

**STORIES OF RELATIONSHIPS IN RECOVERY: A NARRATIVE STUDY EXPLORING
HOW PEOPLE SEEKING TREATMENT FOR EATING DISORDERS EXPERIENCED
WORKING WITH HEALTHCARE PROFESSIONALS**

by

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Abstract

This study explored the experience of people, seeking treatment for an eating disorder in BC, of working with healthcare professionals for those. Within the last five years, a significant amount of research has been carried out to develop and inform province-wide guidelines (van der Leer et al., 2016), for multidisciplinary healthcare professionals to follow when offering services to individuals seeking treatment for an eating disorder. Whereas, previous research on the impact of the therapeutic alliance within the field of eating disorders has focused mainly on adolescent populations or populations of people with a diagnosis of anorexia nervosa, this research intends to cast the net a little wider to people who are older (20+), who may have had been diagnosed with an eating disorder that is broader than just anorexia nervosa, and who have had a breadth of experience in different healthcare settings over time. A narrative method was used to gather data from five participants. This data was transcribed and then the researcher worked with the participants to turn transcripts of their interviews into narratives. The narratives were analysed using the Braun & Clarke's (2006) thematic content analysis method. Four main themes and 21 sub-themes were identified.

Lay Summary

The goals of this research study is to explore the experiences of people who have experienced an eating disorder and worked with healthcare professionals in order to seek treatment. This study seeks to explore these people's experience of relationship with healthcare professionals in order to better understand whether, and how the formation of a therapeutic relationships impact a person's recovery from an eating disorder. By seeking the perspectives' of those who have been through the process of recovery, this study aims to enhance best practice among healthcare professionals in both public health and private practice environments, in order to seek improved outcomes for those who experience eating disorders, in a more expedient manner.

Preface

This research was conducted with the approval of the University of British Columbia (UBC) Office of Research Services Ethics Behavioural Research Ethics Board (BREB), certificate number H17-02686. This dissertation is the original work of Andrea Margaret Jones, the author, and all participant interviews and data analysis were undertaken by the author.

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Chapter 1: Introduction

The Research Problem

According to National Eating Disorder Information Centre (NEDIC; 2017), in Canada, anorexia nervosa (AN) has the highest rate of morbidity among all psychiatric illnesses. Canada has the fifth highest mortality rate from eating disorders (EDs), at 19 deaths per year, which is 3.1% of global ED deaths (Bartellas, 2015). It is believed that 10% of individuals with AN will die within 10 years of developing the illness (NEDIC, nedic.ca, 2017). The prevalence of bulimia nervosa (BN) across Canada is also cause for concern, with data indicating that 1.1% to 4.7 % of people experience these potentially life threatening symptoms (Bartellas, 2015), a number slightly higher than the global prevalence rates for bulimia nervosa reported in the American Psychological Association (APA) practice guidelines (1% to 4.2% for women; Yager, Devlin, Halmi, Herzog, Powers, & Zerbe, 2012). EDs can affect anyone, but currently appear to affect females more than males at a ratio of 5:1 (NEDIC, 2017). EDs also occur during vital stages of physical development in children, as evidenced by a BC survey carried out in 2008 in which 53% of girls between grades 7-12 reported trying to lose weight, 46% of girls reported dieting, 36% of girls reported binge eating and 8% reported purging (e.g. vomiting, laxative use etc) (Jamieson, 2012).

Prevalence of Eating Disorders and Response to Concerns in BC

Given these alarming statistics, there is a clear need for ongoing research into how to treat those at risk and affected by an ED. Locally, a research report prepared for the British Columbia Ministry of Children and Family Development (Waddell, Godderis, Schwartz, & Garland 2005) has informed an *Action Plan for Provincial Services for People with Eating Disorders*, which was developed to address issues raised in a forum on EDs held in April 2009 (British Co-

lumbia Ministry of Health Services, 2010). This action plan has led to the implementation of treatment programs throughout British Columbia to address the various needs of people with EDs, and provide individualized treatment for both the people experiencing EDs and their loved ones. In total, (at the time of publishing) there are 45 programs ¹ available across BC to support those living with an eating disorder, and of those 11 are designed to offer service to residents living throughout BC. These programs and services are being offered post development of the Clinical Practice Guidelines for the BC Eating Disorders Continuum of Services (van der Leer, G., Geller, J., Chan, K., Goodrich, S., Cockell, S., & Srikaneswaran, S., 2016). However, while treatment options are growing and services expanding and diversifying in order to make treatment more as accessible as possible, many challenges still face people with EDs in their journey of recovery.

The Challenges of Treating an Eating Disorder

According to the Clinical Practice Guidelines for the BC Eating Disorders Continuum of Services, a key challenge in the treatment of EDS is the ambivalence towards recovery that many people with EDs experience, as in many cases, the eating disorder fulfills a self-perceived valuable function in their lives (van der Leer et al., 2016). People with EDs have described the various functions of an ED as something that: (a) provides a sense of control and safety; (b) helps people with EDs to avoid and manage painful emotions; (c) provides a valued identity; (d) provides a method for staying slim, and (e) is experienced as a reliable guardian or friend (van der Leer et al., 2016). The guidelines describe that these perceived functions inhibit people with EDs from seeking treatment even when they disclose their symptoms in full, especially if they fear being hospitalized for re-feeding. Therefore, a fundamental and important challenge for health-

care providers is developing a, “therapeutic alliance,” in which people with EDs feel able to openly share their experience and talk about their feelings of uncertainty in receiving treatment (van der Leer et al., 2016). When clinicians and people with EDs are able to establish a relationship that invites people with EDs to talk openly about their experiences, acknowledge both fears and desires for change, and develop honest dialogue over time, a “therapeutic alliance,” is formed (van der Leer et al., 2016).

Other challenges for people with EDs in seeking treatment for EDs are described by Gulliver, Griffiths and Christensen (2010) in a systematic review of the perceived barriers and facilitators to mental health help-seeking in young people. They argue that stigma surrounding mental health issues, alongside a lack of education regarding mental illness and desire to be self-reliant, could also contribute to the difficulties in treating EDs. They conclude with strategies to address these issues, including improving education around mental health issues, reducing the stigma of being diagnosed with an mental illness, and acknowledging and working with a young person’s desire and developmental task of needing to experience greater self-reliance (Gulliver et al, 2010).

Further challenges for people with EDs and health care practitioners are outlined by Geller, and colleagues (2001) in research exploring the clinician’s stance in the treatment of chronic eating disorders. The authors state that there are many people with EDs who never fully recover and who struggle with ED symptoms throughout their whole lives (Geller, Williams, & Srikameswaran, 2001). These individuals often demonstrate high levels of ambivalence, present with many experiences of unsuccessful treatment, and often lack interest in recovery. The authors highlight the importance of the clinicians’ attitudes and behaviours when working with people

with chronic EDs, in order to prevent therapeutic interactions from being impacted by clinicians' feelings of hopelessness and frustration (Geller, Williams, & Srikameswaran, 2001).

Further studies acknowledge the complexity of the issues faced by those seeking treatment for an ED. Regarding barriers to access and utilization of ED treatment among women, Thompson and Park (2016) identify the various factors impacting a person's ability to access or continue to access treatment for an ED as including the lack of identification of the ED, financial barriers, and a reluctance to seek treatment (Thompson & Park, 2016). They argue that the differences in physical, psychological and personality traits between the different subgroups of those experiencing an ED may differentially impact a person's ability to access and utilize professional support.

Impact of the Relationship with Healthcare Providers

A key factor linking the above-noted issues (i.e., the stigma that surrounds EDs, clinician's stance) is the interpersonal dynamic that develops between individuals seeking treatment for an ED and the professionals that they work with. Many challenges face people with EDs as they seek help from others. For example, a study by Bartellas (2015), focused on the barriers and facilitators for youth and their families accessing treatment for EDs in Atlantic Canada. Among several barriers identified, the following issues emerged regarding health care professionals: family physicians's lack of ED knowledge may undermine a patient's trust in receiving appropriate support, in addition to an attitude that neglects to take concerns seriously; insensitive comments made by staff of treatment facilities and by family members, attributed to a lack of education; and "bad" health care providers exhibiting a lack of empathy and professionalism when working with people with EDs and their families (Bartellas, 2015).

Interactions between people with EDs and health care professionals are never more vital than in the Primary Care setting. When interventions are employed during the prodromal stage of the illnesses (when a patient may be asymptomatic but screens positively for risk factors) interventions are far more likely to be effective (van der Leer et al., 2016). Several studies have indicated that, while many Primary Care Providers (PSPs) are identifying and supporting people who suffer with EDs well, there are also a substantial number whose stigmatizing attitudes, and beliefs that patients are in some way to blame for their illness, alongside their lack of education regarding EDs serve to act as a barrier (Bartellas, 2015; Currin, Waller and Schmidt, 2009; Roehrig & McLean, 2010).

Individual factors that can undermine the therapeutic nature of interactions between people with EDs and health care providers include patients' feelings of shame that promote self-critical thought processes (Kelly and Carter, 2013), and fear of being judged or forced to make changes before being ready to, which can lead to secretive behaviours (Mehler et al., 2010; van der Leer et al., 2016). Therapies and interventions designed to address issues of denial, ambivalence or resistance to change are posted to be essential for supporting people with EDs experiencing these feelings and concerns. Motivational Enhancement Therapy (MET), which was originally developed for use with those living with substance abuse issues, was designed to address these kinds of issues in order to support and encourage change in way that is warm and empathic (van der Leer et al., 2016). Practitioners using MET are taught to 'roll with resistance' (i.e. resistance to change) and express empathy for the client's subjective experience of their stage of recovery, as resistance is conceptualized as arising when the practitioner believes/perceives the client to be at a different place in the change process from where they actually are, thus causing a

rift in the relationship (van der Leer et al., 2016). Therefore, many studies, as well as the BC Guidelines have promoted the use of Motivational Interviewing (MI), as an empirically supported approach that helps develop, support, and maintain the therapeutic alliance between practitioners and people with with lifestyle issues (Emmons & Rollnick, 2001, Rubak, Snadøek, Lauritzen, and Christensen, 2005, Söderlund, Madson, Rubak & Nilsen 2010; van der Leer et al., 2016). However, there is some contention within the research as to how effective MI interventions are within ED populations. One study carried out by Waller (2012) queries clinicians' current beliefs and goes on to suggest three, "myths," that commonly exist around motivation as the following: clinicians are good at identifying motivation, motivation fits into neat stages, motivational treatments are effective. Waller (2012) goes on to report that the research surrounding the use of MI interventions within ED populations indicates: that there is mixed evidence to suggest that motivational interventions enhance motivation to change ED behaviours; that there is no evidence to suggest that motivational interventions improve treatment engagement, and finally that research findings provide no evidence that motivational interventions enhance the treatment of restriction, or purging despite showing a small effect on bingeing behaviours.

Personal Experience

As a mental health worker, employed at an ED treatment program in BC's Lower Mainland — a residential unit for youth aged 17-24 — I have spent much time and have given much attention towards how my work with residents can best support their recovery. As a result of my experiences in my work, I am continually reminded of the importance of developing therapeutic relationships with the residents that I support. Most notably, when I first started working at the residence as a new member of staff, I asked one resident what did they perceive was the most

important thing for me to be mindful of in my work. That person replied, “Just be kind,” and that comment has stood out in my memory throughout my time working there. The message behind this piece of advice has been echoed by many residents throughout my time working in this environment and I have truly come to be curious about how the attitudes and actions of staff members and other professionals impact the people that we work with. I ask myself questions such as: What other qualities, as opposed to skills or abilities, might a person in recovery value in the professionals who work with them? How do they experience our efforts to facilitate their recovery, and to what degree if any, does that rapport and relationship benefit a person in their recovery journey?

Purpose of the Study

The purpose of this study is to explore the experience of those who have been through the process of recovery from an eating disorder in order to better understand how relationships with professionals influence their recovery journey. There is currently research that identifies the impact of certain factors in healthcare professionals interactions with clients such as clinician stance (Geller et al., 2008), clinician characteristics (Gulliksen, Espeset, Nordbø, Skårderud, Geller & Holte, 2015), or clinician approaches (Geller et al., 2016) that may either help or hinder a person’s recovery. This study specifically seeks to explore the experiences of those who describe themselves to be well established in recovery (this may mean different things to different people and so participants would be asked to provide a definition of what recovery means for them in their life setting) and can now reflect in hindsight upon their experience. Of particular interest is exploring how such individuals describe working with various healthcare professionals

over time and throughout different developmental stages, as well as the various stages of their recovery.

Rationale for the Study

Although, some research has emphasized the importance of developing trusting, open, respectful working relationships with clients who experience an ED, there is very little that explores the importance of this from the clients' perspectives retrospectively. An exception is the Bartellas study (2015), which identified that the ability of healthcare providers to show empathy for those seeking treatment, served as a facilitator when present (and a barrier when absent) for an adolescent population in Atlantic Canada. Additional literature has identified a link between the therapeutic alliance and outcomes in younger populations (e.g., Zaitsoff et al., 2016), and a large meta-analysis carried out by Zaitsoff and colleagues (2015) of 19 studies indicated that the therapeutic alliance may be an important factor in ED treatment for wider populations, but also identified a lack of research on the topic. More recent research by Graves and colleagues (2017) has explored and found significant associations between early symptom reduction, therapeutic alliance and treatment outcomes. However, these associations had a stronger relationship to outcome in younger patients than older patients (Graves et al, 2017). Associations were also found to be moderated by therapies that included a strong behavioural component, which indicated that therapeutic alliance is less involved in outcomes when behavioural modalities have been used. The article concluded that developing a therapeutic alliance with younger patients and those receiving non-behaviourally orientated treatments may require greater focus during treatment (Graves et al, 2017). While the literature also suggests that strong therapeutic alliances can predict the outcomes for patients with AN, there are mixed findings for those suffering with BN (Graves et

al, 2017). Finally, although there is evidence indicating that aspects of the counselling relationship are a core condition of change for individuals engaged in counselling therapy (Norcross & Wampold, 2011), this topic has only begun to be researched in recent years within multi-disciplinary healthcare settings providing treatment for people seeking treatment for EDs (Graves et al., 2017; Sly, Morgan, Mountford, Sawyer, Evans, Hubert Lacey, 2014; Zaitsoff et al., 2015, Zaitsoff et al., 2016).

Research Question

This study will employ a narrative research design to answer the following research question: *How do people, over the age of 20, who have experienced an eating disorder, narrate their experiences of working with health care professionals in BC?*

Significance of the Study

This qualitative study aims to obtain in-depth descriptions of people with EDs' experience of working with healthcare professionals in order to explore whether and how they perceived these relationships in the process of their recovery from an ED. Through gaining a deeper understanding as to how these relationships are experienced, healthcare providers may consider the ways in which this topic might be worthy of further consideration, discussion, and research in order to better facilitate peoples' recovery from an ED.

Chapter 2: Literature Review

Terminology

The literature on the diagnosis and treatment of EDs is vast. For the purposes of this study, I will review literature focusing on the impact of the therapeutic relationship with respect to health care professionals treating people with EDs. I will use the phrase ‘health care professionals’ as a generic term that includes all professionals who play a part in supporting a person suffering with an ED. These professionals may include, but are not limited to: primary care physicians (PCPs), psychiatrists, psychologists, therapists, social workers, dieticians, nurses, nurse practitioners, mental health workers and other support or administrative staff who have direct contact with a person seeking treatment within a therapeutic environment. The settings that may be included under the heading of therapeutic environment may include (but are not limited to) primary health care settings (doctor’s office, walk-in medical centre), inpatient hospital units, emergency rooms, outpatient support groups, and outpatient residential units.

Throughout this study, I will make reference to theories surrounding the concepts of, “alliance,” and so to that end it is important to define the terms used in these theories accurately. The word “alliance,” was first used by Sterba (1934), to describe a therapist’s ability to discern and work with a patient’s capacity to observe themselves from a rational perspective (Zilcha-Mano, 2017). Greenson (1965) later used the term, ‘working alliance,’ to suggest a patient’s ability to work collaboratively when engaged in psychoanalysis (Zilcha-Mano, 2017). In the late 1970’s Luborsky (1976) explored the relational elements between therapist and client and suggested a two-phase development of the alliance (Hovarth, Del Re, Flückiger, & Symonds, 2011). Similarly, Bordin (1976) chose to depart from psychoanalytical theories and offered a pan-theo-

retical view that used the term, “working alliance,” to describe the establishment of a collaborative stance between therapist and client that was built upon three processes: shared therapeutic goals; agreement on the tasks involved in therapy; and an emotional bond between client and therapist (Hovarth et al., 2011). During the late 1970’s and 80’s, researchers developed several measures to further explore this topic (Hovarth et al., 2011). Many studies since have also explored a variety of research areas such as: the relationship between alliance and outcomes within various helping environments; the alliance as described from different perspectives (client, therapist, observer); the alliance/outcome relationship at various stages of therapy; and the role, development and management of the alliance within therapeutic relationships, including the use of rupture and repair within therapeutic relationships to strengthen the alliance (Bedi, Davis, & Williams, 2005; Bedi, 2006; Hovarth, 2007). While research is still emerging that explores the importance of the role of the alliance in psychotherapy, questions remain regarding whether the alliance is curative in and of itself or merely contributes to optimal conditions for therapeutic techniques to be successful (Zilcha-Mano, 2017). Furthermore, one conclusive definition of the, “working” and/or, “therapeutic alliance,” remains unresolved. Therefore, researchers and clinicians are tasked with clearly explaining what they mean when they use the term and rooting this within theory (Hovarth, 2007; Zilcha-Mano, 2017). Added to that, the importance of defining of terminology when discussing alliance is described by MacFarlane, Anderson and McClintock (2015) as being especially important when carrying out qualitative research from the client’s perspective, as clients will mostly likely be unaware of the terminology defined within alliance theories. MacFarlane and colleagues (2015) critique some qualitative approaches, because some client responses in the qualitative literature appear to conflate alliance with the therapy relation-

ship generally. Therefore, when using terms relating to different therapeutic alliance theories I will use the appropriate terminology for that theory and define it accordingly.

However due to the qualitative nature of this research which does seek to explore the alliance as just one aspect of the wider relationship generally, it is also important to allow space for new and multiple ideas about alliance and relationship in clinical work to emerge. Therefore, when making reference to the main construct for the phenomenon under study, I will use the term, “therapeutic relationship,” in order to distinguish these emerging ideas from those constructs already described by alliance theories. Within this study, the therapeutic relationship will be explored as an ever emerging construct within the context of each participant’s individual narrative, with an attempt to avoid any preconceptions or expectations as to how this construct will appear, or impact other emerging constructs within the narrative. Indeed, within the participants’ narratives this construct may not emerge at all.

The Organisation of the Literature Review

This literature review is organised into seven sections: literature that explores and questions theoretical assumptions regarding the therapeutic alliance more generally; literature that explores the importance of the therapeutic alliance between health care professionals and people who suffer with EDs; literature that explores clinician qualities, attitudes, and behaviours that might facilitate a therapeutic relationship; the literature that links emotional abuse and EDs; literature pertaining to complex trauma and to comorbidity of EDs with other mental health diagnoses; literature on other factors that act as a barrier to the development of a therapeutic relationship; literature regarding other factors within health care settings that impact the therapeutic relationship between health care providers and people seeking treatment for an ED; and, finally, lit-

erature that explores clinician strategies for building and maintaining strong therapeutic alliances.

Theoretical Assumptions Regarding Alliance

As previously described, the theory and research surrounding therapeutic alliance has seen several evolutions, whereby, currently, several theoretical positions exist regarding the concept, each with its own assumptions.

Several studies and meta-analysis have found consistent correlations between alliance and outcomes, whereby stronger alliances have been associated with better outcomes where $r = .275$ ($k = 190$) within a 95% confidence interval (Hovarth et al, 2011; Zilcha-Mano, 2017). From this research, it was assumed that the alliance was therapeutic in and of itself, and thus was a necessary tool for psychotherapy (Zilcha-Mano, 2017). Other research has sought to explore the empirical support for this assumption and questioned whether a strong alliance is therapeutic in itself, or whether it merely offers conditions for positive change (Zilcha-Mano, 2017). These studies questioned existing assumptions and posed new perspectives for exploration, such as whether a good alliance may result from early symptom change (Zilcha-Mano, 2017). More specifically, some research has been carried out within populations of people with EDs in order to explore the associations and moderators between alliance, early symptom reduction and treatment outcome (Graves et al, 2017). While some of these studies indicated that only early symptom change and not the alliance, could predict subsequent improvements in symptoms, other studies sought to control for early symptom change and showed that alliance had a unique influence on treatment outcomes (Zilcha-Mano, 2017). Other studies sought to explore the topic from a temporal perspective by researching the development of the alliance throughout treatment and

record how it impacted symptom levels at various stages. Results indicated that the alliance does indeed proceed a reduction in symptoms (Zilcha-Mano, 2017).

Much of the research described above makes assumptions that the development of an alliance is a uniform process that exists in a consistent manner throughout treatment, and does not allow for differences between individuals' ability to form an alliance, or how their capacity to build an alliance might change throughout treatment (Zilcha-Mano, 2017). Revisiting the concept of alliance through the use of more recent methodological advances, Zilcha-Mano (2017) explored the emerging body of empirical work and proposed a new model for understanding the how therapeutic alliance can be sufficient to effect change. This model assumes that individuals enter a therapeutic relationship with different capacities or traits that impact their ability to develop an alliance, and that it is important to differentiate between changes in the alliance caused by the individual's traits, as opposed to states (deviations by the individual from their usual traits) within therapy, in order to discern whether the alliance is curative in and of itself (Zilcha-Mano, 2017). Through having explored the outcomes of several research studies, the author surmised that it is improvements in state-like alliance that predict symptom reduction in patients; that it is the way in which an alliance develops and deviates from an individual's usual capacity to develop an alliance that is curative (Zilcha-Mano, 2017).

Due to this study seeking to understand ED clients' experiences of the therapeutic relationships, alliance theories that are of most relevance to this study involve those that have attempt to describe how therapeutic alliances are formed from the clients' perspective. These studies offer several critiques of Bordin's and other theories of therapeutic alliance that have focused mainly on psychotherapists' view of alliance formation. Bedi, Davis and Williams (2005), ar-

gued the need for more research to explore therapeutic alliance from the point of the clients for several reasons. To begin with, research suggested that there is only a low to moderate correlation between client and psychologist rating of therapeutic alliance (Cecero, Fenton, Frankforter, Nich, & Carrol, 2001; Fenton, Cecero, Nich, Frankforter, & Carrol, 2001) indicating that clients and psychotherapists perhaps see the factors involved in building alliances quite differently (Bachelor, 1991; Bachelor & Salamé, 2000; Hatcher, Barends, Hansell, & Gutfreund, 1995; Horvath & Marx, 1991; Tichenor & Hill, 1989). This research along with studies that indicated that clients' ratings over psychologists' ratings regarding the strength of the alliance, tended to be better predictors of clinical outcomes (Horvath & Symonds, 1991), again indicating the importance of the clients' ratings of therapeutic alliance. Bedi (2006) also argued that clients' perspectives on factors that contribute towards therapeutic alliance also created a more homogenous sample that psychotherapists and that the factors that psychotherapists value as important to therapeutic alliance building such as collaboration and mutuality are less important to clients. Indeed, Bedi (2006) argued that the variables that clients identified as important to therapeutic alliance building (counsellor friendliness, humour, advice, client self-understanding), were not well accounted for in the current theories and so called for the development of new theories that explored the development of therapeutic alliance from the client's perspective.

Research began to develop several theories that described the development of the therapeutic alliance from the client's perspective (Bedi, Davis, & Williams, 2005; Bedi, 2006, Bedi & Duffy, 2010; Fitzpatrick, Janzen, Chamodraka, & Park 2006; Fitzpatrick, Janzen, Chamodraka, Gamberg & Blake, 2009; MacFarlane et al., 2015). Bedi and colleagues (2005) investigated how clients understood the formation and strengthening of therapeutic alliance and investigated 376

critical incidents described by participants which were then organised into 25 categories. The findings suggested two key points: (a) that despite interviewer prompting, only a small number of participants (33%) acknowledged any of their own contributions as making a significant difference to the therapeutic alliance suggesting that clients generally hold the psychotherapist responsible for forming the therapeutic alliance; (b) that there are several elements that contribute to the development of the therapeutic alliance as viewed from the perspective of the client, that are currently under-researched (Bedi et al., 2005). In this study, the elements that clients found important for the development of the therapeutic alliance that were not present in many therapeutic alliance theories at the time of writing, included such things as psychotherapist's personal and physical characteristics, the therapeutic environment, and the use of clinical interventions (Bedi et al., 2005). The last point led the researchers to theorise that therapeutic techniques cannot be divorced from the therapeutic alliance (Bedi et al., 2005). Ultimately Bedi and colleagues (2005) concluded that there was a discrepancy between clients' and psychotherapists' or investigators' theories of alliance in the literature of the time.

In a study designed to elicit client perceptions of alliance (Bedi, 2006), 40 clients were asked to identify the observable behaviours and verbalisations of the therapist that contributed to the formation of a therapeutic alliance. 31 of these same participants returned to sort these named behaviours and verbalisations into concept categories (Bedi, 2006). These participants developed 11 reliable categories: setting, presentation & body language, nonverbal gestures, emotional support & care, honesty, validation, guidance & challenging, education, referrals & recommended materials, client's personal responsibility, and session administration (Bedi, 2006). As a result of this research, Bedi (2006) proposed seven key findings of the study as follows: (a)

clients tend not to see alliance formation as a collaborative process but place most of the responsibility for the development of the therapeutic alliance on the psychotherapist; (b) the psychotherapist's use of counselling techniques were seen by participants to be fundamentally important to the development of the therapeutic alliance; (c) clients place emphasis on factors not currently described by existing theories of therapeutic alliance such as session administration, setting, psycho-education, referrals, recommended materials, guidance, and challenge in alliance formation; (d) many clients found that the micro-skills used by psychotherapists such as nonverbal gestures and empathetic listening were important for therapeutic alliance formation; (e) alliance formation may begin earlier than anticipated by psychotherapists as clients may be influenced by first impressions of the psychotherapist or the therapeutic setting; (f) some constructs such as validation, guidance and challenging, presentation and body language were the most homogenous categories as identified by clients; (g) the categories of validation, education, non verbal gestures, as well as presentation and body language, were rated as the most important by clients, and could potentially form the basis for a model of therapeutic alliance from the client's perspective. Many of these findings supporting the findings of Bedi and colleagues (2005).

In later research, Bedi and Duff (2010) also sought to examine the client's perspective on 15 client-identified psychotherapist behaviours that predict the formation of therapeutic alliance. Correlational analyses identified that 11 of the 15 behaviours were moderately to strongly correlated with the strength of the alliance, and regression analyses identified three behaviours as accounting for 62% of the variance in alliance scores (Bedi & Duff, 2010). These three behaviours were: making encouraging statements, making positive comments about the client, and greeting the client with a smile, which led Bedi and Duff (2010) to surmise in the findings that perhaps

seemingly small, counsellor micro-behaviours can play vital roles in the formation of the therapeutic alliance, and that these findings were currently absent or overlooked by theories that only focused on the formation of alliance from the psychotherapist's perspective.

The work of Fitzpatrick, Janzen, Chamodraka, & Park (2006) explored the clients' selection and descriptions of critical incidents that contributed towards the development of the relationship with therapists in the early stages of therapy. This study identified that the incidents that appeared meaningful for the participants, were those that involved a deep and positive emotional experience related to a therapeutic intervention, regardless of the type of intervention employed by the therapist (Fitzpatrick et al., 2006). Fitzpatrick and colleagues (2006) reported that these positive incidences appeared to facilitate greater involvement from the client in their own therapy, encouraging both productive disclosures and a greater level of receptiveness to therapist input, which the writers suggest explains the link between alliance and improved outcomes.

In a later study, replicating the 2006 study with more experienced therapists (the previous study had used master's-degree students), Fitzpatrick, Janzen, Chamodraka, Gamberg, and Blake (2009), again used a critical incident method to explore the experience of a working relationship between 15 participants, seeking treatment for depression, and their therapists. In contrast to the findings of Bedi and colleagues (2005) and Bedi(2006), Fitzpatrick and colleagues (2009) reported that through interview probing by experienced therapists, participants were able to identify their own contributions, through disclosure and receptiveness to therapist input, towards the formation of a therapeutic alliance. Participants' recognition of their own contributions and collaboration with the therapist in the therapeutic process, along with a positive emotional experience in relation to this process, was an important mechanism in the development of a therapeutic

alliance. Both of these studies appear to support the idea that there is value in investigators and therapists using techniques that encourage participants and clients to reflect and identify their own contributions to the development of a therapeutic alliance, rather than relying on just the therapist's or investigator's perception of what factors are facilitating (or not) the formation of a therapeutic alliance (Fitzpatrick et al., 2006, Fitzpatrick et al., 2009).

Through a study into the early formation of the working alliance, MacFarlane, Anderson, and McClintock (2015) aimed to bridge the gap between alliance theory and clients' perspectives of the early experiences of alliance, by focusing on four specific areas: (a) level of client contribution to the therapeutic relationship and the establishment of the alliance; (b) the complex interactions of the components of the alliance, including goals, tasks, and bond; (c) elaboration of the alliance components; and (d) psychotherapist activities that either enhance or reduce the strength of alliance. MacFarlane and colleagues (2015) chose to use an, "above the ground," method due to concerns that using general terms such as, "client–therapist relationship," "working relationship," and, "therapeutic relationship," when asking participants about their experience, could potentially lead to findings that focus on more general aspects of the therapeutic relationship, which may not be connected to the construct of alliance. MacFarlane and colleagues (2015) expressed an acknowledgement that the use of Bordin's theory of, "working alliance," would limit the study due to the lack of evidence in the literature to suggest that use of prompts and questions rooted in Bordin's (1979) model of working alliance, actually results in increased alliances or improved outcomes. The findings of this study identified four clusters of meaning units, categorised as follows: (a) clients initial misgivings about therapy, (b) organisation and meaning making, (c) therapist supportive activities, and (d) client appreciation of techniques (MacFarlane

et al., 2015). These findings supported the study by Bedi and colleagues (2005) in identifying the importance of psychotherapists' use of techniques in contributing to the development of a bond and formation of alliance. MacFarlane and colleagues (2015) also reported that effective communication between client and psychotherapist with particular regard to the formation of goals and engaging in tasks together, as described by Bordin (1979) were vital for the establishment of an alliance. This study also supported the work of Bedi and colleagues (2005) in surmising that clients tend not to recognise their own contributions towards the formation of an alliance (MacFarlane et al., 2015), again suggesting that the collaborative factors involved in psychotherapy, as described by Bordin's (1979) alliance theory, are less important to clients who perhaps see the formation of the alliance as the responsibility of the psychotherapist (MacFarlane et al., 2015, Bedi, 2006). Contrary to Fitzpatrick and colleagues findings (2009), MacFarlane and colleagues (2015) noted that, even when prompted by psychotherapist/investigators to comment on their own contributions to alliance formation, clients did not discuss the phenomenon in the same terms that psychotherapists did, and suggested that perhaps clients are participating in this process before they have the capability to describe it. MacFarlane and colleagues' (2015) study concluded that even when the questions given to clients/participants are rooted in alliance theory, their responses support the literature that has sought to explore alliance formation from the client's perspective.

The Importance of Therapeutic Alliance in ED Treatment

In order to treat an ED, health care professionals need to fully comprehend the symptoms and behaviours of a person seeking treatment for the eating disorder (van der Leer et al., 2016). However, due to individuals with EDs' feelings of shame, regarding ED behaviours, and/or fear

of judgment, many of these symptoms go unreported (Kelly & Carter, 2013; Mehler et al., 2010). The Clinical Practice Guidelines for the BC Eating Disorders has emphasized the importance of healthcare practitioners developing and maintaining strong therapeutic alliances with patients in order to encourage open, honest and clear communication (van der Leer, 2016). As further evidence of the importance of developing a strong therapeutic alliance the guidelines also cited a large meta-analysis of research confirming a correlation between the working alliance and therapeutic outcome (Martin, Gaske, & Davis, 2000). This research is consistent with a meta-analysis carried out by Hovarth and colleagues (2011) exploring the alliance and outcomes within a broader scope of literature pertaining to the general population.

Although some studies have questioned the contribution to treatment outcomes of the therapeutic alliance in the EDs field (Brown, Mountford, & Waller, 2013), there is a growing body of research that has attempted to identify the ways in which therapeutic alliance is linked to successful treatment outcomes in EDs treatment. A systemic review of nine qualitative and two quantitative studies carried out by Antoniou and Cooper (2013) suggested that the therapeutic alliance is significantly associated with successful treatment outcomes in patients with AN. However, the importance of the therapeutic alliance remains unclear with regard to patients with BN. A recent meta-analysis also reported small to moderate effect sizes indicating that early symptom improvement in patients with AN was related to subsequent therapeutic alliance and that therapeutic alliance rating were also linked to subsequent symptom reduction (Graves, Tabri, Thompson-Brenner, Franko, Eddy, Bourion-Bedes, Brown, Constantino, Flückiger, Forsberg, Isserlin, Couturier, Paulson Karlsson, Mander, Teufel, Mitchell, Crosby, Prestano, Satir, Simpson, Sly, Hubert Lacey, Stiles-Shields, Tasca, Waller, Zaitsoff, Rienecke, Le Grange, & Thomas,

2017). The study attributed early symptom reduction to early alliance and treatment outcome, and reported weaker associations between early alliance and with outcome in therapy with strong behavioural components (as opposed to non-behavioural therapies). This suggests that the therapeutic alliance is more vital for the success of therapies that are non-behaviourally-oriented (Graves et al, 2017). The analysis also showed stronger relationships between therapeutic alliance and outcomes for younger patients (Graves et al, 2017).

The importance of establishing the therapeutic alliance sooner than later is also suggested by a study investigating the characteristics and treatment of patients with chronic EDs. The study stated that an average of 20% of patients who experience EDs will struggle with a chronic ED, meaning that 1 in 5 people who suffer with AN or BN will be ill for 10 years or more (Noordenbos, Oldenhav, Muscheter & Terpstra; 2002). Other studies have also supported the notion that, the longer a person struggles, the harder it is for them to recover (Noordenbos, Oldenhav, Muscheter & Terpstra, 2002, Mehler, 2001). Therefore, it can be speculated that establishing therapeutic alliances earlier in treatment could lead to better outcomes in early symptom reduction, and could reduce the period of time a person takes to recover. However, the question still remains as to whether it is early symptom reduction that leads to stronger alliances, and whether the alliance itself can impact the length of a time a person may take to recover.

Clinician Qualities, Attitudes, and Behaviours that Support the Therapeutic Alliance

Qualitative articles and studies have explored the importance of the therapeutic alliance within various healthcare settings. For example, Surtees, an ED nursing specialist, while advocating for a therapeutic alliance that is lenient and flexible, proposes that this alliance can only begin once the patient is no longer nutritionally compromised (Surtees, 2007). Geller and col-

leagues (2001) also highlighted the importance of clinician attitudes and behaviours in treating people with chronic EDs. They reported that many people struggle to fully recover from ED symptoms due to strong feelings of ambivalence, which often present a unique challenge to clinicians. The authors described and promoted certain clinician attitudes and behaviours that foster the longer-term working alliances that are essential for working with people with chronic EDs, so as to help ensure such individuals are able to access professional support and healthcare (Geller et al, 2001). These behaviours include: the communication of certain beliefs by clinicians that support client self-acceptance (such as viewing the eating disorder as a coping strategy); avoiding assumptions; remaining curious and active; and conveying that they are on the client's side, while also maximising client responsibility for change (Geller et al, 2001).

This stance is further supported by a qualitative study that identified the therapeutic alliance as one of the aspects of treatment that adolescent patients found most helpful when receiving treatment for AN (Zaitsoff, Pullmer, Menna, & Geller, 2016). In that study, clinician qualities that supported the establishment of therapeutic alliance were described as: an interest in the client as a person, not just their ED; the expression of empathy and understanding of the client's feelings; ensuring the involvement of clients in establishing treatment goals; genuine support, qualified as a belief that the client can achieve goals; deliberate intentions to avoid making assumptions about clients' thoughts, feelings and actions; and clear attempts to avoid establishing unrealistic goals (Zaitsoff et al, 2016).

More recent qualitative studies have highlighted the preferred characteristics of clinicians for facilitating therapeutic alliance, as described ED patients. (Gulliksen, Espeset, Nordbø, Skårderud, Geller, & Holte, 2015, Sly, Morgan, Mountford, Sawyer, Evans, & Hubert Lacey,

2014). A phenomenological study found that the following clinician qualities were believed to facilitate therapy: acceptance; generosity; kindness; caring; understanding; respectful and non judgmental; showing patience regarding behaviour change; demonstrating vitality by showing an active interest and a sense of humour that allowed individuals with EDs to not take themselves too seriously; presenting challenges while focusing on the client's resources, and supporting them through difficult circumstances; and showing expertise through experientially-acquired knowledge and authoritativeness (Gulliksen et al, 2015). A second study using thematic analysis of another study designed to examine the experiences of service users in developing the therapeutic alliance, reported that the following emerged as dominant categories: alliance as a key experience; the clinician being active, not passive; taboo talking; and first impressions count, demonstrated by less talking and more listening carried out by the clinician (Sly et al, 2014).

Therefore, the value of the therapeutic alliance between health care professionals and people seeking treatment for an ED is supported by a growing body of literature, not only to encourage engagement in diagnosis and treatment but to do so in a timely manner that seeks to prevent the onset of a chronic disorder. While several qualitative studies have been carried out to obtain the viewpoints of people who have suffered with an ED, these studies mostly rely mainly on the experiences of those diagnosed with AN. Thus, there is an opportunity to expand our understanding of how the establishment or lack of therapeutic alliance might be experienced by others who have been diagnosed with other eating disorders such as BN or other specified feeding or eating disorder (OSFED) when viewed retrospectively by survivors.

The Relationship Between Early Emotional Abuse, Neglect, and Eating Disorders

Given the emerging body of research exploring the importance of developing of a therapeutic alliance in EDs treatment, an important questions arise regarding how other factors associated with EDs may influence the therapeutic alliance. In the present literature review, the inclusion of research that explores the relationship between childhood abuse, childhood trauma, and comorbidity with other psychological conditions, in this literature review is not meant to suggest that all EDs are caused by childhood abuse, neglect or trauma but rather to highlight that there may be additional factors impacting or affecting the therapeutic alliance, when treating someone with an ED.

Lampis and colleagues (2014) reported that, in families where parents score more highly on the parental caring scale, as well as in families who score highly on the family cohesiveness scale, the probability of a subject falling into a high risk group for the onset of an ED decreases (Lampis, Agus, & Cacciarru, 2014). Several other studies have drawn a correlation between childhood emotional abuse and neglect and the development of an ED (Hund & Espelage, 2005; Kennedy, Ip, Samra, & Gorzalka, 2007; Kent, Waller, & Dagnan, 1997; Rorty & Yagar, 1996). One study investigated the function of the ED as a mechanism for managing over-whelming affective states, and as a means of providing a sense of self and a system of meaning in the absence of a primary care giver to fulfill the same functions (Rorty & Yagar, 1996). The authors postulated that a need for control, could manifest in the control of body size and shape and food intake, and that these controlling behaviours become essential for managing the fear of unmet needs experienced in childhood (Rorty & Yagar, 1996). The study concluded that forming relationships with others carries elements of risk and benefit; while individuals with EDs have the opportunity

to find health through connection and having their needs met, they also run the risk of further disappointment, abandonment and pain (Rorty & Yagar, 1996).

Further research has explored the way in which a person's experience of childhood emotional abuse can lead to deficits in emotion regulation, which, in turn, mediate later ED symptoms (Burns, Fischer, Jackson, & Harding, 2011; Groleau et al., 2012). The issues that these studies raise are related to the difficulty a person, who is seeking treatment for an ED, might face in building relationship with health care professionals. A history of developmental trauma in forming relationships poses a great challenge to both people with EDs and health care providers in creating the relational conditions necessary to build a healthy and constructive therapeutic alliance. A consequence of childhood emotional abuse and neglect is an inability to discern or express one's own emotions (i.e., alexithymia). This can impact one's ability to be in relationship and also put one at risk for increased distress, and thus a reliance upon ED behaviours (Hund & Espelage, 2005). Therefore, not only might a person experiencing considerable distress lack the necessary developmental tools to acknowledge their distress, they may face the additional challenge of being unable to articulate this to another person, and so may experience even greater seclusion in their suffering. This lends support to the notion of cultivating strong and trusting therapeutic alliances in EDs treatment that are capable of supporting a person in developing the ability to recognise and talk about their experiences, in order to avoid their feeling isolated and alone (Sly et al, 2014).

Comorbidity of EDs with Other Mental Health Diagnosis

Along with experiences of childhood abuse, and neglect, some people with EDs may have developed other mental health issues that also impact the development of the therapeutic

relationship between those seeking treatment for an eating disorder and healthcare providers. In her seminal book, "Trauma and Recovery," Judith Herman called for a new diagnosis of "complex trauma," which she proposed would help better determine and understand the impacts of prolonged exposure to a traumatic environment (Herman, 1997). She stated that this additional diagnosis would allow clinicians and people with EDs alike to better understand how changes in development and personality can be impacted by violence, abuse and neglect. Not only is the term Complex PTSD now included in the DSM-V (APA, 2013), but the phrase, "complex trauma," is also being used with increasing regularity in the field of counselling psychology especially among trauma counsellors, including prominent clinicians such as Christine Courtois (Courtois, 2004).

The challenges of assessing for complex trauma have been outlined by Courtois (2004) in her article, "Complex Trauma, Complex Reactions: Assessment and Treatment." However, she noted that research supports a significant difference between PTSD as defined in the DSM-III and the reactions of people exposed to domestic trauma, child abuse and neglect over a long period of time. She also listed the types of symptoms experienced by those people who would fit a diagnosis of complex trauma as: depression, anxiety, self-hatred, dissociation, substance abuse, self-destructive and risk taking behaviours, revictimization, problems with intimate and interpersonal relationships, medical and somatic concerns, and despair (Courtois, 2004). A study authored by Sanasone and Sansone (2007) discussed the way in which childhood trauma can result in psychological consequences including increased the risk of someone developing symptoms that might result in a diagnosis of both mood and personality disorders, as well as developing an ED. Comorbidity rates for EDs and Axis I & II disorders are often reported as high. For

example, one study reported comorbidity rates of EDs with Axis I disorders of 74% and Axis II disorders at 68% (Milos, Spindler, & Schnyder, 2004). Thus, when a person seeking treatment for an ED, also has a history of childhood abuse or “complex trauma,” they may present with additional psychological issues (Sansone & Sansone, 2007). The relationship between childhood trauma and complex psychiatric presentations has also been supported by Miller-Graff and Howell (2015) in their article entitled, “Post-traumatic Stress Symptom Trajectories Among Children Exposed to Violence.” They suggested that children exposed to violence and neglect are likely to experience chronic risk for poor adjustment, and will most likely require intensive, integrated clinical services (Miller-Graff & Howell, 2015). Indeed, the number and variety of healthcare providers that a person with a complex psychological presentation could be asked or expected to work with, is just one way in which a history of trauma could impact the development of therapeutic relationships in ED treatment.

The lived experience of people with “complex trauma” may take a toll on interpersonal relationships. In her description of one of the fundamental aspects of “complex trauma,” Herman (1997) outlined at length the experience of those who face ongoing traumatic events during vital stages of development, essentially undermining an emerging adult’s sense of autonomy and dignity in a way that teaches the person that they cannot be themselves and be in relationship with others (Herman, 1997). This, too, has implications for healthcare providers attempting to develop a therapeutic relationship with someone who may have experienced complex or acute trauma.

People with EDs may also present with a history of acute trauma or Post Traumatic Stress disorder (PTSD). One study revealed a PTSD rate of 33.9% in patients with EDs, and indicated that those who suffered with PTSD experienced significantly higher levels of severity in their

symptoms (Vierling et al., 2015). Some associations between EDs and PTSD were also found, characterized as significantly higher levels of insecurity and interpersonal mistrust, which may also have relevance to the issue of therapeutic relationship.

Other Factors that May Act as Barriers to the Development of Therapeutic Relationship

As previously in the introductory sections, strong feelings may co-exist with a person's experience of an ED. Feelings of shame regarding symptoms are often inflated by the stigma surrounding a mental illness diagnosis, as well as, by the fears of judgement and making changes, which are often present in a person's experience of living with an ED. Shame appears to play a particularly prominent role in the development and exacerbation of an ED as suggested in an article exploring the role of shame and pride in relation to EDs, which suggested that both globalised internal shame and focal shame could act as both a causes and consequences of symptoms related to AN (Skårderud, 2007). Other studies have also identified this correlation and have recommended interventions that target shame and self-criticism, and that build greater self-compassion (Kelly & Carter, 2013; Kelly, Carter, & Borairi, 2014). Despite experiencing strong feelings of shame and fear, a person with an ED may struggle to identify and express their emotions, which may impede and undermine their ability to seek help.

Moreover, the symptoms of "complex trauma" can leave a person unable to develop their own initiative or gain a sense of self-confidence (Herman, 1997). Basic trust with not only other people but with the world at large is also undermined and often lost, disconnecting a person from not only their intimate relationships and from a sense of being able to connect with a larger community or healthcare professionals (Herman, 1997). Frequently, feelings of guilt, shame and inferiority also impact those who have been witness to, or a victim of, abuse and neglect, which

may lead a person to withdraw from relationships completely or cling anxiously to others (Herman, 1997). Both of these relational styles can present significant challenges for the clinician and create barriers to initiating and building a therapeutic relationship. Indeed, there is a growing body of literature that supports the efficacy of relationship-focused therapies for EDs (Tasca, 2016), however these are still not as widely supported as cognitive behavioural-type therapies.

A client's interpersonal skills may also play a factor in the development of a therapeutic relationship. Research shows that, after controlling for depression and anxiety, the more severe the ED pathology, the more likely the person will struggle to socialize (and, in the case of patients with AN, assert themselves) (Raykos, McEvoy, Carter, Fursland, Nathan, 2014). Therefore, if being in the company of another person, communicating needs to others, and/or asserting wishes for treatment, present a struggle for a person with an ED, an ongoing therapeutic relationship may suffer if the clinician is unable to attend to the true thoughts and feelings of the client.

Finally, the Clinical Practice Guidelines for the BC ED Continuum of Services reported that other complex emotional processes experienced by people with EDs may experience their relationships with health care professionals (although the authors did not directly attribute this to childhood adversity). People with EDs have reported a perception of the ED as something that fulfills a valued need. Therefore, client fears about professional responses and interventions to their ED may undermine the development of open, honest communication. Thus, the guidelines recommended that healthcare providers acknowledge that ambivalence about recovery is normal, avoid judgments or imposing unwanted treatments (except where imminently and medically necessary), and acknowledge and validate feelings of fear surrounding treatment (van der Leer et al., 2016).

Other Factors Within Health Care Settings that Impact the Therapeutic Relationship

Many studies have shown that various issues, both interpersonal and practical, undermine the therapeutic relationship in ED treatment. Research has shown that, when seeking professional help from their family doctor or primary care physician, some individuals with EDs have had unhelpful experiences. Unhelpful prejudices and attitudes (e.g. the view that AN is chronic disease with poor treatment outcomes, or that the person with an eating disorder is using their illness in order to gain attention) towards eating disorders are common among PCPs (Currin, Waller & Schmidt, 2009; Roehrig & McLean, 2010). These views are often reported as resulting from a lack of skill and knowledge, alongside pessimistic beliefs and concerns regarding resources for treatment (Currin, Waller & Schmidt, 2009; Roehrig & McLean, 2010). As noted above, an inability to effectively screen and diagnose an ED can undermined a sufferer's commitment to seeking treatment. However, there are other systemic issues that may factor into this process, such as time constraints caused by large caseloads and brief appointments (van der Leer et al., 2016). These factors may also impact the clinician's ability to develop a therapeutic relationship.

Other studies have indicated that interactions between professionals and ED patients in other healthcare settings (e.g. emergency room, inpatient ward, outpatient groups) can have a negative impact on building therapeutic alliance (Bartellas, 2015). One study identified that a lack of education, understanding and empathy undermined the process of healthcare providers establishing rapport with the patient, thus posing a barrier to treatment (Bartellas, 2015), and, by extension, potentially to the development of a therapeutic alliance.

Clinician Strategies for Developing Strong Therapeutic Alliances with ED Clients

There is a wealth of literature exploring the factors necessary for supporting the strong therapeutic alliances required to support someone in recovery from an ED. Motivational Interviewing (MI) in healthcare settings has been tentatively suggested as effective in addressing lifestyle problems and disease (Emmons & Rollnick, 2001; Lindhe Söderlund, Madson, Rubak & Nilsen, 2010; Rubak, Sandbæk, Lauritzen & Christensen, 2005). The Clinical Practice Guidelines for the BC Eating Disorders Continuum of Services encourages the use of MI when working with patients, supporting this recommendation with literature from around the globe, including NHS Quality Improvement Scotland, 2007; Royal Australian and New Zealand College of Psychiatrists (2004), The National Institute for Health and Care Excellence (NICE) 2004 (van der Leer et al., 2016). The guidelines elaborated that it is not only the technique that is important for the implementation of MI but also the clinician's attitude, which would ideally demonstrate a curious, non-judgmental perspective as well as a genuine interest in the patient's experience of their ED (van der Leer et al., 2016). However, (as previously mentioned) another study suggests the MI interventions do little to enhance the motivation to change for those experiencing restrictive or purging behaviours (Waller, 2012). Bartellas's (2015) recent study also identified several factors demonstrated by health care providers (e.g., such as compassion, empathy and care) that foster a constructive therapeutic alliance between professionals and people with EDs (Bartellas, 2015). Thus, there appears to be evidence that supports not only the importance of a therapeutic alliance (Antoniou & Cooper, 2013; Brown, Mountford, & Waller, 2013; Graves et al, 2017; Martin, Gaske, & David, 2000), but also the qualities and attitude that a healthcare provider

might demonstrate to facilitate the alliance (Geller et al, 2001; Gulliksen et al., 2015; Sly et al., 2014; Zaitsoff et al, 2016).

The aims of the present research are as follows: (a) to explore the therapeutic relationship between people with EDs and healthcare providers, from the perspectives of adult ED survivors who have experienced AN, BN or OSFED, in order to gain a more nuanced understanding of the role of the therapeutic relationship in the recovery process; and (b) to explore the remembered experience of people who have recovered from an ED, of interacting with professionals in a variety of health care settings, within a very specific geographical context.

Research Question

The question the present study will seek to explore is: *How do people, over the age of 20, who have experienced an eating disorder, narrate their experiences of working with health care professionals in BC?* Therefore, it is my intention to use qualitative methods to explore the experience of people who have sought treatment for EDs in working with health care professionals.

This question seeks to explore the experience of the relationship from people with EDs' perspective for several reasons. Due to the often lengthy, sometimes lifetime, experience of living with an ED, as well as the very serious health implications, it is vital that people with EDs can find support and develop working relationships with healthcare providers within as timely a manner as possible. Added to that, if the nature of the working alliance does have an impact on a person's recovery from an ED, there is a clear ethical responsibility to develop working alliances that most benefit the person seeking treatment.

In order to gather data that will support the development of story over time and view these experiences retrospectively, participants will be recruited who will be at least 20 years old.

Also, given that a person with an ED is likely to have experienced emotional abuse, neglect and/or may present with the symptoms of acute or complex trauma, establishing safety within any relationships may present significant barriers to that person finding support personally and professionally. Several studies and the provincial guidelines make recommendations regarding how to develop rapport with a person who experiences an ED. Therefore, this question also seeks to better understand how theory and guidelines are put into practice and perceived by those who have received treatment. Finally, this study aims to add to the voices of people who have suffered and survived an ED to the literature on this topic, in the hope that their stories will further our understanding of the ways in which relationships with healthcare professionals either facilitated, obstructed or were inconsequential to their recovery.

Chapter 3: Research Methods

Introduction

This study used narrative design, which was selected for two main reasons. The first was to seek to gain a more nuanced and detailed picture of the factors impacting a person's experience of working with healthcare professionals when accessing treatment for an ED in British Columbia. The narrative design was also chosen to support the study of how participants might have their own meaning regarding their experiences of both an eating disorder and treatment for an eating disorder. The second reason was to empower the voices of people, who may have experienced feeling labelled and stigmatised within society by the diagnosis of an ED, to speak about their experiences of an ED alongside their treatment for an ED, with words and description to all the ways in which their stories are varied, individual and embedded within the context of their own life experiences and society at this time. This is an important aspect of my choice to use a narrative design, as to quote Kohler Riessman (2008, p8) directly, "Narratives do political work." The role of narratives within society and how they influence the flow of power between groups is an underlying principle of narrative theory (Kohler Riessman, 2008). With this study it was my hope that people who have been through an ED, treatment for an ED, and recovery from an ED, who may have experienced a loss of power through any or all of these processes are able to regain it through authoring their own experiences as contributions to research that informs practice.

Research Design - The Use of Qualitative Methods

My decision to conduct this study using qualitative research methods was based largely upon the research question, "*How do people, over the age of 20, who have experienced an eating disorder, narrate their experiences of working with health care professionals in BC?*" This study

sought to understand how participants have constructed meaning surrounding: (a) their experiences of developing, and living with an ED; and (b) their experience of seeking treatment for an ED from health care professionals. The interest in this question emerged from my epistemological and ontological beliefs. I view life through a social constructivist lens, in that I believe we are all constantly in negotiation with a variety of sources in order to author the meaning that we create in our lives. Our family, the wider community, professionals who offer treatment, wider society and the media, are just a few examples of influences surround us at all times and impact our development as human beings. Therefore, it is my belief that we are never independent from these sources, but use them to orient ourselves in the world as we construct our own life story. Added to that, we also get to contribute our own stories and engage in a wider discourse. These stories, however, in varying degrees, adapt and change over time and, as we narrate them from a retrospective position, as we gain greater exposure to a wider variety of sources or in the moments when we purposefully put words to reflecting upon and describing our lived experience. However, as stated by Catherine Kohler Reissman (2008), “There is a complicated relationship between narrative, time, and memory for we revise and edit the remembered past to square with our identities in the present,” (Kohler Reissman, 2008, p8). Therefore, before carrying out this research, I had an expectation that, throughout the interview process, there may be adaptations and revisions to the participants’ stories, which were welcomed as integral to the exploration of the complexity of the participants’ experiences. The importance of an emergent design was essential, as we sought to understand the nuanced meaning found through reflecting on a process, experienced by this specific group of study participants, situated in the unique context of their own lives as well as in the geographical context of the study - BC, Canada (Creswell, 2014). Ad-

ditionally, qualitative research methods were a natural choice in addressing this question, as the emergent design allowed for, and facilitated, the process that participants entered into with me - the researcher - in co-constructing narratives of their lived experience. A narrative design, through facilitating the process of co-constructing narratives with participants, would allow me the researcher to acknowledge my presence within this process and explore the question of how is this person telling me this story and why, a key feature of narrative analysis (Kohler Reissman, 2008, p11).

Through inductive and deductive methods, the narratives of these participants were analysed in order to draw out and further distill themes, which, in turn, offered insights into the research topic. Qualitative research, by nature, acknowledges the researcher as a key instrument of observation and interpretation within the study and, therefore, the subjectivity of the researcher's lens was also narrated and made transparent through a reflexive process. As I have a personal background in studying and teaching literature, I have an interest in deconstructing, analysing and writing narratives; therefore narrative inquiry was an obvious choice for me to facilitate and support participants in narrating their own stories (Creswell, 2014). Therefore, a key part of my research will focused on the what, how and why of the participants' narrative construction (Kohler Reissman, 2008). The process of analysing the data involved asking the questions: What was the participant's story? How has the participant told their story? Why were they telling this version of their story to me?

Rationale for Using Qualitative Methods in Mental Health Research

The vast majority of the research considered in the literature review that lead to the development of the The Clinical Practice Guidelines for the BC Eating Disorders Continuum of

Services manual drew upon the literature assessing various models of clinical excellence around the world and focused on how services should be implemented (van der Leer et al., 2016). The guidelines list more than 240 references; 180 of these articles are on the topic of EDs. Of these 180 articles only six of those listed, describe using qualitative methods. These guidelines, while incorporating some small quotations from people with EDs, are written from the perspectives of researchers, clinicians, and other healthcare providers with the tone and register of an official document. Due to the purpose and nature of this manual, and despite the substantial amount of research that makes references to people with EDs' experience, their voices have been repurposed for a professional and clinical audience. Therefore, there seems to be a paucity of literature that offers clinicians insight into a cohesive account of people's experience of seeking treatment for an ED throughout their recovery process. The intention of this study is to make an opportunity available to people with EDs to describe their own experience, in their own words and story their experience of treatment and recovery.

Indeed, the nature of this problem is complex, multi-dimensional and multi-faceted. In her article, "Qualitative Research Methods in Mental Health," Peters (2016) argues that the area of mental health research, falls behind many other research areas in healthcare in adopting qualitative methods for studies (Peters, 2016). In his article, "Qualitative and Mixed Methods in Mental Health Services and Implementation Research," Palinkas (2014) also argues that qualitative methods offer great potential for mental health services, by providing a useful depth in understanding of process and context of a research topic, particularly in the initial exploratory and evaluation stages of the research project (Palinkas, 2014). The author also highlights the value of

qualitative methods for gathering data on unexpected or unforeseen elements that impact that research topic (Palinkas, 2014).

The Use of a Narrative Design

A narrative inquiry involves participants co-constructing a chronology of their experiences regarding the study question, with the researcher (Creswell, 2014). This research method was based originally in the humanities but is now more widely used by various disciplines within the social sciences (Kohler Reissman, 2008). Narrative inquiry supports the exploration of research questions that are focused on the way in which participants construct and create meaning about their experiences. This kind of inquiry is ideal for addressing a research problem that could easily reduce a participant's experience to merely narrating the experience of an ED. My intention was that a narrative inquiry would facilitate an exploration of the participants' experience of treatment for an ED within the wider context of their lives, highlighting the ways in which life events may have influenced their interactions with health care professionals and vice versa. I was also curious about the degree to which the narrative remained focused upon working with health-care professionals as opposed to other aspects of treatment that may or may not have been helpful. Finally, I was curious as to how participants narrated their experience of treatment and recovery with the benefit of hindsight? How did they develop their narratives in the process of reflecting on the overall experience?

Inclusion of People with EDs' Voices

Literature within the ED community also calls for greater inclusion of the voices of people with EDs, and their families in the discussions around EDs and their treatment. For example, in her article, "Coming Out," Stacey Huget, one of the executive directors of the Looking Glass

Foundation in Vancouver, BC, shares her experiences of having suffered from an ED and the shame that kept her story hidden. She goes on to make a resounding cry for a change that would allow people with EDs to talk openly about their experiences, thus becoming part of a wider community that acknowledges the challenges and also highlights the idea of a supportive community that is both “inclusive and realistic,” (Huget, 2016).

Findings from Previous Qualitative Study

This study was largely inspired by the study carried out by Bartellas, (2015). Among several findings, his study, highlighted a need for “consumer and family involvement in all aspects of needs,” (Bartellas, 2015). However the voices of people with EDs and parents seem oddly absent from the guidelines and other literature cited above.

Participants

My primary site for recruitment was through the Looking Glass Foundation (LGF), a non-profit organization in Vancouver’s Lower Mainland that seeks to offer support to people, (both sufferer’s and their loved ones) with EDs throughout BC and beyond. Via telephone and chat support lines, summer camps, scholarships, and through partially funding (in collaboration with the Provincial Health Services Authority) the Looking Glass Residence (a voluntary residential program designed to facilitate recovery from an ED for youth aged 17-24), the Looking Glass Foundation continues to develop the scope of their support and services. Their community also includes a broad spectrum of volunteers, who offer support to their social media campaign “Something’s Gotta Give,” which seeks to educate society about EDs and, as a result, address and improve treatment options. I used this organization exclusively as a site for recruitment as their community extends beyond those who are currently accessing treatment to those who have

been through various stages of the illness and recovery and are seeking to support the foundation's campaign. Indeed, many of their volunteers are people in recovery from an ED and therefore did meet the criteria for participation.

Following the tradition of published narrative research, I was able to recruit 5 participants who met specific inclusion criteria (Bartellas, 2016; Hannan-Leith, 2012). The first criterion for participant inclusion was being over the age of 20, since EDs predominantly affect adolescent girls (NEDIC, 2017). Participants needed to have been through the process of recovery and feel well-established within their recovery process in order to reflect upon their whole experience with hindsight. However, engaging participants between 20-24 may have presented an ethical concern regarding a dual relationship should a study participant later relapse and wish to seek out treatment at the Looking Glass Residence where I work. Therefore, I attempted to address and minimize this risk by providing a disclosure of my role at the Looking Glass Residence (LGR), in both the Screening Interview and Informed Consent process. As part of this disclosure, I invited potential participants to consider whether taking part in the study might impact their decision to seek treatment at LGR in the future and should they feel that it could, they would then become ineligible for inclusion.

The second criterion was that participants needed to have had experience of one or more treatment options for an ED within BC. Potential participants who were currently in treatment were excluded from this study so as to prevent the process interfering with, or possibly interrupting, their recovery. For the purposes of selection for this study, 'treatment' included inpatient and outpatient programs operated by the BC Ministry of Health Services, as well as private clinics or health care professionals who participants sought out independently. However, all interactions

with all professionals provided services to the participant with regard to their ED, were of equal interest during the interview process. Participants were sought who either live in BC or lived in BC during the time of engaging in treatment for an ED, and who were willing to travel to the University of British Columbia (UBC) campus in Vancouver, in order to take part in interviews in a safe and neutral environment that is not attached to any one treatment facility. However, one exception was made for a participant, who lives out of province but who wanted to attend an interview while visiting in BC. However, due to a last minute change in circumstances the interview was rescheduled for another day which required that it be carried out over FaceTime. Due to the participant's commitment and interest in the project, an exception was made regarding this participant's involvement, despite them not being able to meet this one criteria for inclusion.

The question for recruitment was stated thus: *Are you over the age of 20? Have you experienced an eating disorder and as a result worked with health care practitioners and programs in BC? Do you feel it would be beneficial for you to share your story with a researcher who seeks to understand your individual experience of working with healthcare providers?* A convenience sample was selected on a first come, first served basis. Through preliminary interviews, I explained the process of inquiry with the potential participants, and ascertained that they met the recruitment criteria by using a screening protocol (See Appendix D for the Screening Protocol). For many people who have experienced an ED, talking about their experiences can sometimes be triggering (can trigger thoughts, feelings, sensations, and occasionally behaviours experienced as symptoms of the ED). Therefore, for ethical reasons of not doing harm, offering as much transparency about the research process was essential. An informed consent process was conducted with clients to ensure that they fully understood their commitment to the study and their rights as

participants, before interviews commenced (Creswell, 2014) (See Appendix A for the Informed Consent Form). Additionally, an interview protocol was used to ensure that questions throughout the interview adhered to the topic being researched by this study and emergent ideas were prompted by very open ended questions to ensure that participants only expanded on answers in ways that feel safe for them (See Appendix E for the Interview Protocol).

Procedure

The steps in gathering data was an iterative process that was reviewed periodically with my research supervisor to determine how many participants might be necessary for the study. Data was collected in stages. The first stage involved the participants documenting a timeline of the key events in the history of their experience of an ED, as well as instances of accessing treatment in order to provide a wider, individualised context for their narrative. Participants were asked to do this in their own time in preparation for the interview. If they did not bring the timeline to the interview for any reason, it was then constructed by both the participant and interviewer collaboratively as the interview took place. The purpose of this initial data was to provide the participant with a useful prompt for the interview process, as well as provide me, the researcher, with a chronological frame of reference for structuring their narrative.

The second phase of developing each participant's narrative involved carrying out an interview, in which the participant described their experience of seeking treatment for an ED within the framework of the larger chronology of their life events. These interviews were recorded by me, the researcher in the form of written notes on the timeline, as well as via audio recording for detail and then transcribed for analysis (See Appendix H for the Transcription Guide). The interviews included broader, open-ended questions/instructions such as: *Describe your experience of*

working with health care professionals while seeking treatment for your eating disorder. Describe moments that stick out in your memory of working with various professionals. Describe the ways in which working with health care professionals impacted your recovery. Is there anything you think I haven't asked about which is important to your story? These questions were used with the intention of avoiding making any assumptions regarding the nature or the quality of these interactions. Clarifying questions/instructions were posed to allow participants to elaborate on any brief comments, in order to further develop thick descriptions. These questions/instructions included: *Can you tell me more about that? Can you elaborate further? How was that for you?* (See Appendix E for the Interview Protocol). My analysis involved rewriting the participants' narratives of both their life and their experience of treatment into one whole, cohesive story, which was shared with the participants in a member checking procedure, so as to verify that the narrative is an accurate reflection of the participants' experiences.

Analysis

To begin with, I collected and organised the data via interview. I then used Braun and Clarke's (2006) 6-Step guidelines for thematic analysis (TA) in order to analyse the data. This involved the following stages: (a) I familiarised myself with the data through the process of transcription and reading and rereading the participants' stories; (b) I manually started to code the data using highlighters and 'post-it' notes to begin to identify important, interesting, or repeated ideas; (c) I reviewed the codes that I generated and began to collate them into possible overarching categories of themes and sub-themes using a mind map to look for potential relationships or patterns between codes; (d) I reviewed these themes in order to rework and refine them until they accurately represented the data set; (e) I defined, refined and named themes, as well as any sub-

themes, in order to describe how the theme captured an essential part of the data; (f) I wrote up my findings using evidence from the data to demonstrate how each theme captured a vital part of the stories told by the data (Braun & Clarke, 2006). Throughout this process, I was careful to explore the participants' multiple perspectives regarding each emerging code, category and theme, and presented these interrelated ideas within the context of the current literature and theories (Creswell, 2014). I was also mindful of my own process in developing the themes, and kept a diary of my own emerging responses to the data as I worked with it, reflecting on my own choices as I crafted narratives and made interpretative choices as Braun and Clarke (2016, p741) describe the TA process of coding and theme development as, "organic, exploratory and inherently subjective, involving active, creative and reflexive researcher."

Role of the Researcher

I am a middle-aged, white woman, who is originally from England and who has no personal history of an ED. My exposure to EDs is through friends as well as my work at the Looking Glass Residence, where I work as a mental health worker. In my position at the residence, I have worked alongside a team of professionals that includes: psychiatrists, doctors, nurses, nutritionists, therapists, social workers and chefs. I entered this research study as one of the professionals who has, in part, provided care for people seeking to recover from an ED, and who sought to understand what else we, as professionals, needed to know in order to continue to develop and improve services. I came to this work with the belief that the current research does not tell the whole story (Creswell, 2014, p187-189). Therefore, I recorded my own emotional responses and thought processes through reflexive journaling throughout the whole research project, in order to aid my understanding of the assumptions and biases I brought to the work.

Trustworthiness and Rigour

The trustworthiness of the research findings was established by combining a variety of perspectives, namely those of the participants, the researcher and the research committee overseeing the study. I employed a member (participant) checking procedure, by sending the narratives that had been developed from the transcripts back to the participants for evaluation, feedback, and comment. (Creswell, 2014). The three criteria that were used in the member checking procedures, in consultation with my supervisor and committee members, and the expert peer reviewer to discern the validity of the findings were the following:

1. Resonance: Do the findings resonate with our conversation together?
2. Comprehensiveness: Is the narrative comprehensive? Is there anything missing? Is there anything that needs correction or expansion?
3. Accuracy: Is this narrative an accurate representation of your experiences?

Responses to these member checking procedures are reported in Appendix I. A general summary of these comments concludes that for most of the participants the answer to all three questions was, “Yes.” However, one participant did offer more detailed comments that identified their subjectivity regarding events, the impossibility of a narrative offering a fully comprehensive version of a person’s experience of an ED, and that the tone resonating more accurately with their current voice as opposed to the voice they might have used at the time of the events they were narrating.

I also sought the support, guidance, and consultation of my supervisor, committee as well as an expert peer advisor who has 20 years of professional experience within the field of EDs and who is a designated Ph.D., R. Psych, and an MSW who has been working in the field of EDs, both private practice and public healthcare for five years, and has been carrying out clini-

cal work for over 15 years. The three criteria that were used in the member checking procedures, in consultation with my supervisor and committee members, and the expert peer reviewer to discern the validity of the findings were the following:

1. Resonance: Do the themes & sub themes resonate with your experience in the field?
2. Comprehensiveness: Do you think the findings are comprehensive?
3. Do the findings have pragmatic value for practitioners?

Responses to these external peer review procedures are reported in Appendix J. For the most part these responses affirmed that the themes resonated with these clinicians' experiences of working in the ED field. They both raise questions about the possibility of comprehensiveness due to the definition of, "comprehensive," qualitative nature of the research, and sample size. Both clinicians felt the work had pragmatic value.

Ethical Considerations

Ethical consideration included developing and gaining verbal and written informed consent in order to protect participants' sense of safety. I also was mindful to observe for any signs that a participant was feeling triggered (if they seemed preoccupied in thought without being able to articulate what they wanted to say, or emotionally flooded or overwhelmed evidenced by uncontrollable tears, anger etc. or behaviours such as fidgeting that appeared to indicate increasing anxiety etc) beyond the scope of their own coping strategies. However, this was not necessary for any of the participants that took part in this study.

Participants' anonymity was protected by keeping all data that was collected separate from any identifying details. This was done by initially keeping the initial contact and screening documents with participant identities locked in my desk at home and then in my supervisor's

drawer in her secure office space at UBC. Only my supervisor and I know the participants true identities. Pseudonyms have been used for data presentation. Additionally, timeline and interview data have been collected, and are now stored and presented with rigorous attention paid to security, in order to protect participants' anonymity and confidentiality. All storage devices, such as computers and external hard drives, are password protected. All documents used for sharing are password protected.

Attempts to access as diverse a population as possible were made through the choice to recruit via an organisation (LGF) that has a large social media presence that was developed to reach as many people as possible.

Representation of Findings

Initially, the findings were intended to be shared as complete narratives of each individual's experience. However, due to the depth of contextual detail shared by the participants, an ethical consideration came to light regarding a need to ensure the protection of the participants' identities and so too the third parties described in their stories. Therefore, after peer consultation and supervision it was decided that the findings for this study would be presented using extracts from the participants' narratives to illustrate the themes and sub-themes.

Participant narratives were developed through a collaborative process and so are a blend of the participants' own words (in order to establish their voice within their story), alongside my words that summarise or amplify various parts of their story. Parts of the narratives were edited in order to focus the content toward exploring the research question. The findings chapter in this study illustrates each theme using extracts from these narratives.

Chapter 4: Results

The purpose of this study was to explore how people seeking treatment for an ED narrate their experience of working with healthcare professionals, in order to further explore the ways in which relationship and different types of alliance may or may not impact a person's recovery. Interviews with five participants were transcribed and then developed into narratives of treatment journeys, though a collaborative process between the participants and me. Decisions, about what content to include and what to edit out, were made by considering two points: does the content address the research question? Does the content provide necessary context to understand the participant's experience? These narratives were then analysed to identify four key themes and further sub-themes via a thematic content analysis method (Braun and Clarke, 2006). The narratives were initially coded, by identifying and coding key quotes that described the participants' experience of interacting or being treated by a healthcare professional. These codes were then organised into categories, which were then grouped into themes.

Each theme conveys a nuanced picture of the many ways in which working with healthcare professionals either did or did not impact a person's road to recovery. Every theme was present in each participant's narrative in some aspect that was unique to the context of their life circumstances, as well as their experience of treatment for an ED. In order to further explore and identify ways in which each theme appeared in particular ways within the various participant's narratives, sub-themes were developed, however these mostly included three or more references to different participants' narratives. Inevitably, as the exploration of relationship dynamics is complex and many experiences are multi-faceted, there is good degree of repetition and overlapping of ideas between themes.

Theme 1: What Healthcare Professionals, “Do,” to Support Recovery

Under this theme several subheadings emerged, namely, “Deep Rooted Healing,” “Take Proactive Steps and Provide Direction,” “Advocate for the Clients,” “Demonstrate Expertise,” “Provide Education,” and, “Acknowledge the Difference Between Medical Recovery and Mental Recovery.”

Deep rooted healing. Several narratives included thick descriptions of the work that healthcare professionals carried out to help them understand how their ED operated in their life to address certain unmet needs. Through learning skills, gaining support for other mental health issues, and processing deeply rooted emotional experiences several of the participants reported a sense of, “deeper healing,” that made the ED no longer necessary. Alyssa’s narrative alluded to the fact that addressing issues aside of the ED, in therapy, was what was really essential to recovery, “It felt like we focused on and talked about what really mattered. I barely remember talking to her about food.”

Charlotte described how finding a safe space to express her emotions, allowed her to no longer need the ED to suppress them:

The whole, “being able to express my emotions,” piece was a big part of my eating disorder recovery, because the restrictive eating was a form of control and emotional suppressing. Being able to not have to control my emotions for fear of the consequences, meant that I didn’t have to control my food intake so strictly.

Having positive experiences around expressing her emotions, even when in conflict with healthcare professionals, deepened Charlotte’s ability to engage in the rupture and repair of a relationship, building her sense of self-efficacy in expressing her emotions. Charlotte describes the im-

pact of confronting a healthcare professional after they made a suggestion for her treatment that was deeply triggering for her:

The big impact was that the week after that healthcare professional had suggested that, I brought it up with the them and I was really, really frank with them and really honest in telling them about my feelings around the subject. They were really apologetic and realised the mistake they had made and after that it didn't really impact our relationship from that point on.

Charlotte also describes how her experience of emotional safety allowed her to feel more assured of a long-term recovery, “The whole team at full-time treatment made me feel so safe and loved and that really was kind of the catalyst for my recovery and I mean a real recovery.”

Mary also described how, “intensive therapy,” was the, “most helpful,” part of her work with healthcare professionals, despite being challenging, “Every psychologist appointment would make me cry and it was really intense but I liked it because I would discover new things about myself.” Mary described the impact of therapy, “Working with the psychologist was probably the most helpful thing I found, because after doing six months of that I wasn't engaging in a lot of the eating disorder behaviours.” Mary also went on to say how this felt different to other treatment that she received:

The intensive therapy that the psychologist offered was something that I think I really needed because with other healthcare providers I was beating around the bush a little bit and didn't want to acknowledge the deep rooted issues or deal with them. But in the room with the psychologist I was forced to deal with them so that was probably one of the most helpful things.

Mary's work with healthcare professionals also helped her understand her ED, "We worked out that the depression was the root of the eating disorder, and how the eating disorder wasn't an entity on its own, but actually a symptom of the depression," as well as how to manage depression, "I learnt strategies to deal with the really severe depression I was experiencing." Understanding more about depression also had a significant role to play in Mary's recovery, "My psychiatrist really helped me with the depression by managing medications and helping me to realize that it's not my fault that I have a chemical imbalance in my brain that I couldn't control. [...] I think knowing that it wasn't my fault was really key to the whole process of recovery too." By supporting Mary in seeking treatment for depression and providing psycho-education about how depression affects the brain, Mary was able to work with the feelings of blame and shame she felt around her mental health.

Kate found deep rooted healing by engaging in treatment with a hypnotherapist, "I found support in hypnotherapy by figuring out what the triggering events were that made such an impact on my childhood," and how this allowed her to experience a kind of recovery she had not thought possible previously, "I always thought, like an alcoholic, you're always going to fight with it, you're just going to have better tools and be stronger. But I haven't found it to be that way since I actually found out the cause of my ED." Kate went on to describe how regression therapy helped her to address the causes of her ED, "Often you don't actually consciously remember the situation that triggered ED behaviour, because you're just triggered and you can't take away it's power until you actually see it again through adult eyes." Kate also explained how hypnotherapy was different to her experience of other treatment, "Hypnotherapy really worked well for me because it was just an option for me to search my brain as to why I was doing the

things I was doing and totally going off of my wants and needs, as opposed to trying to achieve some one else's sense of 'normal.'" Kate also described how this experience of deeper healing changed her self-perception and self-worth, which then made the ED redundant in her life, "Once that truly happens and you're truly on your own side, the food isn't going to matter anymore. You're not going to do that to yourself because you have self-worth and you have value."

Take proactive steps and provide direction. When healthcare professionals were also able to be proactive and provide direction, most of the participants narrated how this supported their recovery, even if it felt uncomfortable at the time. Alyssa described her appreciation for the way in which her dietician offered direction, "The dietician [...] was more directive, saying things like, 'You need to do this now or you're going to get worse,' but there was caring in that." Alyssa also expressed the value of her dietician offering proactive guidance and information that enabled her and her family to make practical as well as psychological preparation:

It was actually the dietician who was encouraging us to plan for university. When everybody else was focused on how well I was doing, she tried to warn us that because university is stressful, I would need to be prepared for relapse. She gave us the information for the treatment program in the new city.

Anne described how the ED specialist doctor that she saw gave her a sense of reassurance as, "they were very proactive about managing things," for example, "They felt that I should be going to inpatient treatment but at the time the waitlist was six months so they referred me to the inpatient services waitlist," and this led Anne to feel, "like things were being done," and "I was in good hands." Anne also expressed frustration when she perceived that a healthcare provider

was being more passive in their role, “The facilitator wouldn’t really do anything so it felt like everyone just talked in circles.”

Mary also described how her psychiatrist gave her very clear direction which at the time she did not appreciate but retrospectively saw value in:

My psychiatrist and I were talking and they decided that I would go and see a nutritionist and so I did that too. At the time I really, I really hated it. [...] That was really helpful in hindsight but during the whole thing I was not a fan.

Charlotte also narrated how her doctor’s direction was not only helpful but potentially life-saving. Initially by understanding the warning signs, “My family doctor was very on top of things and really understood what was going on. I think he had seen it in his practice quite a lot.” Then later by carefully monitoring her health and knowing when to take expedient action:

I had a check up with my family doctor. As I was doing pretty badly at this point, he was seeing me quite regularly, so it had only been two weeks after my last check up with him. I’d lost so much weight in those past two weeks that he said to my mom, who was with me at the appointment, to take me straight to the hospital because my weight and my heart rate were so low that it could lead to me dying if I didn’t get help.

Not only did this action potentially save Charlotte’s life, it was during this admission to hospital that Charlotte realised the impact her ED was having on her general health and experienced motivation to recover for the first time.

Advocate for the clients. Frequently the participants’ narratives described the challenges they and their families faced when trying to negotiate complicated healthcare systems, as well as seek out the appropriate treatment. Several participants describe facing systemic barriers to

treatment due to either their age, their financial situation, long waitlists, challenges around finding a GP or getting referrals, or lack of appropriate resources available in their geographical area. This created a lot of stress, not only for the person experiencing an ED, but their loved ones too as described by Alyssa, “Meanwhile, my parents were freaking out and thinking that something really serious could happen, as I was quite underweight at that point,” often leading them to feel extremely anxious and isolated.

Alyssa explained the value of finding a healthcare professional who provided advocacy and case management after she and her family had been struggling to access treatment:

Eventually, my mom got in touch with a counsellor who worked at the outpatient program in my home town and that was what got us in the door. That counsellor was incredible. She was the first person that I saw who specialised in eating disorders and she really initiated some key parts of my treatment. She got me in to see the doctor. She gave us the name of a private dietician who had space to see me.

Again this kind of guidance and advocacy was necessary when Alyssa had moved to a new city and was needing treatment, “I just wasn’t in a place where I could advocate for myself in that way. So they got me in right away and that support got me through.”

Healthcare professionals played a vital role in Charlotte’s transitions, also through advocating and liaising with other people to seek out ongoing treatment options:

She helped with my transition out of full-time treatment into real life by trying to set up a support system in the community, by bringing in a woman from [healthcare authority] (when she thought I was still going to be living in [city]) and then also by talking with the psychiatrist at full-time treatment about what options I had in moving to [city].

Demonstrate expertise. A key feeling that kept surfacing within the participants' stories was the degree to which a healthcare professional either had expertise in their field of training. Kate described her hypnotherapist with the comment, "She knows her job well," and Alyssa her counsellor, "She [...] was just really skilled at her job," suggested that their expertise, skills and experience were key to facilitating a therapeutic relationship with these participants. Anne explained in detail why her experience of finding an ED specialist made all the difference to her recovery:

I felt that they really knew what they were talking about and really knew what was going on with me both mentally and physically. [...] they were really good with all the medications and everything that I was being treated for. It was good because I felt they were an expert and I could take their word for everything. I felt like things were actually being done. I think I had an expectation that I would like go to see these people and they would make me better. I was placing a lot of onus on other people rather than me to get myself better at that point. I think they kind of filled that need where I felt like they really knew their shit.

Having training, skills, and experience in working with EDs meant that participants narrated their experience of these individuals as having a deeper understanding of the ways in which EDs affect a person and knew how to help them address these symptoms. Mary recounted the importance of her psychologist being trained to work with people at her developmental stage, "Because the psychologist was specifically trained to deal with adolescents with eating disorders, they knew really what to look for and how to fix it."

However, some participants also expressed instances where their treatment had been hindered by a lack of understanding or expertise. Charlotte used her narrative to express a concern regarding the training and expertise of some primary healthcare providers, “Just an aside - there are definitely general practitioners, who don’t understand the illness and who need to learn more.”

Sometimes healthcare professionals were described as providing services that were outside their designation and these had mixed results. Alyssa described an unhelpful experience of seeking counselling:

He wasn’t really a counsellor. He was a GP but he was doing counselling. Basically, when I would talk about something that was bothering me, his approach was to tell me not to worry about it. [...] I felt like he was dismissing my experience. [...] I did not find it helpful.

However, Alyssa had a positive experience with her dietician, “I had the dietician, who was not even trained in counselling but I saw our sessions almost like a second counselling session.” As a result of these experiences, within Alyssa’s narrative she appears to develop clear discernment regarding the degree to which a person’s expertise could help her. When describing her experience of working with a general counsellor she narrated, “She was nice and helped to an extent, but she just she didn’t have the expertise that I needed,” and her experience of a therapist who specialised in EDs, “I was able [...] to find out who was considered to be the best counsellor for what my needs were. She has been absolutely incredible and helped me work through some of the leftover pieces of the eating disorder in a way that I was never able to do with any of my previous counsellors.”

Provide education. Healthcare providers who were able to provide education for the people they were working with, were also identified as making significant contributions to several of the participants' recovery, offering education not only to the person experiencing the ED but their families too.

Mary learned how to use her emotions in sessions with her psychiatrist, "It was educational and I learnt what kinds of emotions needed validation and the purpose of different emotions in helping us to identify our needs for example, what sadness needed and what shame needed. I learned that I can feel these things and they can help me understand what I need because I didn't really know how to vocalise that before." As previously mentioned, Mary also learned that she was not to blame for the feelings of sadness and depression that she experienced. Mary's narrative also made reference to the education that her parents received, "The psychologist also ran a workshop for parents that my mom and dad went to so they could understand my eating disorder a lot more in ways that I couldn't vocalise."

Anne also described how the education that her dietician provided her with, impacted her: One of the biggest things was that they taught me was about food and how the body works, which I realised I didn't know anything about before I saw them. I really like understanding the facts of things and they explained to me why what I was doing wasn't helping me, and wasn't really contributing to any sort of health, so I found our time together really, really informative. I really liked working with them and I was sad when I stopped.

Anne also explained the value of learning more about various support services through the specialist she was seeing, “At the time I was feeling really, really suicidal too and they told me I could go to the hospital if I needed to and I didn’t even know that was an option to.”

Appreciate the difference between medical recovery and psychological recovery. A big issue running through several narratives, were instances when participants felt their experience of the ED was dismissed because they were technically medically stable or within a healthy weight range. Kate in her narrative described the distinction:

You think you’re healthy because you’re a healthy body weight and you’re not. A ‘healthy’ body weight doesn’t mean that you’re ‘healthy’ or ‘recovered’. Not to say that people need to be fixed, but people need to understand that it’s not about the food, it’s not about your body weight, it’s not about the shape of your body, healthy or not healthy. It’s about what your mind is saying to you, what the chatter inside your head is like. If it’s still telling you that you’re not good enough and you need to change things or you need to do this or that, then you’re not healthy and I think that’s where the clinical side of things stops.

Kate also added that being challenged by a healthcare professional within the ED community on this distinction, prompted her to review her own perception of what recovery was and seek further treatment.

In the training [name of healthcare professional] alluded to the fact that if your eating disorder still takes up a lot of your mind space, then you are not on the other side of it. I thought, okay, I think I’m on the wrong side of this program because my eating disorder took up all my mind space. My eating disorder was like making sure I didn’t eat the

wrong things, making sure I exercised enough, making sure I did eat enough... I was very much still having two different conversations in my head. I was of a healthy weight but I still didn't allow myself to have a glass of wine because that was calories.

Anne described the distress she felt after seeking support and treatment from a healthcare professional, after three years of living with her ED, because the primary health care provider judged the severity of her ED based upon her weight:

When we got to go in to see them and I explained what had been happening and [...] they took one look at me and said something like, "Ah well you're not underweight enough to go see an eating disorder specialist so I mean just stay at home and see if you can de-stress." [...] At that point I was so confused. [...] I just didn't know what to do because I had just gone from hearing the people at [university counselling service] telling me I might die [...] to this... I was so dumb founded that I literally got up and started crying and walked out of their office.

As previously mentioned, Anne came to greatly appreciate it when a healthcare professional did understand the psychological impact of an ED as well as the physical impact and addressed these things as equally important, "They [...] knew what was going on with me both mentally and physically [...] they listened to what I had to say about my symptoms and they were very proactive about managing things."

Charlotte also recounted an instance when her treatment needs were judged by her weight, which impacted Charlotte's impressions of that healthcare provider and their level of expertise in treating someone with an ED:

At this point I knew that things weren't getting better [...], so I made the decision to take my recovery into my own hands. I saw a family doctor [...], who really did not understand eating disorders. I only saw her once or twice but one time she said to me, "Oh you're a healthy weight, why do you need to go to full-time treatment? You're medically stable enough."

Knowing the difference between how an eating disorder presents medically and behaviourally and how it presents psychologically often made the difference between whether participants continued to work with particular healthcare providers.

Theme 2: The Presence of Healthcare Professional

Another theme that emerged from the participants' narratives regarding therapeutic relationships, surrounded the participants' experience of what it felt like to be in the presence of a healthcare professional. Often this was described in the participants' narratives as the, "Qualities," they perceived the healthcare professional to have, the experience of, "Connection," within the relationship, the, "Safe Haven," they created, and the experience of, "Support," they provided.

Qualities. The qualities that healthcare professionals were perceived to have by the participants, were frequently commented upon within several of the participants narratives. Healthcare professionals were described as, "kind," "gentle," "nice," "open and non-judgmental," "caring," and "willing." Additionally, several participants made repeated references to the experience of having someone demonstrating the ability and willingness to listen to them, in a way that conveyed genuine interest and curiosity about their experience. Anne describes the impact that this had on her due to the singularity of the experience, "I don't remember exactly what they said, or

what they did, but I just remember it felt like the first time that someone actually listened and cared about what my experience was like.” Within different narratives, different qualities seem to have the most impact. For example, Anne repeatedly noticed when a healthcare professional was listening, “I felt like they listened,” “They took the time to actually listen to what I was saying,” and, “They actually listened to me and they were just so sweet,” all appear to suggest Anne’s appreciation and perhaps surprise that she was being listened to. Mary too expressed appreciation for healthcare providers’ ability to listen, “they really listen,” in a way that conveyed sincere listening as opposed to superficial listening. Kate also expressed the quality of her hypnotherapist’s ability to listen as conveying more than just superficial listening, “She’s there just to let you talk and to understand.” For Charlotte, her experience of being listened to conveyed a sense of willingness, “She was [...] so willing to listen to my story.”

Another key quality that was appreciated by the participants in writing their narratives were the healthcare professionals ability, “make time,” and, “take time.” Mary described her GPs offer of making time, “[she] told me that if I ever needed to talk about something, that I didn’t want to talk about with anyone else, they were always there to listen. [...] I could just come to see them and they’d make time to see me.” Charlotte also expressed appreciation for her therapist’s ability to not rush her during their sessions and work together, “She let me take my time, in being able to express my emotions because she knew it was so difficult for me,” conveying an understanding for the internal struggle that Charlotte was engaged in.

Another key quality that several of the narratives described was a sense of genuine caring, communicated in various ways, that the participants experienced when working with healthcare providers. Charlotte narrated her experience of care as feeling, “remembered,” by healthcare

professionals. Whereas, both Anne and Alyssa described experiencing care as concern for their, “well being,” and, “health.”

Often due to the difficulty of navigating healthcare systems, and the barriers they create such as long waitlists and administrative procedures, several narratives included instances where healthcare professionals demonstrated flexibility to make treatment more accessible for the participants. Mary was offered an open invitation of support, “I could just come and see them and they’d make time,” protocols were bent to secure ongoing treatment for Charlotte, “he agreed to see me back in [name of city] for as long as I needed,” and services not usually performed by the healthcare professionals were made available to Anne, “They said they would handle me medically for the time being until we could think of a game plan,” and Alyssa, “She was kind enough to make an exception for me so I could get into the program.” These instances, where healthcare professionals demonstrated flexibility and a willingness to bend the rules, thus making treatment available to these individuals that might not have normally been available, conveyed a sense of genuine caring within the narratives of the participants.

Alyssa, also described how it felt to work with her counsellor, “That connection wasn’t created by anything she did or technique she used. It was just her presence. She was so open and non-judgmental. I could say anything and she was just always so validating,” where the quality of her counsellor’s presence created a working alliance with longevity.

Kate’s appreciation for her hypnotherapist’s open mindedness, and why that was important to her, was explained in her narrative, “She didn’t even attempt to make judgments about what’s normal and what’s not normal, what you should be and what you shouldn’t be because, in the grand scheme of things, that’s all just another person’s opinion. That’s how I got where I was

in the first place, everything was just built on somebody else's opinion." The hypnotherapist's ability to avoid making judgements seemed to create an opportunity for Kate to orientate to and find her own subjective felt-sense of, "normal," which provided Kate with an important corrective experience that facilitated her recovery.

Connection: Developing a rapport and genuine sense of connection with a healthcare professional was also a topic that surfaced through the narratives. Alyssa emphasised the importance of this experience within treatment:

From all my experiences of working with many healthcare professionals, one thing that really stands out is the importance of fit between clients and counsellors especially, but also doctors and other professionals. When I did connect with somebody, it made all the difference.

In Alyssa's narrative, the absence of connection had the potential to create greater distress, "I did not connect with the counsellor there at all. I ended up feeling worse most of the time when I came back from those appointments." However, when present the connection could make all the difference as suggested by the way working with her first counsellor, "made me feel supported, motivated, and not alone."

Charlotte also expressed the value of feeling connected to a healthcare professional, "This was the first therapist that I had actually liked and she helped me a bit as I was able to get half-way weight restored."

For Mary the experience of connection was hindered by technology, "They were really, really nice and helpful but I think I could have got more out of it, if it was in person because I found it hard to connect with someone that was just on a computer screen."

For Anne a feeling of connection was hindered by personality, “I don’t remember them being a very warm or friendly person. It’s not that they was blatantly rude or anything but I just felt that they were just a very ‘straight-to-the-point’ kind of person.”

Safe haven: All of the participants’ narratives expressed and described the importance of safety in the work they did with healthcare professionals. The ways in which healthcare professionals were either able, or not able, to create a Safe Haven for the participants as they sought treatment, appeared throughout all the narratives. This type of healthcare provider was often described as a person that they could return to and rely on, almost like an anchor point. Throughout her narrative, Alyssa described the way in which her first counsellor, who she really connected with, provided her with a safe space from their first encounter, “The first counsellor that I had was amazing. It felt life-saving at that point, to the extent where I realised that I want to be that person for somebody else,” and then later on, “I went home over the summer and I went back to seeing my first counsellor, so that helped.” Alyssa described the importance of that safe place, “Often with eating disorders there’s a ton of shame and I just never felt that with her. It was such a safe place for me, when I didn’t really have that safety in a lot of other places,” and how it felt to be there, “I could say anything and she was just always so validating.” Whether with this counsellor or other healthcare professionals Alyssa explained the importance of this Safe Haven, “I just felt so much better knowing that I had that person and that I was going to see them the next week or whenever my next appointment was.” Alyssa also described the difference between those healthcare professionals who could make her feel safe and those who did not:

I think that that’s another thing that I really got out of working with good counsellors and healthcare professionals, in that they were just able to normalise my experience. They

might say something like, “Anybody would feel that way in this situation. Maybe the way that you’re reacting to it is a little different than how most people might but those feelings are normal.” That validation was so important. At times when I didn’t have a great experience, it was because people just didn’t really understand why I was doing what I was doing and they expressed that to me like, “Why can’t you just do this? Then everything would be fine,” and I would feel unheard, misunderstood and even more isolated. And my go-to thing when I felt isolated was always to just eat less and then I wouldn’t feel things as strongly.

Mary describes how her relationship with her psychiatrist created a safe place that enabled her to speak freely and trust the psychiatrist’s opinion, “The fact that this psychiatrist was the most objective to the situation was really, really helpful to me because I felt like I had my own doctor that I get to go and see and we built sort of kind of a relationship that I feel really comfortable talking to them about anything.”

Charlotte described experiences of finding a Save Haven both within individual therapeutic environments and group contexts. Charlotte described the impact that one of her therapists had on her:

Right from the first time that I met her, she just made me feel so safe and so comfortable. She was so kind and empathetic. [...] She was the person who supported me through all of the family drama and all of the issues [...] with eating, and feelings, and the other program participants. [...] She would be there for me and she was always going above and beyond what you might think that a healthcare professional usually does, by having check ins with me, and really trying to mend the relationship with my family.

And the impact of not being able to see her, “I would cry myself to sleep because I missed everyone so much but especially her.”

Charlotte also experienced Safe Haven within the context of a whole group of healthcare professionals who, “made me feel so safe and loved,” especially when facing times of challenge:

At the time that I had a panic attack. [...] Just having, what felt like, a whole group of healthcare professionals come and calm me down and support me was a really big moment for me. Again it just made me feel so cared for, and it made me feel safe in the environment, and as if everything would be okay for a little bit.

Charlotte’s description of this incident appears to describe a really significant moment of feeling really safe and cared for within a group context, which made a lasting impression.

In her narrative, Kate emphasised the importance of creating a Safe Haven for people seeking treatment, “We have to get people to feel that they’re safe enough that they don’t need to fake it to their counsellor, to avoid being hospitalised, or forced to do things, or being told that they’re wrong.” Kate’s expression of this opinion implies that treatment might well be hindered by a lack of safety that prompts people to fear seeking treatment, or sharing their true experiences, for fear of the possible consequences.

Support: All the narratives made reference to the value of healthcare providers’ support and in some cases the desire and need for more support. All of the narratives made non-specific references to a general sense of having experienced a feeling of being supported at various times. Some general examples of feeling supported included comments made in Alyssa’s narrative, “Made me feel supported,” and Kate’s, “My hypnotherapist was a really good support,” while

other more specific comments made reference to support that was available, reliable, consistent, sufficient, long-term, helpful and therapeutic.

Alyssa's narrative contained several of these references where she narrated her experience of consistent, reliable, helpful support that had longevity, "What helped the most was the support from the dietician and the counsellor and so I continued seeing them weekly." Alyssa also described support that was sufficient for an interim and met a short term need, "that support got me through until I could get into the outpatient program," but would not be enough for long term treatment. Another kind of support that Alyssa describes that had a therapeutic impact on her, was support that targeted the part of her that wanted recovery, "I never had a time when there wasn't a part of me that wanted to get better and so I think that the people that helped me were the ones that supported that part [of me]," where healthcare professionals were able to discern and ally themselves to part of Alyssa that was motivated to recover. Finally, an important part of Alyssa's narrative explains the need for healthcare professionals to be instrumental in setting up long term support, "In terms of the relationship with professionals I think, supporting the other relationships that are already in place is really vital and important." Alyssa described the importance of healthcare providers facilitating and supporting their clients' / patients' in building support within long term relationships, "I'd be like, 'No but these people are really important to me and they're going to be around a lot longer after I'm not seeing you anymore,'".

Charlotte commented on the value of ongoing support through particularly challenging times, "She was the person who supported me through all of the family drama and all of the issues I may have been experiencing during full-time treatment with eating, and feelings, and the other program participants," conveying a sense of availability and reliability. Similarly, Mary de-

scribed support that was consistent and responsive to her needs, “I used to see them every week but I don’t really need as much support now.”

For Anne, the support of healthcare professionals was mainly experienced as expertise and guidance and was of more of a practical nature, “I think they can really help you find treatment and support you in that way, but I don’t think anyone can convince you to get better and then you’re instantly better which was the expectation that I had going into it.

For Kate, the support she experienced was facilitated by her hypnotherapist being an expert in a modality that worked for Kate, “My hypnotherapist was a really, really good support. She’s knows her job very well.” Kate described the way her therapist did this by facilitating Kate’s ability to vocalise the support she needed:

I remember my hypnotherapist taking me back to that point in my childhood and me describing the scene to her and then her talking me through the situation as an adult saying, “How do you feel as an adult looking back? What would you have liked to happen? How would you have liked the younger self to have been treated in that situation? What kind of support would you have liked in that situation?”

The absence of support was also clearly a concern for participants and their loved ones. Alyssa described how the challenge of accessing treatment, due to systemic barriers, not only affected her but also her family, “Meanwhile, my parents were freaking out and thinking that something really serious could happen.” She also described understanding when the support she was receiving was inadequate for her needs, “I just sort of nodded along even though I knew I wouldn’t be able to recover without a lot more support.”

Charlotte recounted the emotional upset of losing supports, “I missed my therapist,” and, “I missed the program in general and those first couple of months in [city] I would cry myself to sleep because I missed everyone so much.”

Theme 3: Healthcare Professionals’ Attitudes, and Stance

Alongside what healthcare providers actually, “do,” another theme emerged, that suggested that the attitudes and the stance that healthcare providers adopt, is experienced through their actions and words, by people seeking treatment for an ED, and can have an impact on the therapeutic relationship. This theme was grouped under the following subheadings: “Championing Autonomy and Self Determination,” “Valuing Collaboration,” “Checking Expectations and Assumptions,” and, “Seeing the Person Not Just the ED.”

Championing autonomy and self-determination. Several narratives contained examples of when participants felt that the healthcare providers were championing their autonomy and self-determination, by individualising treatment for their particular life circumstances. Alyssa narrates her experience of two different clinical attitudes displayed by two different healthcare providers, when she made the decision to leave an inpatient program which she had joined voluntarily. One doctor demonstrated skepticism about her choice, “She was not keen on me leaving,” while the other communicated trust in the value of her exploring the option, “My doctor agreed to me trying to go back to school half days and seeing how that went,” emphasising that the choice depended upon what Alyssa felt she could do, “the [...] doctor said, “Yeah, you know, if you think you can manage.” The difference between these two attitudes was later commented on again by Alyssa as empowering her in her treatment and indeed in life, “I think the fact that they didn’t tell me what to do made it so I could make the choice to prioritize my health on my

own and that was empowering,” where she was not patronized but respected, “There was this sense that they knew, that I knew what I needed to do to get better.”

Kate’s experience of using hypnotherapy and working with a hypnotherapist also supported her sense of autonomy and self-determination. While carrying out regression therapy, Kate described the way in which her hypnotherapist would engage in those sessions, where Kate worked with memories from her childhood. Kate compared this to previous experiences of therapy:

My hypnotherapist didn’t give me those words or those thoughts she just, asked me, “How do you feel about? Does that make sense to you? How do you want to deal with that? How do you want to work through that?” That kind of thing was such a great support for me. The counsellor that I went to see years before was also a great support but gave opinions and not in a bad way, but it was like ... “You can’t think that way. You know that’s not a healthy way to think.”

Later Kate describes why working with the hypnotherapist was so powerful and healing for her, “I got to say what would have felt good to me, what would have made sense to me, and how I saw the situation as an adult. It just took away so much energy around me punishing myself when I did things wrong.”

Anne also described the experience of working with a dietician who, “really took my preferences into consideration,” and who supported Anne in determining when she was ready for next steps, “They never really forced me to do anything I wasn’t comfortable with doing too quickly.”

Mary also recounted finding herself more able to engage in treatment when her choices were considered and supported, “Personally, I found it was easier to talk to my psychiatrist about my meal plan as I could say, “This is all of the food that I like to eat - what should I do with it?”

Valuing collaboration. Healthcare professionals who also appeared to value and engage in treatment collaboratively with the participants, appear in several narratives. Within her narrative, Mary frequently uses the pronoun, “We,” to describe her work with her psychologist. This part of her narrative also describes the ways in which her psychologist displayed a collaborative approach to the content of her therapy, “Every week I would go in and they would ask me what I wanted to talk about,” as well as therapeutic interventions, “Whenever something would come up we would deal with it.”

Alyssa also narrated experiences of working in collaboration with healthcare providers, “my family and the treatment team started to help me make some plans,” where both she and her family all felt involved in her treatment plans. Also in her narrative, Alyssa explains how she experienced collaboration as not always an easy experience but a beneficial and supportive one, “With the professionals who were more supportive, there was still conflict, but I felt like they were on my side and I didn’t feel pushed.”

Checking expectations and assumptions. Two narratives made reference to experiences the narrators had where they felt healthcare providers had adopted a stance that supported certain assumptions or judgments about them, their experience of the ED, and sometimes even their relationships. In these instances, participants described what that was like, and how it affected the working alliance and relationship with the healthcare provider.

Alyssa described how, through the process of reflecting on her experience of treatment, she became aware of how some healthcare professionals conveyed different attitudes towards her as a person:

I don't think I recognised it as this at the time but the way that they were approaching me felt like they would expect me to behave in a certain way, expecting me to be manipulative and fully controlled by the eating disorder. That was not really me. I've always wanted to get better. [...] Whereas the people who were really helpful were the ones who walked in with no assumptions and just took me as I was in that moment and recognised what was different about me compared to other people rather than what was the same.

Alyssa also found that one healthcare provider, who expressed judgments about one of her relationships and who was unable to express empathy, "This counsellor could not comprehend why that mattered so much to me," or validation, led her to feel misunderstood and criticized:

I felt like he was dismissing my experience, and pathologizing the relationship [...], making it like the problem was not that someone I loved was having this deeply painful experience and I wasn't able to be there to support [them] but that I was too involved in [their] life and that meant something was wrong with me.

Alyssa used her narrative to express the importance of empathy, understanding, and validation in her recovery. She also described how it affected her when she felt invalidated:

That validation was so important. At times when I didn't have a great experience, it was because people just didn't really understand why I was doing what I was doing and they expressed that to me like, "Why can't you just do this? Then everything would be fine," and I would feel unheard, misunderstood and even more isolated. And my go-to thing

when I felt isolated was always to just eat less and then I wouldn't feel things as strongly and I thought that would be better and of course it wasn't, but there was some short-term relief.

Anne's narrative included several references to expectations, both her own and the healthcare providers. She described how she had to address her own expectations of healthcare providers, "I'd thought that I would see these specialists and that they would fix everything for me. Then when I realised that I would have to gain weight, that was when I felt unsure about recovery. I really had to want to get better," in order to find her own motivation to recover. Anne also described the pressure she felt from one healthcare provider to show continual improvement, which conversely appeared to hinder treatment:

It felt almost as if they were prompting me to answer specific ways sometimes. Sometimes they were and right and that would be the way I felt. I guess I felt I was just expected to say certain things and I was expected to see improvement every time I came in. [...] It was almost as if the questions they was asking me, were prompting me to give them good news and I just wanted to say, "lay off me!" I felt like I could be honest about most things but I couldn't go into too much depth about how I was really feeling because I felt like they put a lot of pressure on me.

Anne also described the impact of not feeling the pressure of a healthcare provider's expectations, which appears to have not only allowed her to see improvement quickly but also share her feelings of suicidality and get the support and information she needed:

I felt like the eating disorder specialist didn't have any expectations like the psychiatrist had had, and it was okay if I came in and nothing was really improving. They were on

the ball though and noticed things right away, which is why they referred me to inpatient treatment. At the time I was feeling really, really suicidal too and they told me I could go to the hospital if I needed to [...]. It's hard to explain but I really, really liked them. I feel like once I started seeing them I got better quite a lot more quickly than I thought I could and I ended up not needing to go in to inpatient by the time the referral came through which was great.

Seeing the person not just the ED. Three participants described the value they found in interactions where the attitude and stance that a healthcare provider took demonstrated an awareness and interest in them as an individual person not just someone with an ED. Often this was experienced when healthcare providers took time and made efforts to individualise treatment, the impact of which was described by Anne in her work with her dietician:

They framed a lot of what they were teaching me by focusing on the things I wanted to do in life. One of the things that kept me going with the recovery process, was the fact that there was a lot I wanted to do with my life - I didn't want to just sit around and have an eating disorder, so when they used actual tangible examples of what I could do if I was well fed, it gave me more concrete goals to work towards. They would also give me tangible meals plans of what I should be eating and they always took into consideration things that I actually like. Things were specifically measured out and I appreciated being given something customised that could actually work for me.

Mary also described that value of having someone who is sensitive to who she is as a person, "We can kind of joke a little bit about things and they know me enough to know what they can joke about and what they can't joke about. [...] I felt like I had my own doctor that I get to

go and see and we built a relationship that I feel really comfortable talking to them about anything.”

Several times in her narrative, Alyssa made reference to the importance she placed on feeling seen for who she was not just the illness that she was being treated for, “I felt like she was seeing me, she wasn’t seeing the eating disorder.” When healthcare providers conveyed a stance of working with the person behind the ED, it left a lasting impression of support, “The people that helped me were the ones that supported that part and saw that I was a lot more complicated than just my symptoms.”

Alyssa also described the importance of finding an identity outside of the ED in order to recover, she explained how healthcare providers can support this process:

Eating disorder recovery is all about finding that identity outside of the disorder so being treated like an individual was what helped me to find that. Connecting with those things like volunteering and becoming a counsellor and discovering that other side of myself, that’s what allowed me to finally let go of the eating disorder. There were definitely people that supported that process and made a big difference by just being on my side every step of the way.

Theme 4: Power within Recovery Focused Relationships

This fourth and last theme addresses how power appears and is expressed in professional treatment orientated relationships, by both the people seeking treatment and healthcare professionals. The idea of, “power,” presented itself in several different ways, sometimes exerted or expressed by healthcare professionals, sometimes by people seeking treatment for an ED. The sub-themes that developed under this heading included: “Confronting,” “Challenging Sensitive-

ly,” “Power Struggle,” Superficial Compliance,” “Self- Determination, Self-Efficacy, Self-Em-
powerment,” and, “Motivation.”

Confrontation. Several narratives identified the need for healthcare professionals and medical teams to confront patients with the dangerous reality of engaging in ED behaviours on their physical health, as described by Alyssa, “there are a lot of times when professionals need to be confrontational with people who are really sick with Anorexia.” Several participants expressed a need for these confrontations as indicated by Kate, “I wouldn’t have recovered if it wasn’t for healthcare providers because I didn’t realise that there was an issue,” and Mary, “I knew that for a little while, my family and other people had been saying that things were bad and that I might need to go to the hospital. I don’t think I believed it though because they didn’t sit me down and talk about it.” Kate also highlighted how being very unwell with an ED creates some serious medical issues, “Of course your brain’s not functioning at 100% - it truly is not,” which can impact a person’s decision making ability. However, with the ability to hospitalise someone, medical health professionals carry a lot of power. The various ways in which they expressed this power was experienced differently by the participants. Alyssa described how she experienced different degrees of receptiveness when confronted over an issue, depending on how the healthcare professional approached the conversation:

There were two doctors I worked with at that time. One of them was really good. The other, I didn’t connect with as much. I think doctors are often in the difficult position of being the member of the team that has to deliver the news that people with eating disorders don’t want to hear, whether that’s, “you need to gain 20 lbs,” or, “we’re sending you to the hospital,” but I did notice a difference in terms of the way that these two doctors

approached those conversations. The first one was always really compassionate and tried to understand the struggle, whereas the other gave out a lot of ultimatums and I guess was just harsher about it.

Alyssa's experience of the two different doctors' approaches appear to have impacted the therapeutic relationships she had with each. Alyssa went on to describe her experience of other confrontations with the doctor who issued ultimatums. "The doctor was still [...] seeing me and she kept threatening to put me in the hospital, so that was what would get me eating again." While appearing to be successful on a behavioural level (getting Alyssa to eat), Alyssa explained later in her narrative that these experiences felt punitive and disempowering:

I would go in and the doctor might say something like, "Well, you know, you've lost weight and this isn't okay and you're going to end up in the hospital." So then I felt this big conflict because I had this external voice saying, "All these bad things are going to happen to you if you don't eat," and then I also had the internal eating disorder voice saying to me, "All these bad things are going to happen to you if you do eat. You're going to get fat." So I was paralysed. I didn't know what to do because there were these two really loud voices. Some days one would win, other days the other would win.

The way in which medical concerns were presented to the participants also seemed to have impacted the participants' experiences of confrontation. Mary described the moment she first became aware that she had a really serious problem, when the psychiatrist that she had been seeing for some time, "[...] sat me down and took my pulse and said, 'If your pulse was any lower I would call an ambulance right now and you wouldn't graduate high school.' I was shocked."

Anne was also confronted with the possibility of severe consequences:

I remember the conversation just really scared me because they were asking about what my different habits were and when I would explain them to them they responded, “Oh well if you’re going to do that, you will die. You need to go get help.” At that point I’d had my eating disorder for three years or so, so I guess that really scared me a lot.

However, these two moments of confrontation were interpreted by the participants in quite different ways. Mary felt that the way she was confronted by the psychiatrist was an expression of concern and care, and helped her to understand the severity of her condition and take stock of her mindset:

I was pretty much in denial telling myself that my eating disorder was not that bad and I wasn’t going to go to the hospital. However, I think being in that room with my psychiatrist and having them take my pulse because they were worried enough about it, pulled me out of sort of some irrational thinking.

Whereas, Anne, who was meeting a healthcare professional for the first time, experienced the confrontation as terrifying and it motivated her to seek help through fear:

They just said a lot of all-or-nothing statements like that, and I found they really scared me into seeking more treatment. That was the first time I’d ever been to a counsellor or psychologist or anything like that, so I was a little terrified.

It appears that confrontations in all of these instances were taken seriously due to the healthcare professions’ status and power. All the participant’s responded to these confrontations with action, however the longer term effects of those experiences appear to have left quite varied

residual impressions of the different healthcare professionals, despite them seeming to have the shared goal of motivating their patient / client.

Several participants described confrontations where a healthcare professional's status clearly conveys power and influence. Mary, who saw a psychologist for six months and described many ways in which they helped her, added, "They also brought in my parents which I hated but it was necessary to talk it out with them because they were part of the whole problem." Despite, having strong feelings about having to take part in the family therapy, the psychologist used their influence within their professional relationship to help Mary confront certain issues in her personal relationships with her parents, which with hindsight she appeared to value. Mary also described the way in which healthcare professionals used the power of their opinion to help her confront and challenge the feelings of blame she felt for experiencing mental illness, "Having all of these professional people who are professionally trained telling me that, "It's not your fault," was so reassuring because the eating disorder brain tells you it your fault."

Indeed, when healthcare professionals did not use their power to confront issues, this also left lasting impressions. Charlotte described seeking the support of healthcare professionals to address the physical abuse she had experienced. The healthcare team addressed the issue with her parents in a meeting but did not report the abuse to the authorities, which put an end to the physical abuse but not the emotional, or psychological abuse. In her narrative, Charlotte described the long term impact of that choice that the healthcare professionals made when they did not do everything within their power to address the abuse:

It really makes me upset to this day that they never did anything because it made [the abusers] never acknowledge the amount of pain they obviously caused me not only physically, but also emotionally, and mentally too.

Challenge sensitively. The participants' narratives also contained descriptions of how some healthcare providers were able to challenge them with sensitivity, thus supporting an ongoing working alliance. Alyssa described the different ways in which various healthcare professionals approached challenges and confrontations:

Some of the professionals I worked with were more confrontational and would say, "You need to eat more," or "You need to stop exercising." Both the dietician and the one doctor that I connected with were able to do that. They were able to challenge me in a really sensitive way and still let me know that they cared about me and that it wasn't anything about me as a person, but that they cared about my health.

Despite having to deliver challenging news to Alyssa, it appears that having a sense of connection and feeling that the message was said with care for her and her health, helped to support Alyssa in addressing ED behaviours, while not undermining the therapeutic relationship by conveying any sense of judgment about her.

Charlotte also remembered a moment of challenge while addressing a sensitive issue, when she was experiencing a lot of guilt for engaging in one of her ED behaviours by going for a run, "It was one of the first times I'd broken the rules." When narrating her story however, the power of the dietician's response, "She just kind of sat me down and explored why I thought it was a good idea to go for that run. She was nothing but kind and understanding about why I felt like I needed to do that much exercise," left a lasting impression of care that continued to support

the professional relationship and provide Charlotte with a positive experience of seeking help when having engaged in ED behaviours. The dietician was also able to challenge Charlotte to make a recovery focused decision in response to her momentary engagement in ED behaviours:

She was very gentle in guiding me towards supplementing my snack and having a little bit more food to compensate for the crazy amount of exercise I'd just done. [...] she demonstrated so much care for me.

Power struggle. Several narratives involve instances of power struggle within the relationships between healthcare professionals and people seeking treatment for an ED. Alyssa described the feeling, “Those confrontation conversations felt more like a threat or a power struggle. It was almost like this battle for control and that just made me more defensive and strengthened the eating disorder in a way.” Alyssa’s sense of threat and power struggle not only triggered her ED but also had a significant impact on her recovery by turning her attention from other things that would help her to recover, “I think that having those threats and focusing on the consequences made it actually harder to do the things I needed to do to get better.”

Despite recognising the value of confrontation in some instances, Alyssa described the value of knowing that different members of her treatment team had different roles within her care:

I think there are a lot of times when professionals need to be confrontational with people who are really sick with Anorexia but the counsellor’s role was never to do that with me. That was where I could just talk and say whatever and I knew that I was never going to be really challenged.

The ability to talk freely about her experience, without the fear of facing confrontation about her eating disorder behaviours, allowed Alyssa to begin to talk about other things in her life that she felt made a difference to recovery:

I could just talk about what was going on at school and all the things that were really bothering me that were strengthening the eating disorder and making things worse. It felt like we focused on and talked about what really mattered. I barely remember talking to her about food.

In this instance, it appears that within the context of a team where others had the responsibility of confronting Alyssa about ED behaviours, her therapist was able to offer Alyssa the power within their relationship to dictate what they talked about, and thus enabled her to talk about the things that were fuelling her need to engage in ED behaviours.

Kate's narrative offered insight into how, even when a healthcare professional shares an opinion, it can potentially trigger feelings of defensiveness and create a sense of there being a power struggle within the mind of someone suffering from an ED, especially (as in the case of Kate) someone who attributes adverse childhood events as being the cause of her ED.

The counsellor that I went to see years before was also a great support but gave opinions and not in a bad way, but it was like ... "You can't think that way. You know that's not a healthy way to think." Whether she was right or wrong is not the important part, it's the effect that her opinions had on me because I thought to myself, okay well now I'm wrong again, and wrong equates to bad, and bad equates to punishment and you keep going in that that cycle.

Similarly, the boundaries and expectations set by individuals and programs were experienced by participants as threats to their sense of safety and well being. Kate explained why the boundaries set in place by some programs to support behavioural change, were not tenable for her.

That is what bothers me about the way that the medical model approached my treatment to begin with. I can't speak to what they do now, but it was all about you being punished because of how you are. And I was already punishing myself, I didn't really need to go there and be punished by someone else as well.

Alyssa also found that the boundaries set in place by an inpatient program actually negatively impacted her mental health at that stage in her recovery.

They had their own dietician there, who wanted me to follow their meal plan and rules about things like time limits and bathroom use. It felt very controlling and that was not great for my mental state.

Charlotte's narrative also contained an account of the power struggle created by forced treatment resulting in her refusal to engage in counselling:

She was lovely person but I hated that I had to go there and talk. Well I didn't even talk.

I refused to talk about anything that was going on with me.

At this point in her narrative, due to her age and environment, Charlotte's only recourse, for being forced into a situation that she did not want to engage in, was refusal.

Superficial compliance. When faced with a sense of being disempowered either by a individual healthcare professionals, program boundaries, or forced treatment, or inappropriate treatment provision, several narratives described instances where the participant would display

superficial compliance in response to power within the relationship with healthcare professionals. Alyssa describes her first visit to a GP to seek help:

[...] my doctor was very dismissive, saying something like, “you just need to eat and then you’ll be fine,” and started listing off foods that I needed to start eating in order to gain back the weight. I thought to myself, “That’s not going to happen,” but I didn’t say anything. I just sort of nodded along even though I knew I wouldn’t be able to recover without a lot more support.

When presented with an inappropriate treatment option, Alyssa appears to have felt unable to express her true thoughts and feelings at the time. Similarly, when later on an inpatient ward, Alyssa complied with treatment, not because she valued the program but because she felt it was inhibiting her recovery, “I just did what I needed to do to get out of hospital because it was not an environment that was conducive to recovery.”

Kate also narrated how the threat of medical intervention and the realisation that she could lose all power over her own choices served as a motivator, “the threat of taking away control absolutely motivated me to start looking at what I could do to appease the medical system,” but describes how this was not a recovery focused choice, “I wasn’t seeking help because I thought I needed to do anything differently.” Kate also commented that attending treatment did not always mean that she was engaged in treatment, “There’s counselling but you know we can fool counsellors pretty easily.”

Charlotte described how early on in her experience of her illness, before she had developed any motivation to recover, she adapted her ED behaviours to superficially comply with treatment demands, both in therapy, “I remember when she asked questions I would pretend to

think about an answer, just to prolong the time between her asking the question and me giving an answer, so that I wouldn't have to answer as much," and behaviourally:

So because I didn't like her so much, and I hated the the physician that I had to see, and the dietician that I had to see, I just fixed my eating patterns in order show my parents that I was fine. But instead of really obviously restricting, I was just covering it in a veil of 'healthy eating' and everyone was praising me for it.

Later, Charlotte was superficially compliant to avoid treatment completely, "I fixed the eating but was still over exercising. My parents thought I was fine so I didn't have to see the doctors, dieticians, and counsellors anymore."

Anne describes the pressure she felt to engage in therapy in specific ways, "They would ask me a lot of really probing questions without much explanation regarding what they was trying to accomplish. I remember being caught off guard. It felt almost as if they was prompting me to answer specific ways sometimes," which hindered her ability to fully engage in the process, "I felt like I could be honest about most things but I couldn't go into too much depth about how I was really feeling because I felt like they put a lot of pressure on me."

Self- determination, self-efficacy, self-empowerment. All of the narratives contain accounts of instances when healthcare professionals supported the participants to exercise power within their recovery through moments of self-determination. These moments in the narratives often came across as expressions of self-efficacy and self-empowerment, where participants appeared to take greater ownership over their recovery process.

Mary describes an important moment, when her attempt to advocate for herself was supported, "I was able to vocalise that I wanted to change psychiatrists and I was really proud of

myself - I don't know how I did that," and surprised herself with her own ability to speak up for her needs. Developing a sense of self-efficacy and internal support was also key to Mary's therapy:

We [my therapist and I] also had a metaphor which we developed in art therapy. I drew what we would call my Little Sprout (like a little bean that would grow), which was like my inner 'cheering me on voice' and it helped me to visualise this little thing saying, "Mary you can do it!" It was really great and super helpful.

Mary went on to foster her ability to speak up for herself and to seek out treatment and support when it is required, "I can vocalise it when I'm not feeling good and I tell my friends and I'll tell my doctor."

Alyssa also described the tentativeness with which she began to learn to advocate for herself, "I got up the nerve to ask if I could switch counsellors," and through a series of trial and error moments, "I thought to myself, "I don't really need treatment right now. I'm doing well," but I had another relapse that summer," developed a proactive attitude to seeking out support when it was required, "I was able to use my professional network to find out who was considered to be the best counsellor for what my needs were." Alyssa concluded her narrative with a sense of self-efficacy, despite being aware of the likelihood that triggers would present themselves in her work:

My eating disorder history will keep coming up occasionally in my therapy but I see it as maintenance rather than ongoing treatment. I find therapy really valuable, but I don't feel the need to go every week anymore. For the most part, I'm able to cope on my own now.

Charlotte also went on to develop a proactive recovery focused attitude, after she understood the physical implications of how living with an ED was affecting her health. She independently sought out treatment, “I ended up doing all the work of getting the referral,” and described making choices that focused on ensuring the success of her recovery, “I stayed in full-time treatment [...] because I needed to. I knew I needed to get a place where I was really, really stable both with my recovery and with my living situation.” At this point in her narrative, Charlotte appears to feel more empowered and confident in her ability to make recovery-focused decisions.

Motivation. Feelings of power within their recovery process were expressed by several participants as being strongly aligned to the motivation and proactive recovery choices. Within all the narratives, there appear to be instances when the participants were either motivated by wanting to avoid certain things, or wanting to achieve or gain certain things. Charlotte recounts the moment when she began to develop the self-motivation to engage in treatment more fully:

Once I was a couple of days into being hospitalised, I realised that the reason my [sports injury] wasn't healing was because I wasn't eating and because I was so unhealthy. So because my motivation to get back to [sports] was so strong, I had a little bit of motivation to eat everything that they gave me.

Charlotte's motivation appears to have been nurtured by the medical professionals who chose not to escalate her treatment to a higher level of intervention, “because the doctors saw that enthusiasm and that motivation from me, instead of putting me in the regular inpatient eating disorders program at [the hospital] they kept me on the cardiac ward.” Charlotte's narrative involves another instance where a healthcare professional highlighted the power of Charlotte's motivation,

“Right from the first session with my therapist, I knew that I was in the right place and knew that I could get better because I had the motivation to get better and I wanted to.”

Mary described feeling motivated both by wanting to avoid the hospital as well as wanting to graduate. The psychiatrist, who initially confronted Mary about the toll the ED was taking on her health, made reference to both these things, “If your pulse was any lower I would call an ambulance right now and you wouldn’t graduate high school,” when explaining the choice point they faced as a medical professional. Also by sharing the potential consequences of her ED, Mary had time to consider that she had a choice, “I think at that particular moment, or perhaps during the weeks after, I realised there’s two options here: I can get better or I can die this way... and I don’t want to die this way I want to live my life,” and a chance to find motivation within herself to engage in treatment, “It was a huge shift and I realised I really needed to graduate.”

Anne described ways in which working with a dietician helped to motivate her:

They framed a lot of what they were teaching me by focusing on the things I wanted to do in life. They might say, “If you want to travel eventually you need to be able to fuel yourself to be able to do the kinds of activities you want to do,” as opposed to just saying, “You have to eat to stay alive.”

However, Anne described the pivotal point in her recovery journey that motivated her to recover as being entirely unrelated to her work with healthcare professionals:

It was weird because I was in treatment for about a year and a half, perhaps two years, and I always wanted the eating disorder to be something I got over and moved on from. Then I’d see these people that had dealt with it through their entire lives and I just re-

member thinking that that was absolutely not the way I wanted to live. Once I made that decision I was out of treatment within three months or so.

Later in her narrative, as Anne reflected on her work with healthcare professionals, she expressed her views regarding her own sense of motivation, “I don’t think anyone can convince you to get better,” and how the power of making a choice for herself to recover, was what ultimately led to her engagement in treatment, “I really had to want to get better.”

Chapter 5: Discussion

This study sought to explore the experiences of people who had been through treatment for an eating disorder within BC, Canada, who now described themselves as, “well established in recovery,” and who could reflect on their experiences of working with healthcare professionals from the point of view of hindsight. Through developing a narrative with the participants of their experiences, a process of co-construction began, wherein I attempted to bring my awareness to the questions: why were the participants telling me this story? how did they decide what elements (as it would be impossible to include everything) of their experience to include in their story? what is it that they really wanted me along with the wider community to know about their experience?

In this final chapter, I will review each theme and consider how it relates to current theory and existing research, I will consider the limitations of this study and the implications of this research for the field of counselling psychology, and I will propose some novel findings and areas for future research.

Implications for Alliance Theory

Throughout all the narratives and underlying all the themes was a sense of what did and what did not facilitate an alliance between people seeking treatment for an ED and healthcare professionals. Various different kinds of alliances appeared to be present within the narratives: some that were functional and fulfilled the three key processes described by Bordin (Hovarth et al., 2011), others that appeared to support theories of alliance developed from the point of view of the client (Bedi et al., 2005; Bedi, 2006; Duff & Bedi, 2010; Fitzpatrick et al., 2009; MacFarlane et al., 2015). When referring to alliances within these narratives, I will differentiate them

into those that support alliance theory from the point of view of the psychotherapist or clinician and those that support alliance theory from client's perspective.

I will focus on Bordin's (1979) theory of, "working alliance," to explore the findings of this study in relationship to theories developed from the point of view of the psychotherapist or clinician, due to prevalence of this theory in the literature (MacFarlane et al., 2015). The three key processes described by Bordin, when providing a definition of, "working alliance," involve: the client and therapist developing a collaborative stance and engaging in the processes of sharing goals; agreeing on tasks in therapy; and developing an emotional bond (Hovarth et al., 2011). Although, these processes were sometimes complicated by the age, stage of development, and impact of the symptoms of an ED, there are many instances where they are present in the themes described in the findings chapter of this study, and so it is helpful to bear this definition in mind.

What healthcare professionals, "do," to support recovery. Every key process described by Bordin's definition of a, "working alliance," is present within this theme. However, in contradiction to the idea that collaboration is a key factor in developing an alliance, within this theme there is a suggestion that the expertise or experience of the healthcare professional, in knowing how to take the lead in several aspects of the therapeutic relationship, such as supporting deep rooted healing, providing direction, advocating for clients, providing education, and having a nuanced understanding of how people experience EDs, is vital for the alliance to develop. On one hand, we might view this kind of alliance as providing the therapeutic conditions necessary for the treatment and interventions to take place and be effective. However, from another perspective, this expertise in some way suggests an authority or a power that is more assured than the power that the eating disorder might offer and so it could be argued that the alliance

itself has curative effects. An example of this is most pronounced in Anne's narrative when her experience of working with an eating disorder specialist very quickly reassures her that she's, "in good hands." Is it possible that the kind of reassurance provided by a strong alliance might weaken the allure of the reassurance provided by engaging in ED behaviours? Later in her narrative, Anne comments that although healthcare providers can support and facilitate recovery, it is down to the individual themselves to find the motivation to recover, thereby suggesting that in her view, although helpful, this alliance only really provided the conditions necessary for recovery but was not curative in and of itself.

This theme also supports a lot of the literature that has explored the alliance from the client's perspective. Several sub-themes such as, "Deep Rooted Healing," "Provide Education," and, "Demonstrate Expertise," all support the findings of Bedi and colleagues (2005), Bedi (2006), and MacFarlane et al. (2015), that the techniques (including providing education) that psychotherapists use, do support the therapeutic relationship and possibly contribute towards the formation of an alliance. This is particularly evident in the narrative of Mary who described her intensive sessions of psychotherapy, "every session would make me cry and it was really intense but I liked it because I would discover new things about myself."

The sub-theme of, "Deep Rooted Healing," lends particular support to the findings of Fitzpatrick et al. (2006) and Fitzpatrick et al. (2009) that often a positive emotional experience of a therapeutic intervention is important for alliance formation. When Charlotte describes disclosing an instance of engaging in ED behaviour to her dietician and it met with support and gentle redirection, her positive emotional experience of this interaction, some might say intervention, leaves a lasting impression that she can confide in others when she is struggling with ED urges.

This theme also lends support for the suggestion made by Bedi (2006) that some of the more routine activities that take place as part of psychotherapy such as providing education, making referrals, providing guidance and direction, and providing challenge all contribute towards client's perceptions of what creates an alliance and yet are currently under-acknowledged by the theories such as Bordin's (1979). An example of this is described by Alyssa when her dietician recommended that she started planning for treatment in the city that she was moving to and made referrals for her. Similarly, for Charlotte, the help and support of healthcare providers, during her transition from one city to another, was notable enough to be commented on in her narrative twice, suggesting that perhaps actions that may seem small, or routine parts of a healthcare provider's role may be very meaningful for clients.

This theme also supports the proposition by Bedi (2006) that there is greater homogeneity among clients of certain constructs that support alliance such as guidance through education and direction, and providing emotional validation which are both present in all the narratives to greater or lesser degrees.

The presence of the healthcare professional. This theme speaks to one of the key processes in developing working alliance, described by Bordin as developing an emotional bond (Hovarth et al., 2011). To greater and lesser extents, all of the narratives included references to how the presence of at least one or more healthcare provider, made it possible for them to engage in therapeutic tasks. This was particularly evident in Charlotte's narrative where frequent references were made to the impact it had on her to feel genuinely cared for and supported by the healthcare professionals she was working with. Indeed it could be argued that being in emotionally supportive environments in and of itself, had curative effects, "It was amazing and I really

started to open up about my experiences. I was able to share my feelings, after having had to suppress them for so long.” The sub-theme of, “Safe Haven,” also seemed to suggest that even if a person did not experience an emotional bond with every healthcare professional that they worked with, as long as they had an emotionally safe space with at least one person within their treatment team they could still experience the benefits of working with other healthcare professionals with whom they did not experience the same emotional bond.

This theme also supports the findings of other studies that have explored the alliance from the client’s perspective. The sub-theme of, “Qualities,” supports the findings of the work by Bedi and colleagues (2005) and Bedi (2006) that suggest that the psychotherapist’s personal characteristics as well as their ability to listen empathetically and provide validation are all important factors in the formation of strong alliances from the client’s perspective. The sub-theme of, “Connection,” also highlights the importance of the physical being of the psychotherapist, as Mary’s narrative gives an example of how trying to conduct sessions over the internet made it hard for her to connect to her dietician, perhaps due to the lack of being able to read body language and micro gestures quite as easily. Mary narrated, that even though she liked the dietician, “I might have got more out of it, if it was in person.”

Clinician attitudes and stance. This theme and more directly the sub-theme of, “Valuing Collaboration,” directly relates to Bordin’s definition of, “working alliance,” and is present in all the narratives, where the participants describe all the ways in which healthcare professionals elicited their input into therapeutic tasks, and most of the narratives described the importance of developing an emotional bond with at least one healthcare provider who made them feel genuinely cared for (although this seemed less important for Kate and Anne who appeared to value

expertise in the professional person with whom they working, which in turn seemed to provide them with the emotional safety they required to engage in therapy). When someone seeks out treatment for an ED, there is an over-arching implicit goal implied i.e. to recover from the ED, however this can become an contentious issue when the client has feelings of ambivalence, as described by Anne, “I’d thought that I would see these specialists and that they would fix everything for me. Then when I realised that I would have to gain weight and that was when I felt unsure about recovery.” At this point it appears, in some narratives it became important for a therapeutic relationship to be able to turn tac and and prioritise other goals for therapy that the client may have (assuming they have a degree of medical stability.) This identifies a key issue and complication in working with people who are experiencing an ED in that depending on a client or patient’s medical stability, prioritising their physical health sometimes becomes a necessity and so often the conditions for working collaboratively are significantly challenged.

However, there is disagreement about the importance of collaboration in forming alliance from the client’s perspective. While some investigators have argued that clients do not see the development of the alliance as a collaborative task but very much the responsibility of the psychotherapist (Bedi et al., 2005; Bedi, 2006; MacFarlane et al., 2015), other investigators have argued that an alliance is actually formed and strengthened by the psychotherapist prompting clients to identify their part in forming the alliance, along with positive emotional experiences related to therapeutic interventions (Fitzpatrick et al. 2006; Fitzpatrick et al. 2009). This theme does support the idea that while clients do value collaboration in goal setting and therapeutic tasks, they tend not to view the formation of the alliance as a collaborative process. In no instances did any of the narratives contain descriptions of ways in which the participants supported

or made deliberate attempts to form alliances with healthcare professionals. In most instances where strong alliances were described these were seen to be due to the qualities, expertise, or presence of the healthcare professional. Therefore, the findings of this study appear to support the work of Bedi et al. (2005), Bedi (2006), and MacFarlane et al. (2015). However, it is to be noted that due to the exploratory nature of this study, most questions were left very open ended and no question prompted the participants to think about their own contributions towards forming the relationships that they had with healthcare professionals.

Power within recovery focused relationships. This theme addresses the issue of how therapeutic relationships may or may not face ruptures when the issue of power within the relationship arises. There were several instances in the narratives that continue to support the theory of, “working alliance,” where even direct confrontations, when handled skillfully by the healthcare professional could help to negotiate new goals for treatment. This was particularly evident in Mary’s narrative when her psychiatrist confronted her regarding the possibility of hospitalisation if her pulse was any lower. Before taking that action, Mary’s psychiatrist made Mary aware that she had the power to hospitalise her. However, because she had been working with Mary for a while and knew what Mary was motivated by, the psychiatrist was able to suggest a new shared goal in her confrontation - to get Mary well enough to graduate. Not only did Mary’s psychiatrist manage to convey a desire to still work collaboratively with Mary, they also managed to convey caring, “having them take my pulse because they were worried enough about it, pulled me out of sort of some irrational thinking,” supporting an ongoing emotional bond.

However, where a clinician’s power was used to threaten or disempower someone who was seeking treatment, none of the key processes in forming a, “working alliance,” were present.

In Alyssa's narrative, when she describes the impact of feeling threatened with hospitalization by a clinician, in order to get her to eat, there is the sense that Alyssa and the clinician did not share the same goals, were not in agreement over treatment tasks, and did not share an emotional bond. This might be described as a, "forced alliance," where the person seeking treatment is forced to comply due to their need to access treatment and having limited options. Is there value in this kind of alliance? It could be argued that this clinician's strategy ensured that Alyssa was accessing treatment and that boundaries were set around the eating disorder, that ensured that at least she did not regress. Is there a place for, "forced alliances," or, "begrudging alliances," within eating disorder treatment? Obviously, this question involves careful consideration, especially regarding the ethical implications of the relational dynamic it addresses.

In considering this theme, in relation to the work of Bedi (2006) which explored alliance formation from the point of view of client, it does also support the findings that there is a good deal of homogeneity regarding factors that are described by clients as important to the formation and development of the alliance. The sub-theme of, "Confrontation," is present in all the narratives and valued by all the participants in different ways depending on the context and manner of confrontation. Although confrontation is often challenging in the treatment of an ED, all of the narratives at the very least described it as being a necessary, if sometimes very difficult, experience.

Is a, "working alliance," therapeutic in ED treatment? This study provides data that shows that in every one of these narratives of recovery, there were at least two out of the three working alliance processes present in many of the professional relationships, described by the participants as being the most influential in supporting their recovery process. Not one narrative

contained an instance where a relationship without a working alliance, as defined by Bordin, resulted in recovery.

However, due to the medical complexity of treating an ED that often starts to present itself at the early stages of development in children or youth, it is also important to note that none of the narratives contained examples of ways in which recovery was attained through merely the presence of working alliance. Several sub-themes make reference to the emphasis placed by the participants, on the importance of healthcare professionals being able to demonstrate specialism, expertise, and experiences in working with mental health issues and more particularly EDs, as being essential to recovery. It could be argued that a healthcare professional's ability to do this might provide the reassurance and safety necessary for the development of an emotional bond. In this case, therefore it becomes extremely difficult to tease apart a sense of whether the development of an early working alliance prompts more expedient symptom reduction (on a psychological level as well as a physical level) or whether symptom reduction facilitates working alliance as the two appear at least on psychological and emotional level to perhaps be intertwined. Anne's narrative makes particular reference to this when she started to work with the ED specialist. At different points in her narrative, she attributes the speed of her recovery to two different things. After she started to see the ED specialist, Anne described starting to feel better quite a lot quickly. She attributes this to several things: feeling like they know what's going on with her physically and mentally; feeling like they know what to do; feeling like they are being proactive with treatment (both pharmacological and therapeutic); feeling like they are taking her seriously; feeling like she can talk to them about all the challenges she is facing such as feeling suicidal; and generally providing the reassurance that she's, "in good hands." Within this list are several items

that imply that offering clear direction over working collaboratively, is what helped at this stage of Anne's recovery and tends to offer more support to the findings of studies that investigate the client's perspective of alliance formation and strengthening (Bedi et al., 2005; Bedi 2006; MacFarlane et al., 2015). However, later in the narrative she also attributes the speed of her recovery to finding the motivation within herself to not want to live with an ED forever, perhaps motivating her to engage in working alliances that were more collaborative and required less direction.

This narrative is not alone in suggesting that recovery happens in stages, and at different stages different kinds of support and working alliance may be more or less influential and effective. This seems to support the working model developed by Zilcha- Mano (2017) that suggests that people enter therapy (or treatment) with different capacities or traits in their ability to develop an alliance. In the case of someone who is experiencing an ED, this may be because they are medically compromised or experiencing other mental health challenges. However, as medical issues are addressed such as weight restoration and the management of other mental health issues such as depression, anxiety, PTSD, or OCD are supported or stabilized, they may experience state-like changes to their ability to develop a working alliance with healthcare professionals which indeed facilitate a more expedient experience of recovery.

Implications for Existing Research

Attitudes and stance of healthcare professionals that support the therapeutic relationship. There are many instances where the themes and sub-themes in this study support previous research. Although all of the participants taking part in this study are self-identified as in recovery and do not live with a chronic condition, there are similarities to the findings of the

study carried out by Geller et al., (2001) to identify attitudes and behaviours in clinicians that are foster longer term working alliances with chronic sufferers. Consistencies between the findings of these studies include: avoiding assumptions, being proactive; and conveying caring and support while also championing clients' autonomy and self-determination (where age and developmentally appropriate.)

This study also support the research carried out by Zaitsoff et al., (2016) to explore the qualities in clinicians that adolescents found most helpful for establishing therapeutic alliance, when receiving treatment for AN. Similarities in the findings included: seeing the person not just the ED; expressing an understanding of the clients' feelings with particular regard to their feelings of ambivalence and struggle; being collaborative with regard to treatment plans; and again avoiding assumptions.

Overlap with other studies that sought to identify qualities that were most therapeutic were also supported by the findings of this study, which identified: kindness, caring, non-judgment; checking expectations; providing support through difficult circumstances; being proactive; and being able to really listen, as vital qualities in a healthcare providers (Gulliksen et al., 2015, Sly et al., 2014).

The relationship between early abuse, neglect, and eating disorders. Although some narratives did contain descriptions of childhood abuse and neglect not all of them did. The ways in which this study identified how these adverse childhood events impacted the therapeutic relationship was when healthcare providers failed to take adequate steps to address abuse and so were responsible for inflicting further emotional and psychological distress upon the participant.

Complex trauma and ongoing mental health issues. None of the narratives contained instances where participants self-identified as experiencing complex trauma and so this did not appear in the themes, although several participants did describe having experienced or still experiencing other mental health issues such as depression and anxiety. The theme of, “What Healthcare Professionals ‘Do’ to Support Recovery,” made several references to instances when healthcare professionals were able to support these participants with their other mental health concerns alongside the ED, which also supported a working alliance if not a therapeutic relationship.

Stigma, shame, and self-criticism. Some narratives did involve references to feelings of shame and self-criticism and the benefits of targeting these issues, particularly evidenced by Kate’s narrative, in which she describes the boundaries and expectations of some programs as feeling punitive, and leading her to feel like she was being punished for having an ED. Therapy that supported her own journey of understanding the impact that adverse childhood events had on her, as well as developing self-compassion, was essential for making what she describes as a fully recovery. This supports the literature produced by Kelly & Carter (2013) and Kelly et al., (2014).

Other factors within healthcare settings that impact the therapeutic relationship. The theme of, “Healthcare Providers’ Attitudes and Stance,” makes reference to the negative impact of clinician prejudices and assumptions both within Primary Care Settings and sometimes in established program settings, which supports the work Currin et al., (2009) and Roehrig & McKelean (2010).

The issue of systemic barriers that was reviewed in the literature by van der Leer et al. (2016) did appear in the theme of, “What Healthcare Professionals ‘Do’ to Support Recovery,”

which identified, “Advocate for Clients,” as a sub-theme. In several of the narratives, many instances were narrated where systemic barriers not only inhibited clients receiving timely, affordable treatment but also inhibited the development of a therapeutic relationship. In contrast, when healthcare professionals were able to advocate for their clients and seek to connect them with the appropriate treatment and supports, this was hugely beneficial for building therapeutic relationships.

Several narratives made references to instances when healthcare providers lacked the education or understanding of EDs, which was reported under the sub-theme of, “Expertise,” in the findings. This consistently had a negative impact on therapeutic relationships, again supporting the findings of the Bartallas study (2015).

Clinical strategies for building and maintaining strong therapeutic alliances. Although none of the participants could speak to the specific interventions being used by healthcare providers (such as MI), the sub-theme of, “Motivation,” did appear in the findings. From these findings, supporting clients to find their own inner motivators, is key to establishing an enduring commitment to recovery. In the findings from this study, healthcare professionals could help clients identify and make reference to these motivating factors, but they could not manufacture or convince clients of them. Reasons for recovery had to come from the client.

Implications for the Field of Counselling Psychology

This study suggests clear implications for the field of counselling psychology and suggests the importance and value of clinicians considering not only their training but also who they are as a clinician. As EDs are an incredibly complex mental illness, with often very severe sometimes fatal outcomes, the findings of this study appear to emphasize the importance of clinicians

being specially trained to work with people who experience them as a clear ethical obligation. A key part of that training requires clinicians to, not only learn and develop techniques that support the recovery process, but also consider their own underlying attitudes and stance surrounding how they view EDs, how they view people who experience an ED, how they work with power within the relationship, and whether they themselves possess the qualities to be able to create connections, provide a safe haven, and support those attempting to recover from such a complicated, challenging, and wearing illness.

The theme of, “Deeper Healing,” also suggests a challenge to the counselling field to look beyond just behavioural change and seek to support clients to make longer-term emotional and psychological changes. The narratives within this study suggest the argument that there is more to recovery than medical stability and being weight restored. There is a suggestion that recovery also involves emotional and psychological changes regarding not just how a client views food and their body shape, but how they view themselves as a person, how they experience and perceive both their internal and external environment, and how they interact with the people and the world around them. For some, this deeper healing may involve addressing and processing adverse childhood experiences, for others it may involve finding support with other issues in life such as other mental illnesses, or challenging life circumstances.

Ultimately, this study emphasises that while some themes do run throughout the participants stories, their experience of the ED, as well as their treatment, and how these things transect with their life circumstances are incredibly complex, nuanced and different for each individual and so when working with someone who experiences an ED, it is essential to approach every client with an expectation that their experiences are unique.

Novel Findings

While many of the findings of this study support the current research regarding the importance and development of therapeutic relationship in the treatment of EDs, there are several sub-themes that suggest novel findings.

“Deep Rooted Healing,” and, “Acknowledging the Difference Between Medical Recovery and Psychological Recovery,” are yet to appear in the literature that I have seen. Additionally the findings that describe the benefits of providing those seeking treatment for an ED with a clinician, whose specific role is to support the whole person and create a, “Safe Haven,” are also yet to be seen. Finally, the larger issue of how, “Power Within Recovery Focused Relationships,” is expressed and experienced, especially within relationship to what motivates someone to recover, also seems to me to be a new idea.

Study Limitations

There are several limitations to this study that are important to note. As a narrative study, where small study samples are typical, this study only explores a limited range of people’s experience. Added to that, the criteria for participation in the study required those taking part to self-identify as well-established in recovery and so this study does not explore the experience of those who experience chronic EDs or are still in the process of recovery. Indeed, because the process of recovery is often long and takes many years, for several of the participants, trying to remember the initial stages of their treatment was challenging for several reasons. Therefore, while exploring people’s experiences from the position of hindsight offers some useful overviews, it also limits the findings by relying on memories tainted by time, and in many cases malnutrition. The study involved a fairly homogenous sample in which all the participants were

of a certain demographic and had the means to access private healthcare as well as public. Finally, the study was also limited by the homogeneity of the participants' diagnosis, age, financial means and life-stage. This may, in part, be due to using only one recruitment site and so extending the means by which participants are recruited could address to this issue.

Areas for Future Research

Due to the limitations of a small, and fairly homogenous sample, there is justification to broaden the research sample and seek to explore the stories and experiences of people who display greater diversity particularly with regard to the financial means they have to seek treatment. Exploring the experiences of people who also vary more in developmental stage, and diagnosis would also be useful.

This study also suggests the value of further exploring the themes of power and how it manifests within relationships where people with EDs are working with healthcare professionals in order to seek treatment, with particular regard to how this is experienced by those of limited financial means, who rely on public services for their treatment.

Finally, future research on the development and impact of the therapeutic relationship in ED treatment could be extended to exploring how Zilcha-Mano's (2017) model of trait and state alliances might apply to the specific population of people who seek treatment for an ED. Due to the considerable physical and mental impact caused by living with an ED, research that attempts to explore whether changes in state-like alliance (the client's ability to deviate from their usual trait-like capacity to develop an alliance) also sees symptom reduction, might offer some valuable insight into how various stages of recovery from an ED, transect with alliance formation.

Footnote

¹ Support and treatment options within BC for those living with an ED are listed under the Kelty Eating Disorders resource website are: Abbotsford Eating Disorders Services, Abbotsford Eating Disorders Services (Child & Youth MCFD), Adult Mental Health Substance-Use Team in Nanaimo, Campbell River North Island Eating Disorders Program, Canadian Mental Health Association- Cowichan Valley Branch Disordered Eating Program, Child & Youth Mental Health MCFD (Northern Region), Cowichan District Hospital Outpatient Nutrition Services, Child and Youth Mental Health (Central Okanagan) MCFD, Chilliwack Mental Health - Eating Disorders, Community Outreach Partnership Program (In collaboration with St. Paul's Eating Disorders Program), Comox Valley North Island Eating Disorders Program, Discovery Vista House (In collaboration with St. Paul's Eating Disorders Program), The Eating Disorders Program and Sexual Abuse Programs run by NARSF (Nanaimo and Associated Regions Services for Families), Eating Disorders Program in South Vancouver Island Region (Victoria C&Y Mental Health, MCFD), East Kootenay Eating Disorder Program, Fraser Outpatient Nutrition Programs, Fraser South Eating Disorders Program (MCFD & Adult Mental Health), Interior Outpatient Nutrition Programs, Jessie's Legacy Eating Disorders Prevention and Awareness Program, Kamloops Eating Disorders Program (Thompson Shuswap Health Services) MCFD, Kelowna Eating Disorders Program, The Kelty Mental Health Resource Centre, The Looking Glass Foundation for Eating Disorders, The Looking Glass Residence, North Fraser Eating Disorders Program, North Okanagan Eating Disorders Program, North Shore Youth Eating Disorders Program, Northern Regional Eating Disorders Clinic, Outpatient Dietitian Services for Central (Vancouver) Island, Outpatient Nutrition Programs (Northern Region), Pediatric Ambulatory Health Clinic in Nanaimo-Dietitian

& Social Work Services (Trial of Pediatric Eating Disorder Clinic for Central Island patients), Port Alberni Child & Youth Mental Health Services, Port Alberni Mental Health and Substance-use ASTAT Team, Provincial Adult Tertiary Specialized Eating Disorders Program, Provincial Specialized Eating Disorders Program for Children and Adolescents at BC Children's Hospital, Richmond Eating Disorders Program, South Inpatient Eating Disorder Service at Royal Jubilee Hospital (Victoria), Vancouver Coastal Health Eating Disorders Program, Vancouver Coastal Outpatient Nutrition Programs, Vancouver Island Outpatient Nutrition Programs, Vancouver Island Adolescent Outpatient Services St. Joseph's Hospital, Victoria General Hospital, West Kootenay Eating Disorder Clinic, Williams Lake Child and Youth Mental Health Program, and Williams Lake Eating Disorders Program (for Adults) (Kelty Eating Disorders, 2017).

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Appendices

Appendix A: Informed Consent Form



a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

Consent Form

Study Title: A narrative study to explore how people, who seek treatment for an eating disorder, experience relationships with health care professionals.

Principle Investigator: Dr Marla Buchanan, Department of Education and Counselling Psychology, UBC, marla.buchanan@ubc.ca.

Co-investigator: Andrea Jones, Department of Education and Counselling Psychology, UBC, a.jones.2@alumni.ubc.ca. This research is being conducted as part of the thesis requirement for a Master's degree in Counselling Psychology. Upon completion, the thesis will be a public document that can be viewed through the UBC library.

Study Team Members: Dr Robinder Bedi, Department of Education and Counselling Psychology, UBC, robinder.bedi@ubc.ca; Dr William Borgen, Department of Education and Counselling Psychology, UBC, william.borgen@ubc.ca; Dr Meris Williams, Private Practice Clinician, (866) 421-5443

Disclosure: I currently work at the Looking Glass Residence a residential program that provides support in recovery from an eating disorder for 16-24 year olds. If you feel that in taking part in this study and sharing personal information with me might prevent you from accessing help from The Looking Glass Residence then it is advisable that you proceed no further with participation in this study.

Purpose: The purpose of the study is to explore the experience of those who have been through the process of recovery from an eating disorder in order to better understand how relationships with professionals transect with their recovery journey. The aim is to gain a deeper understanding of sufferers' experience of working with healthcare professionals in order to seek insight into how these relationships and interactions impact a person's recovery process, if at all. The study specifically seeks to explore the experiences of those who have been through the process of recovery and can now reflect with hindsight upon their experience. The current research has emphasized the importance of developing trusting, open, respectful working relationships with suf-

ferers, however there is little research that explains the importance of this from the clients' point of view retrospectively. Therefore the significance of this study will revolve around gaining thicker descriptions of the experience of sufferers working with healthcare professionals in seeking treatment for an eating disorder. Through gaining more understanding as to how these professional relationships are experienced, healthcare providers may consider the ways in which this topic might be worthy of further consideration, discussion, and research.

Study Procedures: As a result of the screening interview that you completed already over the phone this consent form confirms your eligibility to be included in the study described above. You may not choose to continue to participate in the study, in which case, the information about yourself including your identify will be securely destroyed. If you choose to continue to participate in the study, you will asked to describe and reflect on your experiences of working with healthcare professionals while receiving treatment for an eating disorder, either for Anorexia Nervosa, or Bulimia Nervosa. If you feel comfortable doing so, you will asked to give some contextual information regarding the onset and duration of the eating disorder as well as the treatment options you accessed during this time as represented on a time line. You will then be asked to participate in a 1-hour interview where you will be asked to speak about your experience of working with healthcare professionals during this time. The interview will be carried out in person by the co-investigator, Andrea Jones, on site at UBC. Once your interview has been transcribed, and developed into a chronological narrative of your experience, it will be sent out to you as an encrypted and password protected document via email or via the mail (depending on your preference) for your comments and amendments to ensure that the narrative accurately reflects your experience. You will be asked to return the document either via email or by mail with any comments or edits that you wish to make, within one week of receiving it. Further written consent will be sought again via email and mail to publish your narrative as part of this Master's thesis project. The time commitment in total will be approximately 2-3 hours.

Potential Risks: We do not think there is anything in this study that could harm you or be bad for you. Some of the questions we ask may seem sensitive or personal. You may find that sharing your experiences promotes strong emotions or elicits memories from the period of time during your treatment. You do not have to answer any question if you do not want to. Also please know that you are also free to stop your participation in the interview, or withdraw from participating in the study at any time.

In addition to encouraging you to seek out your regular resources and supports, you will be provided with a list of counselling services that you might want to use in the event that our interview triggers a a need to further process or explore arising issues with a trained mental health professional (please see Community Resources sheet).

Potential Benefits: You may find that participation in the study and sharing of your experiences throughout your recovery journey is rewarding and beneficial. You may gain new insights through articulating your own experiences and/or reviewing the compiled data at the conclusion of the study. Your participation will be contributing valuable information to our understanding of

treatment delivery that may serve to continue to develop and improve services. Research on therapeutic practices helps to make them better understood, ethical, and empirically supported methods for all healthcare professionals to use.

Confidentiality: The data gathered from the screening interview, the study interview and follow-up contact is confidential, and steps will be taken to protect your identity. Only my supervisor and I with review interview data, transcripts, and audio recordings. No individual identities will be used in any reports or publications resulting from the study. To protect your identity, pseudonyms will be used when reporting findings. All audio recordings, transcripts, and summaries will be given codes and stored separately from any names or other direct identifying information of participants. This audio recording will not be saved to any computer or back up devices. Research information will be kept in a lockbox in the researchers home at all times. After the study is completed and all data has been transcribed from the audio recordings, the audio recordings will be held for five years and then destroyed.

There are three exceptional circumstances under which confidentiality cannot be maintained including if a participant discloses:

1. Legitimate concern of or actual harm being done to a child or vulnerable person,
2. Serious and imminent risk of harm to self, and
3. clear and imminent threat of harm to someone else.

If at any point a participant's self-disclosure includes any of these three situations, the researchers are required to take steps to ensure the safety of the participant and those disclosed in harm's way. This might include but is not limited to: contacting emergency services, the Ministry of Child and Family Development, and counselling support services. If confidentiality needs to be broken in these ways the participant will be informed at every stage and will be given every opportunity to engage in accessing these services him, her, them/selves, with the support of the investigator.

Remuneration: You will receive compensation for your participation in this study in the form of a gift cards for Indigo potentially totaling \$25. You will receive one gift card of \$10 at the completion of your involvement in the interview section of the study and a further gift card worth \$15 when you have returned the narrative of your experiences with any comments or amendments you wish to be added. You may retain the gift cards received if you opt to withdraw from the study.

Contact: At any time during the study, if you have questions with respect to the study, you may contact Andrea Jones at 604-379-1487 or via email: a.jones.2@alumni.ubc.ca. You may also contact Dr. Marla Buchanan at 604-822-4625 or via email: marla.buchanan@ubc.ca.

If you have any concerns about your treatment or rights as a research participant, you may contact the Research Participant Complaint Line at the UBC Office of Research Ethics at 604-822-8598, toll free at 1-877-822-8598 or email RSIL@ors.ubc.ca.

Consent: Your participation in this research study is entirely voluntary. You may decline to participate in this study or withdraw your participation at any time without negative consequences.

Your signature indicates that you have read, understood, and agree to this information and consent to participate in this study. Your signature also indicates that you consent to the audio taping of the interview. You will be given a copy of this consent form to keep, for your records.

Signature: _____ Date: _____

Appendix B: Recruitment Poster

SEEKING PARTICIPANTS FOR A RESEARCH STUDY

Have you experienced an eating disorder and as a result worked with healthcare practitioners and programs in lower mainland, BC? Do you feel it would be beneficial for you to share your story with a researcher who seeks to understand your individual experience of working with healthcare providers?

STUDY AIM: to explore the experience of people working with healthcare professionals while seeking and engaging in treatment for an eating disorder

WHAT DOES PARTICIPATING IN THIS STUDY INVOLVE?

Participation will involve:

- A 15 minute telephone screening interview
- A longer in-depth interview (max. 1 hour) either face to face or via written correspondence of answers to research questions
- One - three instances of follow up correspondence
- Participant anonymity will be carefully protected unless participants choose otherwise

WHO CAN PARTICIPATE?

Participants are needed who:

- are aged 20 or above;
- have been diagnosed with an eating disorder;
- have had experience of working with two or more healthcare professionals in order to seek treatment for an eating disorder in lower mainland B.C. (psychiatrists, doctors, nurses, therapists, dieticians, social workers, mental health workers etc);
- would describe themselves as currently well established in recovery;
- are confident at communicating in English.

BENEFITS OF PARTICIPATING:

In gratitude for your participation a \$20 Indigo voucher will be sent to you on completion of two separate data collection processes.

IF YOU ARE INTERESTING IN PARTICIPATING, PLEASE CONTACT ME AT:

a.jones.2@alumni.ubc.ca

PRINCIPLE INVESTIGATORS: Andrea Jones (MA Student of Counselling Psychology), Supervised by Marla Buchanan, Ph.D. UBC

Appendix C: Looking Glass Agreement for Distribution of Letter



Andrea Jones
a.jones.2@alumni.ubc.ca

September 6th, 2017

Re: Distribution of Study Invitation Poster

The Looking Glass Foundation for Eating Disorders is willing to distribute recruitment posters that invite participants to the research study being conducted by Andrea Jones, assuming the final draft of the poster still meets with the Foundation's approval.

The posters will be distributed digitally to our volunteers and community members.

Warmest regards,

Daniel Kong
Project Manager
Looking Glass Foundation for Eating Disorders



Appendix D: Initial Contact Participant Screening Form



a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

Study Title: A narrative study to explore how people, who seek treatment for an eating disorder, experience relationships with health care professionals.

Principle Investigator: Dr Marla Buchanan, Department of Education and Counselling Psychology, UBC, marla.buchanan@ubc.ca.

Co-investigator: Andrea Jones, Department of Education and Counselling Psychology, UBC, a.jones.2@alumni.ubc.ca. This research is being conducted by a student of Counselling Psychology, as part of the thesis requirement for a Master's degree in Counselling Psychology. Upon completion, the thesis will be a public document that can be viewed through the UBC library.

Study Team Members: Dr Robinder Bedi, Department of Education and Counselling Psychology, UBC, robinder.bedi@ubc.ca; Dr William Borgen, Department of Education and Counselling Psychology, UBC, william.borgen@ubc.ca; Dr Meris Williams, Private Practice Clinician, (866) 421-5443

Participant Initial Contact & Screening Protocol:

If a potential participant contacts me and is interested in the study, I will use the following protocol to screen for their eligibility to participate:

“Thank you so much for taking an interest in this study. This phone call is an opportunity for me to explain a little bit more to you about the study itself, what participating in the study involves, as well as answer any questions you might have regarding participation. In order to ensure I cover all the information that is relevant, I will now be reading from a script. If I say anything that is unclear or if you have any questions as I share information regarding the study please don't hesitate to stop me and ask me to repeat or clarify the point. I will also need to ask you some questions in order to determine if you are eligible to take part in the study. These questions allow us to screen potential participants in order to ensure the trustworthiness of any research findings. Should you be eligible and agree to participate in this study you will be informed either in an email or via the post, within 5 working days. A template for a timeline and the Informed Consent document will also be sent to you so that you can look over them before attending the interview. As you answer questions during this screening interview, if any of your answers indicate that you do not meet the criteria for inclusion in the study you will be informed of this immediately and the screening interview will stop to ensure that you share no more per-

sonal information than is necessary. This is to protect your confidentiality. Any information you have already shared will be destroyed in a secure manner.

However first it is important that I disclose: I currently work at the Looking Glass Residence - a residential program in Vancouver - that provides support in recovery from an eating disorder for 16-24 year olds. Do you think there is a chance that, by taking part in this study and sharing personal information with me, you might feel uncomfortable or unsure about seeking help from The Looking Glass Residence in the future? [Pause - and ascertain answer. If the answer is yes / maybe / perhaps, then proceed with...] Thank you for your honesty. It would be unethical of me to include you in this study as participation in research should not prevent you from seeking out or receiving future treatment, so we will need to end the interview here. Thank you so much for taking an interest and best of luck for the future. [If the answer is no] Thank you for taking the time to think about that. I think we can proceed on with the interview if that's okay with you?

The purpose of the study is to explore the stories of people seeking treatment for an eating disorder (ED) in order to better understand different people's experiences of working with various healthcare professionals. The aim is to gain a deeper understanding of people with EDs experience of working with healthcare professionals in order to seek insight into whether and how these relationships impact a person's recovery process. The study specifically seeks to explore the experiences of those who have been through the process of recovery and can now reflect with hindsight upon their experience from a place of feeling more secure in their recovery. It's hoped that through gaining more understanding as to how these relationships are experienced by those seeking treatment, healthcare providers may consider ways in which this topic might be worthy of further consideration, discussion, and research.

This is a narrative study which means we will work together to develop a story of your experiences. The most important aspect of this kind of story is that you get to choose what you include and what you leave out. If you were to choose to participate you would facilitate this process by: (a) completing a timeline of key events (as you see them - only include what feels comfortable to you) in your experience of the eating disorder as well as key events in the treatment that you sought in preparation for your interview; (b) attend an interview at UBC that would take no longer than an hour to describe the experiences that you deem as significant in working with healthcare professionals; (c) read the narrative developed from your interview and provide feedback and suggestions for any edits that you feel necessary for the story to accurately represent your experience. At the completion of the interview you will receive a gift card for \$10 and after providing feedback and comments on the narrative of your experience you will receive a \$15 Indigo voucher as a token of appreciation.

Please know that this information along with any other information that you provide in the study will remain confidential. The data gathered from the screening interview, the study interview and follow-up contact is confidential, and steps will be taken to protect your identity. Only my supervisor and I will review interview data, transcripts, and audio recordings. No indi-

vidual identities will be used in any reports or publications resulting from the study. To protect your identity, pseudonyms will be used when reporting findings. All audio recordings, transcripts, and summaries will be given codes and stored separately from any names or other direct identifying information of participants. This audio recording will not be saved to any computer or back up devices. Research information will be kept in a lockbox in the researcher's home at all times. After the study is completed and all data has been transcribed from the audio recordings, the audio recordings will be held for five years and then destroyed.

Furthermore, if you are eligible and choose to participate in the study, the information that you share with me now will be kept initially in a locked drawer in my apartment and then in a locked drawer in my supervisor's office for 5 years before being destroyed. However, if you are not eligible or if you decide to decline to participate in the study then your information will be destroyed in a secure manner at UBC at the earliest convenience. Did you want to ask any questions regarding that?

So now I have some questions for you. Please know that you can decline to answer any questions that you don't feel comfortable answering. However, also please understand that this might affect your ability to participate in the study, as participants have to match certain criteria. So if you're still interested in participating in the study, I just need to ask you several questions:

1. How did you hear about the study?
2. Would you describe yourself as currently well established in recovery?
3. Have you been diagnosed with an eating disorder and if so which diagnosis did you receive?
4. In seeking treatment for the eating disorder have you worked with two or more healthcare providers (these could include psychiatrists, doctors, nurses, therapists, dieticians, social workers, mental health workers etc)? And where?
5. Are you aged 20 or older?
6. Are you experiencing any other mental health issues that you think might affect your participation in the study?
7. If you were to feel triggered by the process of participating in the study do you feel confident that you have an adequate support network to turn to?
8. Do you feel confident to understand and speak English?
9. Will you be able to attend an interview at UBC?"

Appendix E: Interview Protocol

Orientation: Orientation to the site, bathrooms, water fountain etc. Share Informed Consent Form and do not proceed any further until this is signed.

Interview Process Orientation:

I'm interested in hearing about your experience of working with healthcare professionals while seeking treatment for an eating disorder. I would like to hear and fully understand your perspective. I may ask you specific questions if I need clarification or if I want to know more about something you mention. I really want to follow you and go where you are interested in taking me. This is about your experience. I want to clarify I am interested in your experience of working with various healthcare professionals and not necessarily the content, or the details of what you discussed, although this may come up or be a part of how you describe your experience. If there is anything that you feel uncomfortable sharing, remember that you can always choose to not include something, to not respond to a question, or to stop the interview at any time. It is your choice about what you choose to share and include in this interview. Also, please feel free to take as much time as you need to respond to a question or think about what you would like to say. At this point it might be helpful to have the timeline with your notes on it in front of you to refer to if you need it. Before we begin, do you have any questions for me? Let's begin the interview now.

Main Interview Questions:

- In your own words can you describe your initial experience or working with a healthcare providers while seeking treatment for an eating disorder.
- Can you tell me more about the moments that stick out in your memory during your experience of working with healthcare providers for your treatment.
- Can you describe the ways in which working with healthcare providers impacted (or didn't) your recovery.
- Is there anything you think I have asked about your experience of working with healthcare providers that you think would be important for you story?

Possible Facilitating Questions:

I intend on starting with the main interview question in order to explore each participant's experience in a very open fashion, to follow where they go, and probe aspects of the experience they raise and deem important. I have included the following prompting questions in case a participant finds it challenging to continue to access their experience without facilitation. These may or may not be used in interviews.

- Can you tell me more about that?
- Can you elaborate a little further?
- How was that for you?

Appendix F: Community Resources Sheet

Community Resources

Crisis Centre Distress Lines:

Greater Vancouver 604-872-3311
BC-wide 1-800-SUICIDE (1-800-784-2433)
Online Distress Services www.crisiscentrechat.ca

211 - Call this 3-digit number for information and referral to a range of community, social, and government services

Dragonstone Counselling

604-738-7557
In Kitsilano neighbourhood in Vancouver, BC
(Sliding scale counselling offered with supervised interns)

Family Services of Greater Vancouver, Counselling Program

604-874-2938
Fees based on household income
(Can have a waitlist)

Oak Counselling

604-266-5611
Reduced fee counselling provided by supervised volunteers with Master's degrees
On Oak St. in Vancouver, BC

UBC Scarfe Counselling Centre

604-822-4639
(Free counselling provided by counselling psychology graduate students)

Terra Counselling

604-442-4769
(Sliding scale, long-term counselling (if appropriate))

Appendix G: Consent for Publication

Consent For Publication

Study Title: A narrative study to explore how people, who seek treatment for an eating disorder, experience relationships with health care professionals.

Principle Investigator: Dr Marla Buchanan, Department of Education and Counselling Psychology, UBC, marla.buchanan@ubc.ca.

Co-investigator: Andrea Jones, Department of Education and Counselling Psychology, UBC, a.jones.2@alumni.ubc.ca. This research is being conducted as part of the thesis requirement for a Master's degree in Counselling Psychology. Upon completion, the thesis will be a public document that can be viewed through the UBC library.

Study Team Members: Dr Robinder Bedi, Department of Education and Counselling Psychology, UBC, robinder.bedi@ubc.ca; Dr William Borgen, Department of Education and Counselling Psychology, UBC, william.borgen@ubc.ca; Dr Meris Williams, Private Practice Clinician, (866) 421-5443

Contact: At any time during the study, if you have questions with respect to the study, you may contact Andrea Jones at 604-379-1487 or via email: a.jones.2@alumni.ubc.ca. You may also contact Dr. Marla Buchanan at 604-822-4625 or via email: marla.buchanan@ubc.ca.

If you have any concerns about your treatment or rights as a research participant, you may contact the Research Participant Complaint Line at the UBC Office of Research Ethics at 604-822-8598, toll free at 1-877-822-8598 or email RSIL@ors.ubc.ca.

Consent: Your participation in this research study is entirely voluntary. You may decline to participate in this study or withdraw your participation at any time without negative consequences.

Your signature indicates that you have read, understood, and agree to this information and consent to your narrative being published as part of this research study.

Signature: _____ Date: _____

Appendix H: Transcription Guide and Key

Study Title: A narrative study to explore how people, who seek treatment for an eating disorder, experience relationships with health care professionals.

Transcription guide

Below is a key detailing the abbreviations and punctuation used to transcribe taped interviews to paper in order to ensure consistency across transcription data as well as provide the reader with a guide as to how to interpret marks used within these items of data. As this is a narrative study, only the final narratives and not the transcriptions appear in the published piece. The original interview recordings and transcripts are with the Main Investigator of this study.

Key

I: Interviewer

P: Participant

(...) - Rounded brackets contain action or additional info. i.e. either the participant, the interviewee or object creating additional sounds like laughing, clearing their throat, mobile device sounding

[...] - Interjections by either the interviewer or participant. These square brackets also house information that is being changed to allow anonymity.

Mmm hmmm - used to express affirmation, agreement, understanding, interest, - a sound of encouragement by one person for the other to continue talking.

Umm - discourse marker to indicate a pause in expression

... - a pause where there is quiet. Also indicates where a sentence trails off.

Appendix I: Member Checking Responses

Study Title: A narrative study to explore how people, who seek treatment for an eating disorder, experience relationships with health care professionals.

In answer to the question... *“How do people, over the age of 20, who have experienced an eating disorder narrate their experiences of working with healthcare professionals in BC, Canada?”* does your narrative convey...

Alyssa

1. Accuracy: Is your narrative accurate?

Several years have passed since many of the events that make up this narrative and any retelling is, necessarily, going to be a reconstruction. This account is also just my perception of the events – an outside observer might have a very different perspective. I did my best to corroborate things like dates and important key points using diary entries and correspondence in constructing the timeline, but there were certain things I had no record of and some of my memories are somewhat unclear.

2. Resonance: Does your narrative resonate with our conversation together?

Yes, the narrative more or less resonates with the interview. It is always a bit jarring to see written speech (especially one’s own voice) written out in this way and it appears less eloquent than I might like it to, but I think it does preserve the tone of what I was trying to convey for the most part. One thing I did notice as I was rereading the narrative is that some of the language I use is quite clinical. I definitely have heard some eating disorder clients use that type of language after spending a lot of time in the mental health system, but for me, that was something I definitely picked up afterwards from working and not from my time as a client. So that is something that reflects my current lens that does not necessarily reflect how I would have spoken or conceptualized things back in the time the narrative describes.

3. Comprehensiveness: Is your narrative comprehensive? Is there anything missing? Is there anything that needs correction or expansion?

I would be very hesitant and uncomfortable to claim that a comprehensive account of my experience is at all possible. The experience of living with Anorexia is – like most other human experiences – complex and takes place within the context of normal everyday life, which is itself complex. I would say that the narrative is more or less coherent and represents certain aspects of my experience, but I want to be clear that the version presented does not capture everything that I went through in those years, nor can it represent the entirety of what it was like for me to struggle with Anorexia.

Mary

1. Accuracy: Is your narrative accurate? *yes*

2. Resonance: Does your narrative resonate with our conversation together? *yes*

3. Comprehensiveness: Is your narrative comprehensive? Is there anything missing? Is there anything that needs correction or expansion? **Yes i believe it is comprehensive. I do not think there is anything missing and believe that nothing other than what I have modified needs correcting or expansion**

Kate

1. Accuracy: Is your narrative accurate?
2. Resonance: Does your narrative resonate with our conversation together?
3. Comprehensiveness: Is your narrative comprehensive? Is there anything missing? Is there anything that needs correction or expansion?

Good morning, my answers to question 1 2 and 3 at the bottom of my narrative is yes to each individually.

Charlotte

1. Accuracy: Is your narrative accurate? **Yes definitely!**
2. Resonance: Does your narrative resonate with our conversation together? **Yes**
3. Comprehensiveness: Is your narrative comprehensive? Is there anything missing? Is there anything that needs correction or expansion? **I think you did a fantastic job in conveying my experiences, and clarifying points when I wasn't very clear.**

Anne

1. Accuracy: Is your narrative accurate? **Yes!**
2. Resonance: Does your narrative resonate with our conversation together? **It does!**
3. Comprehensiveness: Is your narrative comprehensive? Is there anything missing? Is there anything that needs correction or expansion? **I think it's good – I don't think I'd want to expand more.**

Appendix J: External Expert Peer Review Responses

Study Title: A narrative study to explore how people, who seek treatment for an eating disorder, experience relationships with health care professionals.

In answer to the question... *“How do people, over the age of 20, who have experienced an eating disorder narrate their experiences of working with healthcare professionals in BC, Canada?”*

External Expert Peer Reviewer: 1

1. Do the themes & sub themes resonate with your experience in the field?

Absolutely, the themes resonate with my 20 years of experience in the eating disorders field. Frankly, there was nothing that surprised me. In fact one of things I noticed most when reading the themes was that there was a latent theme (I think) amongst several of them regarding "give me firm guidance, but also autonomy to make my own decisions," which is something I think ED practitioners bump up against all the time in our work. I think this occurs all the time in counselling in general, but with EDs, there are such high stakes around medical stability. It's such delicate work.

2. Do you think the findings are comprehensive?

I think the answer to this questions depends on the definition of "comprehensive." If comprehensive means: did each participant have the opportunity to offer their fullest, richest, thickest description of their experiences with HCPs, then it is more likely the results were comprehensive. If comprehensive means: category/theme saturation, then probably not because I don't think you were adding participants based on trying to saturate categories. I also think I understand from your project that saturation was not a pre-identified criterion for trustworthiness (and may not have been appropriate anyway, if your research was situated more in the constructivist-interpretivist paradigm of science vs. post-positivist). So, I guess I have a definitional question about what comprehensive means in the context of narrative research, and also thematic analysis.

3. Do the findings have pragmatic value for practitioners?

I think that the findings have pragmatic value for practitioners, most definitely. As you mentioned, the themes read as a bit of a recipe for a positive counselling relationship, from the perspective of the client who has an ED. And I think we always want to be listening to clients to help direct us in what helps them feel connected to us. Attunement is so key in relationship.

External Expert Peer Reviewer: 2

1. Does it resonate with your experience in the field?

Yes it does. Nothing stood out as unusual, or misfitting, and no themes/sub-themes stood out as missing...(see the bit about 'comprehensive' below!)

2. Do you think the findings are comprehensive?

I think they are, relative to your case study of 5. Within the 5, I think its very thorough, yes. You pulled a lot out from their stories. I was impressed by the nuance of types/ways of connecting, supporting, advocating, enlisting power, and so forth. Nothing felt missing, with the caveat that I didn't read their transcripts of course. But in terms of transferability to society, I think this is comprehensive, yep!

There are limits to all research, and a narrative study of 5 is important, and impactful, and somewhat generalizable, but it also 'speaks to what it speaks to'. It's the story of 5. Not 500, which would be a different study that would bend and contort stories to fit them in neat little boxes, or omit nuance....I love the 5, because it speaks to the nuance and aims to highlight that random group's themes. I think you did that well.

Things that stood out to me were the absence of explicit narration by participants about influence/power of race, sexuality, or gender, or age. Class was talked about in terms of financial/cash access to services. If any of those 4 (race, sexuality, gender (even binary m-f), age) were expressed in narrations, I'd say that's important to add in for sure - they might fit within themes you already have. Otherwise, I assume the dominant default that 'goes without naming' being white settler, colonial (invisible to whiteness), female bodied and female identified, straight-partnered or single, or asexual, and young adult to late 20s -?? Maybe you discuss this in the methodologies. But interesting that it wasn't named or important maybe in the participants' narrations?

3. Do the findings have pragmatic value for practitioners?

Yah, I think so. As I was reading it, I was thinking, 'I should write down all these theme/sub-theme headings' and see how I'm doing, or have a little check in with my own clients about how I'm doing on those in an embodied way, or how we're doing on those together. Like, what do I more naturally do, or what do I need to work that muscle, so to speak. So yah, I see them being easy to integrate and useful.

I can imagine that newer clinicians might see the themes as a set of 'to-do's rather than a type of relating to embody. The narrations are describing relationships and experiences within the relationship that seem to be speaking about 'ways' of being together, not about one person (clinician) doing a theme to another person (client). I read the themes as really about 'effective welcoming' not in a one-off meaning of the word welcoming, but an eternal-ongoing welcoming of effective support in recovering from and ED.