity runs so deep through a phenomenon and a field, it is necessary to find a way to welcome differences and multiple interpretations.

### **Ambiguity and Hermeneutics**

Hermeneutic inquiry, most simply put, is focused on interpreting phenomena and experience within the world. *Interpretation* refers to when an unknown or apparently unfamiliar meaning is made comprehensible (Grondin, 1994). Hermeneutic inquiry has been described as a “practice and theory of interpretation and understanding in human contexts” (Moules et al., 2015, p. 3). Rather than being driven by a rigid set of methodical rules dictating a pre-determined step-by-step method, hermeneutics offers a philosophy for understanding the world and is substantively driven (Moules et al., 2015). Described by Caputo (2015), hermeneutic inquiry does not apply principles or rules of understanding to cases, because this would imply that the topic and cases within it being studied are common and pre-determined. Rather, hermeneutics offers a way of proceeding in one’s understanding by being led by the topic. Therefore, philosophical traditions cultivated over the last 2000 years guide hermeneutic research and practice.

Applying hermeneutics to applied practice is difficult to put one’s finger on – it is not quite this and not quite that. For hermeneutic inquiry, this ambiguity and openness to possibilities is not considered a problem or a down fall of the approach to understanding, but rather this resistance to categorization is an asset (Moules et al., 2015). In the same sense that hermeneutics is difficult to categorize, no two people’s experiences with AN are the same. Though AN is a categorization of an eating disorder, the factors comprising one’s experience of this disorder are infinite. The variance and ambiguity grows exponentially greater in the recognition, disclosure, assessment, treatment, and recovery processes of AN. The feeling that one can never quite get a handle on AN parallels that of hermeneutics, as the topic of inquiry in hermeneutics is impossible to fully understand and see in its totality.

Hermeneutics requires a tolerance, even an embracing, of uncertainty, both of the topic and interpretation (Moules et al., 2015). To look for possible meanings and understandings of the topic requires one to oscillate within a world of uncertainty and mystery. This ambiguous oscillation parallels how practitioners working with, and family members supporting those with, AN must navigate their daily experiences – living in a world that is unknown to them, trying to do the best they can with little direction. As Gadamer noted, “the true locus of hermeneutics is this in-between” (2013, p. 306). Hermeneutics is not quite this and not quite that, as it is a philosophy and an applied practice.

Hermeneutic inquiry is capable of, and comfortable with, studying something that may never be fully understood, and the same could be said of a practitioner working with, or a researcher studying one’s experience of AN, or a family’s experience of discovering their child or sibling

has AN. The concept of *aletheia*, the process of uncovering pieces of understanding, at the expense of closing others is very much alive in situations involving ambiguous topics. In order to be open to discovery, we must have the ability to encounter the other or the topic in a way that we acknowledge that our understanding is limited and in need of a reworking (Moules et al., 2015). Therefore, in order to discover this topic, and to do so with integrity, hermeneutic work:

lies in its ability to hold tension, to be “not quite this and not quite that,” in recognizing that with every opening, there is a closing of something else, in knowing that openings are invitations and portals to understanding, not dark rabbit holes where the topic disappears. (Moules et al., 2015, p. 179)

This quotation illustrates how we must honour the ambiguity inherent in the experience of having AN, and in a family’s experience of discovering their loved one has AN. In order to discover, we must be flexible when encountering others’ truths and accounts of the topic, and be open to the possibility that we may be changed in the process.

### **Creating Space for Ambiguity**

Openness to ambiguity and not pushing it away may be uncomfortable, but when we are able to do this, it could lead to better research and practice. It is natural to seek clear answers, as certainty helps with decisions about what to do next. Yet, we may take things for granted and act before considering all possibilities when something is clear-cut, and thought of as either this way or that way. When we take pieces of the situation for granted, we start to overlook details, narrowing our considerations for lessons and perspectives that might surprise us. Openness and the ability to work in the grey areas, creating space for different perspectives and different disciplines is advantageous. The solution to ambiguity is not to solve it, in fact, the solution is to do nothing to fix it or make it clear. Rather, in the spirit of *aletheia*, we must be open to the trade-off of concealing some pieces for the benefit of uncovering others, when discovering a topic, or understanding it more deeply.

Evidently, the experience of AN is marked with ambiguity. For adults, there is no best course of treatment for AN and certainly not a clear prognosis (Hubert Lacy & Sly, 2015; Steinhausen, 2008). Further, the recognition of AN adds more complexity; given that many females living in a Western society strive for the thin-ideal, there is a fine line between behaviour that is virtuous, or too far gone. Evidenced by the high mortality rate and inconsistent recovery statistics (Arcelus, Mitchell, Wales, & Nielsen, 2011; Berkman et al., 2007; Keel & Brown, 2010), AN can be likened to an unevenly dispersed thread, a thread with variously spaced stitches, and even at times a stitch that appears to have stopped before it was expected. Interdisciplinary teams must be included in this fight, involving medical doctors, psychologists, social workers, nurses, nutritionists, dietitians, et cetera (American Psychiatric Association [APA], 2010). Though counselling psychologists would be ready to take up arms and use their holistic treatment approach, other professionals may question their place. Counselling psychologists are not limited to a specific type of inquiry, nor are bound to examining solely treatment related phenomenon. Further, the not quite this nor that placement of CP mirrors our research topic, as the study of a family’s discovery that their child or sibling has AN is not quite considered treatment, nor prevention, or psychoeducation.

Given the ambiguity, hermeneutic inquiry is a fit to study the uncertainty that is certain with AN and within the field of CP. Hermeneutics takes history and tradition of a topic into consideration, carefully trying to understand how the topic in its present form has evolved since its beginning. Further, the qualitative approach of hermeneutic inquiry is welcomed by counselling psychologists, who wish to discover the world and are open to multiple interpretations, not bound exclusively by quantitative methods. This openness to multiplicity and the possibility of one's perspective being changed in the process of understanding mirrors how practitioners must hold space for ambiguity. By holding space, not trying to solve for the ambiguity, we can learn from it and possibly grow.

### Conclusion

An openness to working with the unknown is the key to working with individuals with AN. When discovering a topic, especially one marked by so many uncertainties and multiple interpretations, we must make a "hermeneutic wager" (Kearney, 2010) – taking a risk on an uncertain outcome, hoping we might better understand. In order to better understand the experiences of families discovering their child has AN and to learn more generally what it might be like for someone living with AN, we must be open to stepping into unknown territory and resist the urge to make our surroundings neater or more put together. By acknowledging the ambiguity inherent in one's experience of AN, we respect the complexity of the situation. By conceptualizing the many moving parts at play within this complex situation, as a tapestry of ambiguity, we reveal and hold space for interwoven complexities. By acknowledging, we are not solving for, nor are we tiptoeing around it, but rather as we honour ambiguity, we come to accept that it is not quite this, nor that, and that is okay. Perhaps it is even a resource.

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