

# **Client Perspectives of Psychotherapy for Eating Disorders in Community Practice Settings**

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## ABSTRACT

This qualitative study explores client experiences to further understand psychotherapy for the treatment of eating disorders in community practice settings. Eight participants shared their experiences of individual psychotherapy, where eating disorders were the primary focus, during minimally-structured and open-ended interviews. Data were analyzed using interpretive phenomenological analysis. Analysis resulted in 20 themes representing what participants described as meaningful in their experience of therapy. These themes are organized in five broader thematic categories: *Goals and Expectations of Therapy*, *Therapist Way of Being*, *Session Process*, *Eating Disorder Specific Interventions*, and *Non-Eating Disorder Specific Interventions*. Each thematic category and theme is described in detail, including verbatim quotes from participant accounts, and depicting points of agreement or divergence among participant experiences. The constructivist orientation, principles of hermeneutic phenomenology, and helpful factors design forefront participant perspectives and allow for elucidation of nuances in which therapy and therapeutic interventions unfold. The findings reinforce and expand upon scholarly literature, including ways that participants find it helpful when therapists consider the client's context, but also value direction provided by therapists who have eating disorder expertise. Implications of the study for research, practice, and training are discussed.

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## CHAPTER ONE

### Introduction to the Research

Two to four percent of the population will be diagnosed with Anorexia or Bulimia Nervosa (Hudson, Hiripi, Pop, & Kessler, 2007), but as many as 86% of women in a Canadian university sample report clinically significant eating disorder (ED) attitudes or behaviours (Miller, Vaillancourt, & Hanna, 2009). Not all of these women will present with need for ED treatment, but individuals who experience symptoms even without completely satisfying full diagnostic criteria (e.g., American Psychiatric Association, 2013) may be referred to as having ED Not Otherwise Specified and could benefit from treatment (Chamay-Weber, Narring, & Michaud, 2005). Atypical, sub-clinical, or partial EDs share many features characteristic of full syndrome anorexia or bulimia, including the extent and duration of complex psychological needs, physiological complications, and exceptionally high mortality rates (American Psychiatric Association, 2006). For the purposes of this research, my interests include understanding treatment for the full spectrum of ED experiences including clinical, atypical, sub-clinical, or partial cases.

Due to their prevalence, psychological and physiological dangers, and risk of mortality the Public Health Agency of Canada has identified EDs as requiring special attention (2002). In Ontario, attention has turned to efforts to promote and enhance the public's access to timely and specialized services for the full spectrum of EDs in community settings (McVey et al., 2005) in addition to, or in lieu of, accessing services in traditional hospital settings. For clients who have either partial or full syndrome symptoms, the best outcomes are associated with early and effective treatment (Treasure, Tchanturia, & Schmidt, 2005). Learning more about treatment in community practice settings could inform that early and effective treatment to improve outcomes.

The need for early and effective ED treatment has been acknowledged, and psychotherapy has been recognized as a necessary part of that treatment (de la Rie, Noordenbos, Donker, & Furth, 2007; Keel, Dorer, Franko, Jackson, & Herzog, 2005; Vandereycken & Vansteenkiste, 2009). However, there is not yet an agreed upon understanding of *what* constitutes that effective ED psychotherapy. Research demonstrates that therapists who treat EDs do not always use empirically supported approaches (Lilienfeld et al., 2013). More specifically, among 265 surveyed clinicians recruited from organizations of ED specialists, only

6% reported using empirically supported therapies, while 73% reported using a “flexible” application of empirically supported manuals, and 21% had never studied a psychotherapy treatment manual informed by research (Tobin, Banker, Weisberg, & Bowers, 2007). Prolific ED researchers le Grange and Lock, who themselves have developed and empirically validated a family-based approach to ED-focal psychotherapy, admit that there remains a “dearth” of research to do the practice of ED-focal psychotherapy justice (2005).

Increasing institutional and government pressures, driven in part by financial consideration and professional regulation, comes with an increased need for scientific evidence to support the effect of clinical practice (Bower & Gilbody, 2010). There are exceptions, but researchers have largely used controlled outcome trials to evaluate the effectiveness of psychotherapies to treat anorexia- or bulimia-specific diagnoses (Rockert, Kaplan, & Olmsted, 2007). Cognitive behavioural therapy has emerged as a “best practice” for ED treatment based on favourable results from controlled outcome trials, and possibly because it is the most studied mode of therapy (Hay, 2013; Kaplan, 2002; Stein et al., 2001; Wilson, Grilo, & Vitousek, 2007). Cognitive behavioural therapy is predominant in ED literature, yet neither it nor any other therapeutic mode results in more favourable outcomes in comparison studies (Le Grange & Lock, 2005; Wilson, Grilo, & Vitousek, 2007). The same limitation exists in the study of psychotherapy to treat EDs as in psychotherapy studies more broadly: No particular mode of psychotherapy is found to be superior to another; they are all effective, such that outcomes among tested modes of psychotherapy are generally equivalent (Siev, Huppert, & Chambles, 2009; Wampold, Imel, & Miller, 2009).

Finally, findings from early study of therapist and client perspectives suggest that manualized practices empirically supported using controlled outcome trials do not translate entirely well to practice. It appears that therapists find it difficult to adhere to modes of ED-focal psychotherapy in the manualized form in which they were tested (Mussell et al., 2000; Wallace & von Ranson, 2012). This is usually because such psychotherapy fails to meet the needs of diverse clientele (Haas & Clopton, 2003; Lowe, Bunnell, Neeren, Chernyak, & Greberman, 2011). Client perspectives show that clients also prefer less reductionist and more flexible therapy. They want opportunity to provide input and to have choice during the course of their ED-focal psychotherapy (Cockell, Zaitsoff, & Geller, 2004). In order to meet the needs of their clients, therapists report integrating elements of multiple modes of psychotherapy, rather than

adhering to any single therapy in the manualized form it was developed (Wallace & von Ranson, 2012). This demonstrates the limitation of controlled outcome trials which risk eliminating the individual differences that can impact the unfolding of therapy. Accordingly, therapists and clients express preference for practices that respond to the individual needs of clients.

### **Personal Prelude**

The study of ED-focal psychotherapy is my chosen area of interest because of the growing need for ED treatment and challenges inherent to that treatment. Learning about psychotherapy theory and ED treatment has provided me with a foundation from which to start practicing, and continues to inform my therapeutic work with clients who experience food- and weight-related concerns. Beyond this foundation, I continue to learn a great deal through day-to-day discussions with clients who come to see me for ED-focal psychotherapy<sup>1</sup>. Working through unique situations and symptoms that clients bring to therapy has often required conversations with my clinical supervisor to consider how I may address issues that arise for which I have no previous experience or scholarly reference point. Addressing a wide range of client cases has expanded my clinical repertoire beyond understanding I garnered from the theory available in ED literature alone. I believe there is much more to learn from clients, whose perspective remains relatively under-represented in ED literature.

This interest in learning about client needs and preferences, from their own perspective, shows my colours as a client-centered practitioner and, similarly, a constructivist researcher who forefronts participant perspectives. That said, I want to be clear that it is not my intention to dismiss post-positivist research that controls for contextual differences in order to make more generalizable claims. Rather, I consider constructivist and post-positivist research approaches among different lenses through which we might more fully understand psychotherapy.

### **Current Study**

The study of psychotherapy is becoming more sophisticated to better appreciate the complexities of therapy. Beyond establishing a relationship between psychotherapy practices and outcomes, researchers have become interested in the nature of that correlation, and plausible explanations linking cause to effect (Haynes & O'Brien, 2000). Methodologies for “identifying,

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<sup>1</sup> The terms ED-focal psychotherapy, ED-specific psychotherapy, psychotherapy for the treatment of EDs, psychotherapy to address an ED, and psychotherapy where ED is the primary focus are used synonymously throughout this research.

describing, explaining, and predicting the effects of the processes that bring about therapeutic change” have evolved with the development of psychotherapy process research (Greenberg, 1986, p. 4). With this evolution, what is considered “evidence” has evolved from “proof” aligned with positivist science to include approaches that further unveil meaning without purporting claims of truth (Paré & Sutherland, in press). Exploring client perspectives is one of these approaches that offers insight into the complexity of psychotherapy and ways that psychotherapy does or does not meet the needs and expectations of clients (Elliott, 2010).

The current study contributes to the emerging body of ED research considering client and therapist perspectives of psychotherapy (House et al., 2012; Lilienfeld et al., 2013). In particular, this study applies a qualitative approach to forefront client experiences of individual ED-focal psychotherapy that took place in community practice settings. Qualitative inquiry allows for consideration of nuances in how therapy unfolds, and what clients experience as meaningful in that unfolding of therapy. The helpful factors design (Elliott, 2010) is used to explore what participants identify as meaningful. Considerations that participants raise can be used to reinforce or expand upon existing understandings of ED-focal psychotherapy with detailed and context specific descriptions.

### **Scope of Psychotherapy**

The scope of “psychotherapy” is central to this research and has evolving implications given new professional regulation in the province of Ontario. In the province of Ontario, the practice of psychotherapy includes assessment and treatment of cognitive, emotional, or behavioural disturbances by psychotherapeutic means delivered through a therapeutic relationship, based primarily on verbal or non-verbal communication (College of Registered Psychotherapists of Ontario, 2015). When conducting the current research and preparing this dissertation, psychotherapy was not a regulated profession in Ontario. However, the Ontario Ministry of Health and Long-Term Care proclaimed the Psychotherapy Act of 2007 effective as of April 1, 2015. With this act, the College of Registered Psychotherapists of Ontario (CRPO) came into effect. This means that psychotherapy is now a regulated profession in the province of Ontario. As such, anyone who uses the title "psychotherapist" or who holds him/herself out as qualified to practise psychotherapy in Ontario must be registered with the CRPO, unless already a member of one of five other regulated professions whose members may also practise psychotherapy (i.e., nurses, occupational therapists, physicians, psychologists and psychological

associates, and social workers). Because the current study was conducted prior to proclamation of the Psychotherapy Act (2007), “psychotherapists” referred to by myself or research participants do not necessarily meet requirements of registration with the CRPO.

### **Thesis Overview**

In the next chapter, I further situate this research with a literature review. I develop rationale for the current study by describing EDs and situating the role of ED-focal psychotherapy in treatment, elaborating on the study of that psychotherapy, and summarizing the state of research considering client perspectives. In Chapter Three, I provide an overview of the current study, including the research question, theoretical orientation with which this research is approached, and methodology used. In Chapter Four, I describe in detail the methods applied to address the research question. In Chapter Five, I present the results, including themes that represent what clients identified as meaningful to their ED-focal psychotherapy. In the last chapter, I summarize main findings of the study, discuss how findings relate to the theory and practice of ED-focal psychotherapy, identify strengths and limitations of this study, and propose possible next steps following from the research.

## CHAPTER TWO

### Literature Review

The following literature review situates the current research. I begin by defining eating disorders (ED) and describing their prevalence, comorbidity, etiology, and the ways in which EDs are treated. After examining the role of psychotherapy in ED treatment, I highlight the practices of psychotherapists treating EDs in community practice settings, and explore how existing “best practices” have been established by researchers. In this exploration, I identify an emerging trend of research done in community practice settings, and the value of including client and therapist perspectives in that research.

#### Defining Eating Disorders

The first description of EDs is accredited to a French neuro-psychiatrist, Ernest Charles Laségue, in 1873. His description “De l’Anorexie Hysterique” is remarkably similar to currently accepted ED definitions (Vandereycken & van Deth, 1990). Laségue described patients in his medical practice who did not eat in order to avoid anticipated pain and to diminish the uneasiness of emotion. After a few weeks of these patients resisting food, Laségue declared the “disease,” and made a differential diagnosis of gastric pain. Laségue also described how the thoughts of his patients became narrowed and how his patients resisted treatment. He noted examples of vomiting, suicidal tendencies, and the poor prognosis of recovery. The only thing he did not mention, central to more current diagnostic elements, is a drive for thinness and obsession with slenderness (Vandereycken & van Deth, 1990).

I will review current DSM diagnostic criteria to help frame EDs, but ultimately consider ED symptoms including comorbidity and range of etiology too diffuse to be captured through diagnosis. While appreciating the importance of diagnostic criteria as a reference point and for controlling treatment trials, I do not use diagnosis as a requirement for participation in this research. Rather I aim to attend to the natural variance among EDs experienced by individuals who pursue psychotherapy treatment in community practice settings. This variance will become more clear as I describe the predominance of ED Not Otherwise Specified (that is, mixed or sub-threshold symptoms) compounded by a wide range of comorbidity and etiology. Further to the complexities of EDs being difficult to capture diagnostically, the idea of classifying experiences conflicts with my constructivist orientation described in the next chapter.

**Diagnostic criteria.** I start this review with a summary of DSM-IV-TR diagnostic criteria in order to demonstrate more recent efforts to make criteria more representative of ED variation in the DSM-5 (APA, 2000, 2013). Three types of EDs are described in the DSM-IV-TR: Anorexia Nervosa, including restricting or binge eating/purging subtypes; Bulimia Nervosa, including purging or non-purging subtypes; and ED Not Otherwise Specified for when symptoms do not meet the specific criteria of either Anorexia or Bulimia. The type of ED diagnosis was classified by combinations of (1) weight loss leading to less than 85.0% of expected body weight, (2) amenorrhea in post-menarcheal females, (3) recurrent episodes of eating an amount of food that is significantly larger than most people would eat within a discrete period of time (e.g., within any two-hour period) under similar circumstances, and (4) inappropriate compensatory behaviour in an effort to prevent weight gain. Other diagnostic criteria listed in the DSM-IV-TR include intense fear of weight gain, disturbance in the way that one's body weight or shape is experienced, undue influence of body weight or shape in self-evaluation, denial of the seriousness of the current low body weight, or a sense of lacking control or feeling that one cannot stop during a binge episode.

Using the DSM-IV-TR's ED diagnostic categories results in the vast majority of treatment-seeking individuals qualifying as ED Not Otherwise Specified. Surveys show over half of treatment-seeking individuals were diagnosed with ED Not Otherwise Specified (Fairburn, 2007; Rockert, Kaplan, & Olmsted, 2007), a rate much higher than that of either the more particular Anorexia or Bulimia diagnoses (Button, Benson, Nollett, & Palmer, 2005; Turner & Bryant-Waugh, 2004). The ED Not Otherwise Specified diagnosis includes all mixed- and sub-threshold experiences of ED, allowing for clear thresholds of anorexia and bulimia. As a catch-all for EDs that do not fit anorexia- or bulimia-specific criteria, there is an inherent lack of specificity to the ED Not Otherwise Specified diagnosis which has made researching its symptoms, course, and outcome difficult (Thomas, Vartanian, & Brownell, 2009).

Recently, changes were made to diagnostic categories now published in the DSM-5 (APA, 2013) to address the preponderance of the ED Not Otherwise Specified diagnosis, and heterogeneity of symptoms that a diagnosis of ED Not Otherwise Specified includes. Major revisions are: (1) elimination of amenorrhoea as a requirement for Anorexia, (2) reduction of binge eating episode and inappropriate compensatory behaviour frequency from twice to once per week for the past three months for Bulimia, (3) recognition of Binge ED as a separate ED

diagnosis, and (4) reduction of binge eating episodes and frequency criteria from twice to once per week for the past three months for Binge ED. Studies where prevalence of diagnoses using the DSM-IV-TR and the DSM-5 are compared show that these changes have resulted in fewer ED Not Otherwise Specified diagnoses (Berg, Peterson, Frazier, & Crow, 2012; Birgegard, Norring, & Clinton, 2012; Keel, Brown, Holm-Denoma, & Bodell, 2011; Quick, Berg, Bucchianeri, & Byrd-Bredbenner, 2014). However, ED Not Otherwise Specified remains the most common classification, comprising 43% of DSM diagnoses (Quick et al., 2014). This demonstrates the difficulty that remains in classifying the variance of ED experiences.

In an attempt to facilitate research and treatment of the diagnoses, ED Not Otherwise Specified is further qualified by six different categories of symptoms in the DSM 5: Atypical anorexia, sub-threshold bulimia, sub-threshold binge ED, purging disorder, night eating syndrome, and other feeding and ED not elsewhere classified. These six symptom presentations are meant to facilitate research by clarifying the diagnoses, but the range of symptoms included in ED Not Otherwise Specified remains large, and the research and practice of psychotherapy for the treatment of ED Not Otherwise Specified remains challenging due to the heterogeneity of symptoms.

**Prevalence.** Only 3% of women and fewer men are expected to be diagnosed with a full threshold ED in their lifetime (Hoek, 2006), but the prevalence of ED Not Otherwise Specified appears to be much higher. Over half of university age students, and almost two-thirds of female university students can be expected to experience some degree of full or sub-threshold ED. Using self-report measures, 54% of university students identified as having some form of ED pathology (Quick et al., 2014). This number increases to 86% when women alone are considered in a university sample (Miller, Vaillancourt, & Hanna, 2009). Not all of these individuals would be diagnosed with an ED, but they report clinically significant body dissatisfaction and/or fear of weight gain indicative of ED thoughts and behaviours. Individuals experiencing sub-threshold ED warrant treatment consideration as they can match full syndrome groups in the use of compensatory behaviours, high depression and anxiety, low life satisfaction, and narrow cognitive processes (Chamay-Weber, Norring, & Michaud, 2005). These findings suggest it would be important to understand the experiences of individuals whose quality of life is impaired by ED thoughts and/or behaviours, and who may pursue psychotherapy to address those symptoms, without necessarily having received an ED diagnosis.

**Comorbidity.** In addition to variance in ED symptoms, the challenge of classifying EDs by diagnosis is further complicated by comorbidity—the presence of two or more disorders concurrently. The range and prevalence of comorbidity can compound the needs of clients presenting with EDs. Comorbid personality, mood, anxiety, and substance abuse issues are most commonly cited among ED populations. Comorbid personality disorders affect from 27 to 93% of individuals with ED (Cassin & von Ranson, 2005). Depression and other affective disorders are reported in 15-80% of ED cases (Godart et al., 2007). More than 50% of patients with ED are reported to have comorbid anxiety disorders, with obsessive-compulsive disorder and social phobia among the most frequently encountered (Arostegui, Padierna, & Quintana, 2010; Strober, Freeman, Lampert, & Diamond, 2007). Nine to 22% of individuals with ED are said to experience comorbid substance abuse (Gadalla & Piran, 2007; Hudson, Hiripi, Pope, & Kessler, 2007). Comorbidity can exacerbate existing ED symptoms, or add additional symptoms to a client’s case, in effect compounding the difficulty of ED treatment. Just as it may be important to study natural variance in ED symptoms that may not be captured by diagnosis, it may be equally important to include study of comorbidity compounding the experience of afflicted individuals.

**Etiology.** The heterogeneity among ED symptoms and complex needs of clients pursuing treatment may be attributable to “multifactorial” causes (Schmidt, 2002). The core features of ED—disturbance in body image, over- or under-control of eating, and extreme behaviours to control weight or shape—are associated with biological underpinnings, psychological factors, socio-cultural influences, and environmental risks (Striegel-Moore & Bulik, 2007).

**Biological underpinnings.** Gastro-intestinal problems (Jacobi, Hayward, de Zwaan, Kraemer, & Agras, 2004), neuroendocrine abnormalities (Rosen, 2010), as well as emotional and physical changes that occur with puberty (Gilbert, 2005) have been identified as a risk factor for EDs. The effects of aging can also trigger an ED. For instance, menopausal changes in women or loss of sexual interest in males have been associated with EDs (Ramacciotti et al., 2002).

The influence of genetics have also been explored. Familial transmission of ED is well established, indicating that genetics play a role in ED etiology (Strober, Freeman, Lampert, Diamond, & Kaye, 2000). However, genetic studies have not clearly confirmed the involvement of any one gene or genetic pathway (Trace, Baker, Penas-Lledo, & Bulik, 2013). Like so many

aspects of ED research and treatment, the study of genetic influence is complicated by heterogeneity among symptoms (Sullivan et al., 2012). Studies considering the genetic influence of anorexia typically combine restricting and binge eating/purging subtypes. Studies considering the genetic influence of bulimia do not usually differentiate individuals who engage in self-induced vomiting from individuals who engage in excessive exercise or another type of purging behaviour. And, studies considering the genetic influence of binge ED do not take into consideration that individuals with binge ED are frequently, although not always, overweight or obese. These different symptom presentations may contribute to the inconclusiveness of genetic studies to date. Although no genetic pathways underlying EDs have been identified, the well-established family transmission of EDs may also reflect environmental risks described later.

***Psychological factors.*** Individuals with elevated body weight and shape concerns, negative self-evaluation, a history of adversity or traumatic experiences, and comorbidity as described earlier are all believed to be at particular risk for developing an ED (Jacobi, Hayward, de Zwaan, Kraemer, & Agras, 2004). Perfectionism, obsessive-compulsive traits, impulsivity, sensation seeking, narcissism, and excessive investment in interpersonal relationships are other psychological features associated with EDs (Cassin & von Ranson, 2005). The link between these factors and EDs has been hypothesized to manifest through an individual's anxiety to please, pursuit of acceptance, feelings of ineffectiveness, inability to communicate, being told what one feels or thinks such that it has interfered with development of self-awareness and trust in one's own faculties, and stress-induced eating for comfort or to avoid feelings (Gilbert, 2005). These psychological factors become particularly relevant when I later discuss how psychological intervention is considered vital to long term recovery from ED.

***Socio-cultural influences.*** Among cultural risk factors it is found that EDs predominantly, although not exclusively, affect females. The disproportionate representation of EDs among the female gender arguably results from the thin female beauty ideal (Schooler, 2008). While it was initially thought that EDs were a "disease of affluence," there no longer appears to be a relationship between parental education or socioeconomic status and ED (Moya, Fleitlich-Bilyk, & Goodman, 2005). In terms of race and ethnicity, white American women appear to be at highest risk for severely restrictive or compensatory behaviours, but not for binge eating. However, women of ethnic minority are less likely to seek treatment for an ED which

may inaccurately suggest that they are less likely to experience ED (Cachelin & Striegel-Moore, 2006).

One of the most recognizable socio-cultural influences is the Western beauty ideal—that is being characteristically thin for women and muscular for men. The pursuit of these ideals is widely believed to result in dieting, tried by at least 50 to 75% of individuals in their lifetime (Gilbert, 2005). Behind these thin and lean ideals in Western culture lies a general attitude that “fat” is synonymous with ill health, and thinness is synonymous with health. Media, including the internet, television, and magazines, have been pegged as promoting beauty ideals, dieting, and subsequent EDs. Pro-Ana and Pro-Mia internet sites, for instance, actively promote Anorexia and Bulimia and are thought to outnumber professional or recovery sites (Keski-Rahkonen et al., 2007). Pro-Ana and Pro-Mia sites provide ideas as to how one might best starve themselves or purge and avoid the detection of these behaviours by others. They often promote EDs as a lifestyle choice, and not as a disease. Professionals are advised to be aware of such sites and their content, to debunk the myths perpetuated and acknowledge the possible awareness of how symptoms may be veiled (Golden et al., 2003). A study on the island of Fiji where individuals previously did not have access to television observed dramatic drops in self-esteem and an increase in ED related behaviours with introduction of Western programming (Becker et al., 2010). Similarly, health and fitness magazines with articles concerning nutrition, exercising, as well as fashion and beauty magazines that include articles concerning sex, dieting and exercising, the latest fashion, and other related topics can perpetuate ideals that impact women’s self-image in particular. Thomsen (2002) found that exposure to these magazines, but not news magazines, was related to women’s greater preoccupation with being thin, dissatisfaction with their bodies, frustration about weight, and fear about deviating from the thin standard.

***Environmental risks.*** In addition to biological, psychological, and socio-cultural factors, there is evidence that EDs are, at times, learned as a result of environmental influences. For instance, dieting can be positively reinforced by feelings of success following a chance remark or “because friends are doing it” (Gilbert, 2005). In addition to the influence of peers in one’s environment, family is thought to have a major influence in the development of EDs. This influence can come in the form of over-protective or rigid environments, environments with a lack of conflict resolution, and where privacy is limited, children become embroiled in

unresolved marital and family conflicts, or parents model desire to lose weight and are critical of appearance.

The environments of athletes and performers are also associated with EDs, particularly when their activities reward lean body types (e.g., gymnastics, running, wrestling, dance, and modeling; Rosen, 2010). The line is fine between a dedicated athlete and someone with an ED. Elite athletes in competitive environments, and athletes whose body type and weight are incongruent with the optimal body build and performance in their sport, are most vulnerable (Garner & Garfinkel, 1980). Female athletes characterized by perfectionism and a high need for achievement are most likely to strive for thinness and develop ED behaviours. However, sport can also enhance self-efficacy and serve as a protective factor against the development of ED assuming the participant's body type fits the optimal body build of their sport (Fulkerson, Keel, Leon, & Dorr, 1999).

It may be that the only thing clear about the etiology of EDs is its complexity. Although no gene or genetic pathway affecting ED has been identified, it is increasingly understood that environmental factors can alter gene expression, and those same genetic factors could increase vulnerability to environmental factors (Trace, Baker, Penas-Lledo, & Bulik, 2013). Like biological influences, cultural influences affecting EDs are diffuse. Eating disorders seem to transcend social and economic status, and perhaps even race and ethnicity. This myriad of ED risk factors may contribute to the heterogeneity among symptoms, and complicate treatment. One implication is that reliance on diagnosis risks over simplifying the diversity among ED experiences.

### **Eating Disorder Treatment**

The risk of over-simplifying EDs is further reflected in basic definitions of recovery that require body weight be restored to within at least 85% of expected ranges, return of menstruation in post-menarcheal women, and cessation of bingeing, purging, or restriction for at least eight consecutive weeks (Couturier & Lock, 2006). These well-defined indicators of physical and behavioural recovery are typical targets in the research and practice of ED treatments, but may not sufficiently address the complexity of EDs. In particular, physical and behavioural changes without psychological considerations are associated with treatment drop-out and ED relapse (Vandereycken & Vansteenkiste, 2009). Rates of relapse range from 22 to 51% in treatment trials where physical and behavioural intervention is the focus (Keel, Dorner, Franko, Jackson, &

Herzog, 2005). Rates of failed treatment may be higher if individuals who drop out were considered. Beyond physical and behavioural intervention, individuals reported that psychological intervention is vital to their ED recovery (de la Rie, Noordenbos, Donker, & Furth, 2007). Addressing physical and behavioural symptoms is an aspect of treatment, and important for the safety of clients, but does not appear to be sufficient without psychological considerations for long term ED remission.

Treatment by medical doctors serves to stabilize the risk of serious physiological consequences (Kaplan, 2002) and reduces the risk of mortality associated with EDs (Hoek, 2006). Medical stabilization is considered essential for correcting cognitive deficits, which can result from the physiological effects of malnutrition, and in turn allows for effective psychological intervention (Rosen, 2010). Psychotherapy is important for addressing misperceptions about body weight or shape, fear of becoming fat, and psychosocial functioning which appear relevant to longer term remission (Keel et al., 2005).

**Psychotherapy for the treatment of eating disorders.** Because both medical professionals and psychotherapists play a role in ED treatment, ED treatment occurs in and outside of hospital settings. Treatment that occurs outside of hospitals will, for the purposes of this research, be referred to as treatment in community practice settings. Community practice settings can be generally distinguished from hospitals by virtue of the population treated. The symptoms of individuals treated in hospitals may be different than the symptoms of individuals who are treated in community practice settings. Presumably, medical intervention is of highest priority for patients treated in hospital settings. As a result, the goals and expectations of psychotherapy occurring in the hospital may be different than that which occurs in community practices. The current study considers ED-focal psychotherapy in community practice settings.

Von Ranson and Robinson (2006) surveyed psychotherapists who work with ED clients in community practice settings. The 52 psychotherapists who completed the survey identified as counsellors, nurses, psychologists, psychiatrists, and social workers. The majority of these psychotherapists reported often or always using an eclectic or integrative approach. The psychotherapists surveyed integrated cognitive behavioural therapy (included by 44.2% of the therapists), interpersonal psychotherapy (13.5%), eye movement desensitization and reprocessing (11.5%), strategic or solution focussed therapy (11.5%), addiction-based therapy (11.5%), feminist therapy (9.6%), narrative therapy (9.6%), hypnosis (7.7%), and systems theory

(5.8%). Reasons therapists provided for choosing their given approaches were research support, consistency with their theoretical orientation, because their clinical experience suggests that the approach is effective, and to tailor treatment to individual client needs.

The integrative use of therapies by clinicians and reference of clinical experience suggesting approaches are effective demonstrate a lack of unified theoretical notions looked upon to guide ED-focal psychotherapy. As with psychotherapy more broadly, the lack of unified guiding principles for ED-focal therapy is not necessarily due to lack of research establishing validity of therapeutic approaches. A “proliferation” of therapeutic theories, numbering in the hundreds, have been developed, to varying degrees in quality and quantity of research, over the last several decades (Duncan, Miller, Wampold, & Hubble, 2010). For addressing EDs, the most commonly cited evidence based or empirically supported psychotherapies include cognitive behavioural therapy, dialectic behaviour therapy, family therapy, and interpersonal therapy (Fairburn & Bohn, 2005; Wilson, Grilo, & Vitousek, 2007). Cognitive therapy, cognitive restructuring, symptom-orientated approaches, exposure treatments, motivational enhancement therapy, supportive therapy, emotion focussed therapy, psychodynamic therapy, and psychoanalytic therapy have also been cited in ED treatment trials (Brauhardt, de Zwaan, Hilbert, 2014). The reality that none of these therapeutic theories prevail as superior may reflect the complexity of EDs, and thus utilization of multiple strategies to address the varied needs of clients.

Given that they are the most commonly researched ED therapies, I highlight below cognitive behavioural therapy, dialectical behaviour therapy, family therapy, and interpersonal therapy. I include the focus of each therapy, implications for how EDs are conceptualized and addressed, and basic strategies employed.

***Cognitive behavioural therapy.*** The theory and procedural details of cognitive behavioural therapy for EDs were first described by Fairburn and colleagues (Fairburn, 1981, 1985; Fairburn, Cooper, & Cooper, 1986). Fairburn, Cooper, and Shafran (2003) describe the current status of cognitive behavioural therapy as a trans-diagnostic theory suitable for all EDs. According to this theory, people with EDs judge themselves largely in terms of their eating habits, body shape, and weight. As a result, their lives become focussed on dietary control, a preoccupation with thinness, and weight loss. It is understood that individuals who diet react negatively when their diets inevitably slip as a result of unrealistic dietary restrictions.

Restriction and resulting dietary slips, even binges, are believed to temporarily neutralize emotional states and distract clients from life difficulties, yet clients interpret the behaviours as evidence that they lack self-control. This negative self-evaluation is thought to maintain the ED by leading clients to strive even harder for unattainable success in terms of eating, shape, and weight control.

The cognitive behavioural therapy manual used most often for research purposes (i.e., controlled outcome trials) outlines four stages of individual psychotherapy (Fairburn, Cooper, & Shafran, 2003). Stage one focuses on normalizing food intake, stage two characterizes barriers to change, stage three addresses clients' cognitive distortions or maladaptive beliefs, and stage four emphasizes relapse prevention. One to two years of individual cognitive behavioural therapy is recommended for clients entering treatment at a low weight, or one year for clients who are not underweight.

***Dialectical behaviour therapy.*** Dialectical behaviour therapy was initially developed by Marsha Linehan (1993) for the psychotherapeutic treatment of borderline personality disorder. It has since been used to treat other mental illnesses with symptoms of emotional dysregulation, including EDs (Linehan & Chen, 2005). The word "dialectical" refers to the concept of being able to hold two seemingly different ideas at once. The two different ideas core to the theory of dialectical behavioural therapy are clients' acceptance of their current distress and behavioural change.

The basic premise of dialectical behaviour therapy is that EDs serve to regulate intolerable affective states in individuals with few or no other adaptive strategies for regulating emotional affect. Eating disorder symptoms are seen as attempts to escape or block aversive emotions that may be triggered by thoughts regarding food, body image, perfectionism, one's self, or interpersonal situations. The ED symptoms are believed to distract attention and cognitive focus from these thoughts, to provide immediate escape from physiological responses and feelings. Over time, the ED symptoms can become a habit, or a relied upon dysfunctional response to otherwise unregulated emotions.

To address this dysfunctional response to aversive thoughts and feelings, dialectical behavioural therapy seeks to help clients accept distress while aiding them with skills to alter their dysfunctional behavioural patterns. Acceptance strategies include mindfulness practices (i.e., learning to observe, describe, and participate in the moment without judgement), and a

variety of validation techniques. Behavioural change strategies include methodical behavioural analysis of dysfunctional chains of behaviour, commitment strategies to engage clients, didactic lessons, exposure-based exercises, and contingency management to reduce or prevent “disordered” responses. These acceptance and behavioural change strategies are consolidated into four modules of dialectical behavioural therapy: core mindfulness skills, interpersonal effectiveness skills, emotional regulation skills, and distress tolerance skills.

***Family therapy.*** Family based psychotherapy for the treatment of EDs has been largely developed by Daniel le Grange (1999) and James Lock (2013). The Maudsley approach (Lock, le Grange, Agras, & Dare, 2001) may be the most recognizable family therapy given its predominance in ED literature and controlled outcome trials in particular (Hay, 2013; Kaplan, 2002; Wilson, Grilo, & Vitousek, 2007; Stein et al., 2001). While the Maudsley approach, named after the London hospital where it was initially studied, is specific to the treatment of EDs in youth and adolescents, family based ED therapy has also been empirically tested for the treatment of adult EDs (Eisler et al., 1997; Russell, Szmulker, Dare, & Eisler, 1987). Family therapy for EDs is characterized by direct inclusion of the client’s family members—whether parents or partners. Using the therapy, families are directly involved in addressing ED symptoms and are given responsibility for facilitating treatment adherence. This treatment is framed by three phases. In the first phase, parents and partners are given chief responsibility for management of the illness and behavioural changes. A fundamental principle of family based therapy is externalization of the ED as an illness. This means separating the client from the ED throughout therapy to reduce blame for and promote empowerment over the ED. For instance, by assigning a name to the ED, parents and partners can work as team with the client against the ED, rather than the client feeling like their family is working against them personally. This first phase is directed towards undermining the power of the ED. In the second phase, the therapeutic focus shifts towards a gradual re-allocation of responsibility for eating and reduction in ED symptoms to the client. However, the therapist remains vigilant, and reminds family members to look out for ED symptoms that the client has difficulties managing. In the final phase, the therapist shifts attention to discussions regarding normal developmental, family roles, and relational issues that may interfere with recovery.

***Interpersonal therapy.*** The last of the commonly cited evidence based or empirically supported therapies, interpersonal therapy, postulates that interpersonal difficulties contribute to

the maintenance of EDs (Murphy, Straebl, Basden, Cooper, & Fairburn, 2012). These difficulties may precede or be a consequence of the ED. In either case, it is expected that the ED results in social withdrawal or low self-esteem which limit client experience in developing and maintaining close relationships.

The social withdrawal and low self-esteem associated with EDs is thought to contribute to the maintenance of the ED through a variety of mechanisms. Individuals may become more isolated from the normalizing influence of their peers and, as a result, their psychopathology may persist unchallenged. Alternatively, certain ED symptoms may be directly maintained by interpersonal difficulties, like unresolved confrontation or loneliness. Or, interpersonal difficulties can worsen self-esteem, which in turn may increase client efforts to control their eating, body shape, and weight to feel more in control. Interpersonal therapy prioritizes recognition and solving of problematic relationships that maintain the ED. It is called “interpersonal” because it focuses on the way people communicate or interact with each other. Focus of the therapy is not on changing eating habits, but rather helping the client to build stronger and healthier relationships with others. As clients feel better about themselves and their relationships, it is expected that ED symptoms will decrease or even disappear.

Interpersonal therapy for EDs has three phases, each with its own aims and strategies. The aim of the first phase is to engage clients in treatment and to describe the rationale and nature of treatment. The goal is for the client and therapist to jointly identify and agree upon the current interpersonal problems, which become the focus of the rest of the treatment. Phase two comprises the bulk of the therapy, and aims to have the client understand the nature of the identified interpersonal problems, and address them. Interpersonal theory categorizes interpersonal problems into four “problem areas” for addressing grief, interpersonal role disputes, role transitions, and interpersonal deficits. In phase three, the goal becomes to ensure that changes made in therapy are maintained and that risk of relapse is minimized.

**Differences in the research and practice of eating disorder psychotherapies.** The integrative use of therapies by practitioners may represent the complexity of EDs, such that no single therapy addresses the needs of clients. It may also reflect a research-practice gap. This is indicated in von Ranson & Robinson’s (2006) survey of therapists treating EDs in community practice settings, where relatively few of the therapists could name authors of the manuals most popularly used in practice. In another study of 265 clinicians specializing in psychotherapy with

ED clients, 21% of the therapists had never studied an evidence based treatment manual (Tobin, Banker, Weisbert, & Bowers, 2007). These findings suggest that the vast majority of clinicians do not use empirically supported treatments when treating clients with EDs.

Lilienfield et al. (2013) propose three potential sources of a “research-practice gap” affecting practitioners’ use of empirically supported ED treatments. For one, they identify attitudinal differences among researchers who often have an aptitude for math and science, compared to practitioners who reflect desire to help others but tend to perform more poorly than other individuals in math and science (Ackerman & Heggstad, 1997). This leads to the second proposed source of a gap: differences among the weight accorded to evidence in clinical decision-making and what constitutes that evidence. Researchers with backgrounds in math and science tend to believe in more rigorous sources of data such as findings from randomized controlled trials, while practitioners may regard intuitions and informal clinical observations as valid evidence regarding the effectiveness of treatment (Banker & Klump, 2010). Third, Lilienfield et al. identify cognitive impediments that can preclude a full appreciation of systemic research evidence necessary for ascertaining treatment effectiveness. For example, naïve realism is the belief that we can trust our perceptions to afford an accurate view of the world, tempting reliance on perceptions of client change when drawing inferences about therapeutic effectiveness. However, those perceptions might be constrained by expectations and bias (i.e., placebo effect, effort justification, regression to the mean, spontaneous remission, or multiple treatment inference) leading to erroneous conclusions. Another cognitive impediment is peoples’ tendency to recall successes while forgetting their failures to seek evidence consistent with hypotheses. Confirmation bias can contribute to researchers identifying illusory correlations that result in false perception that interventions are associated with positive client outcomes (Chapman & Chapman, 1967), or practitioners’ tendency to overestimate their treatment effectiveness and underestimate the proportion of their clients who deteriorate (Brosan, Reynolds, & Moore, 1981; Walfish, McAlister, O’Donnell, & Lambert, 2012). These researcher and practitioner differences are relevant to evolution in how psychotherapy practices are assessed.

### **Assessing Psychotherapy**

Developing and comparing the effectiveness of psychotherapies began when Sigmund Freud published his methods of psychoanalysis in 1924 (Bergin, 1971). Freud’s followers

defended psychoanalysis, developed variations, and modified his original model. The client-centered theory published by Carl Rogers in 1942 was the first significant departure from Freud's "therapist-as-expert" view, rather emphasizing the client's potential for self-healing and need for the therapist to provide an environment rich in respect, warmth, and empathetic connection. Thus launched a competition for "the best" psychotherapy. The latter half of the 20th century saw a proliferation of new psychotherapies, each promising to be superior to the others (Hubble, Duncan, Miller, & Wampold, 2010). In addition to the growing diversity and expansion among modes of psychotherapy, research methods for assessing psychotherapies evolved (Orlinsky, Ronnestad, & Willutzki, 2004).

One way to frame this evolution in research for assessing psychotherapy is to return to differences between research and practice, and in particular what researchers and practitioners typically consider as valid evidence of effectiveness. In the following sections I situate the different types of science and resulting research evidence along a spectrum, from what is traditionally considered "empirical" study associated with post-positivist, quantitative, natural science traditions to what has been called "interpretive" or "discursive" evidence where knowledge is considered to be context-specific and a cultural construction (Paré & Sutherland, in press). I demonstrate how psychotherapy research, including research on ED focal psychotherapy, is evolving to include more interpretive studies and the benefit of that for practitioners.

**Empirical study.** While "empirical study" may refer to any research where knowledge is gained by means of observation or experience, I refer to it as the type of rigorous and objective inquiry that aims for universally valid "truths." Adoption of this approach may have resulted from origins of psychotherapy in hospital psychiatric centers (Albee, 2000). This alignment with medicine meant that organic explanations were sought for diagnoses, and techniques akin to medication were developed to "fix the patients" (Wampold, 2001). To establish its value alongside medical psychiatry, psychotherapy has been compared to drug therapies (Lambert, 2004). Drug approval criteria requires randomized controlled outcome trials. Controlled trials allowed the outcomes of psychotherapy to be compared with results of pharmacotherapy to vie for credibility and funding (Lambert, 2004).

Controlled trials entail the assumption that psychotherapy is an application of fixed techniques to address a diagnosed emotional or behavioural disorder carried passively by patients

who cooperatively receive treatment (Duncan, Miller, Wampold, & Hubble, 2010). Within this paradigm, psychotherapies have been considered “empirically validated” for the treatment of a particular diagnosis when at least two trials show statistically significant change relative to untreated groups in carefully controlled conditions (American Psychological Association, 1995). Throughout the 20th century, controlled outcome trials showed that psychotherapy is remarkably effective. Clients treated with psychotherapy are consistently found to be better off than 80% of participants who do not receive psychotherapy treatment (Lambert & Ogles, 2004; Wampold, 2007). Similarly, ED-focal psychotherapy has been found effective.

Psychotherapies to treat EDs have been largely established by researchers using controlled trials to evaluate the outcome of therapies for treating anorexia or bulimia (Rockert, Kaplan, & Olmsted, 2007). Less is known about the effects of psychotherapy for treatment of ED Not Otherwise Specified, as controlled trials are difficult given the heterogeneity of symptoms included in this diagnostic category. While controlled trials reveal little about treatment of the most prominent ED Not Otherwise Specified category, researchers have established cognitive behavioural therapy as “the best practice,” possibly because it is the most studied approach (Hay, 2013; Kaplan, 2002; Stein et al., 2001; Wilson, Grilo, & Vitousek, 2007). That said, volume of supportive controlled trial data does not mean that a mode of psychotherapy is necessarily superior to other, lesser-studied therapies. Actually, no particular psychotherapy for addressing EDs has been shown to have a more favourable outcome than another (le Grange & Lock, 2005; Wilson, Grilo, & Vitousek, 2007). Although no single theory of psychotherapy stands out as superior to others, psychotherapies that specifically address EDs are shown, using controlled trials, to be more effective than routine (not ED-focal) psychotherapies (Dare, Eisler, Russell, Treasure, & Dodge, 2001). This to say that psychotherapy where ED is the primary focus is important for the treatment of EDs, but warrants further study to understand what constitutes that effectiveness.

The same limitation of equivalency among outcomes exists in the study of ED psychotherapy as in the study of psychotherapy more broadly. Outcomes among tested psychotherapies are generally equivalent (Siev, Huppert, & Chambles, 2009; Wampold, Imel, & Miller, 2009). Meta-analyses of controlled outcome trials reveal that techniques unique to each therapeutic approach account for only 15% of the therapeutic effect or benefit (Lambert, 1986, 1992). In addition to technique, Lambert found that extra-therapeutic variables account for 40%

of client change, factors common among theories account for 30%, and the remaining 15% of therapeutic effect is attributed to hope, expectancy, and placebo. Beyond the actual techniques used, the course of psychotherapy can be impacted by client and therapist variables.

Psychotherapy is delivered through a therapeutic relationship and based primarily on verbal or non-verbal communication. As such, therapists and clients play a role in directing the course, and subsequent outcome of psychotherapy. This leads to the prevalent criticism of empirical study of psychotherapy, which is by nature reductionist. Empirical study reduces the highly complex and dynamic practice of psychotherapy to a subset of discrete, measurable variables (Castelnuovo, 2010; Mahrer, 2004; Paré & Sutherland, in press).

It may be that human sciences are more complex than can be understood by measuring the outcome of fixed techniques under well-controlled conditions. Dr. Gabor Maté (2003) summarizes the problem referencing Einstein's theory of relativity; that an observer's position influences the phenomenon being observed, which affects resulting observations. Similarly, clients and therapists can have their own unique experiences of psychotherapy. They each come to therapy with their own personalities, backgrounds, beliefs, preferences, needs, and expectations, all of which can influence the course of psychotherapy and perceived reality of what occurs.

The idea that people experience psychotherapy differently depending on their vantage point or role in the therapeutic process is supported in psychotherapy research. Researchers, psychotherapists, and clients are all found to be biased depending on their level and type of involvement (Hill & Lambert, 2004). For instance, psychotherapists and clients have privileged information about what happens based on their participation in and experience of sessions, whereas nonparticipant observers have to rely on their imagination of how it may have felt to be involved in the psychotherapy. Overall, there is low correlation among different perspectives on psychotherapeutic measures. Clients, therapists, and non-participant observers generally have different impressions of therapeutic processes and outcomes (Orlinsky, Ronnestad, & Willutzki, 2004). This means that researchers cannot assume that they are able to objectively observe therapeutic events, and psychotherapists cannot assume that their assessment of therapeutic events is "right." How clients experience psychotherapy may or may not align with researcher or therapist interpretations. As a result, considering different perspectives of therapy can add value to research (Lambert & Shimokawa, 2011).

**Interpretive study.** Towards the end of the 20th century, the focus of psychotherapy research extended beyond establishing a relationship between psychotherapy and outcome. Increasingly, understanding the nature of that relationship and plausible explanations linking cause to effect is valued (Haynes & O'Brien, 2000). Therapist and client perspectives can be used to elucidate “what happens” in therapy. This consideration of therapist and client perspectives is reflective of interpretive study where the interactions of psychotherapy are observed and analyzed. Different than the “universal truths” pursued by post-positivist study, findings from interpretive study are subjective and considered transferable rather than generalizable (Creswell, 2013). However, the often qualitative and typically context-specific research results in “experience-near” (Geertz, 1976) rich descriptions of psychotherapy. A growing body of literature suggests that psychotherapists consider interpretive research to be more relevant, understandable, and reflective of everyday practice (Goss & Rowland, 2000; McLeod, 2011). This finding also fits with therapist perspectives reported in interpretive research, which I will review shortly.

To prevent confusion, it is worth noting that interpretive research can be referred to and approached in different ways. *Practice based evidence* utilizes client feedback from practice in naturalistic settings to evaluate treatment fit and outcome (Duncan, Miller, Wampold, & Hubble, 2010). *Good moments research* examines instances of “very good moments” in therapeutic sessions to then identify therapist operations judged as instrumental in the consequent occurrence of the good moment, as well as the in-session client condition or state under which the therapist operations were carried out (Mahrer, White, Howard, Gagnon, & MacPhee, 1992). *Common factors* have also been associated with interpretive inquiry, which observes dimensions of treatment that are not specific to any particular theory or technique—like expectation for improvement; therapist confidence; and a therapeutic relationship that is characterized by trust, warmth, understanding, acceptance, kindness, and human wisdom (Castelnuovo, 2010). Such observations discourage reliance on operationalized techniques that are inherent to post-positivist study, as common factors suggest more than specific intervention protocols have therapeutic effects (Duncan & Miller, 2005). One way these approaches are unified and distinct from traditionally post-positivist empirical study is that they are discovery orientated, as opposed to bound by hypotheses (Mahrer, 1988). Discovery orientated research opens the field to new or unanticipated findings reflective of what is experienced in actual therapeutic encounters, and

findings that offer a more holistic view of therapy. Paré and Sutherland (in press) point out that this allows for idiosyncratic information that can inform how practical dilemmas are dealt with in therapy. Inability to inform the nuances of *how* therapy unfolds given different contexts is a shortcoming of nomothetic findings resulting from other empirical study, which reduce psychotherapy to algorithms of discrete variables.

Elliot's *qualitative helpful factors design* (2010) is an example of interpretive research. The design involves either interviewing clients or giving them a post-session questionnaire (e.g., the Session Rating Scale and Outcome Rating Scale; Miller, 2012). These strategies allow for consideration of immediate and delayed effects that clients experience, depending on the proximity of the interview or questionnaire to therapy. It allows clients to describe how they have changed over the course of therapy to date and what they attribute those changes to, recognizing that the impact of some events may be diffuse or not immediately apparent. The experiences of very few (i.e., one to 12) participants are typically considered in depth to develop detailed and idiographic understandings of therapeutic change. The nature of this research is discovery orientated in that it allows for consideration of individual experiences in real contexts, rather than pursuing hypotheses under well controlled conditions. Without being confined to a hypothesis, new or underdeveloped considerations can be elucidated. These considerations can include common factors or theory specific interventions.

Exploring participant perspectives, either the perspectives of therapists or clients, using the qualitative helpful factors design can be used to inspire new models of therapy, or to identify problems and improve the application of existing therapeutic modes. The latter is well illustrated in a developing body of ED research in which researchers consider feedback from clients and therapists about the actual utility of psychotherapy practices (House et al., 2012; Lilienfeld et al., 2013).

***Therapist perspectives.*** Therapists have reported reluctance adhering to “best practices” established by researchers using controlled outcome trials (Mussell et al., 2000; Wallace & von Ranson, 2012), because those modes of psychotherapy fail to meet the diverse needs of their clients (Haas & Clopton, 2003; Lowe, Bunnell, Neeren, Chernyak, & Greberman, 2011). Best practices to date may not meet the diverse needs of clients as controlled trials have revolved around the treatment of well-defined anorexia- and bulimia-specific diagnoses, at the exclusion of the larger but heterogeneous ED Not Otherwise Specified diagnosis (Rockert, Kaplan, &

Olmsted, 2007; Quick et al., 2014). Co-morbidity of anxiety, depression, other mood disorders, and personality disorders is also common and adds to the complexity of working with ED clients, but is relatively excluded from controlled studies (Fairburn & Bohn, 2005; Martin, Williamson, & Thaw, 2000; Ricca et al., 2001; Turner & Bryant-Waugh, 2004).

When asked to describe what it was like to implement a mode of ED-specific cognitive behavioural therapy, practitioners reported that the manualized approach did not meet the needs of their clients (Lowe et al., 2011). Therapists felt forced to limit their clients' emotional expression in order to focus on areas imposed by the manual. Adhering to the manual further prevented therapists from responding to their clients' negative affect in response to the imposed focus of therapy. It was found that therapists needed to deviate from the manuals in order to sustain client motivation, commitment, and progress in therapy.

Eating disordered clients are less likely to deteriorate, more likely to stay in therapy longer, and twice as likely to achieve clinically significant change when psychotherapists have access to in-session outcomes and therapeutic alliance information (Lambert et al., 2003). Psychotherapists with this information are able to adjust therapy accordingly to meet the needs of their clients. Similarly, in ED-focal psychotherapy research, clients were more satisfied, stayed in therapy longer, and had better outcomes when their therapists provided them with choice and opportunity to provide input during the course of therapy, rather than used fixed approaches (Cockell, Zaitsoff, & Geller, 2004). These findings demonstrate the value of also considering client perspectives in research and practice.

*Client perspectives.* Understandings from empirical inquiry may be limited by virtue of having been developed using controlled outcome trials that do not account for the varied needs of clients in community practice settings (Lowe et al., 2011). To better understand the needs of clients, researchers are starting to consider client experiences of psychotherapy to treat EDs in practice settings (House, Schmidt, Craig et al., 2012; Lilienfeld et al., 2013). I am aware of three studies that forefront client perspectives of ED focal psychotherapy.

In the first study, researchers considered 20 participants with anorexia or bulimia who were referred by a physician to an outpatient service with multi-professional staffing that included psychiatrists, clinical psychologists, and nurses (Reid, Burr, Williams, & Hammersley, 2008). When asked what they felt was most useful in their experience of treatment, participants pointed to the importance of feeling cared for and understood by the staff. Participants also

valued opportunity to acquire strategies for managing emotions, feelings, unrealistic beliefs, high risk situations, social relationships, self-esteem, and self-worth. This study considered clients' encounters with medical doctors and nurses, in addition to psychotherapists, but the authors say that capturing client experiences of these services can inform psychotherapy processes. The findings suggest that clients appreciate strategies offered by therapists who are well informed about EDs, as well as individual consideration so that they feel understood and cared for by therapists. Clinical expertise was considered important because participants did not feel that empathy alone would redress their problems. The strategies that participants reported experts imparting included clear guidance and goal setting, as well as cognitive behavioural "mental tools" to manage their feelings and emotions, work on unrealistic beliefs about diet and restraint, practical suggestions for managing "high risk" situations without resorting to problematic behaviour, building self-esteem and self-worth, and reviewing and managing social relationships. However, in addition to imparting knowledge and expertise, participants also considered therapists having effective communication skills as paramount for recognizing their needs and successfully suggesting replacement coping strategies. Participants described this as therapists supporting them in maintaining a sense of autonomy through a more consultative rather than directive approach, offering love and support, and "actually wanting to see" the client get better.

In a second study, Marchant and Payne (2002) explored client experiences of psychotherapy received for anorexia. Participants identified the importance of therapists having specialized knowledge about anorexia, using an ED-focal counselling process, and developing a trusting relationship by being empathetic to their individual needs. As in the first study described, these findings reinforce the importance of expert therapists who use specialized ED-techniques, as well as who consider contextual factors to understand and care for clients. More specifically, the findings of this study elaborate on how therapists can share their knowledge with clients and influence client change in supportive ways that do not feel punitive or that reduce the message to "go away and eat." Participants reported a warm and respectful relationship, in which trust, honesty, and openness were present on the part of the therapist and client, as beneficial. In such a relationship, the participants felt informed choices regarding their symptoms were made available to them but that they ultimately held the power to make those changes for themselves.

In a third study, participants treated for anorexia in hospital and community practice settings were asked to reflect on their experiences of psychotherapy, from which preferred therapist characteristics were drawn (Gulliksen et al., 2012). Therapist characteristics associated with client satisfaction included acceptance of the client, vitality in their work, and specialized ED expertise. Acceptance was associated with the therapist presenting generosity, respect, and patience in their work with clients. Vitality was associated with therapists demonstrating “active interest” and a sense of humour in their work with clients. Expertise was perceived as therapists having knowledge and authoritativeness. *Knowledge* referred to a therapist’s ability to understand how clients with EDs might think, feel, or act which, upon sharing with clients, could help clients to better understand, recognize, and accept themselves. *Authoritativeness* referred to therapists’ confidence which, when perceived, made clients feel more secure in their treatment.

The above three studies draw on client experiences to illuminate what clients perceive to be meaningful in their ED-focal psychotherapy. The results of each study indicates the importance of therapist expertise, as well as therapists considering each individual client’s context such that the client feels understood and cared for. The findings offer insight into what clients actually experience as useful and beneficial in their experiences of ED-focal psychotherapy. These studies start to establish a picture of nuances informing how psychotherapy unfolds in helpful ways. In all three studies, data were in the form of client descriptions of therapy experiences and were analyzed using heuristic (Marchant & Payne, 2002) or thematic techniques (Gulliksen et al., 2012; Reid, Burr, Williams, & Hammersley, 2008) resulting in conditions, factors, and themes associated with helpful therapy. However, these studies are limited in that participants received psychotherapy specifically for Anorexia and Bulimia, at the exclusion of ED Not Otherwise Specified. Further, the studies considered services provided by medical professionals in addition to psychotherapists (Reid, Burr, Williams, & Hammersley, 2008), and psychotherapy that occurred in both hospital and community practice settings (Gulliksen et al., 2012). Using a similar methodology, consideration of participants with a wider range of EDs and who have received services from psychotherapists in community practice settings could further contribute to our understanding of ED-focal therapy by deepening illustration of nuances in *what* and *how* therapy unfolds. Methodology for doing this, including strengths and limitations of interpretive research, will be more thoroughly reviewed in the next chapter.

## CHAPTER THREE

### The Current Study

Psychotherapies for the treatment of EDs have been largely researched to date using controlled outcome trials of manualized modes of psychotherapy (Rockert, Kaplan, & Olmsted, 2007). These controlled outcome trials demonstrate that ED-focal psychotherapy is effective (Dare, Eisler, Russell, Treasure, & Dodge, 2001), but reveal little about what accounts for that effectiveness (Kaplan, 2002; Kraemer, Wilson, Fairburn, & Agras, 2002). A significant number of clients fail to respond to tested modes of psychotherapy (Fisher, Hetrick, & Rushford, 2010; McIntosh et al., 2005), or relapse post treatment (Keel, Dorer, Franko, Jackson, & Herzog, 2005). And, understanding of ED-focal psychotherapy from controlled trials is limited in that trials are typically restricted to Anorexia or Bulimia specific diagnoses, excluding individuals with the more prevalent ED Not Otherwise Specified (Quick et al., 2014) and co-morbidity (Fairburn & Bohn, 2005).

Exploring what therapists and clients perceive to be meaningful in their experience of ED-focal psychotherapy can add value to research by elaborating on the nuances of what occurs in actual therapy and how that therapy unfolds in real-world contexts (Lambert & Shimokawa, 2011). In a growing trend, researchers consider the perspectives of therapists and clients to further elucidate what, in their experience, is meaningful to the practice of psychotherapy for treating EDs (House et al., 2012; Lilienfeld et al., 2013). Exploration of these perspectives is showing that clients prefer to have their input considered in therapy, including choice in the unfolding of that therapy (Cockell, Zaitsoff, & Geller, 2004), and that therapists recognize the ability to adjust therapy according to clients' varied needs as necessary (Haas & Clopton, 2003; Mussell et al., 2000; Wallace & von Ranson, 2012). Therapists report that it is difficult to adhere to manualized approaches established using controlled outcome trials, as the approaches prescribe strategies of fixed content, length, intensity, and target without consideration of individual client needs and context (Lowe et al., 2011). While manualized approaches validated using controlled trials can demonstrate specific interventions associated with effective therapy, they do not seem to do justice to the nuances of how that therapy unfolds in real-world contexts.

The current study seeks to further understand psychotherapy for the treatment of ED in community practice settings. More specifically, to better understand what clients experience as meaningful beyond what is included in the hypotheses of psychotherapies tested in well

controlled empirical study. This research follows three qualitative studies by Marchant and Payne (2002), Reid, Burr, Williams, and Hammersley (2008), and Gulliksen et al. (2012) where client experiences of ED-focal psychotherapy were explored to elucidate perceptions of therapists and interventions. Similar to the preceding studies, client perspectives were explored using semi-structured interviews to illuminate experiences of therapy that clients undertook to address an ED. However, the current study is different in that it: (a) recruited a natural sample of clients who pursued ED-focal psychotherapy without diagnostic limitations, allowing for inclusion of clients experiencing ED Not Otherwise Specified, diagnostic cross over, or co-morbidity; (b) explored psychotherapy in community practice settings which may differ from psychotherapy received in hospital settings; and (c) considered ED-focal psychotherapy specifically with psychotherapists rather than also including client experiences of related services provided by dietitians, medical practitioners, and other staff in practice settings.

### **Research Question**

To obtain a deeper understanding of what clients experience as meaningful in ED-focal psychotherapy, the current study asks: “How do clients experience psychotherapy in community practice settings where ED is the primary focus?” The purpose of this study is to continue delineating the nuances of how ED-focal therapy unfolds in community practice settings to inform research, practice, and training. To this end, the study aimed to (a) capture client experiences and perceptions of therapy, (b) assess how clients were affected by that therapy, and (c) consider to what clients attribute that effect. I do not impose any valence on what participants describe as meaningful when exploring the research question. Rather, participants were invited to begin by describing what they found meaningful in their therapy, then I invited them to reflect on the extent to which they considered those meaningful experiences to be helpful or hindering within their therapy. I elaborate on why I do not impose valence on “meaningful” when describing the theoretical orientation of this study.

### **Scope of the Study**

The focus of the current study is on individual ED-focal psychotherapy, rather than therapy that occurred in a group, family, or couple format. While it is possible that what is identified as meaningful within individual psychotherapy could also be important in small group formats, these formats are commonly differentiated in research due to their unique features (e.g., see Lambert, 2004). The study was also limited to adult participants 18 years or older, and did

not include youth. Different modes of psychotherapy have been studied for the treatment of EDs in youth and in adults to address different issues and developmental needs (e.g., see Wilson, Grilo, & Vitousek, 2007). Differences among youth and adults with EDs are evidenced by the distinction among instruments for identifying, describing, and understanding ED psychopathology in youth and adults. For example, the Eating Disorder Inventory-Child version (EDI-C) is the youth version of the now Eating Disorder Inventory-3 (EDI-3; Eklund, Paavonen, & Almqvist, 2005). The Youth Eating Disorder Examination Questionnaire (Youth EDE-Q) is also differentiated from the adult version of the same instrument, the Eating Disorder Examination Questionnaire (EDE-Q; Goldschmidt, Doyle, & Wilfey, 2007). The therapeutic needs of youth could differ from those of adults, and individuals 18 years or older are more likely able to reflect on and articulate their perspectives to a depth suitable for this constructivist and phenomenological study.

### **Theoretical Orientation**

This research was conducted using a constructivist framework and principles of hermeneutic phenomenology. Constructivism espouses a relativist position that assumes multiple, accessible, and equally valid realities (Schwandt, 1994). “Reality” as understood using constructivism is subjective and context bound, whereas the reality pursued by post-positivists is considered objective and generalizable. The subjectivity and context-bound ontology of constructivism is consistent with the pursuit of multiple lived experiences and perspectives in phenomenological study. Phenomenology is the use of first-person experiences to describe the nature of what is studied (van Manen, 1990). It forefronts the experiences of individuals, recognizing that there is no singular or “right” experience. Rather, like constructivism, phenomenology considers “reality” to be an individual process dependent on the knower’s historical context, and mental or cognitive processes. This approach suits the study of psychotherapy as it allows for consideration of internal processes and interpersonal transactions (Neimeyer, 1998). In the current study, an understanding of what individuals perceive as meaningful in their experience of psychotherapy to address an ED is co-constructed considering first person experiences.

Co-construction means that a composite description of a shared experience is developed, reflecting the experiences of all research participants surrounding the same phenomenon under study. Data include the perspectives of individuals who have experienced that phenomenon of

interest, where the phenomenon is any “object” of human experience (van Manen, 1990, p. 177). For the current study, the phenomenon of interest is the experience of individual psychotherapy, where ED is the primary focus, in a community practice setting. Participant perspectives contribute to rich descriptions of “how” this phenomenon of interest was experienced (Moustakas, 1994). Results represent the “essence” of a phenomenon at a particular time and in a particular context. That understanding is not necessarily generalizable, but rather said to be transferable to different contexts depending on similarities or differences among experiences (Creswell, 2013), which can be evaluated by the extent to which the reader recognizes his or her own self in the descriptions (Morrow, 2007).

In addition to participants, researchers also play an active role in the co-construction of results. As such, Heidegger’s hermeneutic phenomenology (1927/1962) is relevant to the orientation of this study. When researchers apply Husserl’s phenomenology (1952/1980, 1970), they should bracket their own world views to avoid individual bias and to suspend one’s judgement or particular beliefs about the phenomena in order to see it clearly. Alternatively, Heidegger stresses that every encounter involves interpretation that is influenced by the interpreters’ own background and pre-understandings. Where Husserl pursued knowledge of the world, Heidegger saw people as their world (Polkinghorne, 1983). Consequently, Heidegger disagreed with Husserl that a person’s history or background could be bracketed or made completely explicit. Heidegger went so far as to claim that nothing can be encountered without reference to one’s own background or pre-understanding (Lavery, 2003). Koch (1995) described this as an indissoluble unity between person and the world, whereby meaning is found via transaction between the individual and world as they constitute, and are constituted by, each other.

Making sense of the phenomenon, and constructing a composite description of its essence for the current time and context, requires an interpretive process by which the researcher mediates between perspectives to negotiate shared meaning, and differences, among research participants (van Manen, 1990). The process of iterating among experiences within and across individuals is called the “hermeneutic circle” (Kvale, 1996; Polkinghorne, 1983). Meanings that emerge through this iterative process provide a synthesis of idiographic considerations for the given context, but may not translate to other instances. This shared meaning is one way of understanding a phenomenon for the particular moment.

Idiographic knowledge, co-constructed by participants and the researcher, provides a detailed, ‘zoomed in’ view of a phenomenon. Such contextualized knowledge can inform practitioners on the particularities of clients and contexts in the unfolding of therapy (Bohart, 2005). However, relying on experiential reports introduces subjectivity to the research process. Post-positivist empirical research, such as well-controlled outcome trials, eliminates that subjectivity to allow for non-controversial claims of “truth,” but at the expense of idiosyncrasies intrinsic to the dynamic unfolding of therapy across different circumstances (i.e., different client-therapist dyads). Achieving universal explanations across instances requires a large number of subjects to receive the same treatment, after which outcomes are measured and compared to other “subjects” who received other or no treatment. The results of this approach are said to prove whether or not a treatment is effective. However, the context in which the trials take place, interventions which are tested, and outcome measures used are standardized to reduce contamination by bias or other conflating factors. Using this approach introduces risk of reducing the complexity of psychotherapy to discrete input and output variables, when in reality the context of therapists and clients, interventions used, and assessment of outcome can vary.

How a phenomenon is understood can be influenced by the context in which participants have experienced it, as well as the background and pre-understandings that participants and researchers bring to the study. Backgrounds and pre-understandings include constantly evolving individual and social scripts that help us to make sense of things (Polkinghorne, 1983). Understandings that emerge in this study reflect the context, backgrounds, and knowledge brought forth by the participants sharing their experiences. Acknowledging that the researcher also impacts the findings, I explored and interpreted participant experiences with my own perspective influenced by over six years studying and working with clients in ED-focal therapy. I did not bracket my stances, motivations, assumptions, and biases but rather consider them essential in the hermeneutic process of negotiating meaning with participants (Laverly, 2003). According to hermeneutic phenomenology, my own experiences and understandings are inevitable, and require that similarities and differences among my position and what is conveyed by participants be explored in order to do justice to participant experiences. Rather than bracketing, I have identified my stance, motivations, assumptions, and biases in Appendix A of this dissertation. This was meant to help situate readers to my own experience and orientation in regards to the phenomenon under study. Recognizing my background and pre-understandings

could inform readers' interpretations of the results and utilization of the findings by illuminating why I pursued or elaborated on the elements that I did. Other measures that I took, in addition to disclosing my own experience and pre-understandings, to promote representation of participant experiences without eclipsing them with my own stances, motivations, assumptions, and biases are described with the research methods in Chapter 4.

Exploration and synthesis of understanding regarding participant experiences, co-constructed with the researcher using constructivism and hermeneutic phenomenology results in a shared understanding of ED-focal psychotherapy in a particular context. While this understanding may not translate to all contexts, it captures idiographic considerations consistent with the objective of this study: To obtain a deeper understanding of psychotherapy for the treatment of EDs in community practice settings. Resulting idiographic knowledge can reveal nuances and subjectivity reflective of real-world practice. Such understandings are often considered more useful by practitioners who can integrate the nuances into their own practice as needed (Goss & Rowland, 2000; McLeod, 2011).

## **Methodology**

Building on the above theoretical orientation, I introduce the design of the study, and how epistemological principles of constructivism and hermeneutic phenomenology are incorporated into that design. The actual methods used are delineated in Chapter Four.

This study is framed using the qualitative helpful factors design (Elliott, 2010). The qualitative helpful factors design utilizes interactive participant-researcher dialogue, which is useful for negotiating shared meaning among participants and the researcher (Kvale, 1996; Polkinghorne, 1983). Researcher-participant dialogue is also useful for accessing privileged perspectives of internal and interpersonal aspects of therapy as experienced by clients (Neimeyer, 1998). Interpretive phenomenological analysis informs how data were organized (Smith, Flowers, & Larkin, 2009).

**Qualitative helpful factors design.** The qualitative helpful factors design is a means to develop and modify theories of what does and does not work in therapy (Elliott, 2010). It refers to clients of psychotherapy for informing what they experience as helpful or unhelpful in their therapy. The participants are asked to describe how they have changed over the course of therapy, and to what they attribute those changes. The design has become more popular with the

emergence of qualitative research and the trend towards asking therapists and clients about their experiences of therapy.

Two alternatives for helpful factors research have emerged. First, clients can be interviewed part way through, or at the end of therapy (Elliott, Slatick, & Urman, 2000). Using this approach, clients are interviewed for 30 to 90 minutes during which time they are asked simply what they found helpful, useful, or important during therapy. This produces a broad qualitative review of what clients perceived as meaningful in their therapy. Second, clients can be given a post-session questionnaire (i.e., Llewelyn, 1988), asking clients to describe the most helpful or important thing that happened in the session they have just completed and what made that helpful. Simple quantitative rating scales can also be used to provide means of comparison among significant events from different sessions. To remain close to the constructivist and phenomenological orientation of the study, in the current study clients are interviewed rather than administered a post-session questionnaire following completion of their therapy.

The helpful factors design honours the experiences of research participants by allowing them to put valence on their experiences in terms of what they perceive to be helpful or hindering. Another benefit of the design is that it allows participants and researcher to consider experiences over the course of psychotherapy, including descriptions of immediate and delayed effects. This allows for elucidation of experiences where the impact may not have been immediately apparent to the participant, or how a participant's perspective of an experience may have changed over the course of therapy. The context-specific descriptions reveal nuances in which what is considered meaningful unfolded. Inclusion of internal processes and context that can impact the qualities attributed to an experience fits with constructivism and hermeneutic phenomenology, in that knowledge is defined by the knower and is subjective. For instance, one participant might describe a therapeutic intervention as helpful given his or her particular context, but another participant in a different context may experience the same intervention as unhelpful.

The qualitative helpful factors design is an "ask the client" approach compatible with the theoretical orientation of this study and the trend of considering client perspectives in community practice settings to which this study contributes. Strengths of the design are that it focuses on matters of importance to the participants, and results in rich qualitative accounts of what they consider to be meaningful. Criticisms of the design are likely to come from believers in the

superiority of quantitative methods (e.g., Lilienfeld, Lynn, & Lohr, 2003) who dismiss the qualitative helpful factors design as providing anecdotal testimony of therapeutic effect. In the literature review, I identified that practitioners often regard intuitions and informal clinical observations as valid evidence regarding the effectiveness of treatment (Banker & Klump, 2010). I also noted cognitive impediments that could inhibit client reports and interpretation of those reports for ascertaining treatment effectiveness. Cognitive errors are a limitation of the qualitative helpful factors design. Participants may mistakenly attribute changes to therapy that are actually attributable to other factors (e.g., their own efforts independent of therapy or other life events). Or, clients could simply lack the ability to access and verbally express important but subtle change processes. Efforts to neutralize these limitations will be described along with efforts to bolster trustworthiness and credibility of the results presented in Chapter Four.

**Interpretive phenomenological analysis.** The helpful factors design addresses how data are collected while interpretive phenomenological analysis regards how data are organized. Data collected using the helpful factors design is typically transcribed and analyzed using a method of systematic qualitative analysis, like interpretive phenomenological analysis (Smith, Flowers, & Larkin, 2009), grounded theory (Rennie, Phillips, & Quartaro, 1988), or consensual qualitative research (Hill et al., 2005). Interpretive phenomenological analysis is used to inform data analysis in the current study given its consistency with the theoretical framework of the study. Hermeneutic phenomenology requires that researchers make sense of the data using a number of reflective operations characterized in interpretive phenomenological analysis. Those reflective operations include organizing the data in multiple ways, considering context, and valuing different perspectives throughout the process of analysis. Throughout this process, researchers are encouraged to note emotions, thoughts, observations, and questions elicited, and to describe and comment on language used by participants. Ultimately, through a series of re-visiting and re-organizing the data, units of meaning are distilled and organized into themes based on similarities or differences. Themes are described using rich idiographic narratives supported by verbatim excerpts of participant accounts. This iterative process reflects constructivism and hermeneutic phenomenology in that the context and perspectives of participants, and the perspective of the researcher, are taken into account while remaining grounded in the participants' actual accounts of their experiences.

## CHAPTER FOUR

### Method

In this chapter, I offer a detailed description of the research instruments used for the study, auditing provided by my thesis supervisor, data collection methods including participant recruitment and screening, data analysis procedures, and member checking. I close the chapter with measures taken to address quality and trustworthiness of the study.

### Research Instruments

Two instruments were developed to guide research conversations: a form to collect demographic and background information, and the semi-structured interview guide to elicit client experiences of therapy. Additionally, consistent with constructivism and hermeneutic phenomenology, the role of the primary researcher as an “instrument” for data collection and interpretation is described.

**Demographic and background information form.** The first guide (Appendix B) was developed to gather relevant details for situating participant experiences. It included questions to collect demographic information (i.e., age, gender), descriptive information about the ED that participants self-identified as having (i.e., diagnosis, co-morbidity, treatment), psychotherapist descriptors (i.e., credentials, gender), and the nature of psychotherapy received (i.e., whether individual and ED-focal, number of sessions, duration, termination). In addition to providing context for situating participant experiences to assist with the interpretation of results, collecting this information also served as a mechanism for screening volunteer participants.

**Semi-structured interview guide.** The second guide (Appendix C) was developed to gather rich descriptions of experiences related to the psychotherapy participants pursued where ED was the primary focus, while allowing for interactive dialogue between the researcher and participants. The guide served as a reference point, but I assumed responsibility to develop an environment of safety and trust, and to ensure that sufficient breadth and depth of experiences were acquired across participants (Polkinghorne, 1983). Interviews were fashioned around the principles of hermeneutic phenomenology: asking open-ended questions to increase the likelihood of eliciting what was important to the participants, and exploring what participants and the researcher perceived as meaningful to the phenomenon of interest (Heidegger, 1927/1962).

The interview guide framed five sections of research conversation to be explored. Questions from the first section were geared to the general context of individual ED-focal psychotherapy, extending what was collected using the demographic and background information form (e.g., How old were you when you first remember being affected by an eating disorder? At what point did you seek treatment for that eating disorder?) These initial questions served as a warm-up for the interview, and opportunity to elicit further context with which to situate the findings. Questions in the second section were about collecting context and background specific to individual psychotherapy where ED was the primary focus (e.g., What led you to seek psychotherapy focussing on eating disorder issues? Do you know if your therapist used specific models, techniques, approaches, or types of therapy?). These questions focussed research interviews on experiences of ED-focal psychotherapy with therapists in community practice settings. Questions in the third section of the interview guide were to collect specific examples of what participants experienced as meaningful in their therapy (e.g., Can you tell me about something that stood out to you as meaningful in your therapy?). Follow-up questions were devised to help understand the qualities of what participants identified as meaningful (e.g., Did you experience that as helpful or hindering? Did you always feel that way about the event? What was it like for you before that happened? What was it like for you when it happened? What was it like for you after?). This third section of the interview guide was to be repeated with each participant until they had no further experiences that they considered meaningful and wanted to share. Questions in the fourth section were to access wish list items, as inspired by the critical incident technique (Butterfield, Borgen, Maglio, & Amundson, 2009), and regarded questions about anything that the participants wish had occurred or had occurred differently in their therapy (e.g., I am wondering if there is anything that you wish had occurred differently in your therapy?). Follow up questions were devised to enhance understanding of the wish list items provided (e.g., How would that have improved your experience of therapy? When would that have been most helpful during your therapy? At what point did you become aware that this would be helpful to your sessions?). As with the third section, this fourth set of questions was repeated with each participant until they had no further wish list items that they wanted to share. Questions in the fifth and final section of the interview addressed what it was like for the participants to share their experiences with me, and whether there was anything else that they would want therapists working with ED to know about (e.g., What was it like to share

your experiences with me? Is there anything else that you would want therapists working with eating disorders to know?). These questions provided opportunity to debrief and provide closure to the interview.

**Primary researcher.** As the researcher, I came to this study steeped in ED and psychotherapy literature, and having received training and worked with clients in ED-focal psychotherapy. This means that I have pre-understandings that inform how I respond to and interpret participant experiences of that phenomenon. As initially described when reviewing relevant principles of hermeneutic phenomenology, I did not bracket my pre-understandings to “set them aside” during the research, but rather consider this background and understanding essential in the hermeneutic process of negotiating meaning with participants (Laverly, 2003). Heidegger (1927/1962) said that pre-understandings are not something a person can step outside of or put aside, but are a necessary and useful reference. Discussing my pre-understandings as they were evoked during research conversations with participants helped me to explore participant experiences and co-construct with them an understanding of the phenomenon. However, the influence of my pre-understandings can also affect the trustworthiness of this study. A statement of relevant pre-understandings that I bring to the research is provided (Appendix A) for transparency. Revealing interests, training and experience, personal views, theoretical allegiances, and assumptions inherent to my own practice related to ED-focal psychotherapy can inform the reader of what was elicited for me during the research process, including what I discussed further with participants and my interpretation of data as represented in the results. This transparency is also relevant and again referenced when discussing quality and trustworthiness of the study later in the chapter.

### **Auditing by Thesis Supervisor**

According to Creswell (2013), verifying that a method is followed can strengthen the robustness of findings. In the current study, I consulted with my thesis supervisor, Dr. Audet, throughout the research process. Consults provided opportunity to discuss research methods, fidelity to planned research processes, and the fit of those procedures used with the study and its theoretical orientation. I also provided Dr. Audet with updates after every interview during data collection, including interview transcripts (shared via password protected email accounts). Referring to these interview transcripts, Dr. Audet considered whether the interview guide was followed and if I asked leading questions. She provided feedback on the first three interview

transcripts with regard to these considerations. This auditing is referenced again when discussing quality and trustworthiness of the study later in the chapter.

### **Participants**

Participant voices were fore-fronted in this study. Here I describe the use of purposeful sampling for identifying participants with relevant experience of the phenomenon, including inclusion and exclusion criteria, and how sample size was established.

**Purposeful sampling.** Purposeful sampling was used to select individuals who could provide relevant information to address the research question (Green & Thorogood, 2004). In particular, I was interested in hearing from people who had experienced the phenomenon of individual psychotherapy where ED was the primary focus and occurred in an out-patient community setting, irrespective of their ED diagnosis or comorbidity. As such, participants were selected according to the following inclusion criteria:

- (a) Were at least 18 years of age to increase the likelihood of being able to reflect on and articulate relevant experiences in depth;
- (b) Identified as having experienced an ED, with or without a formal diagnosis, to include a natural variance of ED experiences;
- (c) Received at least 4 sessions of psychotherapy in a community setting with the purpose of resolving the experienced ED, in order to speak to the unfolding of that therapy over multiple sessions; and
- (d) Had stopped therapy, whether that psychotherapy was completed (i.e., as per agreed upon termination between client and therapist) or ended prematurely (e.g., because of client drop out, therapist referral to other services, etc.), at least three months prior to participation in the research study, suggesting that no therapy was in progress and allowing for reflection on the experience as a whole.

In addition to inclusion criteria, the following exclusion criteria were used to protect individuals who may have been too vulnerable to participate, and to avoid interrupting any pending psychotherapy:

- (a) Currently experiencing depression;
- (b) Currently experiencing suicidal thoughts; or
- (c) Receiving on-going treatment for an ED or co-morbid issue.

**Sample size.** Using the helpful factors design, it is common to interview six to 12 participants with the purpose of producing rich qualitative accounts of therapeutic experiences (Elliott, 2010). A sample size of five or six is recommended for studies using interpretive phenomenological analysis (Smith & Osborn, 2008). With these guidelines in mind, appropriate sample size for this study was determined by redundancy of the data collected during research interviews. Redundancy can be used in qualitative research to suggest that sufficient data has been collected (Morrow, 2007), occurring when no new categories or themes emerge with the collection and interpretation of new data (Guba & Lincoln, 2005). I used a chart to track participant sampling, and updated it with information for each new participant. Information tracked included the context of ED-focal therapy (i.e., duration of therapy, nature of termination, time elapsed since termination) and therapist characteristics (i.e., gender, qualifications). Data analysis took place concurrently with participant recruitment as new data was collected, and any new themes identified during within-person data analysis of interview transcripts (described below) were added to the chart. Using this chart, I monitored redundancy of data collected. No new themes emerged after the first five participants, however data was collected with three further participants to increase the variety, extensiveness, and depth of experiences described, for a total of eight participants.

## **Procedures**

**Participant recruitment.** Participant recruitment began as soon as ethics approval was received from the University of Ottawa's Research Ethics Board (Appendix D). Calls for participants were disseminated through an ED resource center serving eastern Ontario, and at a university in Ontario. The poster calling for volunteer participants (Appendix E) was included in four of the resource center's electronic newsletters, released at the beginning of April, May, June, and July 2014. Each issue of this newsletter reaches over 800 people who have accessed or provide ED resources in eastern Ontario (C. Flammer, personal communication, April 9, 2013). Additionally, 100 recruitment posters were displayed around the athletic complex and on billboards in high traffic areas of the university. Half of the posters were displayed at the end of winter semester in April 2014, and the other half were displayed at the beginning of spring/summer session in May 2014 for at least 30 days each time.

**Participant screening.** Inclusion and exclusion criteria were listed on the recruitment poster (Appendix E) to encourage prospective participants' appropriate self-selection.

Prospective participants who self-selected according to inclusion and exclusion criteria were directed, on the recruitment posters, to contact me by email or phone for further description of the study. The study description (Appendix F) was then sent to prospective participants by email. With that email, I also requested to arrange a phone call with the volunteer to clarify nature of the study, and parameters of participant involvement. Of 13 volunteer participants who contacted me, eight answered the study description email agreeing to proceed with a phone call. During these phone calls, I answered any questions prospective participants had, and verified each volunteer's suitability to participate. Prospective participants were reminded of inclusion and exclusion criteria, and if applicable told what criteria precluded them from participating in the study.

**Collecting demographic and background information.** If participants met the selection criteria, and were willing and able to proceed with the study, informed consent for participation in the study was verbally reviewed during the initial phone call (Appendix G). Participants were informed of what their involvement would entail: that participation was voluntary, they would have opportunity to review their individual interview transcripts as well as the study results after data analysis, and they were free to withdraw at any point up until publication of the dissertation. Member checking procedures, where participants were invited to review results after data analysis, are presented after data analysis procedures in this chapter. Participants were offered an opportunity to raise any questions or concerns about being involved in the study, which were promptly addressed. Once consent was verbally obtained, preliminary demographic and background information was collected (Appendix B) during the phone call. Collecting background information provided contextual data to help situate participant experiences, and opportunity for participants to begin reflecting on what they wanted to share during their subsequently scheduled in-person interview. Any contextual information that could potentially identify participants or their therapists was redacted to preserve anonymity.

**Data collection.** Participants were provided a copy of the interview questions (Appendix C) by email after speaking with the researcher on the phone, and indicating that they were willing and able to participate in the study. Participants were invited to reflect on the interview questions and consider relevant experiences prior to meeting for the scheduled in-person interview.

Informed consent (Appendix G) was revisited upon meeting for the in-person research interview. After written consent for participation in the study was obtained, I conducted minimally structured interviews using open-ended questions according to the semi-structured interview guide (Appendix C) described earlier in this chapter. Minimally structured interviews allowed me to explore participants' relevant experiences, without confining data to my own pre-understandings about ED-focal psychotherapy. Questions that I asked supplemented what participants spontaneously provided during the interview. This interview style elicited specific examples and rich descriptions of experiences that participants identified as meaningful in their psychotherapy where ED was the primary focus, and additional information about the participants' overall experience of therapy. Throughout the interviews, I also explored meanings attributed by different participants to similar experiences. Whenever I noticed competing understandings, either among participant accounts or my own experiences, I would ask the participant I was interviewing to help me reconcile a shared understanding accounting for each participant's experience. This provided a safeguard from privileging my own biases. For example, "I am hearing you say that you needed to take stepping stones [or pursue smaller goals] there, you couldn't just take that leap of faith. [Smaller goals] sound like they help participants both emotionally and physically. Is that your experience?" The interviews were audio recorded and ranged in duration from 49 minutes to 98 minutes, with a mean duration of 69 minutes.

At the end of each interview, participants were reminded that they would receive a copy of the individual interview transcript for review. Interviews were transcribed verbatim. As per interpretive phenomenological analysis, all spoken words were included (Smith & Osborn, 2008). Ellipses were used to represent false starts, stutters, inaudible words, and significant pauses. Participant emphasis was identified using italics. I sent transcripts by email and invited participants to provide feedback on their respective transcripts by commenting on anything that they wished to modify, add, or omit. Upon receiving their transcripts, two participants provided feedback. One participant corrected the age that she was at the start of her ED-focal psychotherapy. The other participant clarified or elaborated on examples she had provided (i.e., what books she had read, the origin of a reaction, and rewording her ideas for clarity). Original transcripts for participants who did not request modifications, and the modified transcripts for the two participants who did request changes were used for data analysis.

**Data analysis.** Data that were analyzed consisted of client experiences of individual psychotherapy in community practice settings, where ED was the primary focus. These data were analyzed using interpretive phenomenological analysis (Smith, Flowers, & Larkin, 2009). The following table summarizes steps taken in the analysis process, which are then described in detail below.

**Table 1**

*Steps of Data Analysis Conducted*

Level of Analysis	Task	Purpose
1. Within-Person Analysis	a) Read transcript several times considering the overall sense, and looking for units of meaning.	Make notes in left margin to summarize, paraphrase, draw associations, and make connections among text.
	b) Consider similarities and differences among units of meaning, making notes in the right margin to identify essential qualities of what each participant describes.	Starts to distill possible themes.
	c) Copy and paste units of meaning into chart organized by possible themes identified in step 1(b).	Each section of the chart now represents a possible “theme” with a provisional title and associated units of meaning.
	d) Re-organize sections of the chart by clustering “themes” based on their similarities, and consider title for each cluster of similar themes.	This creates provisional “thematic categories.”
2. Between-Person Analysis	a) Consolidate “themes” and “thematic categories,” including associated units of meaning, from each participant into a single chart.	“Theme” and “thematic category” titles may require amendment depending on similarities and differences among participant experiences included.
	b) Develop descriptions of “themes” and “thematic categories” with narrative and verbatim participant quotes.	Provides rich descriptions including nuances of context, helpful and unhelpful experiences, or experiences that participants wish had been different.

***Within-person analysis.*** Interpretive phenomenological analysis is an idiographic approach to analysis that requires the researcher to begin by considering transcripts on a case by case basis to identify relevant examples of participant experiences, before slowly working toward more general categorization of themes. This within-person analysis was conducted separately for each participant, as data was collected, using the following four steps as per interpretive phenomenological analysis described by Smith, Flowers, and Larkin (2009) unless otherwise stated:

(a) Each transcript was read several times to gain an overall sense of the participant's experience. During the initial two or three readings, I made notes on my preliminary interpretations in the left margin to summarize, paraphrase, draw associations, or make connections among what the participant was saying. At the same time, I highlighted "units of meaning" that revealed contextual data and what participants described as meaningful to their experience of therapy. These units of meaning included any reference to contextual data, helpful experiences, unhelpful experiences, and experiences that participants wish had been different. Units of meaning could be as short as a single sentence, but were not limited by length. Participants' entire descriptions associated with a unit of meaning were highlighted to include as much perspective as possible. Identification of helpful, hindering, and wish list experiences was inspired by the enhanced critical incident technique (Butterfield, Borgen, Maglio, & Amundson, 2009), which I felt complimented Elliott's (2010) qualitative helpful factors design while addressing nuances sought in narrative descriptions using interpretive phenomenological analysis. Consistent with the critical incident technique, different colours were used to highlight contextual data (yellow), experiences that participants described as helpful (green), experiences that participants described as unhelpful or hindering (pink), and "wish list" experiences that participants wish had occurred or occurred differently in their psychotherapy (blue). At this stage, the entire transcript was treated as data, and no attempt was made to omit redundancy. However, not every line generated descriptions of contextual data or meaningful experiences. Example of contextual data identified:

5	<b>Sonia:</b>	When I was first affected by it would be somewhere when I was 14. So it would have
6		been June, May or June. Yeah, so then when I actually sought treatment it would have been August.
7		
8	<b>Diana:</b>	Ok, so May or June and then a couple of months later you sought treatment?
9		
10	<b>Sonia:</b>	Yes.

11  
 12 **Diana:** Ok, and did you ever receive treatment in a hospital setting or inpatient program?  
 13  
 14 **Sonia:** Yes, well I just went to [name of hospital] for a checkup because once I went to my  
 15 doctor, my family doctor, he then sent a referral to [name of hospital] with their eating disorder  
 16 program. So it was just a one day, an outpatient assessment.  
 17  
 18 **Diana:** Ok, and then did you go on your own accord to a therapist in the community or were you  
 19 referred to one?  
 20  
 21 **Sonia:** Yes, so my family doctor referred me to either a behavioural therapist or a psychologist in  
 22 the community. [Name of hospital] had said that the eating disorder wasn't severe enough to be  
 23 inpatient, in that I wasn't underweight or anything so I didn't have to be monitored.

Example of a helpful experience identified:

136 **Kelly:** Her personality was definitely a big plus for her: Very open, empathetic, very nurturing.  
 137 She was also about the same age, we were both mothers. So we had a lot of common ground where  
 138 we could connect, and she went through her own issues at the time with her partner. I think all of  
 139 this together, she just truly got what I was going through and understood it. I often didn't need to  
 140 explain in long sentences, she just knew it. Sure, there was some counter transference there, but I  
 141 just felt totally understood and supported by her. For me, that was exactly what I needed at the  
 142 time. Somebody who could understand where I was coming from, what I lived through, how I felt.

Example of an unhelpful or hindering experience identified:

243 **Jenny:** Maybe some people really do need that all or nothing approach, being told "You need to  
 244 do this." But a lot of times, for me, being told that I need to do "this" and not being able to do that  
 245 meant that I had to end the therapy because it really felt that when I was not understood, I was  
 246 interpreted as being treatment resistant. So telling me that if I wasn't going to take a medication,  
 247 they would see me next in the ICU, I would just shut down. As soon as I felt that the therapist was  
 248 not hearing me, I would just stop talking and revert back to that mute I was as a child, which I now  
 249 recognize [is because] I could not trust or be understood in the situation so escaping was the only  
 250 option, and the therapist would just get frustrated and say "See because you aren't doing well you  
 251 can't even talk" and that was like, ok that is the end of that relationship! And I would just leave.  
 252 But it was frustrating, because deep down it wasn't like I didn't want the help.

Example of a wish list experience identified:

438 **Suzanne:** I would have liked if we talked more about how I felt inside, but I didn't want to, I don't  
 439 know if she was comfortable—maybe she had more experience in the behaviour part? And I felt  
 440 like, I didn't want to say "help me with this, because I have a hard time with it" because I didn't  
 441 want to be too demanding.

(b) Upon subsequent readings of each transcript, I synthesized the notes in the left margin into more concise phrases aimed to represent the essential qualities of "units of meaning" identified. These more concise phrases, recorded in the right margin, documented possible "themes" and provisional titles for those themes. The titles were provisional because they would be amended as needed throughout readings of the transcript, iterating between the transcript and

theme titles, to better represent what participants described. The titles may also be amended depending on similarities or differences among participant experiences identified in later steps of data analysis.

(c) Provisional themes and associated units of meaning (i.e., highlighted excerpts) were then cut and pasted into a single chart for each participant. Each participant’s chart was organized by similarities among the units of meaning. Each grouping in the chart was identified by the theme titles initially proposed in the previous step of the within-person analysis. Identifiers, including the transcript page and line number, were included with each excerpt to allow for easy reference.

The following demonstrates this process, using sample excerpts from Kelly’s transcript for the theme titled *client willingness*, which I also considered calling *client readiness* during analysis:

<p><b>Client Willingness (or Readiness?)</b></p>	<p>“And I think if you aren’t ready to fight your demons, then you keep it about the food. If you focus on the food, then you are not ready to really do the necessary work.” (p.7, lines 328-329)</p> <p>“I had episodes and then the symptoms would disappear again. But the last time that this happened, it got to the point that I couldn’t control it anymore. [The eating disorder] got totally out of control. So, for that time I needed help to get back on track. I guess my life had been totally thrown off track, totally and I just couldn’t hold on to anything else.” (p.8, lines 349-353)</p> <p>“I had to figure it out on my own. I just couldn’t deal with [the eating disorder] anymore. And then she came along and said, you know ‘Yes, there is always a way and if you want to you can find it.’ But you have to be ready to fight and you cannot give up.” (p.8, lines 389-391)</p> <p>“Because when you are really depressed, or you are not able to function anymore, you have like tunnel vision. You can’t really see anything left or right, up or down. You only see what you want to see, and your perception is off. She was able to bring this all back to the basics, and I think that is exactly what I needed at the time. I can’t really remember if we talked about a lot of, you know, some plans or what to do about the symptoms, but for me in this case she was really there to say ‘Ok, we need to rebuild you, you need to get stronger, you need to be more reassured of yourself, you need to trust yourself.” (p.9, lines 396-402)</p> <p>“Her main focus was to stabilize me...to keep me safe, to stabilize me. I kept passing out. At one point, she called an ambulance because I kept passing out. I lost my driver’s license on top of that, because of that, but you know at the time, it was the right thing. I was mad, but it was the right thing to do.” (p.9, lines 421-423)</p> <p>“As far as I can remember, it was about trying to get me to realize that life is worth living, that there are reasons to stay here and to embrace that. You know, really find meaning and purpose in this life which I had totally lost along the way. I think this was her main</p>
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	<p>focus initially.” (p.9, lines 436-440)</p> <p>“[Therapy] requires the client’s willingness, because if the clients aren’t willing to put in the work then this all will not work out. You need to be willing to go forward.” (p. 13, lines 642-643)</p> <p>“Once in a while there are situations where [the therapist] can really set you off, but if you take time to think about it, most of the time there is a reason why things are said the way they are said and if you try to understand that it makes sense. But again, to do that you need to be in a certain place to be ready, and if you have really strong eating disorder issues you are in no place to do that. Because like I said, if your brain is starving you aren’t thinking clearly, you need to be at a certain level to be able to do that.” (p. 14, lines 691-699)</p> <p>“I think this with all kinds of therapy, that if the client doesn’t want to participate, I mean I am a strong believer that you get out what you put into it. I mean it wasn’t always like this for me, like a clear path. There were certainly many ups and downs between, but I am quite happy where I am today.” (p.14, lines 653-656)</p> <p>“I always had it under control. I knew that there was something off, because I have two cousins who were severely eating disordered while they were teenagers, and I am a nurse, so I know about the whole problem. I knew that what I was doing wasn’t the right thing but it worked and it was OK.” (p.15, lines 712-714)</p> <p>“I don’t think that anybody would admit to symptoms if the symptoms weren’t already becoming a problem. As you know, like how many people control their weight through purging, which is eating disordered but wouldn’t call it a problem or get help.” (p.15, lines 726-728)</p>
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(d) Until this point in the data analysis, identified units of meaning and possible themes were charted in the order which they appeared in transcripts. This next step of within-person analysis involved re-ordering themes based on connections among the themes. To do this, themes were clustered based on similarities. For instance, all themes related to ED-specific interventions were grouped together. This was the start of thematic categories, or higher order groups of themes. As was previously done with the themes, each thematic category was given a provisional title.

The following demonstrates themes and excerpts, from Sonia’s transcript, grouped within the thematic category titled *Therapist Way of Being*:

<p><b>Genuine Curiosity</b></p>	<p>“I think throughout it all was really her belief in me and my healing process. From the day I met her she showed this genuine interest and care in me. That care was the way that she approached me, the way that she told me she thought of me, and that something would remind her of me during the week.” (p. 5, lines 234-237)</p> <p>“When I first came there she seemed very genuine in wanting to meet me and wanting to get to know me. I was definitely closed off. I was not the most open person in the beginning. I was not quite sure. I was still very on edge. Was she really going to help me? Or are we just going to go like before [with the first therapist]? Because I was not going to let go of the eating disorder as quickly as before. You know, I am going to hold on to this. But she was very much more, she didn’t even really ask me about the eating</p>
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	<p>disorder directly, or question me on it, she didn't focus on it. It wasn't her focus to get down to the eating disorder—'Let's figure out how to get rid of it.'—She was much more focussed on everything else in my life." (p. 3, lines 95-102)</p> <p>"I was more curious then, I became more curious about all of these things in my life. I was in a bad relationship, I wanted to let go of the eating disorder but I didn't know how. So I would talk to my mom, talk to my dad, talk to my boyfriend at the time. I talked about it with friends and I still wouldn't be able to let it go. But in the back of my mind there was a trauma. It was in the back of my mind that I was not going to tell anyone, because I told myself that it was my fault, I didn't really want anyone else to know about it. But deep down I knew that it was probably why I was still holding on to my eating disorder. And, so I thought one night, I was just like why not write [my therapist] an email and let her know? She is the one person if anyone that will still love you. So I wrote that email, and it was a sense of release, and I ended up showing my mom that email and just laid in bed and cried that night. And my therapist emailed me back and said 'Wow, this is not your fault, this is something that happened to you. I am here for you. When can you come in?'" (p. 9, lines 442-453)</p> <p>"She was very non-judgemental. There have definitely been times when I have done things, like a past relationship that wasn't healthy, and I felt really bummed out in the beginning. How did I let that happen? How did I not see that? I should have known better. All of this past work and this is where I put myself? But my therapist was just so gentle and said 'Sonia this makes sense, you did a lot better, you made better choices, and you are still on the right path, and even that you are recognizing it is great. You know there are healthy parts, and you did make a move.' So I think those little things allowed me to be honest with myself and not get down, you know, on choices that I have made. Because I think even that fosters unhealthy stuff. Even with her, I kind of avoided her with that unhealthy relationship because I knew if I went to see her I would have to tell her what was going on and I would have to, not that she would force me to but I knew that I would want to be honest with her." (p. 15, lines 719-730)</p>
<p><b>Trust</b></p>	<p>"She was very non-judgemental. There have definitely been times when I have done things, like a past relationship that wasn't healthy. And I felt really bummed out in the beginning. How did I let that happen? How did I not see that? I should have known better. All of this past work and this is where I put myself? But my therapist was just so gentle and said 'Sonia this makes sense, you did a lot better, you made better choices, and you are still on the right path, and even that you are recognizing it is great. You know there are healthy parts, and you did make a move.' So I think those little things allowed me to be honest with myself and not get down, you know, on choices that I have made. Because I think even that fosters unhealthy stuff. Even with her, I kind of avoided her with that unhealthy relationship because I knew if I went to see her I would have to tell her what was going on and I would have to, not that she would force me to but I knew that I would want to be honest with her." (p. 15, lines 719-730)</p> <p>"I was more curious then, I became more curious about all of these things in my life. I was in a bad relationship, I wanted to let go of the eating disorder but I didn't know how. So I would talk to my mom, talk to my dad, talk to my boyfriend at the time. I talked about it with friends and I still wouldn't be able to let it go. But in the back of my mind there was a trauma. It was in the back of my mind that I was not going to tell anyone, because I told myself that it was my fault, I didn't really want anyone else to know about it. But deep down I knew that it was probably why I was still holding on to my eating disorder. And, so I thought one night, I was just like why not write [my therapist] an email and let her know? She is the one person if anyone that will still love you. So I wrote that email, and it was a sense of release, and I ended up showing my mom that email and just laid in bed and cried that night. And my therapist emailed me back and said 'Wow, this is not your fault, this is something that happened to you. I am here for</p>

	<p>you. When can you come in?” (p. 9, lines 442-453)</p> <p>“I just had a connection with her. I just loved her style. I loved how she presented herself. I loved how she cared. To me, something drew me to her. I don’t know if we just have those connections with people we stick to, but it was hard sometimes and she did push for things and want to know more, but I trusted her. I trusted her with my feelings and my thoughts, so that allowed me to open up.” (p. 11, lines 510-514)</p>
<p><b>Eating Disorder Expertise</b></p>	<p>“The social worker just said ‘Bring her in and I’ll take care of the rest.’ My mom told me this, and I remember just feeling this sense of hope and feeling that someone actually cares and can help me. I think just her saying that she will take care of the rest, somehow something hit inside that she wanted to and could do something. That she was really going to take care of this, and help me with this. And that hope to somehow heal from it.” (p. 2 lines 86-88)</p> <p>“She was always going to workshops and conferences, and wants to learn more... it is almost like she would come back from a workshop and say Sonia I have just learned this and do you want to try it? Let’s see if this helps you. It felt like we were a team, and we were going to try this, how will that help to deal with the feelings? Maybe this or that will resonate with me.” (p. 17, lines 807-811)</p> <p>“I know that you need to have some understanding and some background, some tools that the client can use but also understanding the process. Because even simple things like when I started to see her and I started to unravel my feelings I was really emotional, and I would come apart at home. My mom was like ‘Oh my god what is going on!’ And she called my social worker. The therapist said, ‘This is good, she is finally letting go of years holding it all together.’ But a therapist who doesn’t know that might freak out and say ‘Oh my god, oh my god, what is she doing, we are going backwards’ but really was going forward.” (p. 17, lines 816-822)</p> <p>“I think it is huge, education, but also I think that care and love.” (p. 17, line 827)</p>
<p><b>Engaging with the Client</b></p>	<p>“I would say not to be shy that you really care and to do the little things like send an email to show that you do. I think that for me that was really huge because it showed me that someone was on my side. I think that some people with eating disorders have a lot of chaos in their lives, and may not have the most supportive people in their lives. So just having one can make a huge difference. So her just showing that care made a difference to me.” (p. 16, lines 785-789).</p> <p>Little emails even saying I am thinking of you, and I hope this is going ok for you. And I would also, either cry on her voice mail for half an hour, and I’d be crying and telling her something, then she would email me back and say ‘So I didn’t really understand what you were saying, but how about you give me a call because it sounds like you are really upset and I want to be there for you.’ In the emails, she wouldn’t even have to write “Ok I think you should do this in this situation.” She would just write, “Hey Sonia, thanks so much for sharing. Just remember that you are strong, you are intelligent,” and reminding me of my qualities and saying “I am here for you and you are doing well, you are on the right track, doing what you need to do.” Those little things told me that she was on my side, that she was there for me, that she was not just shutting me off once the therapy door shuts.” (p. 5, lines 237-246)</p> <p>“It was always healthy in a way that she was never seeking my approval and I never needed her approval. It was just a healthy role model. There was a sense that she loved what she did and that she loved being there for me. She wanted to see me grow, she wanted to see me be healthy.” (p. 11, lines 527-530)</p> <p>“I think throughout it all was really her belief in me and my healing process. From the day I met her she showed this genuine interest and care in me. That care was the way that</p>

	she approached me, the way that she told me she thought of me, and that something would remind her of me during the week.” (p. 5, lines 234-237)
<b>Environment</b>	“[Her place] was very comforting, very much like a home environment that I felt safe there. The other [therapist’s] place was very formal, it was very office like. So to me, the more of the home-like, with couches, feel to it made me feel much more safe and comfortable in the environment.” (p. 3, lines 88-91).

When clustering themes into thematic categories, I regularly returned to the transcript to check that my thematic interpretations fit with the actual experience the participant described. The identifiers (i.e., line and page numbers) helped to reference units of meaning within the corresponding transcript.

This within-person analysis was done for each transcript. Repetition among themes and thematic categories that emerged during analysis was easily discerned among the individual cases. However, as Smith and Osborn (2008) advise, I was careful to acknowledge new or different experiences in addition to similarities among participation descriptions in each subsequent transcript. I aimed to respect convergences and divergences that I noticed in the data, changing or developing new provisional titles for themes and thematic categories as needed to reflect participant experiences. With analysis of each participant’s transcript, I noted whether or not any new themes or thematic categories materialized in order to track redundancy in data collected (as described in the section on participant sample.)

**Between-person analysis.** Still using interpretive phenomenological analysis (Smith, Flowers, & Larkin, 2009), I consolidated themes and thematic categories identified and organized for each participant’s transcript during within-person analysis in a single chart during the between-person analysis. This was done by combining charts of thematic categories and themes, including associated units of meaning, constructed during the within-person analyses. The following steps were used:

a) I considered similarities and differences among themes and the thematic categories that had been clustered during within-person analyses. While not all participants identified experiences related to every theme, there was considerable consistency among themes and thematic categories across participants. This made it relatively easy to merge the titles and associated units of meaning from each transcript into a single chart. However, themes and thematic categories were changed as needed to better reflect the participant experiences included. In this study, one thematic category and four themes were changed during between-person analyses of this study. I combined the thematic category I had called *Collaboration* with the

thematic category I called *Session Process*. This resulted in a total of five thematic categories represented across participants: *Goals and Expectations of Therapy*, *Therapist Way of Being*, *Session Process*, *ED Specific Interventions*, and *Non-ED Specific Interventions*. The four changes to themes that I made to better reflect participant accounts of experiences included: (1) combining *client willingness* and *client readiness* into a single theme, called *client willingness*; (2) changing the title *therapy as a gradual process* to *therapy as an individual process*; (3) combining *authentic self* and *best self* into a single theme called *pursuing “best self”*; and (4) renaming the *collaboration in the therapeutic relationship* theme as *sharing power*. This resulted in a total of 20 themes, each placed within one of the five thematic categories.

In addition to establishing thematic categories and themes, I should note that I also collected all units of meaning pertaining to “contextual data” in another section of the chart. These data were not analysed into themes or thematic categories, but served as a useful reference when describing participant demographics and situating participant experiences. For example, contextual data could elucidate nuances or differences among participant experiences, or help to explain low frequency of participation within a theme.

(b) Descriptions of themes were developed next by adding a narrative account to the units of meaning included within each theme. This required expanding on the participant quotes to explain each theme and to illustrate the nuances of context, helpful experiences, hindering experiences, and experiences that participants wish had occurred or had occurred differently. Verbatim participant quotes were kept in these narrative descriptions to support the case, and the language used in the narrative descriptions was consistent with language used by the participants themselves. The results can be seen in Chapter 5, presented in summary chart and full narrative forms.

### **Member Checking**

After within- and between-person analyses, participants were sent a summary of the thematic categories and themes by email, including instructions for member checking (Appendix H). The instructions indicated that participants were to provide feedback as they desired, considering if they felt themes and descriptions including excerpts from their transcripts reflected their experience of psychotherapy. Participants were invited to make clarifications or request additions and omissions of details as they saw fit, understanding that I would consider each participant’s feedback and incorporate it wherever possible.

Only one participant requested modifications, mainly in the form of adding details. Specifically, the participant offered experiences to be included in the themes *discussing body weight* and *alternative ways to cope*. She also clarified her experience of *addressing thoughts and feelings*. These three changes are incorporated in the results provided in Chapter 5.

### **Quality and Trustworthiness**

The understanding created with use of constructivist and phenomenological research is a complex structure of knowledge and meaning (Creswell, 2013). The qualitative approach used to gain such understanding is value-bound, such that I could not maintain objectivity in relation to the phenomenon being studied (Schwandt, Lincoln, & Guba, 2007). My values, the participants' values, and context are all inherent to the inquiry. Because qualitative inquiry is value-bound, language used for comment on the quality of a study is different than what is suitable for objective quantitative inquiry. Where validity is typically used to assess quantitative study, Lincoln and Guba (1985) used the term trustworthiness for qualitative study. Trustworthiness refers to the credibility, transferability, dependability, and confirmability of a qualitative study. I will describe these constructs of trustworthiness and how they were addressed in this study.

**Credibility.** A qualitative study is credible when it provides an accurate description or interpretation of an experience under study, in the sense that people who share that experience would recognize the descriptions (Sandelowski, 1986). Employing sound research methods (Lincoln & Guba, 2000) and conducting member checks (Lincoln & Guba, 1985) are ways to establish that credibility. In this study, auditing by the thesis supervisor helped to ensure that sound research methods were adhered to, including thorough exploration of participant experiences during data collection and analysis. Participants were also invited to member check their individual interview transcripts and the thematic descriptions to verify that their experiences were accurately represented.

**Transferability.** Generalizability cannot be claimed in qualitative research since each finding is unique and context specific. Instead, qualitative findings can be transferable. Transferability refers to the degree to which findings can be applied to other similar contexts, persons, or groups (Krefting, 1991). It is the researcher's responsibility to provide sufficient contextual description within the study so that readers can determine transferability of findings (Lincoln and Guba, 1985). For this study, I provided background information for each

participant (see Table 1: Contextual Information, in Chapter 5) to inform readers' decisions of transferability.

**Dependability.** Dependability, like the concept of reliability, is an assessment of whether the findings would be consistent if the study was repeated with similar participants and contexts (Sandelowski, 1986). For a study to be dependable, its research method must be clearly outlined so that the procedures are replicable (Lincoln & Guba, 1985). Dependability of this study is enhanced by providing a detailed description of the research method, delineating data analysis, providing background information for the participants, and identifying my own background as a practitioner working in the field of psychotherapy for ED treatment (Appendix A). Concordance among the results and literature, described in Chapter 6, further suggests dependability of the findings.

**Confirmability.** Confirmability refers to the extent that research conditions are free of bias so findings reflect participant experiences (Guba, 1981). This is similar to the concept of objectivity, where the researcher puts distance between him or herself and participants to minimize bias. However, qualitative research is a personal process enhanced by decreasing distance between researchers and the participants (Krefting, 1991). Therefore, confirmability for qualitative study is not about the neutrality of the researcher, but rather about the transparency of the researcher and the research process (Lincoln & Guba, 1985). Thus, I identified my own pre-understandings (Appendix A) that could influence the research process. I also discussed my thoughts with participants, as those thoughts were elicited during research interviews. Often this would be in the form of my asking questions to clarify a participant's experience. For instance, "I gather that you found the therapist to be generally helpful?" or "Did the therapist give you any reference point as to what 'normal eating' looks like?" More rarely, but when I noticed a possible discrepancy between my own pre-understandings and the participant's experience, I would inquire with participants to help me better understand and represent their experience. For example, "What I am hearing is that you needed smaller goals there, you couldn't just take that leap of faith [with the therapist]. It can be a big step for people, on many levels; emotionally, physically. Is that right?" Or, "There is research, particularly with anorexia, that indicates that until someone is nourished they can't really appreciate the benefits of [re-nourishment]. How would you describe your experience of being pushed to re-nourish and gain weight?" Such discussions helped me to further explore and understand participant experiences when

negotiating meaning as per the hermeneutic process. Asking for clarification from participants, and conducting member checks as previously described, helped to verify that I fairly represented participant experiences without bias for my own pre-understandings.

## CHAPTER FIVE

### Results

Results from the study are presented in this chapter. I begin by presenting demographic and relevant background information for participants who shared their experiences of individual eating disorder (ED)-focal psychotherapy. This information can provide context with which to understand the results. Results, provided after the participant context, are organized in two levels: Thematic categories and themes. Titles and descriptions are provided for both thematic categories and themes.

#### Participant Context

Contextual information can be used to help situate the experiences of ED-focal psychotherapy that participants shared, and can serve as a reference point when making sense of the findings. Participant information (i.e., pseudonym used, current age, self-reported ED diagnosis, self-reported comorbidity), the circumstances of ED-focal therapy (i.e., duration, nature of termination, time lapse since termination), and therapist characteristics (i.e., gender, credentials reported by participants) are summarized in Table 1 for each of the eight participants who completed a research interview. To clarify, one of the selection criteria was that participants had not been in therapy for at least three months preceding their participation in the research. In some cases, participants were involved in therapy with more than one therapist. All participants were asked to identify whether the therapy (or therapies) they had engaged in was, in their view, complete or incomplete upon termination. This is reflected under “nature of termination” in Table 1.

**The participants.** Of the 13 individuals who expressed interest in the study, 8 fit the inclusion criteria and volunteered to participate. The participant sample was entirely female, and participants ranged in age from 21 to 47 years with a mean 31 years of age. All were Caucasian. Occupations of the participants were university student (3), nurse (2), teacher (1), photographer (1), and not declared (1). Participants self-reported the following EDs for which they engaged in individual psychotherapy: anorexia (4), bulimia (3), ED Not Otherwise specified (3), and binge ED (1).

**Table 1*****Contextual Information***

Participant Information				ED-Focal Psychotherapy			ED Therapist	
Pseudonym	Current Age (years)	ED Diagnosis	Co-Morbidity	Duration	Time since termination	Nature of termination	Gender	Credentials
Suzanne	22	EDNOS	Depression	16sessions	1 year	Complete	F	Counsellor
Sonia	27	Bulimia		3 sessions	11 years	Incomplete	F	
				3 years	10 years	Complete	F	Social Work
Jenny	30	Anorexia	PTSD	6 years	6months	Complete	F	Psychologist
Kelly	47	EDNOS	Depression	2 years	5 years	Complete	F	Counsellor
Lindsay	46	EDNOS	Depression, Anxiety	5 sessions	29 years	Incomplete	M	Psychiatrist
				6 months	25 years	Complete	F	Psychiatrist
				1 year	15 years	Complete	M	Psychologist
Tia	28	Anorexia	Depression	2 sessions	14 years	Incomplete	F	Psychologist
				1 year <sup>a</sup>	13 years	Complete	F	Counsellor
				1 year	1 year	Complete	M	Psychologist
Lydia	30	Anorexia Binge Eating	Anxiety, Depression	6 months	10 years	Complete	F	Psychologist
				1 year	3 years	Complete	F	Psychologist
Beth	21	Anorexia Bulimia		2.5 years	3months	Complete	F	Counsellor

*Note.* “EDNOS” is Eating Disorder Not Otherwise Specified; “F” is Female, “M” is Male; “PTSD” is Post Traumatic Stress Disorder; Nature of termination is “complete” when participants finished therapy that they started, “incomplete” when therapy was not finished.

<sup>a</sup> This therapy was conducted online, via Skype meetings between client and therapist.

Participants self-reported their ED diagnosis and comorbidity, although three of the participants said that they had received diagnoses from professionals. One participant received the diagnosis of ED Not Otherwise Specified from her psychiatrist. Two other participants reported receiving diagnoses from their psychologists: one received the diagnosis of anorexia with comorbid post-traumatic stress disorder, the other received the diagnosis of anorexia and later binge eating with comorbid depression. Two participants described what could be considered diagnostic cross-over: one participant was diagnosed by her first psychologist as

having anorexia and was years later diagnosed with binge ED by a second psychologist, the other participant self-reported experiencing anorexia followed by bulimia. In addition to the two participants who reported receiving comorbid diagnoses of post-traumatic stress disorder (1) and of depression (1) from their psychologists, the latter participant also self-identified experiencing anxiety, and four other participants self-identified as having experienced comorbid symptoms of depression (3), or depression and anxiety (1). Two participants self-reported no comorbidity.

Participants had worked with a single therapist (4), two different therapists (2), or three different therapists (2) over the duration of their ED treatment. The credentials of therapists reported by participants included psychologist (6), psychiatrist (2), counsellor (4), social worker (1), and unknown (1). Three of the therapists reported were male, 11 were female. Participants were unable to specify therapists' theoretical orientations but speculated about theories informing therapeutic interventions. Duration of therapeutic relationships reported by participants ranged from two sessions to six years. Excluding the three therapeutic relationships that were deemed incomplete by participants and terminated within the first four sessions, the duration of therapy with a single therapist spanned four months to 6 years, with a mean of 20.55 months or 1.71 years. One of the therapeutic encounters was via an audio-visual connection over the internet, where the participant met with her therapist using "Skype." Of the 11 therapeutic relationships discussed by participants, including only therapy that lasted four or more sessions, termination had occurred 3 months to approximately 25 years prior to the research interview, for a mean of 7.61 years prior to the research interview.

### **Thematic Categories and Themes**

Themes were generated using interpretive phenomenological analysis (Smith, Flowers, & Larkin, 2009). Including descriptions of helpful, hindering, and wish list experiences in resulting thematic categories was inspired by the critical incident technique (Butterfield, Borgen, Maglio, & Amundson, 2009). Thematic categories are groups of themes, a higher order level of thematic organization, based on similarities and differences of the content described within the themes. Titles and descriptions of thematic categories and themes adhere closely to participant accounts, reflecting the language participants used to describe experiences that they perceived to be either helpful, unhelpful, or wish had occurred or occurred differently in their experiences of ED-focal psychotherapy. Where relevant, verbatim quotes are included in descriptions of thematic categories. Verbatim quotes are always included in descriptions of themes. The depth and

breadth of theme and thematic category descriptions varies as a reflection of what was reported by participants. Similarly, some of the experiences described are more technical while others are more abstract or general.

Participants had opportunity to review and provide feedback regarding the thematic categories and themes, including whether the titles and descriptions reflected their experiences. After reviewing the findings, one participant requested modifications. Those modifications (described in Chapter 4) are reflected in the following results.

Data analysis resulted in the development of 20 themes to represent experiences that participants described as meaningful to their ED-focal psychotherapy. These themes are summarized in thematic categories: *Goals and Expectations of Therapy*, *Therapist Way of Being*, *Session Process*, *Eating Disorder Specific Interventions*, and *Non-Eating Disorder Specific Interventions*. Thematic categories and themes are summarized in Table 2. Full narrative descriptions, including verbatim participant quotes, are provided after the table. These descriptions include the nuances of participant experiences, delineating what participants experienced as helpful, unhelpful, or wish had occurred differently. Pseudonyms are used in lieu of participant names, throughout Table 2 and the descriptions provided thereafter, to preserve anonymity.

**Table 2**

*Summary of Thematic Categories and Themes*

Thematic Categories	Themes
Goals & Expectations of Therapy	<p>Experiences related to the goals and expectations of therapy that the therapist and/or participant pursued in therapy. Participants indicate that addressing ED<sup>1</sup> symptoms is necessary, but insufficient without consideration of broader or underlying issues.</p> <p>Client Willingness</p> <p>Participants associated their own willingness to confront challenging goals and expectations as helpful. They shared how therapists might help them to develop that willingness, including how therapists may encourage clients to expand their expectations of therapy beyond addressing ED symptoms alone.</p>

<sup>1</sup> ED is abbreviation for Eating Disorder

		Therapy as an Individual Process	Participants said it was helpful when therapeutic goals and expectations were adjusted depending on what happened in and between their sessions.
		Collaborative Goal Setting	It mattered to participants that therapists considered their perspectives when establishing and pursuing therapeutic goals. Participants recognized the need for goals and expectations to minimally ensure their safety and wellbeing, but also wanted their preferences to be considered when establishing goals.
		Pursuing “Best Self”	Participants described their therapists as encouraging them to pursue their “best self,” or to self-actualize. This reminded participants that there was more than the ED in their lives, which helped them to overcome ED symptoms and to pursue goals and expectations beyond the ED.
Therapist Way of Being	Participants described therapist characteristics, ways that their therapists interacted with them, and how therapists expressed themselves through their work environments as affecting their experience of therapy.	Genuine Curiosity	Participants appreciated when they perceived their therapists to be genuinely curious, or interested in their clients’ experiences, in a tentative and non-judgemental way. Participants said this helped them to feel more comfortable and to engage in therapy.
		Trust	Participants described how their therapists earned and lost their trust, and how trust or lack thereof affected their experience of therapy. When participants trusted their therapists, they felt more willing to discuss difficult issues.

		ED Expertise	Participants described it as helpful for therapists to have ED specialized knowledge and experience to draw on, but indicated that how therapists exercise that expertise made a difference to their experience of therapy. Participants found it helpful when therapists were familiar with experiences of ED, but found it unhelpful when therapists made presumptions based on that knowledge and experience.
		Engaging with the Client	Participants liked mutual conversation with their therapists, finding it helpful when therapists both listened and offered some self-disclosure. Participants said this helped them to connect to their therapist and to feel understood, cared for, and supported so long as therapeutic boundaries were practiced and what therapists disclosed was considered relevant to the client.
		Environment	Participants described how they perceived their therapists' way of being to be reflected through the therapists' office environment. Participants considered environments to be a reflection of their therapist's work style, which could impact whether or not the participant continued to work with the therapist.
Session Process	Participants described differences between a rigid or more flexible process in sessions depending on the degree that therapists shared power with clients, and considered the client's individual context.	Sharing Power	Participants found it helpful when their therapists provided some direction in sessions, while also encouraging clients to use their own voices when discussing session direction and negotiating solutions.

		Considering the Client's Context	Participants found it unhelpful when therapists organized sessions using a template or fixed schedule. Participants found it helpful when their individual circumstances, needs, and preferences were considered throughout the therapeutic process.
ED Specific Interventions	Describes interventions used by therapists that specifically relate to ED issues.	ED Education	Participants described learning about the physiological side effects of ED, and resources that could support them in their pursuit of wellbeing. Participants experienced receiving this educational information as helpful, if the information was relevant and presented in a considerate way.
		Food Journals	Participants described helpful and unhelpful experiences of therapists using food journals as an intervention. Participants understood food journals were intended to help them recognize ED related patterns, but some reported that the exercise triggered their ED more than it helped them to work through the ED.
		Challenge Foods	Participants said challenge foods were most helpful when their therapists allowed them to choose foods that they would expand their nutrition with, as opposed to therapists prescribing specific challenge foods and quantities which felt unnatural to participants and often resulted in their feeling like a failure.
		Discussing Body Weight	Participants found discussing their weight and weight changes in therapy could be helpful, but that it was a delicate issue that warranted careful consideration by their therapists.

		Identifying the Purpose Served by the ED	Participants described learning to recognize how they used ED behaviours to cope with uncomfortable feelings, emotions, thoughts, or situations as a helpful exercise.
		Separating Self from the ED	Participants said it was helpful when their therapists explored ways in which the ED was a separate entity in clients' lives, and not actually a reflection of their whole life. This reminded participants that there were other healthy aspects of their life that they could pursue in lieu of the ED.
Non-ED Specific Interventions	Interventions that were not directly related to the ED, but that participants considered a meaningful part of their ED therapy.	Addressing Thoughts and Feelings	Participants found it helpful when therapists helped them to articulate their thoughts and feelings, especially when therapists validated those thoughts and feelings.
		Alternative Ways to Cope	Participants found it helpful when their therapists taught ways to cope with distress and anxiety in their life and felt during therapy. They described ways that therapists helped them to feel able to continue working through difficult experiences and the challenges of therapy.
		Exploring Identity	Participants described ways that their therapists helped them to connect with interests and values, to develop aspects of their self that they wished to pursue further. Participants said this helped them to want to take better care of themselves.

**Goals and expectations of therapy.** This thematic category includes description of incidents and items that participants experienced as impacting the goals set in their psychotherapy and their expectations of that therapy. All eight participants recognized the necessity of therapeutic goals that specifically address ED symptoms, and they expected ED specific symptoms to be addressed in therapy, but indicated that addressing the ED alone would

not be sufficient to meet their expectations of therapy. As Beth said, “In my sessions I think at first the focus was very much on the symptoms because they were kind of the overriding issue.” This initial focus on addressing ED symptoms was considered important to clear the client’s “cognitive ability” (Kelly) in order to work through the “underbelly” (Tia) of the ED, or other issues troubling the client.

So much stuff crowded in my brain that I just couldn’t set things aside to say why am I acting like this, or why do I feel like this? I couldn’t see what I wasn’t happy about, so I just automatically blamed my eating disorder, body, and that stuff. (Tia)

Kelly said that until the ED symptoms were addressed, the underlying issues could not be explored. She referred to the ED as “tunnel vision,” and described it as “You can’t really see anything left or right, up or down. You only see what you want to see, and your perception is off.” (Kelly)

The therapist working with clients to set goals and establish expectations that the ED would first be confronted was considered important by participants in order to make way for processing other issues in therapy. For instance, Kelly understood that addressing the ED was immediately important to her overall safety and wellbeing. “Her [the therapist’s] main focus at first was to stabilize me, to keep me safe. I kept passing out.”

Participants described ED symptom interruption as a necessary initial goal in order to move forward in therapy, but recognized the need to go beyond addressing ED symptoms. “I understood that the symptom interruption was a band aid, and that if I did not really work on the cause of my eating disorder that I would be back there in some time.” (Kelly) Albeit to different degrees, all of the participants wanted to explore underlying motivations, thoughts, and behavioural patterns. This is best depicted by Kelly:

The most helpful part [of therapy] was that I learned why I am behaving the way I am behaving. What is restricting me, where are my issues, where are my triggers—that’s definitely a long process. You have to figure out the root of your issues to really work through them...And if you don’t do that, you will constantly keep being in this vicious cycle of getting better and then returning to your old behaviours to cope with whatever comes up. (Kelly)

The degree to which the underlying motivations, thoughts, and behavioural issues were explored may have been influenced by the therapists. While all eight participants recognized the value of going deeper than ED symptoms in their psychotherapy, the link between symptoms and other issues was not always apparent to participants during therapy. Sonia described how her first therapist did not explore with her the relationship between her ED symptoms and other issues, but how much more helpful it was when her second therapist did:

I just focussed on my eating and that is the only thing I wanted to focus on because, to me, everything else including my emotions, my past trauma—I didn't want to look there...but it turns out that is why my eating disorder was there. Now I understand that from my second therapist, but in the beginning I definitely was lost. So to me, it was almost like her guidance was really needed to know what and why I am experiencing this. (Sonia)

With her first therapist, who addressed the ED symptoms but did not explore other issues, Sonia felt that her symptoms were inadvertently aggravated.

I thought I was good, I was eating now so I was good to go. [The therapist] said "Ok we are done." So that is when I started to gain weight very fast. In about a month's span, I had gained a bunch of weight and then I got really upset because that is the last thing that I wanted to do...I was really discouraged about treatment and about seeking help. (Sonia)

Sonia appreciated her second therapist taking responsibility to show her how it can be helpful to explore issues beyond ED symptoms. Suzanne's experience further illustrates how clients may rely on their therapist to guide exploration and establish links with issues beyond ED symptoms. Although Suzanne met the goal of no longer engaging in ED behaviours, she described outstanding challenges. Further, she was reluctant to disappoint her therapist by saying that she was still experiencing difficulties.

Well therapy really helped. It didn't take much time before I stopped completely purging. But I would have liked to have learned more, because my negative thoughts were still there... I understand that it is really difficult to change someone's thoughts. But when I completely stopped doing the purging behaviour, she was like "Ok, so we are almost done."...I was shy to tell her that in my head I was still thinking of ways to not become fat! (Suzanne)

Suzanne described a sense that there was more to explore and wished that her therapist had introduced the idea of and explored other issues that may have continued to affect her even though she was no longer engaging in ED symptoms.

Participants described learning to understanding that while their ED warranted attention, they benefited by expanding therapeutic goals and expectations beyond ED symptoms, as described by Kelly:

You have to figure out the root of your issues to really work through them, and to work through the eating disorder. And if you don't do that, you will constantly keep being in this vicious cycle of getting better and then returning to your old behaviours to cope with whatever comes up.

All eight participants felt strongly about the need to extend the goals and expectations of therapy to deal with issues beyond the ED. They described four themes regarding the goals and expectations of therapy. Participants described (a) client willingness, (b) therapy as an individual process, (c) realistic goals, and (d) pursuing their best selves as relating to the goals and expectations of therapy, and affecting their experience of ED-focal psychotherapy.

***Client willingness.*** Four participants spoke about the value of their own willingness to confront issues in ED focal psychotherapy. "I think if you aren't ready to fight your demons, then you keep it at the food. If you focus on the food, then you are not ready to really do the work." (Kelly) For Kelly, this readiness to confront issues beyond the ED came at the point where she could no longer "control the eating disorder anymore." She states that her ED "got totally out of control" and that she "needed help to get back on track." Upon feeling "out of control," Kelly was willing and wanting to explore the ED and underlying issues with her therapist in an effort to overcome her troubles.

Sonia said that given her experience, she believes clients "will only go as deep as they want to." Beth echoed the sentiment that clients will only go as far as they want to: "I have seen lots of girls, lots of my friends, go to therapy and just choose to not let it work...and that not being a conscious choice but them not being ready to go to that kind of ugly place." Sonia said that therapists might help facilitate client willingness by being "super patient." Jenny described how her therapist helped to promote her willingness by reviewing outstanding work to be done in realistic terms.

She has often tried to emphasize by knocking on a table and saying “this is a table, we can’t pretend it is not a table.” That was big for me because for a long time I would come to her and say everything is great, everything is fine. She would say, “But you are here, something is going on, something is not right.” So, I learned to not always put on that everything was fine, but became more able to see things for what they are.

Jenny said that her therapist helped her to become more willing to go deeper in therapy by pointing out issues that seemed to continue to trouble her, which the therapist was also willing to explore with her.

*Therapy as an individual process.* Five participants commented on how they came to understand therapy as a process that gradually evolved with their individual needs, rather than an “algorithm” with a clear beginning and clear end. Goals and expectations therefore evolved with the unfolding of each individual’s therapy. “Labelling the patient and the disorder can lead to assuming that there is a simple algorithm of what they need.” (Jenny) Jenny understood therapy as a process that evolved depending on what emerged for the client during and between sessions.

I think [the therapist] made it clear that the goals were important, but it was just as important—really for her more so—to understand what was bringing me to those behaviours. That was critical before I could think of the possibility of changing the behaviours. We had to figure out where they were coming from.

Jenny describes how instead of systematically eliminating the ED symptoms, her therapist seemed to emphasize the importance of understanding and solving triggers, and suggested that understanding these issues could evolve with experience and discussion. Tia elaborates, describing how her therapy evolved with experience and discussion:

It is not like the door is closed once you have recovered so to speak, and if you do start having symptoms again you shouldn’t see it as a failure. There is obviously something else going on, so just to take it as “Ok, there is something going on” and reassess what it is. I think everyone, anyone suffering an eating disorder just wants it to be done and over with, but it is more of an up and down type thing.

Similarly, Lindsay said that she was always waiting for the ED symptoms to be done, but that the ED would “pop its ugly head from time to time among long periods of being pretty fine.” Over

time, with experience and her therapist's feedback, she started to recognize things in her life, other than the ED, that made her feel better and stronger.

Jenny indicated that her progress in therapy varied, but even when progress slowed it did not mean that things were not evolving. "I am recovering, and maybe I am going to have ups and downs but I want to be recovering throughout. I had to extinguish from my mind that recovery was all or nothing." She said that it may be helpful for therapists to adjust goals and expectations throughout therapy depending on what is happening for the client.

My first week there I was like I can't do this! I felt defeated, and ready to leave.

I was trying, I was committed, but it was just too much for me and I told [the therapist] that I was leaving...I was just the scared patient. In a way I understand how the goals were necessary at the time, on the other hand it was kind of like the feeling of being trapped and having lost control. (Jenny)

Jenny believed that a client could be having a difficult time and that their progress may slow, but they could still be wanting and willing to move forward. Therefore, she suggests that adjusting goals and expectations throughout therapy, depending on what happens in and between sessions for clients, could help to address clients' individual needs.

***Collaborative goal setting.*** Two participants spoke specifically about the importance of setting realistic goals, done collaboratively through consideration of client and therapist perspectives. This theme builds on the idea that therapy is an individual process that may evolve differently depending on what happens for each client. Jenny and Kelly identified the need for therapists to enforce certain goals necessary for health and safety, but also identified the benefit of therapists working collaboratively with clients to define individual goals and to celebrate individual successes related to those goals.

[My therapist] would say "yes, let's recognize that as a success, at the same time we are not going to pretend that it is [enough], we don't want to celebrate and then think that it is ok to stop there if it is not." She would say that you need to recognize that someone who is very sick with their eating disorder is going to think it is a huge success to take a few sips of water, and maybe that is a huge success for them, but in the grand scheme of things can we call it [enough]? So being able to see things the way they are, but still be able to celebrate every step. (Jenny)

Jenny said that her therapist set clear expectations for her therapy, while also considering Jenny's perspective and the relative magnitude of steps taken towards reaching goals.

It was really upsetting to me when it was all or nothing, that if you couldn't get it right then you felt like a failure and felt like you had failed treatment. Perhaps you don't need to aim only for 100%.

Jenny appreciated incremental goals relative to where she was at as helpful, but also appreciated that non-negotiable goals and expectations established by her therapist could at times also be helpful:

Sometimes if there was a serious concern she would request a written contract, a true commitment. It wasn't often, and it would have been communicated to me that this was a particularly serious situation she was concerned about, and she needed me on board to do my part. For example, committing to putting an absolute halt to self-injury...or agreeing to an absolute minimum weight... Goals that she felt were necessary and reasonable for me at that stage, she would make clear.

Jenny said that these non-negotiable goals and expectations were helpful because she felt that her therapist still allowed her to express her concerns. This allowed Jenny to be "true" to what she could commit to. She appreciated her therapist's perspective, and opportunity for both her and the therapist to agree on goals. Jenny experienced this as opportunity to understand her commitment and to take responsibility in pursuit of the goals and expectations.

Jenny elaborated on the delicate balance between her therapist enforcing goals to protect her health and safety, while not discouraging her:

She definitely would try to make it clear that she needed my commitment to progress and to being there [in therapy], but she knew that other approaches that had been used by other professionals had only frightened me away from therapy and enhanced my struggle. She asked me to agree that although she wouldn't have expectations of me having to gain weight at the time, she wanted me to commit to at the very least not lose any, to do my best to make progress, and to have an open mind to possibilities.

Similarly, Kelly described how her therapist was adamant about minimal expectations for health and safety. Kelly said that her therapist went so far as to break confidentiality to get her medical

intervention. “I was mad... but it was the right thing to do.” Even though this was a difficult time, Kelly understood and found it helpful because her therapist was clear about why health and safety was central to therapeutic goals and expectations. This helped Kelly to recognize that the therapist was right to enforce medical intervention. Once immediate health and safety had been attended to, Kelly reported that her therapist proceeded to set goals more collaboratively with her. “Before the hospital, her main goal was really to stabilize me, to not kill myself, and afterwards she just supported me along the way.”

Both Jenny and Kelly recognized the need for therapists to ensure client safety with appropriate non-negotiable goals and minimal expectations, but warn against overwhelming clients with goals and expectations beyond what they feel capable of pursuing. “For an eating disorder client, if anything comes up against your beliefs, you are backing up, you are saying OK that is not what I want and then leaving.” (Kelly) Jenny and Kelly appreciated their therapists being clear about expectations, and collaborative discussions that considered their own perspectives as helpful in the setting and pursuit of relevant goals.

***Pursuing “best self.”*** Seven participants identified the concept of exploring their “best self” as helpful in relation to therapeutic goals and expectations. They described therapy as increasingly meeting their expectations when therapists supported them in their pursuit of doing their best. Doing their best at times referred to overcoming ED symptoms, but was also experienced in other domains of their lives. Beth said, “The process of recovery is so much more than just getting rid of symptoms. It is a process of discovering who you are, and who you want to be, and the things that are stopping you from getting there. Kelly said that her therapist helped her to care about herself by encouraging her to pursue her best self. “I think her goal was to empower me, to say, you know, I am here, I am important too.” This provided Kelly with a renewed sense of purpose and excitement for her life. “It was about trying to get through to me that life is worth living, that there are reasons to stay here and to embrace that. You know, really find meaning and purposes in this life which I had totally lost along the way.” To this end, participants described consideration of their best self to be motivating in pursuit of therapeutic goals and expectations.

Beth said that by introducing consideration of her best self, her therapists helped her to take therapeutic goals and expectations beyond ED symptoms: “How can you become the best version of yourself? That has always been the overriding goal, the overriding principle that my

therapist worked with. As a human being, you are more than this [eating disorder] so let's figure that out, and how you can get there." Beth found this helpful because it reminded her that there is more to her identity and life than the ED, and invited her to pursue those other aspects of herself. Participants described how the pursuit of their best self was inspiring and got them excited about their lives, helping them to overcome ED symptoms to pursue other things that mattered to them.

**Therapist way of being.** This category of themes speaks to different ways that participants experienced their therapists as expressing themselves through their work style. The themes include characteristics that the participants perceive their therapists to have exuded, ways in which the therapists interacted with clients, and the therapists' environment which participants felt reflected their therapists' approach to therapy and impacted the participants' experience of that therapy. At best, Kelly said that her therapist's way of being could be "a big plus for her: very open, empathetic, very nurturing." At worst, Lindsay described how there was "nothing warm or supportive or caring" about one of her therapists, which made her feel "very nervous and very embarrassed, and very vulnerable." She emphasized, "I didn't know anything and I didn't know how to talk to him, he was very cold and very matter of fact." Impact of the therapists' way of being could go so far as in to influence whether or not participants continued to work with a therapist. Participants described themes regarding their therapists' (a) genuine curiosity about the client, (b) developing a trusting relationship, (c) ED expertise, (d) engaging with the client, and (e) office space as affecting their experience of the therapist and therapy.

**Genuine curiosity.** Seven participants elaborated on how they perceived their therapists as being genuinely interested in their work and clients. These participants indicated that the therapist being genuinely curious contributed to a stronger therapeutic relationship. Participants described therapists as expressing their curiosity by noticing their reactions, validating or emphasizing something the client said, or following up on what was discussed in previous sessions. Most generally, participants experienced the "curious therapists" as "nice and approachable..." Suzanne elaborates: "I felt that she really wanted to help me and she was a good listener, and would ask questions to help me go deeper, and really listen to what I said". In Lindsay's words, this was important because she "wanted somebody to notice and really compassionately ask 'What's up?'" Lindsay went on to describe how she enjoyed discussions with her therapist whom she experienced as "interested to understand" what was happening in

her life, or why she felt the way that she did. Participants reported that their therapists indicated care for them by being curious and following up on current events in their lives or what had been discussed in previous sessions. “She would always follow up. That meant that somebody cared about me, that somebody really meant it. I guess that is exactly what I needed.” (Kelly)

Suzanne felt that she and whatever had been introduced in previous sessions lacked importance when her therapist was not curious about following up on these things in subsequent sessions. “I would notice that she would not remember stuff that she had said the week before.... And sometimes it made me feel a bit like I was just one of her clients she sees and then forgets about.” Suzanne found the psychotherapy more helpful when her therapist did follow up on whatever had been discussed in previous sessions.

Beyond following up on current events in their lives and what had been discussed in previous sessions, participants indicated that their therapists portrayed curiosity in the way that they interacted with the clients. “From the day I met her she showed this genuine interest in me. She showed me that she cared by how she approached me, and told me she would often think of me during the week.” This helped Sonia to feel more comfortable and to engage in therapy with her second therapist.

My therapist seemed very genuine in wanting to meet me and wanting to get to know me... I was not the most open person in the beginning. I was not quite sure. I was still very on edge. Was she really going to help me, or are we just going to go like before? Because I was not going to let go of the eating disorder as quickly as before. You know, I am going to hold on to this. But she was much more patient and curious [than my first therapist]. She asked me about me—questions—but didn’t focus on the eating disorder alone. It wasn’t her focus to just get rid of the eating disorder. She was much more curious about everything in my life.

As she experienced her therapist’s curiosity, Sonia said that she became more curious herself. “I became more curious about all of these things in my life...I would talk to my mom, I would talk to my dad, talk to my boyfriend at the time, and with friends.” She said that this helped her to engage in therapy, explore possibilities, and make changes.

Sonia described non-judgement as a significant part of her therapist’s curiosity. This encouraged Sonia to share more openly with her therapist. Sonia described an instance when she felt able to be more honest with the therapist:

In the back of my mind there was a trauma. I was not going to tell anyone, because I told myself that it was my fault, and I wasn't sure whether I really wanted anyone to know. But deep down I knew that that was probably why I still held on to my eating disorder.

Sonia elaborates on the importance of her therapist receiving the information she revealed in a non-judgmental, and gentle way. "I think her encouragement allowed me to be honest with myself and to not get down, you know, on choices that I have made, which I think even that fosters unhealthy stuff."

Like Sonia, Jenny felt compelled to share more openly because of her therapist's genuine curiosity. Jenny expanded on how she experienced her therapist's curiosity, without criticism or judgement, as encouraging: "She would gently encourage me by saying that you may not be able to think about taking this challenge, or able to do this huge step, but I need you to have an open mind about it and explore it." Jenny found it helpful that her therapist both modelled curiosity, and requested her to be curious herself.

All participants described genuine curiosity as helpful, except Tia who shared an alternative perspective. Instead of experiencing her therapist as genuinely curious, Tia described an example where she found it helpful that her therapist was "blunt and to the point."

She was a very patient listener, you know. I guess in a way I liked it, but sometimes I liked when people have a not so gentle approach. I look back on that doctor who said "Well I guess you could eat a little bit more" rather than saying "You need to eat more or you are going to die." I probably wouldn't have snapped out of the eating disorder [if the second therapist hadn't been so] blunt and to the point. I appreciated that, instead of [her] pussy footing around it. So I was thankful for that. She would call me out on stuff. At first I would be like whoa! I didn't want to admit to things...Sometimes when you are dealing with something it is easier to blame someone else, but she'd be like well you're the one that is doing this! And I was like "Yeah, I am"... I would just sort of submit, and then say that I don't know how to deal with that, or how to change that behaviour. So she gave me tips.

Tia found that her therapist being blunt and to the point, rather than curious and gently exploring things, helped her to realize issues that required work in therapy. Once

identified, Tia said her therapist gave her “tips” to help work through those issues. While Tia appreciated her therapist being, at times, more blunt and to the point, Lydia felt that being genuinely curious still plays a helpful role by providing therapists with opportunity to check in with their clients to verify understanding and fit of “tips” offered. “Everyone sort of perceives and reacts to things differently, so you can’t possibly hit the nail on the head every time knowing how someone wants to be approached, or how certain people are going to deal with your evaluations, ideas.”

**Trust.** Five participants spoke about trusting their therapists, and how they perceived their therapists to have developed that trustworthiness. Two of those participants described how they initially trusted their therapists to help them address the ED, but how that trust dissipated. Participants described how their therapists’ elicited trust, how at times that trust was subsequently ruptured, and how having or losing trust affected their experience of therapy.

One way that participants described therapists as developing trust in the therapeutic relationship was by hearing and acknowledging their clients. For instance:

A huge part is the trusting relationship is being heard and acknowledged. I know that there are agendas to where [the therapists] want to go with their patients, and obviously the patient coming to therapy means that they want to get better, but clients still need to be heard and accepted and understood. (Jenny)

In addition to feeling heard and acknowledged by her therapist, Jenny said that her therapist’s “voice of reason” also elicited trust. “The therapist could offer back her reflections of what the client is saying along with perspective and insights.” This resulted in Jenny feeling understood by her therapist, and therefore more trusting of the therapist. Having this trust in her therapist helped Jenny to become more open and authentic in therapy.

A critical lesson for me through therapy has been learning that I didn’t have to be afraid to tell her what was really going on, as that had been my pattern. It was easy for me to portray to therapists that I am happy and all is well for me, and I never liked to say anything different than that. Opening up about the real pain and struggles has always felt for me like an impossible task. Learning that I could really trust her and didn’t have to be afraid of her reaction if something wasn’t the way she would want it to be was new for me. Jenny’s therapist affirmed this trust by listening without judgement.

I remember once sharing with her something that I had been afraid to do so and her saying, “Has this been going on for a while?” I said “Yeah,” and she said “You never told me that.” The tone of her reply really emphasized to me that I could trust her and there was not a need to fear her reaction.

Jenny describes how this trust elicited by the therapist was helpful in therapy, and also relevant to relationships outside of therapy: “Learning how to trust people was particularly important to me based on my past.” Her ED therapist was the first person whom she felt she trusted enough to open up to. Because she found it helpful to open up to the therapist, she was more inclined to start trusting other people in her life, which she found additionally helpful.

Beth reiterates a similar sentiment to Jenny, that feeling understood and comfortable with the therapist fostered her trust in the therapeutic relationship. Beth said that knowing her therapist had experience working with EDs, in conjunction with the therapist’s belief in her to get better, enhanced Beth’s experience of therapy.

I think the fact that she truly believed that I could be well someday also created trust. Knowing that she genuinely believed that I could do better was a big thing for me too. If she genuinely believes that I can be better, I think I can put some trust in her, and believe that what she wants me to do is a good thing.

Kelly elaborates on the implicit trust that Beth mentioned, knowing that her therapist had experience working with EDs. The previous experience Kelly’s therapist had working with EDs gave Kelly trust and confidence in her therapist. This trust in the therapist supported Kelly’s relationship with the therapist through a difficult junction, when the therapist broke confidentiality and requested the support of ambulance services and medical treatment for Kelly. “I trusted her. I knew she was right even though I was not happy that she called the ambulance.” Even though it was a difficult situation that upset Kelly, Kelly said that she appreciated the therapist being upfront, and that she trusted the therapist’s judgement. Kelly said the intervention worked because she trusted the therapist.

Lydia described implicitly trusting her first therapist because her medical doctor had recommended the therapist.

At the time I think I was just being trustworthy. This was a recommendation of my doctor, based on the fact that the therapist specialized in eating

disorders. I thought, not having any prior experience with therapy and it being my doctor's recommendation, it seemed like it would be a good match. Lydia said she automatically trusted her therapist because she "needed" the therapist. "When it comes down to such an immediate need, you don't really shop around I guess. And at the time, it felt fine, but I didn't know what to expect." However, subsequent experience with other therapists changed how Lydia perceived that first therapist. Retrospectively, given experiences with alternative therapists as a reference point, Lydia reported less trust in her first therapist.

Sonia also reported losing trust in a therapist whom she had initially trusted. For Sonia, that trust dissipated when the therapist was not upfront with her about what she could expect as she started eating more consistently and stopped purging. As a result, Sonia "was really discouraged about treatment and about seeking help." Sonia perceived this first therapist to have "taken away" her ED without telling her what to expect. She did not like the unanticipated repercussions (i.e., weight gain), and was subsequently hesitant to trust another therapist. Sonia did see a second therapist who she said sounded very confident when speaking on the phone with her mother. This confidence provided Sonia and her family with a sense of assurance and trust. This second therapist built upon that initial sense of trust by recognizing the ED symptoms, taking time to appreciate the ways in which the ED helped or worked for Sonia, and more thoroughly explaining alternatives to the ED.

***Eating disorder expertise.*** All eight participants described perceptions of their therapists' knowledge in the field of EDs. Participants who recognized that their previous therapist lacked sufficient understanding of EDs felt that a therapist with more ED-specific experience and expertise could more effectively help them. Beth describes an experience of seeing a therapist without ED expertise: "I think expertise is essentially important. For example, when I went to one appointment at the general psychology clinic...I remember leaving and not feeling understood." Alternatively, Beth reported feeling immediately as though she was in the right place upon connecting with a therapist who had ED expertise.

I think that expertise is a very important part, and one of the things that struck me and made me very comfortable right away with my therapist. She fully understood my experience, where I was at, how I was feeling, and she was able to meet me there in a way that I don't think someone could if they didn't really understand what eating disorders are all about. (Beth)

Kelly reiterates that no matter how good other therapists may be, a therapist with ED expertise can be particularly helpful.

Suzanne was not sure how many years of experience her therapist had working with EDs, but she still felt that her therapist was well equipped with ED expertise. Sonia describes the hope therapists equipped with ED expertise can provide: “I remember feeling this sense of hope and that someone actually cares and can help me...Something hit me that she wanted and could do something, that she was really going to take care of this, and help me with this.” In addition to the ED expertise that Sonia perceived this therapist to already have, she also appreciated that the therapist continued to learn and expand upon her expertise: “She was always going to workshops and conferences, and wanting to learn more... She would come back from a workshop and say ‘Sonia I have just learned this and do you want to try it? Let’s see if this helps you.’” In addition to providing a repertoire of experiences and exercises to draw on, Sonia found her therapist’s expertise helpful for understanding the challenges associated with ED-focal psychotherapy. Sonia thinks that her therapist’s knowledge of ED therapy processes also helped her family.

The therapist needs to have some understanding and background, some tools that the client can use, as well as understanding of the process. Like, when I started to see her and to unravel my feelings I was feeling really emotional, and I would come apart at home. My mom was like “Oh my god what is going on!” And she called my social worker. The therapist said, “This is good, she is letting go of years of holding it all together.” A therapist who doesn’t recognize that might freak out and say “Oh my god, oh my god, what is she doing, we are going backwards” when really I was going forward.

Tia also said that ED expertise entails more than knowing ED treatment guidelines, but requires an appreciation of the nuances inherent to EDs:

He looked at the BMI chart and said “Well you are still within the healthy range, you are just borderline underweight,” so I was like “Oh, fine.” Then I went to see this other doctor, she was more holistic, and said: “If you don’t start eating now you are going to die.” And I was like “Oh!”... She was very direct, “This is what is happening to you right now, and if you don’t do anything about it then this is what is going to happen.”

Where her first therapist deferred to guidelines to indicate appropriate next steps, Tia said that the second therapist drew on ED expertise and experience with previous clients to recognize the urgency of her situation and that although she “looked” fine she was struggling.

Participants described responding well to interventions guided by therapists who they perceived to have ED expertise, including knowledge and experience working in the field. However, three participants further indicated that *how* therapists exercised their expertise was important. “He certainly had more information than I did, and that is why I was interested to talk to him in the first place, but it was more of an invitation rather than that hierarchy.” (Lindsay) Jenny also described how her therapist had more knowledge and experience than she did, yet the therapist did not use this expertise to put herself above the client.

The relationship was about valuing each other’s opinions, and if you have a therapist that just produces the right answer then they aren’t willing to hear your voice and you can feel trapped... Especially if you have been through trauma, it can bring you back to the same feeling of vulnerability. It is like you have lost autonomy of your life once again.

While Jenny had described the risk of therapists using their expertise to set up a hierarchy in ED therapy, Lydia described a different unhelpful execution of expertise whereby her therapist made assumptions about her eating disorder based on expertise. Initially, Lydia had appreciated her therapist’s experience and knowledge which she felt helped the therapist to better understand and speak to her concerns:

At the beginning, I liked the fact that she had prior knowledge of eating disorders and was able to state things that maybe I wouldn’t have thought of. It made me feel less alone, like what she was saying was true, and impressed that she knew it. I thought it was great. It made me realize things that were symptomatic of the eating disorder.

Initially, her therapist’s recognition of patterns helped guide Lydia out of the “danger zone,” but ultimately left Lydia feeling that the therapist was “leading with her assumptions.” Throughout therapy, Lydia found that her therapist increasingly projected expectations onto her case based on previous experiences.

It was as if at a certain point it was like a game, she was guessing “Oh and I bet this” or “I bet that.” It was like she had seen the patterns so often that she was able to call it which was weird. It kind of bothered me. It made me feel less unique, like less of an individual in something that is supposed to be all about me.

Concerned that the therapist was not actually listening and attending to her unique needs undermined Lydia’s confidence in the therapist. “Maybe she feels that she knows me better than she actually does. But she doesn’t know me. She may know my symptoms and about the issues, but that is not me.” Lydia felt that her therapist projected patterns and expectations onto clients, based on her extensive ED expertise. “If she only deals with the same demographic, she sees patterns and starts throwing them back at you.” Lydia felt that her therapist assumed, based on expertise and experience, that Lydia was experiencing things that were, in fact, incorrect.

Sonia offered a summary of how a therapist with ED expertise could be helpful. She said ED expertise is important, but not enough: “I think expertise is huge, but I also think that care and love are important.” She underscored the importance of therapists exercising their ED expertise in ways that were considerate of the individual client and their unique circumstances.

***Engaging with the client.*** Eight participants spoke about how they perceived their therapists to have engaged with them in therapy sessions. Mutual conversations, meaning that both the therapist and client shared or contributed to topics of therapeutic conversation, and in particular the therapist using self-disclosure were cited as ways that therapists engaged with the client. Participants described how this made them feel cared for, created a comfortable therapeutic environment, and helped them to feel a personal connection with their therapist.

Based on her experience, Sonia suggested that therapists “not be shy that they really care, and to do the little things like send an email to show that they do [care].” Sonia said, this “was really huge because it showed me that someone was on my side. I think that some people with eating disorders...may not have the most supportive people in their lives. So just having one [supportive person] can make a huge difference.” Sonia felt that the care her therapist showed was helpful to her experience of therapy. She said, “The care was in the way that the therapist approached me, the way that she told me she thought of me, and that something would remind her of me during the week.” Sonia also described how her therapist engaged with her through email correspondence.

She wouldn't even have to write "I think you should do this in this situation." She would just write "Hey Sonia, thanks so much for sharing. Remember that you are strong and you are intelligent," reminding me of my qualities, and saying "I am here for you and you are doing well, you are on the right track, doing what you need to do." Those little things told me that she was on my side, she was there for me, and that she was not just closing me off once the [therapy] door shuts.

Similar to Sonia, Jenny appreciated when she perceived her therapist to have shown that she cared. Jenny said this resulted in her feeling as if the relationship with her therapist was bidirectional and more real:

She opened up just enough for me to sense that she was real and that our therapeutic relationship was real, that it wasn't absolutely one sided. Some therapists feel that it needs to be totally a professional relationship, but that can result in an unbalanced sense of vulnerability and lack of sincerity, and ultimately wouldn't have worked for me.

Jenny experienced her therapist engaging in mutual conversations, meaning that they both shared or contributed to topics of therapeutic conversation, as helpful, by encouraging her to open up herself in therapy.

Beth wished that her therapist had at times engaged more with her, to understand where she was coming from and so that she could better appreciate her therapist's intent. Beth found this problematic. Without her therapist engaging in mutual conversation, as described by Jenny, Beth did not feel understood by her therapist and was unsure of her therapist's intentions. As a result, Beth says that she deferred to her therapist: "You sort of allow things to roll in the direction that the therapist is leading." This meant that some of the things Beth wanted to talk about "got swept under the rug or left out." Beth wished that her therapist had made more space in therapeutic conversations to hear about where she was at, and what she was wanting or needing.

When therapists mutually contributed to conversation, participants experienced therapy as more relaxing and were subsequently inclined to share more. Tia said that her therapist made her feel "relaxed" as he was "really chill and laid back" in the conversations that they had. She said this made the therapist easy to talk to, and resulted in therapy feeling less "frantic." Tia

described how by engaging with her in a relaxed way, the therapist helped her to open up and feel more comfortable in therapy. “He would just come in, we would sit down, and I would put my things down. Then he would start with ‘How are you?’” Even when there were “awkward silences,” Tia felt comfortable to “just keep talking.” She said:

He would contribute to the conversation if I really wasn’t sure of what to say, but he just let me talk. He didn’t really [talk] until I was done. And when he would talk, he would sort of pose a question. Mostly he let me talk, he let me ramble.

Jenny elaborates on how her therapist helped her to feel more comfortable in therapy by engaging with her in conversation, providing space to both hear about Jenny and offering her own input.

It is a real relationship, and a real part of both of our lives, not just a fake relationship because it is a therapeutic one. That was important for me, I think to feel that she wasn’t just doing her job, but that the relationship was real. I found it helped that she used an appropriate amount of self-disclosure, enough to make it feel like she is human and also truly present.

Jenny and five other participants mentioned “self-disclosure” when describing ways that their therapist engaged with them. Tia articulates why she found self-disclosure “extremely helpful”: “I find that it is a much more human interaction if people can bring their own personal experiences and present them to you.” Tia said that she perceived her therapist to have more credibility as a result of his sharing through self-disclosure. “Whatever he said in a clinical sense seemed more real, the probability of it working seemed more real. Just what he is saying in general, I listened more because he was being honest.” Like the other participants described when their therapists engaged in mutual conversation with them, Tia associates feeling more comfortable in therapy when her therapist both listened to her and shared his own experiences.

I definitely want to feel like I am having a conversation rather than having somebody analyze me all of the time. Of course I know there was analyzing going on, but it is more I need to have some sharing. I was giving him some personal information, not that I am expecting super personal information, but I need something back.

Participants described self-disclosure as a way that therapists could show that they were able to relate to the clients. In Beth's words;

For me, disclosure that she herself had recovered from disordered eating was, I think, very reassuring for me to know... She had walked the path that I was on. It allowed me to see an example of a person who had fully recovered. That is a really encouraging thing!... I could describe what my experiences had been the last week, and then she was able to relate to them and share what helped her.

This made a really big difference for me.

Beth felt that this self-disclosure provided her therapist with more credibility, but acknowledged possible concerns with a therapist sharing personal information, particularly related to their own story of ED recovery.

I know that there is some talk in the academic world of psychology that it is better [for therapists] to not have experienced an eating disorder, because they can get too close, too invested. I have never felt that way. I think it helped me to know that my therapist fully understood where I was at and wanted to go... And I think it has been really important for me to know that she actually experienced what I was going through. I get to learn more about her on a personal level, and I realize that she only shared little bits of her journey with me. She by no means shared too much and made it about her, or made her story overshadow mine. It was just little tidbits in order to say she gets it, she understands.

Kelly also described how self-disclosure of similarities between them helped her to relate with her therapist:

She was about the same age, we were both mothers, and she had gone through her own similar issues. So we had a lot of common ground where we could connect... I think all of this together, she truly got what I was going through and totally understood it. I didn't often need to explain in long sentences, she just knew it. Sure, there was some counter transference, but I felt totally understood and supported by her. For me, that was exactly what I needed at the time: Somebody who understood where I was coming from, what I lived through, and how I felt.

As a result of her therapist having shared some personal information, Kelly felt able to relate to her therapist and that her therapist was able to better understand and support her.

Both Kelly and Tia perceived their therapists to have more credibility as a result of having engaged with them using self-disclosure, however they described their therapists as engaging with them in different ways. Kelly appreciated that, like her, her therapist was also a mother, about the same age, and had had her own similar difficulties to which Kelly could relate. Where Kelly recognized similarities between herself and what her therapist shared, Tia worked with a therapist who was older and male. This worked for Tia; “I wanted to hear about his different perspective... He is very wise...he would draw from his own experiences, or his daughter’s experiences.” Tia appreciated her therapist’s different perspective as an older male, but also found it helpful when he would reference his daughter’s experiences who Tia figured was likely more similar to her.

As a result of their having engaged with them through mutual conversation including self-disclosure, four of the participants described seeing their therapists as role models. Sonia said that she looked up to her therapist as “being healthy and taking care of herself.” In addition to inspiring her, Sonia felt this helped because the therapist “didn’t need affirmation” and “was comfortable with who she was.”

Sonia felt that she mattered to her therapist, that her therapist wanted her to be well, and that the therapist modelled wellness. Similarly, Jenny saw her therapist as a role model.

She would teach and role model for me about living up to one’s own values...She would mention being true to her values. And I see how I have incorporated that message into my own life by regularly reflecting and clarifying what my values are, and evaluating how those values are being manifested.

Similar to Sonia who felt her therapist engaged with her by sharing personal experiences and feelings, without looking for Sonia’s approval, Jenny also said her therapist established clear boundaries that helped Jenny to feel safe in the therapeutic relationship. “This is a different relationship than you would have in a social context. There was a beginning and an end. We kept therapeutic boundaries, but it was a real relationship and a real part of both of our lives.”

Participants appreciated when their therapists listened and shared their own personal feelings or experiences, but boundaries were identified as important when therapists self-disclosed. Lydia was not sure about appropriate boundaries in a therapeutic relationship, and

says it would have been helpful if her therapist had given her a warning that she would, and why she would make self-disclosures.

I was surprised because I didn't know so much about the relationship between the therapist and the patient, and how much they should be disclosing. I was like "Oh, I am privy to all of this information, should she be telling me this? Am I special? Is this appropriate?" I was surprised because I didn't know that [therapists] did that.

Kelly described situations where she perceived her therapist to notice that she may have been over sharing, or sharing in a way that Kelly could not connect to or was not comfortable with, after which the therapist would redirect the conversation. "Sometimes she made comments like what she had for breakfast that I could not connect to... I think her point was 'try to enjoy that,' but at the time I couldn't connect to it... She realized that I couldn't connect to it, and backed off."

Beyond knowing what and when to share in order to engage with the client, Tia said that it was important to her that her therapist link the relevance of what was disclosed back to her own case. "It related to me in a way. He is talking about his daughter, obviously there are different circumstances, but there are still parallels." Tia appreciated when her therapist engaged by self-disclosing, as long as the self-disclosure was relevant and linked back to her own experience.

Participants reported that therapists engaging with them by both listening and sharing was generally helpful, making them feel cared for, supported, and better able to relate to the therapists. This was helpful so long as they perceived the therapist as not seeking approval, as respecting certain boundaries, and as providing self-disclosure relevant to their own experiences. Suzanne added that at times she did or said things to please the therapist as she learned about her therapist's preferences through the therapist's self-disclosures. Suzanne said that she did not want to disappoint the therapist, and that it would have been helpful if her therapist had given permission for her to disagree. This would have allowed Suzanne to do and express what mattered to her without fear of disappointing her therapist.

***Environment.*** Six participants described experiencing the environment within which their therapists worked as a reflection of the therapists' way of being. What participants perceived the office environments to say about their therapists could influence whether or not the

participants experienced the therapy as helpful, or whether they even continued to work with the therapists. For instance, Beth describes enjoying her therapist's office as a reflection of her therapist's calm way of being:

She is always very soothing so being in a room with her generally makes for a very calming atmosphere and...Her office is also very earthy, natural. It is a place that is very conducive of calmness. That has been nice, it has always been a place where I can go for an hour of refuge. I felt relaxed, that was a huge thing. It was just a really lovely thing to be at her office with her.

Lindsay also described how her therapist's physical space reflected the relaxing affect her therapist had. "Her office was in her home. We had tea, and we chatted. It was very relaxing." When comparing the environments of two therapists, Sonia said: "One office was very comforting, very much like a home environment where I felt safe. The other place was very formal, it was very office like. To me, the more home-like, with couches, environment made me feel safe and comfortable with the therapist."

Lydia introduced concern about food in her ED therapist's work environment, and how that food conveyed insensitivity by her therapist.

I know you aren't supposed to have anything to do with food or drink when you are with a client, but she always had a bowl of candy on her table, and would say "you are allowed to have one." There was some pressure to that, especially when you are in an eating disorder mindset—should I take one, does she want me to take one, should I not take one?

Lydia felt that her therapist should have known better than to have food in her office. The candy preoccupied Lydia, who said she did not want a candy but worried that she would "displease" or hurt her therapist's feelings by not taking one.

Tia had a very different experience of environment and how it impacted her experience of the therapist. She met online with one of her therapists using Skype for videoconferencing. She said she prefers to "talk directly to people" and values "human contact." She elaborates that, by meeting in person, "You get more of an understanding of what the person is like and what they are saying, than is possible on this flat screen and pixelated image." On the computer, Tia did not feel she could "absorb what [the therapist] was saying or what [they] were working towards... It just seemed so impersonal." Tia felt that the online environment made therapy

impersonal, which she may have experienced even if she had met that particular therapist in person. Even so, she felt that meeting with therapists online “is not the same, even though you aren’t touching each other [in therapy], it is the presence. The energy essentially.” Tia found working one-on-one with a therapist in an office allowed her to relate better to the therapist and get more out of the therapy.

**Session process.** The eight participants commented on the unfolding of their therapeutic sessions, referring to *how* their therapist approached the agenda of therapy. Participants appreciated their therapists providing direction in therapy, but also wanted consideration of their needs and preferences. Participants found it helpful when they experienced their therapists as flexible, and considering input from and context of clients throughout the sessions. Participants found it less helpful when they experienced their therapists as imposing a fixed agenda to sessions.

The sharing of power between therapist and client when discussing session content, and consideration of client context throughout the course of therapy were two themes described by participants. Jenny situates the importance of sharing power and considering client context:

Recovery from an eating disorder needs to come at [the client’s] own pace...I think it is an important part of the professional’s job to be able to understand that the [client]’s life experiences, and context needs to be recognized and respected within the plan of treatment.

In both themes within this category, participants discussed ways their therapists provided direction, and how they were more or less flexible about the content of sessions depending on client input. In *sharing power*, participants describe how they found it helpful when therapists considered their input in discussions about what to pursue in session and when negotiating solutions. In *considering client context*, participants describe how they found it unhelpful when therapists used a fixed template or schedule, but rather preferred when their individual needs, preferences, and circumstances were considered and reflected throughout therapeutic discussions.

**Sharing power.** All eight participants described wanting some input and consideration of their perspectives in therapeutic sessions. However, they also said that at times it could be helpful when therapists would take the lead to provide direction in therapy. For instance, Lindsay’s therapist would say “I am going to give you this idea, why don’t you write about this

today.” For Lindsay, “It was almost like a little assignment, I needed something that was a direct thing. Then it was perhaps a springboard for the next step, or the next conversation.” Lindsay found such direction from her therapist helpful for getting started, especially early in the therapeutic process.

Suzanne also found it helpful that her therapist was directive early in therapy. Suzanne said that because she was “shy” and “not good at speaking about [her] emotions,” it would help her when her therapist assumed a “leading position” to get therapy started. Kelly agreed that at certain points in her life it was helpful to have a therapist who was more directive and took the lead in sessions. “There was a part of my life when I needed that, when I needed the structure. But the whole goal of therapy is that you can come out as a person able to manage your own issues.” As her therapy evolved, Kelly perceived her therapist to be less directive and increasingly supportive of where she was at. “Sometimes you need to digest and figure out your next steps.” Kelly valued opportunity to think things through on her own. “I go in [to see my therapist] when I feel the need to discuss stuff, or if I need some kind of support then he will be there.” As Kelly became more comfortable broaching different issues on her own accord, she perceived her therapist to assume a less directive role. Kelly felt that increasing consideration of her perspective by the therapist was a helpful part of therapy, as it allowed her to develop some independence, or rather helped her to not become dependent on the therapist for direction.

Like Kelly, Tia felt it was important that her therapist provided space to consider her own needs and preferences, effectively sharing power when making decisions about what would be discussed and how solutions were negotiated.

[Therapists] are there for this little part of your life, like a booster or something. Just helping you along...and I feel like it is [the client's] job to use the tools [that they can give you] if you come across a road block... And if you are really lost, I feel like that is when the therapist comes in handy... But you have to learn how to do it yourself too. If that doesn't work, if you keep failing, maybe that is when you seek help from the therapist.

Tia perceived her therapist to have helped by providing direction in therapy, while also empowering her to assume an active role in directing her own therapy. Alternatively, she described a therapist who remained directive in the sessions as “helpful to talk to, but then when it came to going off on my own it was sort of like...going back to square one.” Rather than

depending on her therapist for answers, Tia felt that it was more helpful when the therapist supported her in developing a repertoire of tools to use herself. “The whole point of going to therapy is to give you the tools to sort of turn the mirror around so to speak, and say ‘Ok, why am I reacting like this?’ And to learn to analyze it yourself rather than just panicking.” Tia considered her therapist, who had asked her to share throughout therapy, as ultimately helping her to work through problems on her own.

Kelly also perceived her therapist to have empowered her by actively sharing power when discussing issues and pursuing solutions. “She supported me, she was there...to tell me that I had some power here, that I wasn’t this powerless person that I thought I was. So she built up this power in me to say at one point, ‘enough.’” “Enough” meant that Kelly felt sufficiently strong to finally work through ED symptoms and other aspects of her life that she and the therapist agreed were unhealthy. Kelly’s therapist did not impose the issues to be addressed, or solutions. Instead, Kelly reported that her therapist opened up the possibility “that there are all kind of different ways to deal with it.” Kelly appreciated this as giving her confidence to contemplate her own solutions, whereas other people in her life “just saw the right way or the wrong way.” Her therapist helped her to see that “there were all kinds of shades of gray between.” Kelly felt that her therapist empowered her by encouraging her to speak up and find her “place in this world as a person too.” As a result, Kelly said that she became more comfortable asserting herself in both therapy and other domains of her life.

Like Kelly, Sonia considers therapists who position themselves as experts, and impose the direction of therapy without empowering the client, to be less helpful:

I did a course about working with children and youth and it is so “You do this, you don’t do this or this” and you follow this structure... There was no human to human working. It is more like “This is the doctor or this is the therapist, and they’re going to fix you.” I find that to work together as two people fosters more healing.

Sonia felt she was working with her therapist in directing content of therapeutic work, which resulted in Sonia feeling valued by her therapist and therefore more valuable as a person. She experienced this as helpful in therapy, and the benefit translated to other aspects of her life. “She constantly reminded me of my strengths, who I am...That made me recognize that maybe I am something to be cherished...Her simply saying ‘That makes sense, Sonia’ was affirmation that I

am worthwhile.” Sonia described how she perceived her therapist as affirming what she felt or thought, while also providing some direction to the therapy. Sonia said her therapist did this by asking questions to explore what Sonia described. “She helped me to see more of the dynamic of what was happening, which validated what I was feeling because I was able to see why it wasn’t healthy...so she helped me to see, to understand more.” Sonia felt like a “team” with her therapist when the therapist asked questions about whatever she had brought up. “It was like a partnership, like we were going to do this together. Instead of it being like the professional and then the client in a hierarchy, it was like we were equals.”

Jenny further describes a sense of equality with her therapist. She reported that her therapist helped her to understand that “Working together on this takes mind power from both sides, the patient and the therapist, and she needed my contribution.” Jenny appreciated the opportunity to be considered a meaningful contributor to the therapy, versus being told by the therapist what was wrong and what the solution was. Jenny said, “that model of working together, making progress together, instead of ‘I know what is best for you and I am telling you this is going on’” resulted in “being able to take steps together that I could handle.” Jenny appreciated her therapist making space for and considering her perspective in therapy, but also reflected that other clients may prefer and benefit at times from a more directive therapist assuming the lead in therapy sessions.

Maybe some people really do need that all or nothing approach, being told “you need to do this.” But a lot of times, for me, being told that I needed to do “this” and then not being able to do it meant that I ended the therapy. It felt that when I was not understood, I was interpreted as being treatment resistant.... As soon as I felt that the therapist was not hearing me I would just stop talking and revert back to the mute I was as a child, which I now recognize as [a reaction] to my feeling that I could not trust the therapist to understand me in the situation, and seeing escape as the only option. Then [the therapist] would get frustrated and say “see because you aren’t doing well, we can’t even talk” and then I was like, ok this is the end of that relationship! And I would just leave. But it was frustrating, because deep down I really did want the help.

As Jenny suggested some clients may be, Suzanne was one who found it helpful when her therapist was directive, saying that she did not feel comfortable taking the lead herself.

Similarly, Lydia found it helpful when she perceived her therapist to have provided clear reference points and options, however appreciated opportunity to increasingly make decisions as she became more familiar with and comfortable in therapy. Sonia also described becoming more comfortable, and increasingly expressing herself as her work with the therapist evolved.

Sonia said that her therapist would provide a rationale for what she thought would be helpful, but was open to Sonia's input as well:

There were things that I would not be crazy about, but she would encourage me to try... If I said I didn't like something she would just acknowledge that it doesn't work for me and say how about we try something else instead. It was much more "let's try something else to find what works for you"...rather than the therapist forcing her preferences.

As Sonia described, Beth also felt it was helpful when she perceived her therapist to have suggested some direction, but also shared power with her when making therapeutic decisions. Beth said this resulted in her feeling comfortable to tell her therapist what she did and did not find beneficial in therapy sessions.

I think an important part was feeling comfortable telling her that something wasn't helpful, and feeling comfortable being honest with her about how I find the sessions are helping me, or the techniques are helping me. So being able to come back and say that something isn't really working for me, and her being open, like, "Ok that is fine, it doesn't have to work for everybody."

Right off the bat, she took the time to feel out what I tend towards.

Tia also described how she experienced her therapist asking for and listening to what she wanted or would find helpful in therapy. Tia admits that initially she was not sure what to say: "I was just saying a bunch of stuff. I think that is because it was all jammed up in my brain." She goes on to appreciate the importance of opportunity to get her thoughts and feelings out, and sorted through. Tia valued her therapist helping her to sort through her thoughts by having encouraged her to express her ideas. In addition to offering space for Tia to share own thoughts and ideas, Tia valued her therapist's expertise to "analytically" consider what she said. In this sense, Tia felt as if she and her therapist shared power in therapeutic discussions and decisions, each making a meaningful contribution.

Tia, Jenny, and Beth each said it took them what they felt was a long time as clients to feel comfortable with their share of power in therapeutic discussions, but that it was ultimately empowering and helpful. Jenny summarizes:

It may require patience and perseverance from both sides, but therapists shouldn't forget that the [client] is there, longing for hope and that [therapists] have the ability to empower clients to create a better life for themselves. It needs to be a collaborative effort, building trust, developing goals, examining always through a lens of empathy. Consider it a shared journey.

Jenny said that her therapist would emphasize the sharing of power in therapy by saying things like “you are giving me too much credit, and yes I have supported you but you have taken all of these steps and it is you, it is not all me.”

Even Suzanne, who appreciated her therapist directing the content of sessions because she was uncomfortable sharing her own thoughts and feelings, saw benefit to shared power. Suzanne and Jenny described the risk of deferring entirely to the therapist to dictate the sessions, citing instances where they felt inclined to do things to please their therapist versus doing something because they felt it was important. In Jenny's words:

It was so important just to make people around me happy... I was definitely a huge people pleaser, I was there out of fear and kind of wanting to make [the therapists] happy, and I wasn't doing things because I felt that they were really what I wanted to do for myself. So that isn't going to be sustainable.

Suzanne and Jenny said that they were more likely to express their thoughts, feelings, needs, and preferences when their therapists encouraged them to share decision making power. They say that this was important because it made them less prone to accommodate their therapist's agenda to make their therapists happy, rather encouraging them to speak up and make what they felt was better use of their time in therapy.

***Considering client context.*** Where *sharing power* is about therapists empowering clients to develop agency in sessions, *considering client context* is about therapists taking into account individual client needs and preferences when proceeding with therapy, as opposed to following a template to outline the course of therapy. This is different than the thematic category *Goals and Expectations of Therapy*, including the themes *therapy as an individual process* and *collaborative goal setting*, as the theme *considering client context* pertains more specifically to

considering context during the unfolding of discussions, interventions, and negotiating solutions within sessions. Four participants described finding it unhelpful when they perceived their therapists to have applied a “template” or followed preconceived notions to inform the approaches used in therapy. Rather, they found it helpful when their unique circumstances were considered, and their therapists responded accordingly. Kelly described her preference for therapists to consider the whole person that is the client when planning and proceeding with sessions. “You can’t just work with a template, you need to see the person and their needs at that moment. Address that, and be supportive, and empathetic to really understand the issues around them, and see it is not just the person but the whole environment around this person.” Kelly said that she would not have found it helpful if her therapist had adhered to a template like cognitive behavioural therapy.

I guess if [my therapist] had tried to do some CBT [cognitive behavioural therapy] stuff with me, it would not have worked out. Instead, I think she totally understood, and reinforced the needs that I had. She attended to my needs, embracing me the way I was.

While a cognitive behavioural approach to therapy might not have suited Kelly, Beth describes her therapist as “taking the time to feel out what [she] tends towards” and coming to the conclusion that a cognitive behavioural approach would suit her:

After a couple of months it was obvious that cognitive behavioural stuff was generally helpful to me because my mind works that way. Whereas it may be different for other people. [My therapist] would say “because you have always liked behavioural stuff we will try this,” which causes me to think that she wouldn’t do that with everybody.

Even though Beth liked the cognitive behavioural approach, she, like Kelly, appreciated that her therapist considered her individual context and responded accordingly.

Lydia described it as unhelpful when she perceived her therapist as “focussing on the eating disorder agenda” as opposed to considering her individual needs and preferences throughout therapy. She said it felt as if the therapist “came at it knowing what she wanted to talk about every day.” Differentiating this experience from another experience of therapy in which she felt that her therapist did consider her individual context, Lydia said: “The second [therapist] dealt with things session-by-session.” Sonia also described how she believes that her

therapist considered her individual context throughout the course of therapy. She found this to be helpful. “I couldn’t imagine [therapy] happening in a fixed ten sessions or a year. For me, it needed to be ongoing and evolve organically because it hasn’t just helped me heal my eating disorder but rather touches on every part of my life. It is an ongoing healing process.” The participants described how this ongoing process could not be addressed using a template or completed in a fixed period of time, but rather required a more reflexive approach.

**Eating disorder specific interventions.** Eating disorder specific interventions include discussions and exercises that the eight participants described their therapists as offering to directly address the ED. The interventions described include ED-specific education to teach participants about physiological side effects of EDs symptoms and resources available to help them, being encouraged to keep food journals, using challenge foods to expand nutrition, discussing weight, identifying the purpose served by the ED, and differentiating the client from their ED.

**Eating disorder education.** In total, seven participants described it as helpful when their therapists shared information about EDs. Six of those participants discussed learning about how the ED could affect them physiologically, while three of the participants described learning about ED resources more generally that could be of use to them.

Suzanne described learning about the cycle of not eating enough, getting very hungry, and then how she could end up eating more in the long run and later be inclined to purge, leading her back to the start the cycle again. Lindsay described learning about the side effects an ED could have on her body, particularly on her brain. Sonia also learned how restricting, bingeing, and purging could impact the chemicals in her brain, thus affecting how she felt both physically and emotionally. In all of these cases, participants said that learning about the physiological effects of EDs motivated them to take better care of themselves.

Even though Jenny learned about the different nutrients and eating habits necessary for her wellbeing, she said “If you just want to harm yourself, you aren’t so worried about nutrition and its side effects.” She acknowledged that for the intervention to be helpful, she had to want to apply the information that was given to her. Jenny said learning about the physiology of her body and ED effects helped her to understand that her “body is complex,” which did ultimately motivate her to “want to nurture that.”

Similar to Jenny's initial reaction to learning about her body's needs, Lydia said "I don't think that I cared" but elaborated to say that she "was more curious about getting to the root of the problem" after having learned about physiology and the potential effects of an ED on her body. Learning about physiology helped Lydia to appreciate the impact of the ED, and made her "fearful of how dangerous it was, which was like an accelerator to wanting to get better." Despite initial resistance because Jenny and Lydia were not concerned with taking care of themselves, both explained that learning about how EDs could impact their physiology did serve as a motivator in therapy, as previously described by Suzanne, Lindsay, and Sonia.

Kelly remembered her therapist teaching her about physiology as it related to her body weight, which helped her to shift how she felt about herself and the ED.

I really appreciated that the therapist always stressed that you have a natural weight point, and your body will always come back to that. And it is exactly that, I lost weight a couple of times and my body weight would always come back to that pre-set weight. I don't like that, but I am starting to accept it. I can torture myself, I can put myself through diets and whatever, and I lose weight, but within a very short time I have put the same weight back on and maybe more. I think she made this very clear to me, that you need to accept your weight point, your natural weight point, even if it took me a long time to accept.

In addition to learning about physiology, three of the participants described how their therapists presented other ED resources, such as books, pamphlets, or websites with ED information. The participants considered this a helpful part of their therapy. Lindsay described reading books that resonated for her. Her therapist shared the books with her, which gave Lindsay ideas to consider and then discuss in session. Jenny also read books which helped her to better understand ED-focal treatment, and provided her with "hope" for her own psychotherapy.

Tia's therapist offered her resources in the form of information about possible alternative activities that may interest her. She says that her therapist encouraged her to "try focusing on something [she was] good at." Tia said that by providing her with suggestions, her therapist helped to create options to explore. "I started to think about things I enjoyed doing and to get excited about things I enjoy doing, rather than just thinking 'I am useless and I can't do anything,

and I have no skills.” In addition to finding resources about alternative activities, Tia described diagnostic information provided by her therapist as also being helpful.

I felt it was nice to have an actual verbal diagnosis... It was really interesting to me, and then I could do my own research and say, “Oh yeah, that does sound like me.” Or, I could ask questions. Someone like me wants to know “What are the typical symptoms?”... Even though I know technically it is like putting a label on it, but for me some sort of label was great because then I could say that this is what I am experiencing... It also helped my therapist to explain, and show me everything, what it meant. And I was like, “That does sound like me, actually.”... It was very helpful to have, even to tell my family that too, because of course they didn’t get it... So just to have that professional diagnosis to explain, because it was evident in whatever I was experiencing. I could be like, “Yes, this is what I am dealing with.”

For Tia, receiving diagnostic information provided her with an initial understanding from which to ask questions and pursue further information, to better understand her experience, and to help explain her experience to other people.

**Food journals.** Six participants described their therapists using food journals as an ED specific intervention at some point in their therapy. Food journals referred to an exercise of tracking by writing down what food was consumed, and in some cases included recording thoughts, feelings, and events associated with ED behaviours. Jenny indicated that, for her, food journals were not entirely helpful:

For me, I found that it encouraged an obsessive perspective of food. I would think about everything that I was eating in extreme manners and measure everything exactly. Once I started that, it was another addiction that I couldn’t stop... I needed it. Until I had written down everything I had eaten I couldn’t stop thinking about it.

Jenny said that her “natural inclination is to obsess about all that [she ate].” Keeping a food journal gave her a mechanism by which to track food. Even though she understood that the exercise was meant to help her become more aware of ED patterns, it ended up inadvertently fuelling her obsession with what she ate.

I would feel like I wrote so many things [that I ate], way too many. [My therapist] would say, look at your food journal, it is nothing compared to your meal plan. But I sincerely felt that it was so much, too much. And although [my therapist] attempted to show me that it wasn't too much food, relative to my meal plan, it was never something I was able to integrate emotionally. The expectation was that you could compare the food journal to your meal plan, but for me it was overwhelming. I would scrutinize every bite and ruminate over [what I ate], rather than trying to relax and eat because it is part of life.

Beth reiterated Jenny's concerns about the food journal when describing why she believes her therapist did not use food journals as an ED intervention.

I think one of her strong tenets in the beginning of therapy was to try to get away from recording. One of the big issues...that started, precipitated the whole journey of disordered eating for me, and is still one of the residual thought patterns is the tendency to calorie count. So for me, [my therapist] didn't want me to be recording amounts at all. She wanted me to in my head be like, "Ok do I have grains in this meal, that in that meal, or this in this meal," but not keep track on a daily basis of my intake because that was ...leading towards this path of un-wellness for me.

Similar to Jenny and Beth, Suzanne and Lindsay also described difficulties associated with keeping a food journal, yet they found it a generally helpful intervention. Lindsay said that at first she could not keep the food journal "without thinking that somebody is going to be reading this," which she said, "kind of freaks me out, and I have to basically burn the pages as soon as I write them." Likewise, Suzanne was not comfortable analyzing the food journal with her therapist in sessions. However, Suzanne did say that the exercise ultimately showed her that it was ok to eat complete meals. In addition to what she ate, Suzanne's therapist had her record what time she went to bed, woke up, where she ate, when she ate, her emotions, and her thoughts. Suzanne said that tracking this information helped her to realize that she felt better when she ate regular and complete meals. Lindsay became more comfortable with keeping a food journal when her therapist gave her permission to discard entries after they had been considered in session, and felt that the intervention helped her to understand benefits of eating more regularly.

For Sonia, food journals encouraged her to make connections among what made her feel good. The food journal helped her “nutritionally, but also journaling and attending to emotions.” Using the journal, she saw patterns in how she felt relative to what she had, or had not, eaten as well as how she was feeling emotionally before or after she ate.

Tia described the helpful use of a food journal with one therapist, relative to an earlier unhelpful experience with a dietitian.

[The dietitian] was a fitness freak who worked with a lot of athletes. She went through my food journals and said there is too much sugar in this, too much sugar in that...I mean I did have an affinity for cereals when I was recovering.

That was sort of my thing, although I know they are packed full of sugar—but I was eating. And the whole goal of me seeing a dietitian was to just start eating.

Tia had wanted to work with the dietitian to start eating “normally” and “healthy” again, but the experience resulted in her being even more uncomfortable with food. Although this experience was with a dietitian, not a therapist, she felt it was an important and relevant experience to share. She compared that first experience of keeping a food journal with a later experience of using food journals with a therapist, an experience that she found to be much more helpful. Tia’s therapist did not require her to keep a very detailed food journal, but rather asked her to “keep track of things...only to make sure that [she] wasn’t restricting.” Looking at patterns in the food journal, Tia’s therapist showed her that she was not eating enough food. This made sense and felt right to Tia. Tia’s perspective of her eating habits changed with tracking foods to make sure she was getting a large enough quantity and variety of food. Through the exercise, she realized that she wanted to be “a healthy functioning human being” and to do that she would “need to get all of these vitamins in, all of this nutrition in.” She also acquired some confidence that she could enjoy treats within reason. Like Suzanne, Lindsay, and Sonia, Tia learned through tracking food that eating enough throughout the day actually helped her to be able to eat what she enjoyed without feeling compelled to over indulge on “treats.”

**Challenge foods.** Like food journals, challenge foods are related to food consumption. They are different interventions in that challenge foods refer to the introduction of foods that have not been a regular part of a person’s diet, or that the person finds difficult to consume typically because of cognitive reasons like they believe it is bad for them or could cause weight

gain. Seven participants described how their therapists proposed challenge foods in effort to help them expand their dietary intake.

Lindsay described her therapist as starting the exercise by asking, “Is there anything that is safe, that you could nourish your body with?” She found it helpful that her therapist asked her to consider what she could eat to start expanding her dietary intake. Lindsay found this a helpful starting point, because she was able to expand her nourishment with what felt appealing and comfortable to her. Alternatively, Suzanne said her therapist suggested specific challenge foods for her to try instead of encouraging her to try any new foods that she was already comfortable with. Lindsay preferred, and Suzanne would have preferred, being given the choice to start with challenge foods of their own choosing. They both said that trying challenge foods of their own choosing felt more natural to them. For instance, Suzanne said that one week her therapist had asked her to eat ice cream as a challenge food. Suzanne did not feel like eating ice cream that week, but did feel like eating French fries which would also have been a new food for her. She had ice cream because it was what the therapist asked her to try, but said that she would have enjoyed trying French fries more.

Jenny said that she would have felt “trapped” by a therapist asking her to eat specific challenge foods. She found her therapist “very encouraging, but gentle, patient, and flexible” which helped Jenny to work through fears she associated with challenge foods. “She would gently encourage me saying that ‘you may not be able to think about taking this challenge, be able to do this huge step, but I need you to have an open mind that we can talk about it and explore it.’” Jenny said that she would likely not have been able to “handle it” if her therapist had forced a challenge food, which could have resulted in her feeling as if she had failed at the exercise and was failing at therapy. Rather than forcing challenge foods, she found it helpful to talk to her therapist about things like challenges foods “that were not easy to do without fear.” Her therapist would say: “How about next time you aren’t going to eat it, but you can think about what it would be like to eat it, and what the feelings might be afterwards?” This got Jenny to engage with the idea of eating challenge foods, and eased her into feeling more ready for them.

Jenny also spoke to the idea that challenge foods tend to be high in calories, fat, and/or sugar. She felt “like a criminal if [she] ever [bought] a health food item.” To her, buying a snack in and of itself was a challenge. She recognized that what she bought “wouldn’t be ideal through some eyes,” but it was still a significant step requiring for her, requiring “encouragement

and acceptance.” Jenny appreciated that her therapist recognized her step towards eating something when she previously would not have, even if it was a “health” food and not a calorically high option that may be characteristic of typical challenge foods.

Tia spoke about challenge foods often being selections that are high in calories. Like Jenny, she did not find the expectation of calorically high challenge foods to be helpful.

At least one of those meals had to be something greasy or deep fried... I just didn't want it, and had a sensitive stomach to begin with, so it was going to make me feel like crap. That food still makes me feel like crap, so why would I want to eat it?... They were just generalizing what I was going through—“Oh you have an eating disorder so you must be afraid of this and this and this”...and that is what I hated about it.

To work around this generalization about what challenge foods should be, Beth described her therapist as taking time to understand what foods were comfortable and what foods were uncomfortable for her, including why. “One of the things that we did was kind of make a list of fear foods, in ascending order. So foods that I was just not ok with eating, and I would make a goal of trying to start working down that list.” Beth found this helpful. “Conceptually that was good for me to realize that I had so many different foods that I avoided.” Even without deliberately consuming a new challenge food each week, Beth remembers “having that list was good,” because when she did find herself in a situation where the foods were available she would eat them and realize it was a big step. For Beth, the list itself was a helpful reference point. She recognized that the challenge food exercise would typically have required that she systematically work through a list of foods, which she did not think was natural. The list of challenge foods, however, provided Beth with a tool which she found helped her to realize how far she had come when she did try a new food on the list.

Lydia said she experienced her therapist's use of challenge foods as helpful because it liberated her from dietary restriction and ED related food rules. “At first it was such a relief...frankly when you starve yourself for that long...control is really important.” With challenge foods, Lydia said her therapist asked her to “eat at regular times so that you don't push back or miss [a meal]” and “eat a certain amount of things.” However, she was able to choose what constituted those meals and snacks. She found this “exciting,” and said that the exercise made it “easy to start” feeding again, and “to stop the calorie counting.”

Sonia also found it exciting and easier to start eating once challenge foods were introduced by her therapist, however ultimately she did not find the exercise helpful.

It was mostly about just the food content. And I remember telling [the therapist] that I don't want to gain weight. She was like "Yep, ok, no problem. You can eat whatever you want. You want ice cream, go for it, you'll be fine." And so I was like, ok this is a professional telling me that I can eat whatever I want. But, all that it took out of my eating disorder was the purging. I kept the binging. I thought I was good, I was eating now.

Sonia did not find the exercise helpful, because she felt unprepared for what happened next: "I started to gain weight very fast...that is the last thing that I wanted to do. So, I wound up going the other way, where I started to purge a lot...to try to get back on track, my on track." When the therapist did not provide guidance to help Sonia understand what to expect, Sonia says:

It made everything a lot more severe. My eating disorder went full fledged...The eating disorder worked for me and it made me realize that I couldn't let go of it. You let go of this, and you are going to gain weight. That was my only focus at the time, and yeah, it made me hold on to [my eating disorder] even harder.

Sonia said that she would have preferred if her therapist had slowly introduced challenge foods, allowing her to practice with a few select foods as opposed to introducing all food at once.

**Discussing body weight.** Four participants described discussing body weight with their therapists. In particular, body weight as it related to ED-associated thoughts or behaviours was discussed. Lydia, Jenny, Tia, and Suzanne all said that, in their experiences, discussing body weight could be helpful, but was a delicate issue to be carefully addressed in ED therapy.

Lydia said that she was weighed by a medical doctor, who shared the weight with her therapist. Lydia understood that her weight and weight changes provided her therapist with a reference point to know how she was "progressing." This felt "scary" for Lydia, because she did not want to know her weight, as she felt it might upset her. To prevent her from feeling upset or "triggered" by weight and weight changes, Lydia said that her weight was always taken with her standing backwards on the scale so that she could not see the weight registered. Similarly, because of concern that weight changes could "trigger negative feelings," Suzanne and her therapist decided that she would be weighed "back-to-scale" during therapy.

Jenny said that instead of discussing her specific weight numbers, her therapist would say more generally “We should notice that you have lost weight.” That would at times be the extent of the conversation, or other times maybe the weight loss would have happened a few times such that the therapist would continue, “We need to talk about this.” Jenny said that talking about her weight in general terms, without talking about the actual numbers, removed the associated fear of “that reality,” but still allowed the therapist to address weight changes in therapy.

Tia felt that her therapist’s ability to talk about weight in a sensitive but constructive manner differentiated ED-specialized therapists from therapists whom she did not consider to be as well equipped for ED-focal psychotherapy. “It is crazy, people say that they specialize in things, but they really don’t...because [that therapist] wouldn’t have approached me the way she did if she knew.” Tia was referring to the way that her therapist used the Body Mass Index (BMI) chart to determine whether her ED was problematic. Tia’s weight appeared normal according to reference on the BMI chart, but she said: “I wasn’t fine at all.” She observed that BMI norms take into consideration “a cross section, but everybody is different.” Tia felt that by saying her weight was fine according to BMI charts did not reflect the difficulty that she was having as a result of her experience of ED, which undermined her work with that therapist.

***Identifying the purpose served by the eating disorder.*** Six participants described how their therapists helped them to understand how they might use ED behaviours as a means to take care of themselves, even if the ED behaviours in turn caused them difficulties. Participants described learning how they used ED behaviours to make themselves feel temporarily better. For instance, “There was a period...that when I threw up I felt great! I didn’t think of it as hurting myself.” Lindsay said bingeing and purging would temporarily alleviate uncomfortable feelings. “It was temporarily ok for 15 minutes, but then it creates this cascade of other stuff that is unhelpful.” Jenny described the “chain of events” by which her ED behaviours would occur, and how her therapist helped her to understand that her “feelings are not coming out of a vacuum,” helping her “to link the events together.” She elaborated that her therapist used “mindfulness work” to help her understand how a chain of events could affect how she felt, and result in ED thoughts or behaviours. Jenny also learned how to do a “cost-benefit analysis” of the ED behaviours to understand ways that they worked for her, and ways that they caused her difficulty.

Kelly reiterated how ED behaviours could work as a coping mechanism:

The only way that I felt I could control something was to control my eating and to control my purging, but I couldn't control anything around me anymore. It worked, oh it worked well for me, but then there came a point where I couldn't control [the eating disorder] anymore either. At some point it takes its own course. You can't eat anything, you eat something not even very big and you start purging even though you didn't even put your finger down your throat.

That is when I couldn't control it any longer and when I seriously needed help.

Kelly's said her therapist recognized how the ED had served as a comfort for her. "She validated that, and said 'Yes of course, this is what you feel. Your life is scary.'" Kelly said that hearing her therapist say "it is an unhealthy behaviour" but appreciating that she used it as a distraction from other things going on her life helped her to appreciate the effect of the ED, and introduced the possibility of discussing alternative means to comfort herself.

Sonia described learning to connect her feelings to ED behaviours, and discussing alternative ways to address those feelings and make herself feel better. Over time, she said she started taking care of herself without relying on the ED as a distraction.

I think in the beginning I was comfortable with what I was doing, so I wasn't keen on wanting to take care of what was going on, including my feelings and myself. But the more confidence I gained and the more I let go of certain baggage and trauma or whatever, the more it felt really good. It felt really good to let the therapist in, to release how I was feeling, and to eat a certain way. It began to feel better. So that in and of itself started to reinforce things.

Sonia said that her family's "way of dealing with emotions at home had been pretending that they didn't exist." As she became more comfortable sharing openly with her therapist, Sonia started to recognize how she used the ED to cover up troubling thoughts, feelings, and emotions. Sonia also considered her therapist to be a role model of "how people live in healthy ways, and how people take care of themselves."

Sonia, Jenny, Lindsay, and Tia each described learning to recognize, be present with, and cope with thoughts and emotions without resorting to the ED as a distraction or for comfort. Jenny said that she "needed someone to help piece that together." The participants described their therapists as using different techniques to help them identify and work through underlying trauma, thoughts, or feelings for which their ED had helped them to cope. Jenny relates:

One thing that was very helpful to me was DBT [dialectical behaviour therapy] techniques. It was kind of CBT [cognitive behavioural therapy] with a bit extra. I think that the CBT would have never done it for me because there had to be acknowledgement of where all my feelings were coming from, and why it was all there, instead of just behavioural modification. I also really needed the emotional acceptance.

While dialectical behaviour therapy techniques helped Jenny to accept feelings that she had otherwise covered up using ED behaviours, Tia made the point that not all techniques would work the same for different clients. “Like I experienced in my therapy, not all of the tools worked for me. I think it [requires] always trying to find different ways of approaching it, different tools to use.”

Kelly, Sonia, and Jenny mentioned art therapy, journaling, and mindfulness exercises as tools that their therapists used which they found helpful in coming to understand the purposes served by their EDs. For Beth, opportunity to simply talk with her therapist about connections between events, behaviours, and feelings was the most helpful technique.

In session, as I started talking about what was going on for me, I started realizing what else was also going on. There was a definite correlation between “I am a bit stressed about this, this is a bit tricky for me,” and my eating getting harder... I was able to see that correlation, that [the eating disorder] was serving a purpose that I needed to be more careful of, and I needed to be more aware of how I am feeling and how that is going to map on to the way that I eat. I would have a horrible week, and I would go to session, and I would just expect to be talking about the symptoms and then all of the sudden I realized that this other thing was going on and that is probably why [the symptoms] happened. So [my therapist] would kind of guide me there by saying, “What else was going on, and what else is happening in your life?”

Beth said that recognizing the correlation between difficult situations, thoughts, and emotions with her ED was important because it allowed her to acknowledge that using the ED to cope was something she could “choose to or choose not to do.” She recognized that the ED “had gotten bigger,” to the point that she had no longer been choosing it, but that she no longer wanted to rely

on the ED. At this point, she said: “I can choose to stop, and I can choose to reach out to people to help me to stop.”

*Separating self from the eating disorder.* Four participants described how they worked with their therapists to separate their identities from being associated with an ED. Lindsay said that her therapist took the approach that “The eating disorder doesn’t define who you are. It comes from somewhere, and is a part of who you are on some level, but it doesn’t define who you are. It is not your whole person.” Lindsay found this approach helpful because it highlighted that “there are all of these other really great parts that are often, in my experience, functioning really healthfully.” These healthy starting points gave Lindsay something to build upon. Similarly, Kelly remembers her therapist saying “You are you, and then there is this eating disorder here which is not you.” This made it clear to Kelly “that the eating disorder was not me, it was just taking space up sometimes.” Kelly reported that her therapist said “If you decide to live, it is your choice what life you want to live. It might not be easy, but you need to fight for what you want and need.” Kelly found her therapist’s invitation to choose how she wanted to live, while acknowledging that it could be difficult to pursue, was a helpful step in her ED therapy.

Jenny described doing a cost-benefit analysis of the role that the ED played in her life. She and her therapist wrote out the ways in which the ED benefitted her or contributed to her life, and the costs or consequences associated with the ED, including ways in which it hurt her. Jenny said that she slowly realized that she valued her daily activities more than “the suffering” associated with the ED. Jenny admits that she did not immediately find writing out the cost-benefit analysis helpful. “I am not sure if at the time I was able to internalize it all, to believe in what a future was possible.” However, she held on to the notes, and reviewing them over time realized that “Hey that is really true.” Now, Jenny keeps that list of what she values in her life on her desk to remind her of her priorities beyond the ED.

Beth relayed a similar experience, saying that through therapy “I realized what thoughts are mine and what thoughts aren’t mine.” While it is now obvious to her which thoughts are her own and which thoughts come from the ED, she described a time when the “ability to distinguish them was a huge thing.” Beth says that her therapist used “accountability” to help her differentiate her own thoughts and motivations from the thoughts and motivations related to the ED. She said that “learning to be candid” with herself, her therapist, friends, and family

removed the “secrecy and the hiding and sneaking around which wasn’t doing any good.” Although it took “a really long time” for her “walls to come down” and to be “really candid with them in the moment,” Beth says that being upfront with people in her life has helped her to realize that she is not the ED and she does not want to be doing ED related activities.

Beth went on to also describe how her therapist used spirituality and religion to help her learn that there was more to her life than the ED. Re-discovering religion offered Beth “a whole new framework of how to define yourself and how to define your worth.” By connecting with spirituality, Beth realized “that we are loved, and wanted, and accepted, and have a purpose.” Previous to realizing this, Beth said that the ED provided her with an identity by which to “define” herself. Alternatively, spirituality and religion gave her a “foundation” from which “to start rebuilding” who she was and wanted to be in terms of who she believed God wanted her to be. Beth felt that her therapist supported growth in this way by “believing in a higher power, and that we are worth much more than what society tries to tell us we are.” This helped Beth to question cultural norms that were influencing her habits, and to recognize the anxiety those norms resulted in. Through this realization that there is more to her identity than the ED, Beth realized “how brutally” she had been treating herself. She felt “liberated” when her therapist helped her to differentiate herself from the ED using spirituality as a reference point.

**Non eating disorder specific interventions.** The eight participants described their therapists using what were perceived to be techniques not directly related to ED behaviours and symptoms, yet a meaningful part of their ED therapy. Kelly summarized why she felt non-ED specific interventions were important to her therapy: “I truly believe that behind every eating disorder there is an emotional problem, some trauma in one way or another, and if this is not addressed then you are just treating symptoms.” Participants described interventions that helped them to address thoughts and feelings, explore their interests, develop coping mechanisms for dealing with challenges, and practice boundaries in their interpersonal relationships. These themes are described in detail below.

***Addressing thoughts and feelings.*** Seven participants described discussions they had and exercises they did with their therapists regarding thoughts and feelings related to challenges in their life more generally, outside of those related the ED. Lindsay shared a metaphor her therapists used that helped her to appreciate the intervention:

It is like you are used to being on a superhighway. It is fast and it is easy. You can go on autopilot. But, there is also this little tiny gravel path, a dirt road that you are all of the sudden driving down and it is twisty, and it is slow, and you don't know where you are going. It is really, really, really scary. It seems awkwardly slow, like maybe you have to even get out of your car to walk that path. You have to slow down, and observe what is going on around you, and let all of that stuff hang there. It is the rich, interesting, curious stuff about life. Rather than being in your safe little car, and motoring down the super highway not paying attention to anything, you are learning to stop and address the thoughts and feelings.

This metaphor helped Lindsay to “not panic” but rather “realistically assess what is actually happening” in her life. She said this allowed her to “slow down and just do it one step at a time, rather than going through life not paying attention.”

Lydia said that talking about thoughts and feelings was central to and helpful in her therapeutic experience. “I almost feel, at least in my circumstances, that the eating disorder is just like an excuse to get into the therapy office.” She came to see talking about the ED as “a moot point” and was more interested in exploring “the deeper issues.” She felt that the ED was the warning sign, or the opportunity for her therapist to say “Something is going on, let's talk.”

To help her talk through her thoughts and feelings, Lindsay's therapist would give her an idea and ask her to write or draw about it. Kelly, Sonia, and Lydia's therapists also encouraged them to paint and journal as an exercise to help them express their selves, and to provide opportunity to explore what emerged. Lydia did not find the art therapy exercises helpful, but wondered if that was because she studied fine arts in university and perhaps felt “all therapied out in terms of expression.” She did, however, find the journaling helpful. She remembers bringing the journals to therapy in case something she had written about came up, and to take notes on understandings that emerged. Lydia found journaling helpful to “get things out there” and to help “bring subjects back to talk about” with her therapist.

Kelly, Lindsay, Jenny, and Sonia said they learned to listen to their “internal voice” through therapeutic discussions about their thoughts and feelings. At the beginning of their therapy, they said that they were not attuned to, nor did they trust their internal voices, but came to appreciate the voice inside of themselves as a reflection of their thoughts and feelings. Sonia

said that discussing thoughts and feelings with her therapist became less scary during therapy. “I realized that my whole life would not go to shambles. I could unfold these things and be true to myself, and my life is going to be ok.” Sonia perceived her therapist to have helped her develop the confidence to address thoughts and feelings by listening to and validating what she shared.

She encouraged me to seek my own voice and to know that it was my truth. I think that I had lost my inner voice. Elsewhere in my life I was always being told “you are being silly.” ... So my previous examples had been to not express myself, but to pretty much shut myself down... I had learned that you don’t talk about your feelings, you just pretend that they aren’t there and move on. But the therapist started to foster my voice, and to tell me “This is your voice and you listen to it, it makes sense. It makes sense that you are concerned about that.”

As Sonia’s therapist encouraged her to consider and express her thoughts and feelings, Sonia developed confidence in her own voice. She said she increasingly trusted her own internal voice and became more comfortable expressing herself to others.

I was probably scared, a lot! But it was the most empowering experience and there is a feeling, for myself, when I am saying the truth and saying something that is honest and who I am to the core. [The therapist] allowed me to feel that and it felt good. It was weird, and scary because I wasn’t sure how someone might react based on [my] past of [of sharing] experiences that weren’t so good. But my therapist fostered that [self-expression] and made me feel that my inner voice makes sense. This made me feel more comfortable with it.

In addition to asking Sonia about her thoughts and feelings, and validating what she shared, Sonia’s therapist encouraged her to write letters to further express herself. Sonia reported that writing letters allowed her to connect with and process her thoughts and feelings. Her therapist explained that the discussion of her thoughts and feelings was “to find that inner voice, to be heard, to know people are listening to you, and that you have a voice again.”

Learning to recognize her thoughts and feelings, to value that internal voice, and to express herself felt like a helpful release to Sonia.

In the beginning I was holding on to everything. I realize now how much energy it took for me to pretend that everything was great, and to push down all of those negative feelings or difficult thoughts. I felt better after a while of

letting [the therapist] know about them, and finding ways to work through those emotions. I really got into yoga, journaling, and art therapy. That release of everything felt so good, and I felt more in tune with and more accepting of who I was.

Like Sonia, Tia described her therapist validating thoughts and feelings she shared, which her family had previously dismissed. “In my family that is the sort of stuff that we sweep under the rug...which for me was extremely difficult because I can’t say anything, or else I am going to be labeled as being over dramatic.” Tia said that her therapist “validated” her feelings, allowing her to start dealing with them more directly.

Sonia described how art therapy, journaling, yoga, and other relaxation techniques helped her through anxiety she associated with sharing thoughts and feelings. She also identified sand tray therapy as a helpful exercise her therapist employed for identifying and working through thoughts and feelings.

There were a bunch of toys, and my therapist said to choose whatever I wanted to show her my family. I remember being like, “Ok I am going to play in the sand now!” But, it was really interesting because I put out my family and was like everyone is perfect, see, everyone is great. I remember her asking about my dad, because I had him in this sorcerer chair, a big chair. She said, “How is your dad?” And I said, “Oh he is great, he is really good.” And she said, “Ok,” but was trying to dig a little deeper, and I was not going to go there! I didn’t want to tell her, I didn’t even want to go there myself. I was in denial about my relationship with him, and his drinking, and his temper, and stuff like that. I had just kind of learned to pretend that everything was good. That was my first interaction with sand tray. It lead to things that I was pushing down but were still happening.

In addition to the sand tray, art therapy, and journaling Sonia reported that her therapist used “EMDR” (Eye Movement Desensitization and Reprocessing) and “feeling charts” to help her explore and further understand her thoughts and emotions. She said that her therapist being “non-judgmental” was most helpful in facilitating the usefulness of these interventions.

Jenny echoed what Sonia described regarding the value of interventions to help understand her thoughts and feelings. Jenny felt that it was “a confusing and painful world”

around her. Until working with her therapist, Jenny believed that she “must be the problem.” Her therapist helped Jenny to see this differently by being a consistent support, and helping her to make sense of her feelings, and to link those feelings back to what initiated them deep in her past. Eventually, Jenny said that she was able to recognize that her reactions “made sense.” This provided Jenny with “comfort and freedom,” and new ability to understand associated “needs and urges.”

Jenny provided an example of working through thoughts and feelings with her therapist in a way that she found to be helpful. She called this particular intervention “acting opposite your urges,” and likened it to “exposure therapy.” She said it was particularly “helpful in social situations.”

I used to be so anxious socially. Maybe I didn't necessarily let it show, but when I was meeting someone I would keep thinking that in a second they are going to hate me, and I was so scared. [The therapist] would teach me to push just a little harder past my fear each time, so it would gradually become a little less scary. Here, years later, I almost never feel that social anxiety anymore. It taught me that it is possible to overcome some of my greatest fears.

Another technique that Jenny cited as helping her to understand her thoughts and feelings was “recognizing the difference between primary and secondary emotions.” This helped Jenny to “recognize links” between what occurred now, what occurred in the past, and how she felt. Jenny found it helpful to link current events, thoughts, and feelings in order to address core issues.

Jenny, like Sonia, also said that noticing thoughts and feelings without judgement was imperative to her being able to accept and work through them with her therapist.

[My therapist] worked hard to help me validate that it made sense why I was feeling these emotions, and it made sense why I have different coping mechanisms based on whatever has happened to me, that it is all logical. Instead of feeling like a failure that I developed this way of thinking and coping, I came to see the coping mechanisms as valiant survival tools... I didn't do it wrong, I did what made sense. But teaching me that I don't *have* to do that anymore... and rather understanding what I needed, maybe saved my life.

Tia also said how important it was that her therapist validated her thoughts and feelings. She described a situation where she knew she either had to “let it go, or say something” about how she felt. “And knowing that I couldn’t let it go, I had to say something. And so I did, the next day.” After this example of directly addressing her thoughts and feelings, she told her therapist. The therapist validated her, saying “that is what you need to do.” She considered this a formative experience in her being able to deal directly with her thoughts and feelings. “Since then, I would go see my therapist and tell him about certain things that were happening, and he...basically told me that anything I was feeling was valid. It gave me more confidence, or maybe more trust in myself.” After such interventions to help her address her thoughts and feelings, Tia felt less prone to “crumble under pressure.” She said that she still feels the “pressure” of difficult thoughts and feelings, and still “gets anxious,” but that her “eating doesn’t change.” Instead, her therapist taught her to deal directly with thoughts and feelings in order to move forward more constructively by asking her “What is it that is troubling you, and what do you want to do about it?”

*Alternative ways to cope.* Five participants described their therapists teaching them about coping mechanisms for dealing with challenges, typically experienced as anxiety. Jenny said that acquiring coping mechanisms was helpful in therapy when talking about difficult issues. She considered learning to cope with challenges to be critical in helping her to move forward in therapy. “I was able to keep working towards progress, using the tools that had been offered to me to continue.” In particular, she found mindfulness exercises, learning to recognize the difference between rational and emotional thinking, observing and describing her feelings, and journaling as helpful coping mechanisms to be “invaluable.” Jenny elaborated that “Writing has always been a channel of relief” for her mind and a way to make sense of her world. She also appreciated her therapist introducing her to music and art therapy in order “to express yourself and cope with things when there are no words.” She says, “I play and I dance...and I also recognize the value of physical activity.” Jenny noted that her therapist required her to be physically strong enough before suggesting “exercise be incorporated in a healthy way.” To her, healthy use of exercise as a coping strategy meant “within limits and being mindful” of not overdoing it and hurting her body.

Tia found, especially when learning to address thoughts and feelings, that she could become preoccupied with certain experiences. She said that these preoccupations could

sometimes result in feelings of “distress or anxiety.” Her therapist called such preoccupation “a tape” and suggested that once it started to play, Tia might “drop” what she was doing and “do something else to refocus.” For example: “I was having troubles sleeping, so basically it was a physical exercise where I had to squeeze my muscles, and had to release them one by one.” This took Tia’s mind off of the distress and anxiety, and promoted relaxation.

Lydia wished that her therapist had discussed more coping skills to help her through challenging times.

More coping skills would have been helpful. I remember to this day her telling me, “When you are having anxiety physically push on your stomach and take deep stomach breaths, and imagine a calming place.” I think that was maybe the only actual coping mechanism for acute anxiety that she gave me.

Based on books that she read, Lydia felt it would have been helpful if her therapist had normalized her anxiety, explored its unfolding, and offered coping strategies. An idea she acquired from a book which she found to be helpful was to recognize that “anxiety sucks, but you are having it. It is uncomfortable, but it is going to pass. That feeling that you are feeling is physical, and it is happening, and experience it.” Lydia said this guidance helped her to “not get anxious about the anxiety.” By reading books, Lydia learned to acknowledge anxiety, lie down, and perhaps read. She said that these suggestions and breathing exercises helped her to interrupt anxious reactions in order to calm down. Learning about the physiology of anxiety, like “getting enough oxygen to function” and that she was not going to pass out or die also provided her with some relief. Although these strategies helped, she wished that her therapist had spent more time teaching her to “roll with the anxiety.” She believes this would have reduced her reliance on anxiety medications.

Beth described her therapist counselling her to “live in 15 minute increments” as a helpful coping mechanism. This helped Beth when she was having a “bad day.” She said that it helped her to “reset” and “restart.” Living in 15 minute increments during stressful times allowed Beth to “sit in the discomfort” and make a decision on how to move forward. Without the technique, she described herself as getting “caught up” and being unable to “get off the rat wheel.”

***Exploring identity.*** Five participants described how their therapists helped them to explore their identity and interests. Exploring their identity included considering things like their

strengths, values, and principles. Kelly summarized the importance of this, which she found to be helpful:

I think that I didn't know who I really was. And this is definitely one part where the therapist supported me, to find out who I am. The therapist showed me the way, where to go and what to look for. Because at the time, when I was really, really sick I had lost all connections to myself. There was nothing left for me... In the end, she showed me the way that life could be different if I chose to take a different path.

Kelly reported that by drawing attention to her strengths, her therapist gave her permission to be what she wanted to be. "She made it very clear to me that I don't have to fulfill [other peoples'] needs if it goes against me and my needs." This allowed Kelly to pursue her own interests.

Tia said that when she started to explore and embrace her identity, she realized that she was "a decent human being" and a contributing part of her community. This gave her a newfound sense of value that contributed to her developing wellness.

Beth's therapist used identity in a different way than was experienced by Kelly and Tia. Beth said that her therapist had her identify "different roles" and "associated types of distorted thinking and rules." This technique demonstrated to Beth that the roles, and associated thinking and rules, "had no grounding" but dictated how she lived. Beth and her therapist revealed the identities of a "critic, the perfectionist, the worrier, and the victim." Together, Beth and her therapist figured out how these different roles mapped on to different internal voices making demands of her. Having understood how each identity affected Beth, they were able to come up with counter statements for each of the roles which provided her with a tool that she "used daily" to reinforce who and how she wanted to be.

For Sonia, discussing healthy interpersonal boundaries was a significant part of her developing a healthy identity. Sonia said it was helpful to learn that "everyone is responsible for their own health and their own healing." This led Sonia to realize that she was responsible for her own wellbeing, and could not be responsible for other peoples' wellbeing. This realization provided her with a sense of relief. "That was huge, and it still resonates for me today, that no one can do it for you, you have to heal yourself." It empowered her to take better care of herself, and removed guilt she associated with previously assumed responsibility for other people.

One of the ways in which her therapist helped her to acquire interpersonal boundaries was by modelling them for Sonia. Sonia received the message from her therapist that “I love you, and I will be there no matter what, but I can’t do this process for you so I am just going to stay back here. You let me know when you need me.” This provided Sonia a sense of support, and an example of maintaining boundaries with others for whom she cared. “There were times when she would say something like ‘My dog is really sick,’ and she would take time for herself. That showed me that she takes care of herself.” By saying “I’m sorry I can’t get back to you right away but I will get back to you as soon as I can,” Sonia felt that her therapist was there and cared, while also demonstrating self-care. Sonia said that such boundaries between herself and other people has become a part of her own “toolbox” for being healthy. In this way, interpersonal boundaries became a part of what Sonia considers a healthier identity.

## CHAPTER SIX

### Summary and Discussion

In this chapter I describe main findings, including discussion of how results relate to the theory and practice of individual ED-focal psychotherapy. First, I situate the findings in terms of the study's purpose, method, and scope, then I highlight findings that are of interest clinically and meaningful to research. Throughout this discussion I point to nuances in what the participants reported as helpful, unhelpful, or wish had occurred or occurred differently in their experiences of ED-focal psychotherapy. The nuances described include context and exceptions to elucidate where possible what, with whom, when, and under what circumstances participants reported experiences of therapy as meaningful. I conclude the chapter with limitations of the study and possible implications for future research, practice, and training in the field.

### Situating the Findings

This study follows qualitative studies by Marchant and Payne (2002), Reid, Burr, Williams, and Hammersley (2008), and Gulliksen et al. (2012), described in the literature review of this dissertation, that have begun to illuminate what matters to clients in their experience of ED-focal psychotherapy. The current study, which also used qualitative inquiry, is different from preceding research in that it: (a) recruited a natural sample of clients who pursued ED-focal psychotherapy without diagnostic limitations, allowing for inclusion of clients experiencing a diagnosis of ED Not Otherwise Specified, diagnostic cross over, and/or co-morbidity; (b) explored psychotherapy in community practice settings which may differ from psychotherapy received in hospital settings; and (c) considered ED-focal psychotherapy specifically, rather than including client experiences of related services (e.g., medical consultations with nurses or physicians, nutritional consultations with dietitians). The findings add to what is known from previous qualitative study, as well as from outcome studies that have established particular theories and techniques as effective psychotherapy for the treatment of EDs (Hay, 2013; Kaplan, 2002; Rockert, Kaplan, & Olmsted, 2007; Stein et al., 2001; Wilson, Grilo, & Vitousek, 2007) to increase understanding of individual ED-focal psychotherapy in community practice settings.

The current research was conducted using a constructivist framework and principles of hermeneutic phenomenology. This allows for consideration of multiple and equally valid realities (Schwandt, 1994), using first-person experiences to describe the nature of the phenomenon under study (van Manen, 1990). Resulting phenomenological descriptions are

idiographic, taking into consideration participants' internal processes and perceptions of interpersonal transactions. The results of this study represent what participants identified as meaningful in their experiences of therapy. The helpful factors design served to unveil "what" participants perceived as meaningful to their experience of therapy, and "how" they believe it helped them (Elliott, 2010). Building on the helpful factors design, and inspired by the critical incident technique, participants were asked to clarify what they experienced as helpful or unhelpful, or wish had occurred or wish had occurred differently in their therapy (Butterfield, Butterfield, Borgen, Maglio, & Amundson, 2009). Participants described helpful and unhelpful aspects of therapy that were not mutually exclusive, meaning that they might, for instance, experience the same intervention as helpful in one context but unhelpful in another context. All eight participants reported that they or someone else may experience things differently given different circumstances.

Experiences described in the current research are those of adult clients. This is because issues addressed in ED-focal psychotherapy with youth may differ from what is addressed with adults, due to different developmental or life stage issues (Wilson, Grilo, & Vitousek, 2007). Moreover, the study was limited to the modality of individual psychotherapy, since group therapy can also differ from individual therapy in structure and function such that unique features may influence the course of each (Lambert, 2004). Further research would be required to understand the possible implications of findings from this study for ED-focal psychotherapy with youth or in other modalities.

### **Main Findings**

The vocabulary, breadth, and depth of results presented in Chapter 5 of this dissertation adhere to what participants reported as meaningful. The data obtained were based on client recollections of what occurred and what they perceived as meaningful to their experience of ED-focal psychotherapy, regardless of their therapists' theoretical orientations or intentions. I expand on these results in the following discussion of main findings to demonstrate what may be clinically interesting for training and practice purposes, or meaningful to research. In this discussion I do not reflect upon all 20 themes resulting from data analysis, but rather summarize key findings within each of five thematic categories, which are: *Goals and Expectations of Therapy*, *Therapist Way of Being*, *Session Process*, *Eating Disorder Specific Interventions*, and *Non-Eating Disorder Specific Interventions*.

**Goals and expectations of therapy.** What struck me about this thematic category was emphasis from all eight participants that addressing ED symptoms alone did not sufficiently meet their needs or expectations of psychotherapy. Participants recognized that focus on ED symptoms was especially important early in therapy for their health and safety; however, they also considered working through broader issues beyond the ED to be helpful, and even necessary, for longer-term wellness. They realized that nutritional and physical stabilization improved their ability to work through underlying issues that precipitated ED thoughts and behaviours, but then felt it beneficial to also discuss root causes and triggers of the ED once “the worst” of their symptoms had been addressed. Participants considered work beyond their ED symptoms essential in order to transcend the “vicious cycle of getting better and then returning to old behaviours to cope” with challenges.

This finding is not novel but is helpful to hear from clients who have completed ED-focal psychotherapy. It is possible that clients who have not completed psychotherapy could fail to appreciate the benefit of either first resolving potentially dangerous ED symptoms or later talking about issues beyond the ED behaviours and symptoms. In the literature review of this dissertation I identified the importance of medical stabilization, how the initial stage of cognitive behavioural therapy addresses physical symptoms, and the importance of working through psychosocial issues for successful long-term recovery. Normalizing food intake and medical stabilization have been considered necessary for client safety and to correct cognitive deficits that may result from the physiological effects of malnutrition, subsequently allowing for more effective psychotherapeutic intervention (Rosen, 2010). Similarly, the first stage of cognitive behavioural therapy for EDs focuses on normalizing food intake, while subsequent stages are used to characterize barriers to change and address clients’ cognitive “distortions” or “maladaptive beliefs” in order to prevent relapse (Fairburn, Cooper, & Shafran, 2003). Working through issues beyond ED symptoms with further psychotherapy has also been reported as “vital” to participants’ ED recovery in qualitative research preceding the current study (de la Rie, Noordenbos, Donker, & Furth, 2007). Beyond addressing ED-specific physical, behavioural, and cognitive symptoms, addressing psychosocial functioning, including clients’ ability to cope with challenges without turning to the ED, appears relevant to longer term remission (Keel et al., 2005).

Results from the current study underscore the importance of working through ED symptoms as well as fostering other interests, and developing alternative coping mechanisms to reduce clients' focus on the ED or reliance on it as a coping mechanism as identified in previous research. Additionally, the four themes within this first thematic category, *Goals and Expectations of Therapy*, further elucidate what participants found meaningful to pursue in therapy, and "how" they experienced those things unfolding in helpful ways. I will address key points raised within each of those themes: *therapy as an individual process*, *client willingness*, *collaborative goal setting*, and *pursuing "best self."*

***Therapy as an individual process.*** Rather than adhering to "fixed templates," participants said that it helped them when therapists adjusted the goals and expectations of therapy according to their particular circumstances. For example, participants described it as helpful when what was pursued in session evolved depending on what occurred between and in sessions. This reinforces findings from previous research where clients prefer to have input and choice in the unfolding of their therapy (Cockell, Zaitsoff, & Geller, 2004), and that therapists find it difficult to adhere to manualized treatments when addressing the diverse needs of their clients (Haas & Clopton, 2003; Lowe, Bunnell, Neeren, Chernyak, & Greberman, 2011; Wallace & von Ranson, 2012). Participants bringing attention to the perceived benefits of flexible practice reinforce its value and offer further opportunity to extend our understanding with their experience of it. Beyond identifying that clients seem to benefit from reflexive practice, participants in this study observed how their understanding of triggers and associated issues evolved over time and with their own experiences. They seemed to learn from reflection over time with therapists. This suggests a balance between guiding the client to prevent symptom triggers, and allowing the client to make mistakes that they can discuss and learn from in therapy. This balance could provide the direction in therapy that some clients may prefer and benefit from, while dissuading tendency to label and tell clients what they are doing wrong before they are able to realize it themselves.

***Client willingness.*** Participants described their own "willingness to really do the work" as necessary in order for ED-focal psychotherapy to be helpful. They referred to the importance of therapists acknowledging and working with their degree of readiness to address issues in therapy. From clinical and academic points of view, this theme appears to align closely with the ideas of motivation, or readiness to change. Motivational interviewing is defined as a client-

centered and directive method for enhancing clients' intrinsic motivation to change by exploring and resolving ambivalence (Miller & Rollnick, 2002; Wilson & Schlam, 2004). Meeting clients at their level of readiness for ED change has been associated with improved therapeutic relationship, developing client self-efficacy, lowering client concerns about change, enhancing motivation to change, decreasing ambivalence in treatment, and increasing satisfaction with psychotherapy (Geller, Brown, Bates, Zaitsoff, Menna, & Dunn, 2008; Gusella, Butler, Nichols, & Bird, 2003; Henderson et al., 2010; Rieger et al, 2000). Similarly, but in their own words, participants reflected the value of motivational interviewing and stage of change research. Participants said that therapists could promote their willingness to “do the work” by being patient while clearly outlining clinical concerns and therapeutic work to be done. This suggests that the approach promoted with motivational interviewing, being both client-centered and directive, is helpful. However, participants expanded beyond the influence of therapists, also acknowledging that their own circumstances could influence their willingness to engage in therapy. For instance, a few participants reported becoming “totally out of control” in aspects of their lives, and thus recognized the need for help as promoting their willingness to engage in therapy. This is reflective of external factors influencing therapeutic change as identified in the literature review among common factors (i.e., Castelnuovo, 2010; Duncan & Miller, 2005). Such external factors suggest that despite a therapist's well-informed efforts to motivate a client, the client's readiness to change or willingness to engage in therapy may at least in part depend on circumstances outside of therapy.

***Collaborative goal setting.*** Two participants found it helpful that their therapists considered their input when establishing and pursuing therapeutic goals. I want to clarify that while this theme bears similarities to *therapy as an individual process*, which describes participants' preference for flexibility in the course of therapy, *collaborative goal setting* more specifically addresses how success can be defined and celebrated uniquely for each client.

Participants preferred to have their input considered when establishing and pursuing goals. This warrants consideration from therapists but may not be advisable without further clinical consideration. I am thinking of the professionals' “duty to protect” when clients are at risk of harm. In a professional ethics context, Werth, Wright, and Bardash (2003) remind practitioners that EDs can result in significant harm and even death. This means that involuntary, compulsory treatment may be warranted. One participant acknowledged that her

therapist intervened, without her consent, to ensure her health and safety. The participant indicated she was mad at the time of the imposed intervention, but recognized it as helpful after the fact. Participant preference for collaborative goal setting, and their recognition that at times therapists may impose interventions to preserve their health and safety, in conjunction with “duty to protect” literature suggests that the utility of collaboration could exist on a continuum. At one end of that continuum, collaboration is preferable and appropriate. At the other end of the continuum, collaboration may be contraindicated due to the need for intervention to protect client health and safety at a time when the client does not perceive such intervention to be necessary.

Recognizing that collaboration is on a continuum and is context-based could attune therapists to possible times when collaboration with the client is beneficial. At the same time, therapists may need to assess the degree to which collaboration can be safely engaged in. Understanding that clients consider collaborative goal setting as important might remind therapists to clarify with clients why they are not considering their input at times when it is contraindicated. As in one participant’s experience, clients may initially be mad that the therapist does not collaboratively establish and pursue goals, but could come to appreciate the importance of imposed intervention for their health and safety, especially if it saves their life. That the participant appreciated the intervention in hindsight suggests that clients could be more “forgiving” of a therapist who strays from their general collaborative stance for safety reasons, compared to a therapist who perhaps operates less collaboratively or is more directive overall in therapy and subsequently exercises “non-collaboration” for safety purposes.

***Pursuing “best self.”*** Participants also described the importance of therapeutic goals that included pursuit of their “best self.” They saw such a goal as a reminder that more was important to them than the ED, which in turn inspired them to overcome ED tendencies that had been limiting their pursuit or enjoyment of other things that they valued, such as academics, relationships, health, and happiness. As with the *client willingness* theme, the title of this theme reflects language used most often by participants, however it invites debate. Researchers or clinicians may see the theme as more reflective of something like “self-actualization.” I will clarify similarities and differences among best self and self-actualization as it is presented in literature, and what participants described as meaningful to them.

Self-actualization was first described by Kurt Goldstein (see Modell, 1993) as a motive for realizing one’s full potential through activities like expressing creativity, seeking spiritual

enlightenment, pursuing knowledge, and wanting to give to society. In psychotherapy, self-actualization is often considered a Rogerian term. Carl Rogers (1961) refers to a person's tendency to want to fulfill his or her potential by expressing all of their capacities. The term was brought into further popularity by Abraham Maslow (1954/1987) who, in his hierarchy of needs theory, described self-actualization as realization of one's full potential through processes of self-exploration, self-discovery, self-reflection, and self-realisation (Koltko-Rivera, 2006). Participant descriptions of pursuing their "best self" bare similarities to "self-actualization" in that participants were improving themselves through a process of self-exploration, discovery, and reflection. However, "best self" was not necessarily about participants realizing their full potential. For some participants, pursuing their best self meant simply reconnecting with friends and family, or pursuing activities and interests that they enjoyed. In this sense, participants associated pursuit of their best selves with the reminder that there is more in their lives, and more to discuss in therapy, than the ED alone.

The clinical relevance of this theme may be a reminder to therapists to use language that is more familiar or accessible to clients, like "best self" rather than "self-actualization." The concept of self-actualization may also be experienced as lofty to some clients who could be discouraged by the idea of realizing their full potential. A few participants identified with a tendency to want to be "perfect" or a "people pleaser." Perfectionism or people pleasing could be inadvertently triggered if participants perceive therapists to be suggesting what they "should" be and do, rather than encouraging participants to discover what is healthy, fulfilling, and realistic for themselves. Clearly articulating that "best self" refers to a client's pursuit of interests and values beyond the ED, associated with wellness and satisfaction, might help to prevent perfectionism or people pleasing from being inadvertently triggered.

**Therapist way of being.** This thematic category describes characteristics participants attributed to their therapists that were perceived to affect their experience of ED-focal psychotherapy. Themes in this category describe therapists' being genuinely curious, eliciting trust, having ED expertise to inform the therapy, engaging in therapy by listening and sharing in conversations, and working in environments that reflected the therapists' care and creation of a place participants considered "safe" and "comfortable." Participants described *genuine curiosity* as therapists being interested in their clients' experiences, in tentative and non-judgemental ways. Participants consistently experienced this as helpful. *Trust, ED expertise, engaging with*

*the client*, and *environment* included more points of variance among participant experiences and considerations raised. I will elaborate upon these four themes.

**Trust.** Participants said that they were more likely to discuss difficult issues and feel that therapy was helpful when they trusted their therapists. Trust is likely ubiquitously important in all therapy. The ways that I discuss trust being gained are rather general, however the current study points to three ways that trust can be diminished which seem unique to ED-focal psychotherapy.

Some participants described how their therapists elicited trust, while other participants automatically attributed trust to their therapists. Participants described therapists as eliciting trust by listening to and acknowledging what they said without judgement. Not feeling judged was an important part of participants opening up as clients in therapy and not being afraid to discuss difficult or uncomfortable issues. Other participants reported “just being trustworthy” of their therapists because the therapist was recommended by a family physician, resource center, or because they “needed” the therapist and therefore wanted to trust them. These participants may have attributed expert and/or referent power to their therapists.

Expert power comes from having experience, skills, or knowledge in a particular field. Referent power comes from being trusted and respected (French & Raven, 1959; Taylor, Peplau, & Sears, 2006). Expert and referent power could in part illustrate the difference between trust that therapists earn through their actions, versus trust that therapists are automatically given because they are perhaps recommended or have professional experiences and credentials that clients value.

This theme might remind therapists that trust can be earned, and lost, in different ways. Participants described losing trust in their therapists for three reasons specific to ED-focal psychotherapy: (1) the therapist breached confidentiality for safety reasons related to the ED, (2) the therapist did not take time to understand their client’s ED symptoms without judgement, and (3) the therapist did not exercise ED expertise in the form of recognizing symptoms or explaining alternatives in ways that the participants could relate to. This theme indicates that therapists can gain trust either through their actions or because of their position as a professional. Findings indicate that trust is important to clients, but should not be taken for granted as it can be diminished. Unfortunately, the themes do not provide an indication of tolerance different clients

have for breaches in trust, and to what degree certain breaches in trust affect their experience of therapy.

***Eating disorder expertise.*** Participants reported that they were able to recognize whether or not their therapists had ED expertise, citing expertise as a helpful, even necessary, part of their therapy. Expertise included experience working in the field of EDs and possessing ED-specific knowledge. Such expertise provided the participants with confidence in their therapist, unless therapists used their ED-specific knowledge to make assumptions about the clients' experiences and needs. Participants reported that therapists who had expertise could provide them with insight about what to expect in the unfolding of therapy and ED recovery. While transparency around therapeutic processes was considered helpful, one participant reported feeling trapped and re-traumatized by her therapist who "jumped to conclusions" rather than listening to and valuing her thoughts and feelings. She and another participant likened the experience to a hierarchy within the therapeutic relationship whereby they felt undermined by their therapists. These findings indicate that although having ED expertise is helpful for guiding therapy and providing insight into the therapeutic process, how that expertise is exercised matters to clients.

The importance of clients receiving diagnoses related to their EDs is underdeveloped in literature, but seems related to the finding of ED expertise. Three participants reported receiving diagnoses (of ED or comorbidity) from professionals, while other participants described receiving "diagnostic information." Participants experienced diagnoses and diagnostic information as a reference point that offered them understanding and the means to help explain their situations to other people in their lives. According to the Regulated Health Professions Act in Ontario, only members of the College of Physicians and Surgeons of Ontario (i.e., medical doctors) and members of the College of Psychologists of Ontario (i.e., psychologists) can make ED diagnoses (Ontario Ministry of Health and Long Term Care, 2013). Diagnoses are beyond the scope of practice for other psychotherapists, including counsellors, social workers, and nurses, however all therapists might recognize the importance of understanding diagnostic information to help demonstrate their expertise, which could benefit their clients by providing them with information to help situate their experience of ED and recovery. However, as with having experience and expertise more generally, results of this study suggest that therapists exercise that expertise without imposing assumptions about client experiences and needs.

*Engaging with the client.* Related to therapist way of being, participants observed how their therapists engaged with them in mutual conversations. Mutual conversation meant that therapists both listened attentively to the client and shared their own experiences, thoughts, and opinions. Participants considered this helpful as it resulted in their feeling understood, cared for, and supported. However, the helpfulness of therapists engaging in this way seems to depend on therapists' exercising appropriate boundaries. Appropriate boundaries were particularly important to participants when describing what I recognize from scholarly literature as therapist self-disclosure. Only one participant specifically used the term "self-disclosure" when describing ways that her therapist engaged, however all participants described personal disclosures that their therapists made when participating in therapeutic conversations. Boundaries that participants described surrounding the use of therapist self-disclosure included therapists not looking for the client's approval, providing warning when as well as an explanation of why they were going to share something personal, and linking the relevance of what they shared back to the client's context.

As participants in the current study suggest, previous research also indicates that therapist self-disclosure can promote mutuality, modeling, reinforcement, and social exchange in the therapeutic relationship (Henretty & Levitt, 2010). By sharing themselves, therapists can encourage clients to do the same (Knox & Hill, 2003). Preceding research reinforces the finding that therapists who self-disclose are often considered more warm and personable, so long as the disclosures relate to the client's experience. If the disclosure is not linked back to the client's experience, clients can view the therapist as less professional (Audet, 2011; Henretty & Levitt, 2010).

Therapist self-disclosure in the context of EDs has received little attention, however therapists' use of their own ED recovery experience when working with clients has been explored. There are still no guidelines for therapists' use of personal recovery in the treatment of EDs, but advantages and disadvantages have been identified (Costin & Johnson, 2002). Advantages include allowing the therapist to provide understanding, hope, motivation, and empathy; elicit trust; abate shame; challenge clients who "wear their eating disorder like a badge of honour;" and to understand and respect the process of recovery. Disadvantages include vulnerability to countertransference, over-involvement in clients' processes, and risk of relapse.

In addition to exploring therapist use of personal experience with ED clients, researchers have started to consider therapist self-disclosure depending on symptomatology. Early research suggests that therapists self-disclose less to clients with higher symptomatology, perhaps to maintain boundaries in an effort to help clients or for the therapist to distance themselves from clients with greater symptomatology (Kelly & Rodriguez, 2007). Contrarily, other research suggests that therapists self-disclose more with clients who start treatment with particularly high degrees of symptomatology, possibly in an effort to develop the therapeutic relationship (Knox & Hill, 2003). This line of research remains inconclusive (Ziv-Beiman, 2013) and has yet to be considered with ED-specific symptomatology. However, in tandem with previous research as well as participant experiences reported in the current study, it suggests that therapist disclosures—when used with discretion—are a meaningful way that therapists engage with clients.

Disclosures were a primary way that participants described their therapists as engaging with them in mutual conversation, in addition to therapists' listening, checking-in to verify understanding, and following up on current events or outstanding therapeutic "homework." These results suggest that therapists benefit their ED clients through reciprocity in the therapeutic relationship, including different ways of sharing and contributing to therapeutic conversations so that clients do not feel that conversations are single sided. Therapists engaging in mutual conversations resulted in clients feeling more comfortable in therapy and more connected to their therapist, which was considered helpful.

***Environment.*** Readers may wonder about the link between the environment in which a therapist works and the therapist's way of being. To clarify, participants in the study described work environments as a reflection of their therapists that affected their experience of therapy. Two relatively novel observations emerged with exploration of this theme, extending what is already reported in ED literature. The first regards the presence of food in a therapist's office, in particular candy in a bowl made available to clients. A participant reported that a candy bowl in her therapist's office resulted in her feeling uncomfortable. Her therapist was not directive about whether she wanted or expected the client to take a candy, but the client was worried about disappointing her therapist whether or not she took one. One may argue that making food available to clients is opportunity for therapeutic intervention, to work through triggered ED symptoms or perceived pressure to please the therapist. On the other hand, it could be argued

that there is no place for food in therapists' offices because the food can be triggering for ED clients, or because ED clients can be "people pleasers" which may complicate their decision of whether or not to take available food. I also wonder about safety considerations due to possible physiological side effects of consuming food, for instance when clients are significantly over- or underweight, or perhaps have allergies. What can be taken from the participant's experience, given the sensitive relevance of food to their presenting issue, is that it may be helpful for clients if therapists either not have food available to clients in their office, or be transparent about why the food is there and what their expectations are surrounding the food's presence. A therapist having food available in his or her office without that transparency could be perceived as insensitive to clients' presenting issues.

Another participant raised a second observation related to environment where she experienced therapy via videoconference meetings with the therapist. This participant preferred her experience of face-to-face meetings with a therapist for the benefit of non-verbal information and human contact not conveyed well through the "pixelated image" on a flat screen. She found that the videoconference meetings made it more difficult to "absorb" what her therapist said, compared to her experience of face-to-face meetings with a different therapist. However, it is possible that the differences between this participant's online and face-to-face experiences are attributable to therapist differences. For instance, perhaps the therapist online failed to engage her in ways that the therapist she met in person did. Previous research has found that online consulting services can improve access to ED specialized services, especially in rural areas where clients may not otherwise have access to professionals with appropriate ED training and expertise (Grunwald & Busse, 2003). In another study, eight of 12 participants provided with ED specialized psychological and nutritional therapy via videoconferencing preferred it to face-to-face therapy (Simpson et al., 2003). Scholarly literature in combination with the participant's account of therapy via videoconferencing suggest that therapists might use it selectively. Therapy using teleconferencing technology could increase client access to services, but would benefit from careful consideration of how therapists might compensate for potential limitations of using videoconferencing technologies that could interfere with the therapeutic process.

**Session process.** This thematic category includes themes that differentiate between a rigid or "fixed" approach to sessions, and an approach that is more flexible and considerate of individual client context. Research preceding the current study found that clients have better

outcomes, stay in therapy longer, and prefer when therapists consider their input and offer them choices when directing the course of ED-focal psychotherapy (Cockell, Zaitsoff, & Geller, 2004). Likewise, it has been found that ED therapists recognize the need to adjust the course and content of therapy according to the varied needs of clients (Haas & Clopton, 2003; Mussell et al., 2000; Wallace & von Ranson, 2012). Client perspectives from the current study reinforce these findings. Participants appreciate directive approaches at times, but also found it helpful when their therapists “shared power” with them to decide on the course of therapy. Participants reported that it was helpful when their therapists appeared to consider their individual contexts rather than following a fixed template for sessions throughout therapy.

This is an interesting finding in light of the push for manualized treatment approaches discussed in the literature review of this dissertation. Manualized ED treatments, like cognitive behavioural therapy, can inform the course of treatment and therapeutic interventions used (Wilson, Grilo, & Vitousek, 2007). However, current and preceding qualitative inquiry suggest that clients do not always prefer such fixed approaches (Cockell, Zaitsoff, & Geller, 2004), nor do therapists always adhere to them (Haas & Clopton, 2003; Mussell et al., 2000; Wallace & von Ranson, 2012). The diverse etiology of EDs, including variety in symptomatology and co-morbidity with which clients may present, could complicate or hinder use of fixed, manualized therapies. Rather than therapists adhering to manualized approaches in their entirety or researchers pursuing the development of manuals to direct the entire course of therapy, the field may benefit from developing an understanding of what influences the course of therapy, including decision points to guide therapists depending on client needs and what unfolds in therapy.

Previous research findings and participant perspectives from the current study suggest that working collaboratively, and considering client context and preferences, are important when therapists make decisions regarding the direction and content of therapy. But, participants also appreciated therapists with ED expertise (described in the *Therapist Way of Being* thematic category) as helpful, even essential, for informing therapeutic work. This points to the value of therapists being directive, but with consideration of client context. As said previously, therapists may view direction and collaboration on a continuum, upon which they situate themselves depending on the type and severity of their clients’ symptoms.

**Eating disorder specific interventions.** Within this next thematic category, participants described six ED-specific techniques related to increasing their ED understanding, and addressing ED-related thoughts, feelings, and behaviours. Within each theme (i.e., *eating disorder education, food journals, challenge foods, discussing body weight, identifying the purpose served by the eating disorder, and separating self from the eating disorder*), participants highlighted the importance of monitoring client responses to any intervention—that is, considering whether the intervention was helping the client to address and overcome symptoms, or contrarily inadvertently reinforced ED symptoms.

Participant experiences suggest that monitoring client responses is particularly important with the use of food journals and discussing weight. For instance, not all participants found food journals helpful. Similarly, some participants did not discuss weight changes with their therapists, and how it was discussed varied for those who did. For instance, some participants found it helpful to know whether they gained or lost weight, while others found it triggering. Also, even if a participant found it helpful to know whether they gained or lost weight, they did not necessarily want to know the amount their weight had changed.

It appears that the value, or effectiveness, of ED-specific techniques used resides in the timing of their application vis à vis the suitability to the client based on their readiness, needs, or preferences. This dependency on client context fits with the constructivist lens of the current study, whereby the value of interventions can vary depending on individual perspective. The value of interventions has been established in theory and using controlled trials, but also depends on therapists' use of clinical judgement regarding when to apply what interventions, with whom, under what circumstances. The current study indicates that therapists might best help clients by checking in with them on their needs when selecting appropriate interventions, applying those interventions in ways that are sensitive to the clients' particular circumstances, and verifying with the client regarding ways that the technique is or is not being experienced as helpful.

**Non-eating disorder specific interventions.** Referring back to the thematic category *Goals and Expectations of Therapy*, participants emphasized that addressing ED symptoms alone was not sufficient. They said that addressing broader or underlying issues that precipitated their ED thoughts and behaviours was also helpful. The *Non-Eating Disorder Specific Interventions* thematic category further defines what participants considered helpful for addressing issues beyond ED symptoms. To clarify, what I mean by “non-ED specific” is that the techniques did

not directly address ED symptoms, including associated thoughts and behaviours, weight, or food. Participants described addressing their thoughts and feelings more generally, learning alternative ways to cope with adversity, and developing or exploring their identity as helpful. They reported that these interventions reduced their need for the ED to deal with challenges in their lives.

It is interesting that participants repeatedly noted the importance of addressing issues beyond the ED, such as the interventions described in this thematic category. This is seemingly at odds with popular definitions of ED recovery identified in the literature review and indicators of ED-specific symptoms (i.e., weight restoration, return of menstruation in post-menarcheal women, and cessation of bingeing, purging, or restriction) most commonly used for research and practice (Couturier & Lock, 2006). Addressing ED symptoms at the exclusion of more abstract psychological considerations may reflect manuals developed based on those definitions of recovery. However, results of the current study suggest that addressing ED-specific symptoms without broader consideration and intervention is not as helpful. This is consistent with previous qualitative research that indicates ED-specific physical and behavioural changes without broader psychological considerations can lead to treatment dropout and ED relapse (Keel, Dorer, Franko, Jackson, & Herzog, 2005; Vandereycken & Vansteenkiste, 2009).

Participants point to the importance of non-ED specific interventions as meaningful to their experience of ED-focal psychotherapy, but also agreed unanimously that non-ED specific interventions played a helpful role in their ED-focal psychotherapy. The value attributed to non-ED specific interventions, to address issues broader than ED symptoms, extends what is identified in recovery targets typical of ED psychotherapy and research that tend to be reduced to ED thoughts and behaviours. This finding points to the importance of considering client perspectives to inform understanding of ED-focal psychotherapy.

### **Limitations**

The current study served to identify numerous considerations of ED-focal psychotherapy reflected by the 20 resulting themes. These themes can inform the work of clinicians and researchers. However, there remains room for further understanding. This study resulted in a breadth of considerations, but it is my impression that there is more to learn more about each theme in greater depth. Perhaps due to the breadth of considerations that participants raised, exploration of nuances affecting each experience in particular was diminished. The field may

benefit from continued study of each theme in isolation to further elucidate the nuances of what, when, and with whom is experienced as helpful. In this section I identify sampling, methodological, and design limitations of the current study.

***Sampling limitations.*** Participants varied on some essential characteristics like age, duration of ED-focal psychotherapy and time lapse since that therapy was completed, ED diagnoses, comorbidity, and characteristics of their therapists. However, those who volunteered to participate versus those who did not may represent some bias that could have a bearing on findings. First, all participants were Caucasian and female. Persons who identify as non-Caucasian and/or male may offer different perspectives of what is considered meaningful, and specifically helpful or unhelpful in the experience of psychotherapy. In the literature review, I observe how the etiology and treatment of EDs can differ for White American women compared to women of ethnic minority (e.g., Cachelin & Striegel-Moore, 2006). I also point to how the thin female beauty ideal may influence the course of EDs in women, which could be different than what is experienced by men (Schooler, 2008). It is possible that what non-Caucasian and male participants would identify as meaningful to their ED-focal therapy could differ from what was reported by Caucasian women in the current study. While this poses a possible bias, the current study's participant sample is representative of the majority of treatment seeking individuals, who are Caucasian women (Cachelin & Striegel-Moore, 2006).

Second, all participants said that their therapy was completed and that they found it to be generally helpful. As with characteristics such as non-Caucasian and male, individuals whose therapy ended prematurely or who did not experience therapy as generally helpful may also identify different aspects of therapy as meaningful and affecting their experience. This sampling may have resulted in a halo effect whereby clients who liked or admired their therapists could attribute aspects of therapy as being more helpful, or overlook unhelpful aspects, perhaps not wanting to speak ill or elaborate upon unhelpful experiences of the therapy or therapist.

***Methodological limitations.*** The constructivist methodology and principles of hermeneutic phenomenology applied in this study allow for a broadening and deepening of understanding, rather than more "accurate" understanding (Haverkamp & Young, 2007). The findings are context bound and not necessarily generalizable (Ponterotto, 2005). This means that conclusions drawn are tentative, and reflect participant perceptions and the researcher's interpretations. The methodology used does not allow for "proven" conclusions, but rather

detailed descriptions that attest to the richness and complexity of human experiences. The research also offers opportunity for consumers of the findings to consider the extent to which those findings resonate with their own experiences. This is an aspect of trustworthiness described within the methods of this research in Chapter 4, whereby results have credibility when people who share similar experiences can relate to the descriptions (Sandelowski, 1986).

Developing nuanced understanding in the form of idiographic findings is one of the advantages of the methodology used for this study. While this study resulted in a breadth of considerations participants identified as meaningful to their experiences of ED-focal psychotherapy, it is likely that greater depth of understanding is possible. Changes to the research design could further illuminate those nuances.

***Design limitations.*** Fitting with the methodology, the research design is intended to illuminate client experiences of psychotherapy. The strength of this design resides in its focus on what matters to participants. It allows for inferences to be made about change processes and causal roles, but does not establish cause and effect. There is also danger of attribution error with use of the qualitative helpful factors design (Elliott, 2010). For instance, it is possible that participants mistakenly attributed meaning to therapy that is actually the result of their own efforts independent of therapy, life events, or psychobiological processes (e.g., changes in medication, recovery from illness). Retroactive self-report by participants could further reduce thoroughness of the results. These issues might be exacerbated by novice interviewing or poor analysis technique (e.g., asking leading questions, or relying on superficial descriptions of experience). To counteract these potential limitations, the research process has been thoroughly documented, the researcher received supervision from her thesis supervisor throughout the research process, and participants were given opportunity to member check findings. These efforts indicate that findings are accurate reflections of participant experiences. Still, this study should be accepted as only one line of evidence among others.

Other possible lines of evidence that could further elucidate understanding of ED-focal psychotherapy in community practice settings will be discussed under research implications below, but here I want to identify a design limitation that may have impacted the depth of considerations identified. That design limitation is the very open ended research question: What do clients of individual ED-focal psychotherapy in community practice settings identify as meaningful to their experience of that therapy? This open-ended question, consistent with the

methodology used, allows participants to put valence on what they identify as meaningful. Opportunity for participants to report what they consider meaningful, without imposed limits, resulted in a breadth of considerations but did not permit for depth of nuances to be explored within the hour to hour-and-a-half long research interviews. It is, however, possible to maintain integrity of the methodology while asking a slightly more pointed research question to further explore one aspect of client experiences at a time, in depth, rather than asking about the entire experience of psychotherapy in one study. It is likely that more time pursuing a single theme identified in the current study would result in more nuanced identification of what under which circumstances clients do or do not experience as helpful.

### **Research, Practice, and Training Implications**

The phenomenological methodology of this study forefronts what participants perceive to be meaningful in their client experience of individual ED-focal psychotherapy that took place in community practice settings. The constructivist theoretical framework values alternative perspectives. In this chapter I have highlighted participant perceptions of what is important within experiences of ED-focal psychotherapy as clients, and introduced alternative clinical and research perspectives. Participant perspectives and related scholarly literature invite continued research, and can have implications for practice and training in the field.

**Research implications.** Participants reported that it was important to them that therapists have ED-specific expertise and use ED-specialized interventions, but they also wanted their context and input to be considered throughout the course of therapy. Expertise and interventions can be informed by manualized approaches established using controlled outcome trials. Resulting templates can provide structure and guidance to inform the unfolding of therapy but they do not elucidate client differences or how different contexts can affect the unfolding of therapy. The current study reinforces previous qualitative work, pointing to the dynamic and complex unfolding of ED-focal psychotherapy depending on individual client circumstances. Exploring client experiences demonstrates the value of considering “what” works, with whom, under what circumstances.

Future research could build on what has been identified as meaningful by clients in this and preceding studies, to further understand the unfolding and impact of therapy with different clients in different circumstances. Considering the perspective of clients in different circumstances could help to unveil a deeper understanding of themes identified in the current

study. A deeper understanding of themes could, in turn, help to operationalize identified considerations, which could then be tied to therapeutic outcomes using qualitative and quantitative research efforts. A more nuanced understanding of considerations, tied to therapeutic outcomes, could progress the field towards a therapeutic “map” including decision points that would allow for reflexive practice according to client circumstances throughout the unfolding of therapy. Participant-informed methods, such as the helpful factors design, could be used to develop theories for testing, while task analysis or controlled trials could be used to evaluate the outcomes of therapeutic directions and techniques used given particular client circumstances. Linking what participants identify as meaningful to therapeutic outcomes could help inform therapist expertise with contextual nuances.

In addition to exploring client perspectives, it could also be important to include therapist perspectives. Exploring the therapist perspective could illuminate points of convergence and divergence with understandings garnered from client perspectives or scholarly literature for a more comprehensive understanding of therapy.

**Practice implications.** As indicated with research implications, participants value therapists whose work is informed by ED expertise, but also want their individual context considered during the course of therapy. This points to the importance of content and process in therapy. Controlled outcome trials can establish the effect of therapeutic content on therapeutic outcomes, while participant-informed research like the current study might best elucidate nuances that inform the unfolding of therapy.

The current study reveals what matters to clients, which can inform ED expertise and the practice of ED-focal psychotherapy. The issues raised appear to depend on client context. For instance, therapist self-disclosure can engage a client in therapy when the disclosure is tied back to the client’s own situation but could have a very different impact if the client does not perceive it as relevant. Or, some clients may require a more directive approach to protect their health and safety, while others will benefit more from organic conversations that emerge depending on what occurs for them in and between sessions. In either of these cases, participants indicate that it is helpful when therapists make informed therapeutic decisions based on their experience and expertise. However, the participants did not find it helpful when therapists made assumptions, without considering the clients’ particular context. Considering client context appeared particularly relevant for the use of ED-specific and non-ED specific interventions. What

interventions were called for and the application of those techniques differed depending on the needs and preferences of participants. Even though participants experienced different techniques as helpful, all participants agreed that expectations, goals, and interventions needed to extend beyond addressing ED symptoms alone. Revisiting the results and discussion of findings could inform how practitioners might proceed at different decision or turning points in therapy depending on context and circumstances.

**Training implications.** The current study in some ways serves to bridge aspects of ED-focal psychotherapy research and practice. It forefronts the experience of clients who actually received individual ED-focal psychotherapy in community practice settings, providing future trainees with exposure to client experiences and opportunity to explore contextual aspects of what clients can perceive as helpful or unhelpful in ED-focal psychotherapy. Exploring client experiences can alert trainees to alternative perspectives they did not otherwise consider, and influence their developing position as a researcher and/or therapist. Learning from client perspectives can help attune therapists and researchers to nuances that affect what clients experience as helpful. Trainees may need to reconcile what is learned from the client perspective with previous understandings, including other therapist and research perspectives. Reconciling client, therapist, and research perspectives can promote a more comprehensive understanding of ED-focal psychotherapy.

### **Final Remarks**

The constructivist orientation and phenomenological approach used for this study allowed for exploration of client experiences, without displacing existing understandings or alternative perspectives. Discussion in terms of scholarly literature adds perspective to the findings, while future exploration of therapist perspectives could further contribute to understanding ED therapy in community settings. The field could also benefit from a deeper look at the broad themes identified by participants in the current study. It could then be useful to operationalize nuances derived from idiographic understandings of ED-focal psychotherapy as identified in this study, in order to tie those influences to therapeutic outcomes. Understanding the links between different experiences and outcomes could inform reflexive practice by elucidating turning and decision points throughout the course of therapy. Findings from the current study highlight the dynamic and complex nature of ED-focal psychotherapy, indicating

that what clients experience as meaningful in therapy depends on their particular needs and what unfolds in therapy.

The current study both reinforces and extends what has been revealed in preceding qualitative inquiry and controlled outcome studies. Continuing to integrate the findings from multiple perspectives and research approaches can further enhance our understanding of ED-focal psychotherapy, perhaps working towards a model that one day does the complexity of ED therapy justice. In the meantime, continuing to develop descriptions of what, when, with whom, and under what circumstances is experienced as meaningful in ED-focal psychotherapy can help to clarify and characterize considerations for research, practice, and training purposes.

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## **Appendix A**

### **Researcher's Pre-Understandings of the Phenomenon under Study**

This statement is meant to reveal for readers where I stand in relation to individual eating disorder (ED) focal psychotherapy, including the pre-understandings I brought to the research. Pointing to relevant aspects of my background and understanding can help situate readers to what I am inclined to consider important, discuss further with participants, and represent in the results of this research. Here I reveal my interests, training and experience, personal views, theoretical allegiances, and assumptions related to my own practice of ED-focal psychotherapy.

#### **Interests**

I first learned about ED treatment as an administrative assistant to a psychotherapist specializing in the field. This was my job as an undergraduate student. For three years I enjoyed exposure to ED treatment guidelines, therapeutic tools, and the therapist's own experiences with clients. It was then that I realized my interests in human physiology and social sciences were relevant to the treatment of EDs, inclining me to pursue further study in the field. I chose to direct those studies towards psychotherapy for the treatment of EDs having seen the positive impact that the therapist for whom I worked had in the lives of her clients.

#### **Training and Experience**

Subsequent training in the field of ED treatment has come in the form of completing a Master degree in counselling and psychotherapy, ongoing PhD study within the same faculty, and attending professional development programs. My university studies have been largely influenced by client-centered professors who encouraged me not to position myself as an expert when working with clients, but rather to support clients as the experts of their own experience. Narrative, humanistic, and interpersonal approaches have been fore-fronted during these studies. Through these studies, I developed an appreciation of the therapeutic relationship, and an integrative approach to address the individual goals, needs, and preferences of each client. However, I felt that a gap remained in my grasp of diagnostic considerations and treatment complications inherent to EDs. Professors and mentors affirmed that further study was necessary in order to work proficiently with clients experiencing EDs, a population that is often considered "difficult" and even "treatment resistant."

To further understand diagnostic considerations and treatment complications inherent to psychotherapy for EDs, I pursued a doctoral level internship with a registered psychologist

working in the field. During that internship, I was further exposed to testing and assessment measures, the practicalities of making diagnoses, and how to use diagnoses to inform work with a client. I was also able to work with clients whose needs were more serious and complex than I would otherwise have been exposed to. I should note that as a psychotherapist in the province of Ontario, making diagnoses is beyond the professional scope of my practice. However, I learned that it is important to recognize diagnostic signs, work with colleagues who can make diagnoses, and know how to proceed therapeutically with diagnostic information. I left the internship better equipped to navigate increasingly serious and complex cases of ED. In particular, I developed a broader repertoire of empirically validated interventions and treatment resources (inpatient and outpatient) for use with clients as needed.

Professional development courses, and extensive extra-curricular reading, have further supplemented my learning. Learning about specific treatment modalities and interventions has further enhanced my knowledge and confidence for working with ED clients. Case studies, and ultimately work with actual clients, have shaped my personal views on the treatment of EDs. Seeing how clients respond to treatment, including psychotherapy, has affected my views.

### **Personal Views**

My personal views have evolved over the last six years of work with ED clients, during internships and in private practice settings. These views include how I conceptualize EDs and frame psychotherapy for ED treatment. In terms of conceptualization, it is my experience that the etiology of EDs can be different for every affected individual. Factors warranting consideration could include, but are not necessarily limited to, issues related to family of origin, trauma, physiology, emotional regulation, interpersonal factors, and culture. I also consider comorbidity an important part of understanding what may affect clients or how they may respond to treatment. It is my experience that the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, provides a useful reference for the range of issues with which ED clients may present. However, while diagnoses may validate the experiences of some clients and provide a reference point for symptoms, I feel it is important to acknowledge that clients' experiences of ED symptoms in particular can vary quickly and greatly in severity or type.

To address the complexity of EDs, I use an integrative approach to therapy. I will describe my theoretical allegiances in the next section of this statement, but here summarize the

structure I typically use when working with an ED client. I typically work with clients to develop a therapeutic relationship, identify when the ED became a factor in their life, what their life was like before that ED was a factor, discuss how the ED affects them (i.e., physically, psychologically, and socially), consider their level of understanding relevant to EDs, address beliefs and myths associated with ED thoughts and behaviours, explore extent of family and social support, and consider their readiness to change. My expectation of “what” happens in therapy, and what will help each client, varies significantly, since these considerations can differ widely across client contexts. The discussions I have and interventions I use with clients are informed by multiple different theories.

### **Theoretical Allegiances**

I typically draw on humanistic, experiential, emotion focussed, interpersonal, cognitive behavioural, family based, and schema therapies. I draw on humanistic approaches to inform how I develop a working alliance with clients by understanding their needs and goals, while sharing with them my own experience and expertise. I draw on experiential approaches to help clients become more aware of and effectively use their feelings (physical and emotional). Emotion focussed therapy provides further tools for helping clients to develop skills for emotional regulation. Improved emotional awareness and regulation can support healthier interpersonal relationships, addressed using interpersonal theory. I consider cognitive behavioural therapy useful for framing the phases and goals of therapy with adult clients, including the priority of physical stabilization (i.e., addressing nutritional deficits, ensuring medical care) in order to allow for clarity of thought necessary for cognitive-emotional work in therapy. Family therapy can help in educating and eliciting support from significant others in clients’ lives. I find that addressing entrenched beliefs using schema therapy can help clients through the challenges of sustaining recovery.

I consider each of these theories to have different, but complementary strengths and limitations. They are complimentary in the sense that the strength of one theory can often offset the limitation of the other. For instance, using humanistic therapy works well for me when developing a relationship with and understanding the experiences of clients, however falls short in providing guidance with a client in denial of the seriousness of their disorder. On the other hand, it can be difficult to develop a strong therapeutic relationship with clients who perceive the phases and goals inherent to cognitive behavioural therapy as an imposition. However, those

phases and goals can provide structure and guide exercises that help the client to move through challenges in their therapeutic processes. I also find that clients differ in their preferences and aptitudes, making the exercises associated with some theories more effective than others depending on the client's personality or learning style. While each of the therapies from which I draw have different theoretical underpinnings and serve my work with clients in different ways, I seek to tie them together for clients through transparency in our therapeutic process. I tell clients from the start of therapy that I will draw on multiple theories, and want them to understand the rationale for each intervention.

### **Assumptions**

I assume that no single therapeutic approach will be sufficient to work through the complexities of an ED. I consider EDs to be a serious illness requiring the support of multiple approaches and professionals, within and across disciplines. Further, I do not limit the work I do with clients experiencing ED to entirely ED-focussed interventions. I assume that in addition to the ED, there are other issues affecting clients' quality of life, for better or worse, which warrant therapeutic consideration. I believe this provides insight to a client's strengths and weaknesses from which to draw, and promotes a strong therapeutic relationship and working alliance necessary to endure the challenges of ED treatment. Because psychotherapy is only part of ED treatment, and the client's life, I consider encouraging constructive relationships with other professionals, friends, and family members an important part of my work with ED clients.

My assumption that factors beyond the ED affect client's quality of life, and that psychotherapy is only one important part of support in their treatment, does not diminish the responsibility I associate with treating clients in ED-focal psychotherapy. It is important to me that psychotherapists working with this population are well informed to recognize the challenges associated with ED treatment. I think that the field can benefit from ongoing development of professional competencies, and recognition of the need for reflexive practice, adjusted depending on the needs and preferences of individual clients. It is my assumption that clients enjoy better therapeutic outcomes when their therapists bring both expertise and reflexivity to their practice.

## Appendix B

### Demographic and Background Information Form

*Informed consent will be reviewed in detail and signed-off upon meeting for the in-person research interview, but the process and points will be reviewed with participants before collecting background and demographic information, as it constitutes a form of data collection.*

To situate your experiences for the upcoming research interview, I would like to collect some demographic and background information. Of course, your identity and the identity of anyone that you mention, including therapists with whom you have worked, will be kept confidential and will not be disclosed beyond myself or my thesis supervisor, Dr. Cristelle Audet. Before starting, I want to remind you that your participation is completely voluntary, and that you can withdraw at any time. If you choose to withdraw, all associated data would be destroyed. You are welcome to ask myself or Dr. Audet questions at any point during the research process.

Do you have any questions before I continue?

Are you ok if I continue with my questions?

1. What is your date of birth?

2. What gender do you identify with?

3. a) Were you formally diagnosed with an eating disorder?

If so, b) What was the diagnosis?

c) Who made the diagnosis?

d) Did the diagnosis ever change?

4. a) Did you have any other diagnoses?

If so, b) What other diagnoses have you received?

5. a) I do not need specific names, but can you list the type of professional(s) involved in your treatment, including their credentials where possible?

b) How long did you work with each professional listed?

6. Regarding your experience of psychotherapy in a community setting:
- a) Did you initiate therapy specifically for an eating disorder, and did your therapist directly address those concerns?
  - b) How long has it been since you completed this psychotherapy for your eating disorder?
  - c) Did you complete that psychotherapy or did it finish prematurely (e.g., drop out, referral)?
  - d) For how long and how many sessions did you see that therapist?

We will discuss your experiences in more detail when we meet for the in-person interview, but those are all of the background and demographic questions I have for today. Is there anything else that you would like to add at this point, that could help me to better understand the context of the psychotherapy you received?

Thank you.

*Schedule in-person interview if the participant wishes to proceed.*

## **Appendix C**

### **Semi-Structured Interview Guide**

*Preamble, including informed consent, will be used to establish safety and trust with each participant, and to facilitate an environment of comfort and openness. The researcher will ask open ended questions to better understand the deeper meanings of events discussed (e.g., What was that like for you? What were your thoughts/feelings when that happened?). The following questions are suggestions to help the researcher get started, and to cover a similar breadth of content across participants.*

#### ***1. Context and Background Information Specific to Seeking Eating Disorder Treatment***

- a) How old were you when you first remember being affected by an eating disorder?
- b) At what point did you seek treatment for that eating disorder?
- c) Did you ever receive treatment in a hospital setting or inpatient program?

#### ***2. Context and Background Information Specific to Psychotherapy in Community Setting***

- a) What led you to seek psychotherapy focusing on eating disorder issues?
- b) Do you know if your therapist used specific models, techniques, approaches, or types of therapy?
- c) How would you generally describe the therapy (e.g., helpful or unhelpful)?

#### ***3. Understanding the Experience of Psychotherapy***

I would like to hear about at least four events, if possible, that you identify as having been significant to the psychotherapy you are describing. We will explore events one at a time.

- a) Can you tell me about something that stood out to you as meaningful in your therapy?

*Ask follow up questions as needed.*

- b) Did you experience that as helpful or hindering?
- c) Did you always feel that way about the event? (e.g., What was it like for you before that happened? What was it like for you when that happened? What was it like for you after?)
- d) Discuss as needed any experiences that diverge from meaning attributed by other participants or in research, to negotiate shared understandings.
- e) Do you have another experience that you would like to share?

#### ***4. Collecting Wish List Items***

- a) I am wondering if there is anything that you wish had occurred differently in your therapy?
  - i) How would that have improved your experience of therapy?
  - ii) When would that have been most helpful during your therapy?
  - iii) At what point did you become aware that this would be helpful to your sessions?
- b) Is there anything else that you would like to share, or that you think I would like to know about your experience of therapy?

#### ***5. Closure & Debrief***

- a) What was it like to share your experiences with me?
- b) Is there anything that you would want therapists working with eating disorders to know?

Thank you for sharing with me. That is all of my questions, but it is important to me that your experiences are fairly represented. If you think of any other relevant ideas, details, or experiences that you wish to include in the research, please email me at [REDACTED]@uottawa.ca within the next two weeks. After two weeks, I will transcribe this interview and start interpreting the findings. To interpret the findings, I will be organizing the events that we discussed into categories. I will send these categories with descriptions, and corresponding events that you have mentioned, to the email address that you have provided me with. You are welcome to review the categories and to let me know, within two weeks of receiving the email, if there is anything you would like changed to better reflect your experiences.

## Appendix D

### Research Ethics Approval

File Number: 01-14-02

Date (mm/dd/yyyy): 02/12/2014



**Université d'Ottawa**      **University of Ottawa**  
 Bureau d'éthique et d'intégrité de la recherche      Office of Research Ethics and Integrity

### Ethics Approval Notice

#### Social Science and Humanities REB

#### Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Cristelle	Audet	Education	Supervisor
Diana Barbara	Norton	Education	Student Researcher

**File Number:** 01-14-02

**Type of Project:** PhD Thesis

**Title:** Client Perspectives of Psychotherapy for Eating Disorders in Community Practice Settings

<b>Approval Date (mm/dd/yyyy)</b>	<b>Expiry Date (mm/dd/yyyy)</b>	<b>Approval Type</b>
02/12/2014	02/11/2015	Ia

(Ia: Approval, Ib: Approval for initial stage only)

**Special Conditions / Comments:**

N/A

File Number: 01-14-02

Date (mm/dd/yyyy): 02/12/2014



**Université d'Ottawa**  
Bureau d'éthique et d'intégrité de la recherche

**University of Ottawa**  
Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove participants from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at: <http://www.research.uottawa.ca/ethics/forms.html>.

Please submit an annual status report to the Protocol Officer four weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at: <http://www.research.uottawa.ca/ethics/forms.html>.

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: [ethics@uOttawa.ca](mailto:ethics@uOttawa.ca).

**Signature:**

Kim Thompson  
Protocol Officer for Ethics in Research  
For Barbara Graves, Chair of the Social Sciences and Humanities REB



## Appendix F

### Study Description for Participants

Thank you for your interest in my research project. I am conducting the research in partial fulfillment of a PhD degree in Educational Counselling.

I am interested in hearing about your experience of therapy. I want to learn more about what you experienced as either helpful or hindering in therapy, although your identity and the identity of anyone that you mention will remain confidential when I present findings.

There are a couple of things I would like you to know before proceeding: First, all correspondence and research will be conducted in English. Second, I will not be able to include participants who have also worked with me in the capacity of psychotherapy. If you are fluent in English and do not see/have not seen me for psychotherapy, I hope that you will share your experiences with me although your participation is completely voluntary.

You are welcome to withdraw from the study at any time, and may also contact my thesis supervisor, Dr. Cristelle Audet (613-562-5800 x [REDACTED], [REDACTED]@uottawa.ca), if you have any concerns or questions about the research.

Your commitment, if you choose to participate, would include one in-person interview conducted by myself. This interview is expected to take 1-1.5 hours, but I ask to schedule two hours so that we do not feel rushed when you are sharing your experiences. The interviews will take place at the University of Ottawa, in Lamoureux Hall.

After the interview and data analysis, I will send you the findings by email so you can check that I have fairly represented your experiences.

Thank you again for your interest in this research. To proceed, please email ([REDACTED]@uottawa.ca) or call (613-[REDACTED]) me so that we can discuss next steps.

Appreciatively,

Diana Norton, PhD Candidate

## Appendix G

### Free and Informed Consent Form for Study Participants

Free and Informed Consent for Participation in a Qualitative Exploration of Psychotherapy for the Treatment of Eating Disorders in Community Settings

I, \_\_\_\_\_, am aware that the purpose of this study is to learn more about psychotherapy for eating disorders from the perspective of clients. Through an interview format, I will be asked to describe my experiences of psychotherapy in as much detail as possible, including events that I feel helped or hindered in my progress of that therapy. I understand that the study will be conducted as part of a PhD degree research requirement by Diana Norton, under the supervision of Dr. Cristelle Audet of the Department of Educational Counselling at the University of Ottawa.

Benefits to participating in this study may include helping researchers, students, educators, and practitioners to better understand and improve the delivery of psychotherapy for eating disorders. Participation may also help me to better understand my own experience of therapy. A risk to participating in this study is that discussing my experiences could raise concerns for me that I wish to discuss further with a counsellor. For support as needed, I can contact the Pinecrest-Queensway Community Health Center (613-820-4922), University of Ottawa SASS Counselling Services (613-562-5200), and/or Hopewell Eating Disorder Resource Center (613-241-3428). I may contact the researcher for additional resources; however, Diana Norton herself cannot support me in a capacity other than as the researcher.

I am aware that all information associated with this study is strictly confidential and that my identity, or that of anyone that I mention, will be known only to the researcher and thesis supervisor, and will not be further revealed at any time. When transcribing the interview recordings, the researcher will use pseudonyms (i.e., false names) for my name or for the names of anyone that I mention. The pseudonyms will continue to be used during interpretation and reporting of research findings, including in the PhD thesis, publications, and presentations. Any details that might identify me or any persons that I mention will also be changed or blacked out during transcription and data analysis. Quotes from my contributions to the research may be used; however, no information that can identify me or others that I mention will be revealed. Further, the researcher and researcher's thesis advisor will be the only people with access to the audio-recordings, interview transcripts, and other correspondence related to data

collection. All of this data will be stored in a secure place for five years after which time it will be destroyed.

I agree to participate in the study and am willing to share my experiences with the interviewer, Diana Norton. I am aware that as a part of the data collection process one in-person interview of approximately one to one-and-a-half hours in length will be audio-recorded and later transcribed. I understand that I will have opportunity to review my interview transcript, and opportunity to review findings related to my interview to ensure that the results fairly depict my experience of psychotherapy. At this time, I can verify that my anonymity and the anonymity of others involved in my eating disorder treatment has been maintained in the findings. I realize that my participation in the interview is completely voluntary and that I can withdraw from the study at any time without penalty. If I choose to withdraw from the study, any related information and data will be destroyed immediately.

I understand that information obtained from the interview and in correspondence with me will be used by the researcher for the sole purpose of this research. I acknowledge that the results of this study may be disseminated through conferences and publications, and that once the results are published there is no way the researcher can remove information related to me.

I am also aware that any inquiries about the research can be addressed to: Diana Norton by phone at 613-██████████ or by email at ██████████@uottawa.ca, or to her advisor Dr. Cristelle Audet by phone at 613-562-5800 ext. ██████████ or by email at ██████████@uottawa.ca.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5, by phone at 613-562-5387 or by email at ethics@uottawa.ca.

There are two copies of the consent form, one of which is mine to keep.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Participant

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Printed Name of Researcher

\_\_\_\_\_  
Signature of Researcher

## Appendix H

### Member Checking Instructions

In this document I provide a summary of findings for the study you participated in during Winter/Spring 2014, called *Client Perspectives of Psychotherapy for Eating Disorders in Community Practice Settings*. The purpose of member checking is to provide you with opportunity to review the findings, and to comment if there are ways that the findings could better represent your experiences. I will first provide a brief overview of how I interpreted and organized the data, and then I invite you to review the findings.

**Overview.** In a previous step, you had the opportunity to review and provide feedback on the transcript of our interview together. After this was done for all of the participants, I organized the data into categories and themes based on what you described as helpful or hindering in your experience of therapy for an eating disorder, including what you wish had occurred or occurred differently in therapy. Each category and theme has a title and description based on my interpretation of your experiences. The five categories and associated themes are summarized in the chart that follows. I gave each participant a pseudonym (fake name), which you have been provided with. I indicate in the far right column of the chart who (using the pseudonyms) provided examples for each of the themes.

**Member checking.** For this step, I invite you to review the themes, especially those that have your pseudonym next to. Please provide feedback as you desire, and let me know if you feel the theme or theme description does not fit with your experience. More specifically, I want to know whether the themes reflect your experience of psychotherapy. In your feedback feel free to clarify, add, or delete details as you see fit. I will consider each participant's feedback and incorporate it wherever possible.

Please respond to me within two weeks, by midday on **Friday January 23**. After this point, I will complete the write up of the findings. If I do not hear from you by midday on Friday January 23, I will assume that you are satisfied with how the findings reflect your experience.

On the following pages is the chart summarizing the findings. Please do not hesitate to contact me if you have any questions. I am available by phone at 613-██████████, or by email at ██████████@uottawa.ca.

### Summary of Thematic Categories and Themes

Thematic Categories	Themes		Participants
Goals & Expectations of Therapy	Client Willingness	Participants associated their own willingness to confront challenging goals and expectations as helpful. They shared how therapists might help them to develop that willingness, including how therapists may encourage clients to expand their expectations of therapy beyond addressing ED symptoms alone.	Beth Jenny Sonia Tia
	Therapy as an Individual Process	Participants said it was helpful when therapeutic goals and expectations were adjusted depending on what happened in and between their sessions.	Jenny Kelly Lindsay Sonia Tia
	Collaborative Goal Setting	It mattered to participants that therapists considered their perspectives when establishing and pursuing therapeutic goals. Participants recognized the need for goals and expectations to minimally ensure their safety and wellbeing, but also wanted their preferences to be considered when establishing goals.	Jenny Kelly

<sup>1</sup> ED is abbreviation for Eating Disorder

		Pursuing “Best Self”	Participants described their therapists as encouraging them to pursue “their best self,” or to self-actualize. This reminded participants that there was more than the ED in their lives, which helped them to overcome ED symptoms and to pursue goals and expectations beyond the ED.	Beth Jenny Kelly Lindsay Lydia Sonia Tia
Therapist Way of Being	Participants described therapist characteristics, ways that their therapists interacted with them, and the therapists work environment as affecting their experience of therapy.	Genuine Curiosity	Participants appreciated when they perceived their therapists to be genuinely curious, or interested in their clients’ experiences, in a tentative and non-judgemental way. Participants said this helped them to feel more comfortable and to engage in therapy.	Jenny Kelly Lindsay Lydia Sonia Suzanne Tia
		Trust	Participants described how their therapists earned and lost their trust, and how trust or lack thereof affected their experience of therapy. When participants trusted their therapists, they felt more willing to discuss difficult issues.	Beth Jenny Kelly Sonia Tia
		ED Expertise	Participants described it as helpful for therapists to have ED specialized knowledge and experience to draw on, but indicated that how therapists exercise that expertise made a difference to their experience of therapy. Participants found it helpful when therapists were familiar with experiences of ED, but found it unhelpful when therapists made presumptions based on that knowledge and experience.	Beth Jenny Kelly Lindsay Lydia Sonia Suzanne Tia

		Engaging with the Client	Participants liked mutual conversation with their therapists, finding it helpful when therapists both listened and offered some self-disclosure. Participants said this helped them to connect to their therapist and to feel understood, cared for, and supported so long as therapeutic boundaries were practiced and what therapists disclosed was considered relevant to the client.	Beth Jenny Kelly Lindsay Lydia Sonia Suzanne Tia
		Environment	Participants described how their therapists' work environment affected their experience of therapy. They considered the environments a reflection of their therapist's work style. The environment could impact whether or not the participant continued to work with the therapist.	Beth Lindsay Lydia Sonia Suzanne Tia
Session Process	Participants described how therapists structured the therapeutic sessions, including differences between a rigid or more flexible approach considerate of individual client context.	Sharing Power	Participants found it helpful when their therapists provided some direction in sessions, while also encouraging clients to use their own voices when discussing session direction and negotiating solutions.	Beth Jenny Kelly Lindsay Lydia Sonia Suzanne Tia
		Considering the Client's Context	Participants found it unhelpful when therapists structured sessions using a template or fixed schedule. Participants found it helpful when their individual circumstances, needs, and preferences were considered throughout the therapeutic work.	Kelly Lydia Sonia Suzanne

ED Specific Interventions	Describes interventions used by therapists that specifically relate to ED issues.	ED Education	<p>Participants described learning about the physiological side effects of ED, and resources that could support them in their pursuit of wellbeing. Participants experienced receiving this educational information as helpful, if the information was relevant and presented in a considerate way.</p>	<p>Jenny Kelly Lindsay Lydia Sonia Suzanne Tia</p>
		Food Journals	<p>Participants described helpful and unhelpful experiences of therapists using food journals as an intervention. Participants understood food journals were intended to help them recognize ED related patterns, but some reported that the exercise triggered their ED more than it helped them to work through the ED.</p>	<p>Beth Jenny Lindsay Sonia Suzanne Tia</p>
		Challenge Foods	<p>Participants said challenge foods were most helpful when their therapists allowed them to choose foods that they would expand their nutrition with, as opposed to therapists prescribing specific challenge foods and quantities which felt unnatural to participants and often resulted in their feeling like a failure.</p>	<p>Beth Jenny Lindsay Lydia Sonia Suzanne Tia</p>
		Discussing Body Weight	<p>Participants found discussing their weight and weight changes in therapy could be helpful, but that it was a delicate issue that warranted careful consideration by their therapists.</p>	<p>Jenny Lydia Tia</p>

		Identifying the Purpose Served by the ED	Participants described learning to recognize how they used ED behaviours to cope with uncomfortable feelings, emotions, thoughts, or situations as a helpful exercise.	Beth Jenny Kelly Lindsay Sonia Tia
		Separating Self from the ED	Participants said it was helpful when their therapists explored ways in which the ED was a separate entity in clients' lives, and not actually a reflection of their whole life. This reminded participants that there were other healthy aspects of their life that they could pursue in lieu of the ED.	Beth Jenny Kelly Lindsay
Non-ED Specific Interventions	Interventions which were not directly related to the ED, but that participants considered a meaningful part of their ED therapy.	Addressing Thoughts and Feelings	Participants found it helpful when therapists helped them to articulate their thoughts and feelings, especially when therapists validated those thoughts and feelings.	Jenny Kelly Lindsay Lydia Sonia Suzanne Tia
		Alternative Ways to Cope	Participants found it helpful when their therapists taught ways to cope with distress and anxiety in their life and felt during therapy. They described ways that therapists helped them to feel able to continue working through difficult experiences and the challenges of therapy.	Beth Jenny Lydia Tia
		Exploring Identity	Participants described ways that their therapists helped them to connect with interests and values, to develop aspects of their self that they wished to pursue further. Participants said this helped them to want to take better care of themselves.	Beth Kelly Lydia Sonia Tia

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