One size doesn't fit all: the nature and context of the therapeutic relationship in the treatment of adults with anorexia nervosa: a grounded theory study

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Abstract

Anorexia nervosa is a serious, life threatening mental disorder that is difficult to treat. Research suggests that the therapeutic relationship is an aspect of therapy that is valued by recipients of eating disorder services and viewed as essential in the quality of any treatment undertaken. Establishing a helpful therapeutic relationship can be equally challenging for both the therapist and the client. Additionally, what the nature of the therapeutic relationship needs to be is often unclear and there is limited research into this aspect of the therapeutic relationship from the perspective of adults with anorexia nervosa specifically. Therefore, the aim of this study set out to answer the research question:

- What is the nature and context of the therapeutic relationship from the perspective of adults with anorexia nervosa?

Following a constructivist grounded theory methodology, elicited written data were gathered from adults with anorexia nervosa using asynchronous online research methods via a bespoke confidential website. The participants were recruited through the eating disorder charity Beat. Additional existing autobiographical material including books and online blogs were also used as supplementary data. Data collection and analysis was carried out over three phases.

Three theoretical categories were constructed that explicate the significant aspects of a positive therapeutic relationship: Balancing control in the therapeutic relationship; Developing trust; and "They just got me" - feeling understood by the therapist.

The central category of individuality or "one size doesn't fit all" underpins these categories, hence requiring a therapist to tailor the therapeutic relationship to the individual.

In conclusion, this study offers a substantive theoretical understanding of the critical aspects of the therapeutic relationship as described by adults with anorexia nervosa. These factors

have utility across a range of recommended psychological therapies for anorexia nervosa and could be usefully deployed by any health, social care or education professional.

DECLARATION

This work has not been submitted in substance for any other degree or award at this or any other university or place of learning, nor is being submitted concurrently in candidature for any degree or other award.

Signed …………………………………………………… (candidate)   Date ……………………………….………

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This thesis is being submitted in partial fulfilment of the requirements for the degree of
…PhD……(insert MCh, MD, MPhil, PhD etc., as appropriate)

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This thesis is the result of my own independent work/investigation, except where otherwise stated, and the thesis has not been edited by a third party beyond what is permitted by Cardiff University's Policy on the Use of Third Party Editors by Research Degree Students. Other sources are acknowledged by explicit references. The views expressed are my own.

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Conference Presentations

The following short paper conference presentations were undertaken during the process of completing this study:

Seymour, A., Boniface, G. and Gambling, T. Understanding the therapeutic relationship between people with anorexia nervosa and their therapists. *Eating Disorders International Conference.* Institute of Education, London, 17th - 19th March 2016.

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Glossary and explanation of terms and abbreviations

Throughout this thesis, I have used a range of definitions, terminology, abbreviations and professional language. Although I attempt to be clear in the use of such within the text; this glossary of terms aims to help the reader navigate the plethora of meanings available and achieve consistency in their use throughout the thesis. Where relevant, these terms have been referenced to original sources; other terms are presented as my interpretation and clarify the use of that term within the thesis.

Anorexia nervosa: often referred to as AN or anorexia within eating disorder literature. In this thesis, I have chosen not to abbreviate the term throughout the text.

Client: can also be referred to as patient, service user or sufferer in eating disorder literature. Throughout my study and in this thesis, I have used the term **client** in a generic way to denote an individual with an eating disorder seeking help from a **therapist.**

Eating disorders: a generic name for a range of clinically significant eating behaviours commonly classified using a diagnostic system (Palmer 2000).

Epistemic Trust: refers to the process of trusting that information that one receives through social and personal interaction is relevant and authentic to the individual. It allows individuals to learn from new social experiences and achieve change in thinking flexibly as well as learning about one's own actions and behaviours. The experience of feeling subjectively understood in therapy helps individuals to restore trust in learning from social experiences, thus the therapeutic relationship has the capacity to create an environment that allows the client to learn about themselves and others outside of the therapy setting (Fonagy and Allison 2014).

Ego-syntonic: refers to holding beliefs, values and subsequent behaviours, that are consistent with one's ideal image of the self. Anorexia nervosa is often described as ego –

syntonic as people are often perfectionist in nature and place high value on self-control and the pursuit of thinness. Therefore, they deny that they have an illness and are reluctant to seek help that challenges their beliefs and behaviours (Eating Disorder Glossary 2017).

Severe and enduring eating disorders (SEED): an eating disorder that is severe enough to cause significant physical, psychological and social difficulties to the individual and lasts for 10 years or longer. The subtype abbreviation, **SEED – AN** has the underlying diagnosis of anorexia nervosa (Robinson 2009).

Therapeutic relationship: can also be referred to as the therapeutic alliance, working alliance, rapport and the therapeutic use of self within the literature. I have used the term **therapeutic relationship** as a generic term to denote the professional interaction and relationship that occurs between a **client** and **therapist** throughout the process of a therapeutic encounter.

Therapist: throughout my study and this thesis, I have used the term **therapist** in a generic way to denote any health professional or other who works with people with eating disorders.

The following terms refer to those used to inform the process of data analysis I used in this thesis. I generally adopted the terms and processes described by Charmaz (2006, 2014) and Corbin and Strauss (2008):

Initial or open coding: the process of close examination, often on a line by line or excerpt basis, of the raw data and the naming of codes to begin to analyse what the data is describing.

Focused coding: using the most significant and/or frequent initial codes to further direct the analysis of current or new data.

Properties: the characteristics and dimensions that describe and define specific concepts.

Memo writing: the analytical process of recording thoughts, insights, and exposition around the emerging codes. Memo writing drives the process of theory development and moves analysis beyond the description of data into concept driven analysis.

Conceptual category: the conceptual categories in this thesis were constructed through the process of memo writing. These categories formed the basis of the findings chapters seven to ten. Within these chapters I explored the properties or characteristics of each category and theorised how they operate and the context they operate within. Relationships between the conceptual categories were also considered.

Core or central category: Corbin and Strauss (2008) describe the central or core category as the main theme of the research. It has the greatest explanatory power and potential for linking the conceptual categories.

Substantive theory: this is a theory that offers an interpretation or explanation of a phenomenon within a specific situation. In this study, the theory developed pertains to an explanation of the nature of the therapeutic relationship in relation to adults with anorexia nervosa.

Although I have not used abbreviations frequently in the thesis, the following are commonly used in eating disorder literature and clinical practice and have been included as a quick reference:

DSM – 5: The Diagnostic and Statistical Manual of the American Psychiatric Association version five (American Psychiatric Association 2013). The diagnosis of a range of eating disorders, including anorexia nervosa are normally made based on the criteria outlined.

BN: Bulimia Nervosa, an eating disorder characterised by frequent episodes of binge eating and recurrent use of compensatory behaviours such as self-induced vomiting, misuse of laxatives or exercise.

BED: Binge Eating Disorder, recently included for the first time in the DSM-5 categorisation, this eating disorder is characterised by recurrent episodes of binge eating but with an absence of compensatory behaviours. There is marked distress associated with binge eating and a sense of lack of control during the eating episodes.

BEAT: A leading charity in the United Kingdom supporting those with an eating disorder and their carers (formerly known as the Eating Disorder Association)

OSFED: A residual diagnostic category; Other Specified Feeding or Eating Disorder. This replaces the widely used **EDNOS;** Eating Disorders Not Otherwise Specified as detailed in DSM IV.

BMI: Body Mass Index. An index to compare the mass and height of adults. The value is derived from dividing weight in kilograms with the height in metre squared. It is frequently used to denote whether an individual is within normal weight range.

CBT: Cognitive Behavioural Therapy. This psychological intervention is designed to help people understand and re-evaluate the links between their thoughts, feelings and behaviours. It is a well evidenced therapy for a range of mental health problems including depressions and anxiety

CBT-E: Enhanced Cognitive Behavioural Therapy for Eating Disorders. Attributed primarily to Christopher Fairburn (2008), this adapted form of CBT is applied to eating disorders including anorexia nervosa.

CAT: Cognitive Analytic Therapy. This is a specific time limited, problem focused psychotherapy that combines cognitive and psychodynamic theories (NICE 2004).

IPT: Interpersonal Psychotherapy. This is a specific form of focal psychotherapy that is designed to help patients identify and address interpersonal problems. Originally developed for the treatment of depression it has been adapted for use with eating disorders (NICE 2004).

FPT: Focal Psychodynamic Therapy. A manualised approach for the treatment of anorexia nervosa that uses psychodynamic principles that are focused on specific pro-anorexia attitudes and beliefs. There is also a focus on the therapeutic relationship and the association between other interpersonal relationships and eating (Zipfel et al. 2014). FPT is now recommended as a second line psychological treatment for adults with anorexia nervosa (NICE 2017).

MANTRA: The Maudsley Model of Treatment for Adults with Anorexia Nervosa. This is a manualised approach to treatment based on the cognitive – interpersonal model of anorexia nervosa originally presented by (Schmidt and Treasure 2006). The MANTRA approach targets cognitive and social-emotional deficits related to starvation and brain function and recognises the unique experience and the utility of anorexia nervosa in the individual's life. The approach follows hierarchal treatment procedures, uses individualised formulation and a collaborative therapist stance (Schmidt et al. 2013). MANTRA is now recommended as a first line psychological treatment for adults with anorexia nervosa (NICE 2017).

SSCM: Specialist Supportive Clinical Management (McIntosh et al. 2006). This approach combines clinical management and supportive psychotherapy in the treatment of adults with anorexia nervosa. The treatment aims to restore normal eating and a healthy weight. Support, education and care are offered and the development of a positive therapeutic relationship is encouraged that aims to foster treatment adherence and promote change. SSCM is now recommended as a first line psychological treatment for adults with anorexia nervosa (NICE 2017).

List of Contents

Chapter 1

Introduction

This grounded theory study offers an in-depth understanding of the nature of the therapeutic relationship as constructed from the experiences and perspectives of adults with the eating disorder; anorexia nervosa. Anorexia nervosa is a serious mental disorder that has been described as the most difficult to treat (Bamford and Mountford 2012). The therapeutic relationship is highly valued as an essential element of the quality of treatment received by people with anorexia nervosa (De la Rie 2008, Reid et al. 2010, Escobar-Koch et al. 2010, Fogarty and Ramjan 2016). However, establishing a helpful therapeutic relationship can be equally challenging for both the therapist and the client (Jones and Larner 2004, Ramjan 2004, Snell et al. 2010, Wright 2010).

In this introductory chapter, I firstly detail my professional and academic reasons for focusing on the therapeutic relationship in this research before leading into the overall aim of the study. I then provide an overview of the thesis by outlining the content of each chapter.

1.1. Background to the study: professional

I qualified as an occupational therapist in 1985 and worked for the next twenty years in mental health services. Developing a sound therapeutic relationship was an essential aspect of my practice, however as a young practitioner I often felt overwhelmed and lacked confidence in knowing how to best establish and utilise the relationship in therapy. I began working with adults with anorexia nervosa in 1990, with an innovative consultant psychiatrist who had a vision to develop services for adults with anorexia nervosa that offered treatment in the community as far as possible. It was here, that I really learned about the value and the art of the therapeutic relationship and the use of self in clinical practice (Mosey 1981, Punwar and Peloquin 2000, Taylor 2008) and established my interest in the therapeutic relationship that I have carried through into my academic career. Having the opportunity to

pursue this interest by undertaking a PhD, led me to reflect on some of the difficulties I had encountered as a therapist working with people with anorexia nervosa. One client stands out. In my first encounter with her, she threw down the opening challenge: "If you say the wrong thing, I won't come back!" Needless to say, I did. Frequently. However, following a tricky start, we managed to develop what I perceived to be a good therapeutic relationship based on openness and honesty. On discussing her discharge from the service two years later, she apologised for being so testing and difficult throughout our work together. I asked her why she had stuck with the treatment and she told me, "you never let me get away with anything but you were also able to make me laugh". I was slightly taken aback by her response as these were not the factors that I would have anticipated her to reflect on. The perceptions of the therapeutic relationship often differ between the therapist and the client; undertaking this research gave me the opportunity to learn from people with anorexia nervosa what factors within the relationship really make a difference to them.

1.2. Background to the study: academic

The therapeutic relationship has been described as "the quintessential integrative variable" across the range of psychotherapies (Wolfe and Goldfried 1988 p449). Much research has concentrated on the predictive value of the therapeutic relationship on the outcomes of therapy and it is known that the therapeutic relationship has a moderate therapeutic effect regardless of the therapy orientation (Horvath and Symonds 1991, Martin et al. 2000). Although there are accepted, generalised constructs of the therapeutic relationship it has also been suggested that different conditions may require distinct types of therapeutic relationship (Bordin 1979, 1994). Regarding eating disorders generally, the therapeutic relationship has often been cited as an essential aspect of the quality of eating disorder services and treatment, both from a service user and therapist perspective (De la Rie et al. 2008, Reid et al. 2010, Escobar-Koch et al. 2010, Fogarty and Ramjan 2016). However, what the nature of the therapeutic relationship needs to be is often unclear and there has

been limited research into this aspect of the therapeutic relationship from the perspective of adults with anorexia nervosa specifically (Gulliksen et al. 2012, Wright and Hacking 2012, Wright 2013). Subsequently, I felt this was important to investigate further as anorexia nervosa has the highest mortality rate of all mental health disorders (NICE 2017) whilst paradoxically, sufferers frequently deny both the seriousness of the illness and the necessity to seek help and treatment. When they do so, the initial impressions a client may form about the therapist can be vital in their decision as to whether they 'come back or not' to establish an early therapeutic relationship and engage in therapy.

1.3. The aim of the study

The research methodology used in this study was constructivist grounded theory as described by Kathy Charmaz (2006, 2014). Grounded theory is an approach to conducting qualitative research that creates theoretical frameworks or theories that are built through an inductive analytical process. Hence, theory is derived from the data rather than from preconceived assumptions (Charmaz 2006) (This will be explored in detail in chapters four, five and six). Akin to the methodology, I began planning the study with broad questions about the therapeutic relationship in my mind: Is there a distinctive style of therapeutic relationship that is needed in the engagement and treatment of eating disorders? What constructs of the therapeutic relationship do people with eating disorders find helpful? How important do they think the therapeutic relationship is? What can the therapist do to establish a good therapeutic relationship? Subsequently the initial aim was to investigate the nature of the therapeutic relationship regarding all eating disorders, however, as I will go on to explain in the thesis in chapter six, the aim was eventually narrowed down to the final research question:

- What is the nature and context of the therapeutic relationship from the perspective of adults with anorexia nervosa?

1.4. Writing in the first person

I have written this thesis in the first person. As a researcher as well as a therapist with a background and interest in the therapeutic relationship and eating disorders, being reflexive throughout this study has been critical. Thus, I have always been part of the research, not distant from it (Charmaz 2006). Using the first person to detail the process of the research and the construction of the theory is congruent with the grounded theory methodology as it reflects my interpretation of the contribution and interactions between myself and the participants. I now outline the structure of the thesis and the content of each chapter.

1.5. Outline of the thesis

This thesis is comprised of twelve chapters. Chapter one offers an introduction that outlines both my professional and academic reasons for undertaking this study. Chapter two details the initial literature I considered in the development of the research proposal and the planning stage of the study. I also outline and justify how I undertook the literature review in keeping with grounded theory methodology. Chapter three is a second literature chapter that introduces the eating disorder; anorexia nervosa and details contemporary treatment research and practice guideline recommendations. Chapter four is the first of three methodological chapters. In this chapter, I position myself as a researcher from a philosophical stance and as a reflexive researcher. I also justify the methodology and research methods used in the study from a theoretical perspective, namely constructivist grounded theory combined with online research methods. Chapter five details the practical and ethical application of using online research methods in this study. Chapter six outlines the data collection and analysis. In chapter seven I offer an overview of the findings of the study and explain how I constructed the resultant theory including the core category. This theory is then presented in the findings and discussion chapters eight, nine and ten where I explicate the conceptual categories in detail. In chapter eleven, I reflect on the research

design and my presence as a researcher in the development of the theory presented. Chapter twelve concludes the thesis. Here, I summarise the theoretical framework of the therapeutic relationship for adults with anorexia nervosa: "one size doesn't fit all" and offer recommendations for the use of the framework in practice. Finally, I detail what the study adds to existing knowledge and make suggestions for future research.

Chapter 2

The therapeutic relationship and eating disorders: a preliminary consideration of the literature

2.1. Introduction

This chapter is the first of two literature chapters. Here I detail the literature that I reviewed in the development of the research proposal and the subsequent justification and aims of this study. I begin by outlining the approach I adopted in the initial literature review to ensure that this was congruent with grounded theory methods. I then move on to explain why I have used the terms therapeutic relationship, client and therapist throughout this study and thesis and explore my understanding of the therapeutic relationship as an occupational therapist. Following that, I detail the historical conceptualisation of the therapeutic relationship from the perspective of three key psychotherapy orientations. Finally, I review selected literature pertaining to previous research that has considered the therapeutic relationship and eating disorders, thus offering a justification for this study.

2.2. Reviewing the literature in a grounded theory study

In the field of grounded theory research, the timing of when the researcher should carry out the literature review has stimulated much debate (Birks and Mills 2011, 2015). In fact, it has led to this dilemma being referred to as "the disputed literature review" (Charmaz 2014 p306). One of the key arguments is that the literature review should be delayed in the initial stages of a grounded theory study so as not to overly influence the researcher through the imposition of existing or "received theory" (Charmaz 2014 p165). It is therefore, generally accepted that a substantive review of existing literature in the area of the phenomenon that is to be researched should not be undertaken until after the stages of data collection and analysis (Corbin and Strauss 2008, Charmaz 2014, Birks and Mills 2015).

Despite this assertion, Glaser and Strauss (1967), in their original presentation of grounded theory methods, did in fact, recognise that no researcher comes to a study without any prior knowledge of the topic. This stance was later clarified by Glaser who suggested that in the early stage of a study, researchers should focus any reading of the existing literature to areas outside of the substantive topic of concern. For example, concentrating on aspects such as methodological aspects of existing research rather than the topic under investigation (Glaser 1992).

However, in more contemporary debates of grounded theory methods it is suggested that it is unlikely that a researcher will undertake a study without any prior familiarity with the area of concern. Thus, grounded theory methods are never entirely inductive, in that theory is derived purely from the data (Charmaz 2014, Birks and Mills 2015). It is suggested therefore that the researcher assumes a reflexive consideration throughout the research process both towards themselves as a part of that process and in tandem with their prior knowledge and experience of the area of concern under investigation (Thornberg 2012, Charmaz 2014).

Therefore, as an occupational therapist with previous experience and knowledge of working in the field of eating disorders, I had to take a realistic approach to the consideration of when and how to undertake a review of the existing theory and literature in the area I was interested in investigating.   It was also important that I engaged with any early review of the existing literature in a reflexive way, thus demonstrating what theory had been incorporated into the process of the development of the original research proposal (Charmaz 2014).

Thus, when considering the parameters of the initial literature search that I undertook during the planning and application stages of this study, I was aware that my interest in the therapeutic relationship was twofold. First, having previously worked with people with eating disorders, I was aware that I had prior ideas derived from practice about the type and importance of the therapeutic relationship that I had developed with clients.   Second, working as a lecturer in occupational therapy in my current role, I teach students about eating disorders and the wider use of the therapeutic relationship in occupational therapy

practice. This involves me having up-to-date profession-specific theoretical knowledge. In addition, at the time of planning this study I was also writing a book chapter on the therapeutic use of self in occupational therapy practice (Seymour 2012). Subsequently, some of the initial ideas I had about my study were drawn from prior knowledge and professional practice as well as from theoretical knowledge gained through teaching and other academic activities. In addition, to satisfy the requirements of the university PhD application process I was required to justify the relevance of the area of investigation through a considered review of existing literature (Birks and Mills 2015).

2.3. The initial literature review strategy

Considering the above issues in relation to my prior knowledge about the topic of interest and in an attempt to maintain methodological congruence with grounded theory, I limited the initial review of existing literature to the minimum depth and breadth I deemed necessary to meeting the requirements of the research proposal and subsequent ethical approval (Birks and Mills 2015). I then broadened this literature review and critique later in the research, following the completion of data gathering and analysis: again, in line with grounded theory methodology (this is further detailed in chapter seven).

Consequently, I approached the initial search for relevant literature in three ways. First, rather than undertake a traditional key word-based search on relevant search engines, I began with considering literature related to my prior knowledge of the therapeutic relationship or therapeutic use of self as it known in the discipline of occupational therapy. This literature covered seminal writings on the therapeutic use of self which began in 1981 by Anne Cronin Mosey who first coined the term, up to more recent research undertaken by Taylor 2008, Taylor et al. 2009). I used this literature to think about my own understanding and conceptualisation of the therapeutic relationship. This led me to look at wider conceptualisations from other key disciplines, namely psychiatry and psychology.

To do this I utilised the Cardiff university library database which accessed a range of search engines such as OVID, CINAHL and PubMed. I used the broad key search terms; therapeutic relationship, therapeutic alliance and working alliance, as these are terms often used in the disciplines of nursing, psychiatry, psychology and counselling. From this initial search and for the purposes of providing an introductory overview for the justification of this study, I reviewed a summary paper by Adam Horvath (2000) which explored the historical and conceptual development of the therapeutic relationship in psychotherapy. This paper then led me to track back to other theory related to four key conceptual theories of the therapeutic relationship: the psychoanalytic perspective, the humanistic/client centred perspective, the cognitive behavioural perspective and finally a pan – theoretical conceptualisation of the therapeutic relationship which has been widely utilised in research. A book by Muran and Barber (2010) was a key text that I also drew on to examine an overview of contemporary evidence based practice in relation to the therapeutic relationship from a clinical and research perspective. In addition, two key systematic reviews were considered by Horvath and Symonds (1991) and Martin et al. (2000). These reviews are known to be the most conclusive regarding the question as to whether the quality of the therapeutic alliance is a robust predictor of the outcome of psychological therapy.

Finally, the third stage of the initial literature review focused specifically on the cross over between eating disorders and the therapeutic relationship/alliance/working alliance. Again, using these terms as the key search terms, I found and reviewed 10 research papers published between 2003 and 2011 (the year my application for this study was submitted). This broad search provided an overview of literature sufficient for the formulation of the research proposal. However, it was not comprehensive and additional literature that was also available in this timeframe was subsequently used in the later literature review following the data analysis.

This chapter, therefore details the initial literature I considered in the planning stages of my study. It begins with a description of theoretical definitions and conceptual models of the

therapeutic relationship, firstly from an occupational therapy perspective and then from wider psychological conceptualisations of the therapeutic relationship. I then review how these conceptual models have been used in research to investigate their predictive use as a measure of outcomes of psychological therapy. Lastly, I considered a range of research specifically in relation to eating disorders and the links with therapeutic relationship. Although I looked at the overall findings of eating disorder based studies, I was simultaneously aware that I also needed to minimise my exposure to the findings so that I would not be overly influenced by pre-existing themes and categories in the substantive area of eating disorders and the therapeutic relationship (Charmaz 2014). Subsequently, in line with grounded theory methods, following the process of writing the initial research proposal I put the literature aside or as described by Charmaz (2014 p307) "laid it fallow". I therefore did not undertake a further literature review until after the completion of the final phase of data collection and analysis. This later review of the literature was then focused around the emerging theoretical ideas and used to develop the findings chapters (see chapters eight, nine and ten). Chapter seven provides detail on the search strategy and use of additional literature in subsequent stages of this study.

The purpose of the initial review described in this chapter served to develop my understanding of the definitions and historical conceptualisation of the therapeutic relationship and to identify the key debates and research directions that have been taken in the past. This led me to then consider how the therapeutic relationship has been considered in the field of eating disorder therapies which helped me to refine my ideas in the justification of the aims of my study.

Within this chapter I also define how the term therapeutic relationship is used throughout my study and explain my reasons for using the terminology selected in respect to the participants who contributed.

<u>2.4. The therapeutic relationship: a plethora of terms</u>

So, what is the therapeutic relationship? Key theories in the conceptualisation of the therapeutic relationship derive primarily from the disciplines of psychiatry, clinical and counselling psychology as well as nursing and allied health professions such as occupational therapy. Theoretical and clinical practice based discussions relating to the concept of the therapeutic relationship often address issues of therapist communication style, collaborative working with clients and the emotional components of the relationship that may occur between the therapist and client.

From my own professional knowledge as well as my preliminary considerations of the literature, it was clear that there are numerous terms that describe the therapist/client interaction and its various components. Terms are often used interchangeably within theoretical, clinical and research literature; the most frequent include, the development of rapport, the therapeutic or working alliance, the therapeutic relationship, the helping relationship and the therapeutic or conscious use of self. Definitions of these terms are relative to the time and theoretical stance of their proponents and recognise the nuances of the various conceptualisations. A range of terms for the therapist/client relationship are also favoured or adopted by different professional disciplines. So, for example, medical professionals tend to use the term patient/doctor or nurse relationship whereas psychological and counselling professions favour client/therapist relationship. Occupational therapists frequently use the term client/therapist relationship, which is suggestive of a more equal and collaborative relationship and therapy process (Taylor 2008).

2.4.1. The way in which the various terms are used in this thesis

During the initial process of reading about the therapeutic relationship it was evident that despite being a generalisable construct, the term, 'therapeutic relationship' encompasses a range of definitions. It is for this reason, I have adopted the generic and widely known term,

'therapeutic relationship' throughout this study. This was primarily so that the nature of this research could be easily understood by potential participants. In addition, by inviting them to describe the therapeutic relationship in any way that they wanted to, I attempted to avoid imposing a pre-existing definition or framework for the concept.

Therefore, throughout this thesis, the term, 'the therapeutic relationship' is used in several ways. Firstly, it may refer to the context of the macro dimensions of the relationship such as the ethical or professional parameters of the relationship. Secondly, it may refer to the micro interactions and techniques that the therapist may use to enhance the quality and effectiveness of the relationship within the therapy encounter. Thirdly, it may also refer to the personal, affective components of reciprocal feelings and emotions that may occur as in any other two-person relationship. Throughout this chapter I have also used a range of terms to refer to the individuals engaged in the therapeutic relationship as was evident in the literature I reviewed. These terms – including patient, client and service user - often appeared to be profession related and not necessarily be how a recipient of services may refer to themselves. I therefore decided to ask some of the participants that contributed to my study what they would wish to be referred to as. They suggested the use of the terms, 'client' and 'therapist' as their preferred choice. Therefore, for the purposes of this study I use this terminology for consistency unless otherwise specified. I use the term 'therapist' as a generic term to include all medical, nursing, allied healthcare and counselling professionals that may offer a therapeutic service to people with eating disorders. For quick reference, these terms are explained at the beginning of the thesis.

2.5. The therapeutic relationship: my understanding as an occupational therapist

In the planning stages of this study with a background as an occupational therapist I was already familiar with the terms the conscious/ therapeutic or intentional use of self (Mosey 1981, Punwar and Peloquin 2000, Taylor 2008). These descriptions of the therapeutic

relationship refer to how the relationship is used by the therapist rather than just the nature of the relationship. For example, Mosey (1981 p 96) described the conscious use of self as:

> "a planned, deliberate interaction with another person where there is a more deliberate, manipulation of one's responses to assist a client."

Thus, the conscious use of self involves not only the components of the therapeutic relationship but also how the occupational therapist utilises this relationship by being sensitive to his or her personal response to the client and using this evaluation to give clues as to the direction or interpersonal stance the therapist may take. Similarly, Punwar and Peloquin's (2000) definition of the therapeutic use of self concurs with Mosey's original description. They also refer to the therapist's "planned use of his or her personality, insights, perceptions and judgements as part of the therapeutic process" (Punwar and Peloquin 2000 p285). They suggest that this deliberate, conscious use of interpersonal strategies occurs once a comfortable relationship or rapport is established between the occupational therapist and the client.

A renewed interest in the therapeutic relationship as an aspect of occupational therapy practice has been promoted by research carried out initially in the United States of America (USA). A nationwide survey of occupational therapists practising in the USA found that there was a gap between the value that occupational therapists placed on the therapeutic relationship and the translation of this value through the skill level and strategies that they perceived themselves to have (Taylor et al. 2009). Research carried out using extensive qualitative interviews and practice based observations of peer nominated exemplars of occupational therapy practice was also undertaken across a range of practice settings in the USA, the United Kingdom of Britain (UK) and Europe. The findings of this study were used to develop a model of the therapeutic relationship known as the intentional relationship (Taylor 2008). She contends that the therapeutic relationship in occupational therapy practice is comprised of three key areas: the use of collaboration and other client -centred methods, an emphasis on care and empathy and the use of personal narrative or in other words, the

context of the client's story in understanding the meaning of their unique experiences (Taylor 2008). Her model of the intentional relationship is comprised of a description of three aspects of occupational therapists' interpersonal capacities that are used to develop and utilise the therapeutic relationship with the client:

- An interpersonal skill base

- Therapeutic modes or styles

- The capacity for interpersonal reasoning

The model has been designed as a teaching aid for developing occupational therapists and its impact and use in practice has not yet been established through further research. However, what the model suggests is that the process of developing the therapeutic relationship is complex, made up of layers of skills and interactions and is a personally interpreted interaction between the person receiving a service for a specific need and the therapist (Taylor and Melton 2009). Thus, in occupational therapy practice, the therapeutic relationship operates at both a macro and micro level of interaction; the macro being the context of the relationship and the processes that define it whilst the micro dimensions are the immediate events and interactions that occur during the therapeutic interaction.

2.6. Historical developments in the conceptualisation of the therapeutic relationship: wider disciplinary perspectives

The consideration of the nature and role of the therapeutic relationship between the therapist and the client and its potential impact on the outcomes of therapy go back as far as Sigmund Freud in 1913 in his development of psychoanalysis. Based on descriptions of his clinical practice, Freud recognised that a process of collaboration and cooperation was essential between the patient and the doctor (Horvath 2000). Freud referred to this process as rapport and viewed it as the pre-condition and vehicle for successful treatment although he

did not think the therapeutic relationship alone was curative (Messer and Wolitzky 2010). This is because the primary aim of psychoanalysis is for the analyst to offer interpretations of the patient's neurosis which subsequently leads to the development of insight by the patient. These neuroses are viewed as being based on the influences of past experiences and relationships (Horvath 2000). The interpretations made by the therapist were seen as being the primary curative factor within the therapy with the relationship or rapport simply being a pre-condition to achieving a cure rather than having a therapeutic effect in itself. Messer and Wolitzky (2010) described key factors outlined by Freud that are necessary for a patient to be receptive to the therapist interpretations. These were that the therapist must show a serious interest in the patient. There must be an association by the patient towards the therapist based on at least one benign, affectionate figure from the past. The therapist must clear away the resistances of the patient and moreover maintain an attitude of sympathetic understanding whilst avoiding taking a moralistic stance with the patient. These factors are what Freud meant as developing rapport between the therapist and the patient and contribute to what is now known as the therapeutic relationship (Messer and Wolitzky 2010).

Messer and Wolitzky (2010) also offer a summary of the key research that has been undertaken in recent years in respect to the therapeutic relationship and psychoanalytic therapies. They do so with some reservation as they acknowledge that the therapeutic relationship is difficult to research as it is not something that is easily reduced to measurable concepts. In addition, the complexity and subtlety of the relationship is often based on factors that are unconscious both within the therapist and the patient. Overall their summary from available research concludes that to enhance the therapeutic alliance in psychoanalytic therapies, the therapist should adjust their interventions to match the patient's defence mechanisms, explore interpersonal themes, develop specific goals, facilitate affect in patients and attend to their past experiences.

It is now known that the therapeutic relationship does in fact have a healing effect in its own right and is not just a pre-condition to therapeutic change. It is Carl Rogers (1951, 1957) who is credited with this supposition (Horvath 2000).

In his seminal works on client centred therapy, Carl Rogers, for the first time, offered a theoretical argument suggesting that it is the relationship that the therapist provides, rather than the techniques they apply, that is responsible for the effectiveness of the therapy. Consequently, it is the process of engaging in therapy through a genuine person to person experience which can have a healing effect on the individual (Horvath 2000, Watson and Kalogerakos 2010).

At the time of writing about the conditions of the therapeutic relationship, Rogers (1951) acknowledged that his ideas were based on clinical experience and judgements as there was little scientific, objective research available in the therapy field. He credits work carried out by Miller (1949) cited in Rogers (1951) which he considered to be the first study carried out to measure the experience of the relationship from the client's perspective. Rogers also described PhD research carried out in 1949 by Fred Fiedler. The premise of his study was based on the assumption that the relationship was an important element in facilitating therapy and consequently all therapists should endeavour to create what they see as the ideal therapeutic relationship. Fiedler's original hypothesis was based on the following considerations:

> "If there are in fact several different types of therapeutic relationship, each distinctive of a different school of therapy, then the ideals toward which experienced therapists of these different schools are working will show relatively little similarity. If, however, there is but one type of relationship which is actually therapeutic, then there should be concordance in the concept of an ideal relationship as held by experienced therapists."

> (Fiedler 1950 p239)

Fielder's study was carried out across ten therapists from different therapeutic orientations. They were asked to describe the ideal therapeutic relationship based on statements drawn from existing literature at the time. The results suggested that the most highly rated characteristic seen as ideal by therapists was that the therapist can participate completely in the patient's communication. Other highly rated characteristics of the ideal relationship included that the therapists' comments are always right in line with what the patient is trying to convey; the therapist sees the patient as a co-worker on a common problem and treats the patient as an equal; the therapist can understand the patient's feelings and the therapist follows the line of the patient's thought (Fieldler 1950). This small study influenced Rogers' thinking about the core constructs of his own theory. He viewed Fiedler's work as an important basis for future research which needed to be "based in objective verified terms, based on clinical hypotheses, scientifically tested" (Rogers 1951 p. 56).

Rogers (1951) subsequently undertook an empirical approach to his own theoretical hypotheses that was based on extensive examination and research into taped therapy sessions. In this research, he was concerned with answering questions as to whether the relationship offered by the therapist was effective and curative in its own right and if the curative elements of the relationship were effective across all approaches to therapy (Horvath 2000). Subsequently, in the original client centered therapy theory he proposed that there are three components provided by the therapist that are necessary to produce a curative effect within the therapy: unconditional positive regard, empathy and congruence (Rogers 1951,1957).

In respect to his original hypothesis regarding the curative components of the therapeutic relationship, it is now generally accepted through research that a good relationship based on Rogers' three components is correlated with positive outcomes of therapy (Horvath 2000) However, this assumption is not necessarily associated to the objective measured level of the therapist's unconditional positive regard, empathy and congruence but rather it is more related to the client's perception of these qualities in the therapist. In addition, it has been

found that therapists who ally themselves more strongly to the client centred approach and are perceived by their clients as having positive relationship qualities are as effective as those who use specific treatment techniques within therapy (Horvath 2000). This suggests that the conditions of the therapeutic relationship provided by the therapist do have a healing effect regardless of the type of therapy offered. However, the assessment of the therapeutic effect is contingent on the perception of the client in respect to the conditions of the therapeutic relationship as purported by Rogers (1951, 1957).

Rogers' work on the necessary conditions for change through the therapeutic relationship also influenced the approach of cognitive behaviour therapists. In the early days of the development of the behavioural and cognitive behavioural therapies in the 1950s and 1960s the emphasis of the therapist's stance tended to focus on the importance of techniques rather than on the therapeutic relationship (Horvath 2000). The therapist's role was that of a trainer who would assume a more distant, detached position that focused on observable events in the therapy rather than processes. Therefore, it was suggested that the relationship developed through a direct consequence of the effectiveness of the therapist's techniques and skills. Subsequently, the impact of the therapeutic relationship was given little consideration. Horvath (2000) therefore suggests that the early cognitive and behavioural therapists tended to take a similar stance to the early psychoanalysts, namely that the therapeutic relationship is not an effective therapeutic agent but rather creates an environment of safety and trust where specific techniques and approaches can be employed. Thus, it was viewed that it is the techniques that effect therapeutic change rather than the relationship.

However, the necessary conditions for change of unconditional positive regard, empathy and congruence as suggested by Rogers were still considered to be the main factors required in the development of the therapeutic relationship that were supported through empirical investigation as being effective (Rogers 1951, 1957). Thus, there was a recognition that successful cognitive and behaviour therapists also needed to interact with their clients in a

warm and empathic manner (Castonguay et al. 2010). Following further empirical evidence that supported the notion of therapeutic factors within the therapeutic relationship there began to be a resurgence in interest towards the hypothesis that the therapeutic relationship was potentially a "potent treatment factor in its own right" (Castonguay et al. 2010 p151).

It is often suggested that in cognitive behavioural therapy the therapeutic relationship has been considered as having secondary importance to the application of learning techniques and strategies within the therapy. However, as demonstrated by Beck et al. (1979), the therapeutic alliance has consistently been viewed as a necessary factor in successful cognitive behavioural therapy. Indeed, the level of collaboration and quality of the relationship have been evidenced as being robust predictors of improved outcome in cognitive therapy with the relationship components of trust and rapport being highly valued (Beck et al. 1979, Castonguay et al. 2010). What is highlighted, however, is that the therapeutic relationship is different in cognitive behavioural therapy as compared to other therapies, in so much as it emphasises collaboration and teamwork between the therapist and client rather than the therapist providing the conditions of the relationship as in Rogers' client centered therapy (Rogers 1951, 1957). The model of "collaborative empiricism" continues to be central to more contemporary cognitive behavioural therapy (Beck et al. 1979 p6). What this refers to is cognitive therapy as a process of "continuously active and deliberately interacting with the client" where there is an emphasis on the therapist assuming a systematic exploration of the client's thoughts, beliefs and assumptions (Beck et al. 1979 p6). Thus, in cognitive behavioural therapy, there is a collaborative relationship where the client and therapist work together to identify the central problems and solutions. Using a scientific analogy, Beck et al. (1979) described the client as providing the raw data and the therapist asking the guiding research questions. This approach contrasts with other views of the therapeutic relationship. For example, in psychoanalytic therapy, the source for change is focused on the therapist's insights developed through the transference relationship and

Rogerian client centered therapy where the source for change is centred with the client and provided through the therapeutic conditions offered within the relationship.

The preceding description provides an overview of significant developments in the conceptualisation of the therapeutic relationship within three key psychotherapy orientations; psychoanalysis, client centred therapy and cognitive behavioural therapy. As an occupational therapist, I had some previous knowledge of these therapeutic approaches when I began this study. Specifically, the central tenets of Rogers' client centered therapy theory inform the basis of the philosophy of occupational therapy. However, I had limited knowledge of the position of the therapeutic relationship in respect to each therapy orientation. I therefore, made the decision during the planning stages of the study, not to explore this in any further depth other than that which has been presented in this chapter. Consequently, in keeping with grounded theory methods, further consideration of the therapeutic relationship relative to the theory of different therapeutic approaches and this thesis data analysis are considered in relation to the findings and discussion of my study in chapters eight to ten (Charmaz 2006, 2014).

Interest in the nature and effectiveness of the therapeutic relationship continued into the 1970s and beyond. This was due in part to further developments in different approaches to psychotherapy whilst simultaneous recognition that there was little research based evidence to suggest that one form of psychotherapy was superior to another. An important development in the conceptualisation of the therapeutic relationship that proposed a synthesis of common significant factors in the therapeutic relationship was originally proposed in 1975 by Edward Bordin. He presented a pan – theoretical concept of what he called the working alliance (Bordin 1979). His conceptual framework of the therapeutic relationship has had a major influence in psychotherapy as the basis for most empirical research into the predictive nature of the quality of the therapeutic relationship on the outcomes of therapy. The disciplines of clinical psychology, psychiatry and counselling often favour the term working or therapeutic alliance within the literature. Thus, for clarity, I will

refer to Bordin's terminology of the working alliance during the following section where relevant.

Bordin's construct of the working alliance was aimed to stimulate therapists and researchers to look at areas of generalisability in therapy processes which could subsequently impact on research, teaching and therapeutic application. He suggested that the working alliance was generic to all orientations of therapy and therefore there were elements of the working alliance construct that could be universally applicable to all psychotherapies. His concept of the working alliance was more akin to that of cognitive behaviour therapists, in that he saw the relationship as being bi-directional and not just the responsibility of the therapist to provide the necessary conditions to effect change (Bordin 1979, Horvath 2000).

Bordin (1979) suggested there were three interlocking generalisable features of the working alliance: an agreement on goals, an assignment of tasks and the development of bonds. Regarding the agreement of goals, he proposed that there needed to be a pre-therapy agreement between the therapist and client and an acceptance by clients that they needed to take responsibility for their own change process through the identification and setting of goals. He saw the tasks that needed to be assigned to meet these goals as being distinct to the type of therapy being undertaken. So, for example, the use of diaries and homework in cognitive behavioural therapy or the use of interpretation in psychoanalysis. He asserted that:

> "The effectiveness of such tasks in furthering movement toward the goal will
> depend upon the vividness with which the therapist can link the assigned task to
> the patient's sense of his difficulties and his wish to change."

(Bordin 1979 p254)

The third factor, he called the "bond" or the "nature of the human relationship between therapist and client" (Bordin 1979 p254). He viewed this as being more than just liking or disliking the therapist but suggested that there also needed to be a basic level of trust in

common for all varieties of therapeutic relationships. However, he also conceded that there may be different bonds required for different assigned tasks. Thus, although he recognised that different orientations of therapy may utilise various forms of goals, tasks and bonds, these three components of the working alliance were applicable to all types of psychological therapies.

This generalisable conceptualisation of the working alliance led to the development of a range of standardised measures for use in research to measure the effectiveness and nature of the therapeutic relationship. Hatcher (2010) suggests that the Working Alliance Inventory (WAI) (Horvath and Greenberg 1989), the Californian Psychotherapy Alliance Scales (CALPAS) (Gaston and Marmar 1994) and the Vanderbilt Therapy Alliance Scales (VTAS) (Hartley and Strupp 1983) are the most widely used. Subsequently, a raft of empirical research into the effectiveness of the therapeutic relationship and its impact on the outcomes of a range of psychological therapies was instigated. Two key meta - analysis on research undertaken into the therapeutic relationship have been carried out, firstly by Horvath and Symonds (1991) and then subsequently by Martin et al. (2000) who updated the 1991 review. Horvath and Symonds (1991) aimed to answer the questions: how strong is the relation between the working alliance and therapy outcome and are there measurement or therapy variables related to the strength of the alliance - outcome relation? This review was based on 24 studies with the following inclusion criteria:

1. Reference to 'alliance' in the study.
2. The study used a quantifiable alliance measure to measure the relationship of the alliance and some assessment of outcome.
3. The study was clinical.
4. It must include at least 5 patients.
5. Therapy must be individual not group based.
6. Data collected within an 11-year span.

The results suggested the following: first, the working alliance is a relatively robust variable linking therapeutic process to outcome. Second, there are moderate but reliable association between good working alliance and positive therapy outcomes. Third, the overall quality of the working alliance is the most predictive of treatment outcomes when it is based on client's evaluations, less so by therapists' evaluations and least by external observers of the therapeutic relationship. Finally, the relationship between the working alliance and therapy outcome does not appear to be influenced by the type of therapy undertake, the length of the treatment, whether the research is published or not, or the number of participants in a study.

Subsequently, Martin et al. (2000) replicated the same methodology in an updated meta-analysis of 79 working alliance studies. They concurred with Horvath and Symonds' conclusion that the strength of the alliance is moderately related to outcome. They also found that the reliability of alliance and outcome appears to be consistent regardless of variables suggested to influence the alliance. They concluded that:

> "The direct association between the alliance and outcome identified in this empirical review is supportive of the hypothesis that the alliance may be therapeutic in and of itself …if a proper alliance is established between a patient and therapist, the patient will experience the relationship as therapeutic, regardless of other psychological interventions….what is evident from this review is that the strength of the alliance is predicative of outcome, whatever the mechanism underlying the relationship."

(Martin et al. 2000 p446)

The review did not find that one alliance measure was more reliable than the others, however it was suggested that the Working Alliance Inventory (WAI) (Horvath and Greenberg 1989) was likely to be most appropriate for research projects. This is because the scale was designed to measure the generalisable working alliance factors outlined by Bordin

(1979) and to measure the theoretical constructs specifically underlying the alliance (Martin et al. 2000).

The review also found that the working alliance ratings of therapists, patients and observers all had adequate reliability; however, across therapy sessions patients tended to rate the working alliance more consistently than therapists and observers (Martin et al. 2000). The implications of this are suggested to be:

> "Because patients tend to view the alliance consistently throughout treatment, they are more likely to view the alliance as positive at termination if their initial assessment was positive."

> (Martin et al. 2000 p447)

Thus, it is suggested that it is important for therapists to establish a positive therapeutic relationship early in the therapy process (Martin et al. 2000).

Horvath (2000) also discussed the issue of the importance of the client's perception of the working alliance, which is more predictive than the therapist's report and that of third party observation of the working alliance. He suggested that therapists are less astute at judging the level of the working alliance and therefore may misjudge the relational experience of the client. Moreover, he suggested that a good working alliance should be established by session 3-5 of the therapy, otherwise commitment to change from the client will not occur or they will discontinue therapy prematurely. Therefore, there may be a window of opportunity in the initial stages of therapy to establish collaborative alliance based on trust, mutual respect and commitment. Once established the working alliance becomes "both context and part of the content of therapy" (Horvath 2000 p169).

This section summarised how the development of a pan-theoretical conceptualisation of the therapeutic relationship has given rise to significant research into the relationship between the working alliance and the outcomes of psychological therapy over the past thirty years. Robust empirical analysis of studies into the working alliance demonstrate that:

- There is a moderate but consistent correlation between the strength of the working alliance and positive outcomes of therapy.

- This is independent of other variables that might impact on the working such as the orientation of the therapy.

- Rating of the working alliance by the client is more consistent over the process of the therapy than by the therapist or a third-party observer.

- This implies that it is important for the therapist to establish a positive working alliance at the beginning of therapy

The findings of these meta-analyses are viewed as conclusive within the field and thus further updates across psychological therapies have not been undertaken.

Nonetheless, there remains an interest in the therapeutic relationship and how it impacts on different therapy orientations; possibly due to the continued failure to find consistent evidence that some forms of treatment for specific health conditions are superior to others as is the case for treatments for eating disorders. There is also a continued interest in the relational factors in therapy that focus primarily on the quality of the relationship rather than the techniques of the therapeutic approach (Safran and Muran 2006). Bordin (1979) also originally postulated that different therapy orientations required distinct types of working alliances but it is suggested that this aspect of the working alliance has been largely unexplored (Horvath 2000). Additionally, Hatcher (2010) suggested that the collaboration component of the therapeutic relationship may have different influences for specific treatment approaches.

During the planning stages of this study, these unanswered concerns about the therapeutic relationship resonated with my experiences of working with people with eating disorders. I was aware that people with eating disorders often experienced relational problems within therapy as well as in a wider social context (Palmer 2000). Furthermore, I had also witnessed reluctance and ambivalence from colleagues in community mental health settings

toward working with people with eating disorders. This reluctance is often due to a lack of confidence and appropriate training and support as well as practitioner beliefs about the nature of people with eating disorders (Jones and Larner 2004). Significantly, ambivalence can impact negatively on the development of a positive therapeutic relationship (Hatcher 2010). In addition, I was also aware that I held the view that the therapeutic relationships I had developed with my clients was an important aspect in engaging and working with the individual; more so at times it seemed than the actual intervention approach I took. However, I also recognised these relationships were also very difficult to establish at times.

Bearing these issues in mind, the next stage in formulating the ideas for my study was to examine what research had previously been carried out in respect to the therapeutic relationship and people with eating disorders.

2.7. The therapeutic relationship and eating disorders

As detailed at the beginning of this chapter, in the planning stages of this study I undertook a limited, preliminary review of eating disorder and therapeutic relationship research published between 2003 and 2011. At this stage, I was primarily interested in gaining an overview of what research had been previously carried out, particularly in relation to the research methodologies and methods that had been used, who were the participants and whether the therapeutic relationship was the primary focus of the project or not. Subsequently, I looked briefly at the findings of the studies I reviewed as I did not want to be influenced too directly by pre - conceived themes pertaining to the therapeutic relationship in this area.

The therapeutic relationship was referred to in four studies that evaluated overall service provision from a practitioner and/or service user perspective.

An audit carried out to evaluate the provision of eating disorder services in Wales found that healthcare practitioners lacked confidence and felt ill equipped to working with people with eating disorders. This led to feelings of ambivalence in the practitioners towards working with

service users due to the complexity of their conditions. In respect to the therapeutic relationship it was acknowledged that the uniqueness of this should be understood within the context of the lived experience of those with an eating disorder (Jones and Larner 2004).

De la Rie et al. (2008) compared therapist and service user views on the quality of treatment of specialised eating disorders services in the Netherlands. A questionnaire was developed that assessed the quality of treatment, namely the structure, process and outcome. The results from 73 therapists and 304 patients who had a range of diagnosed eating disorders were analysed both quantitatively and qualitatively. Both practitioners and service users indicated that the therapeutic relationship was an important aspect of the quality of treatment but it was found that they valued the relationship differently. Notably, service users placed higher value on the therapeutic relationship than practitioners, who tended to place more value on symptom reduction and behavioural change. Specific reference was made to the qualities of therapists valued by the patients including effective communication skills and trust. However, there was little exploration of what these components of the therapeutic relationship comprised of. It was suggested that further research should focus on the variables of the therapeutic relationship and should provide better insight into the day to day experiences of both therapists and patients.

Using qualitative semi structured interviews, Reid et al. (2010) explored healthcare professionals' perspectives of a UK based eating disorder service. The findings focused on unmet needs of people with eating disorders, including practical issues in the management of eating disorders as well as a lack of resources, training and understanding about eating disorders amongst healthcare professionals. Reference was made to the importance of the therapeutic relationship by the participants and it was recognised that the challenges inherent in dealing with the behavioural aspects of the service users and the lack of specialist training impeded the development of the therapeutic relationship.

A further evaluation study explored an in-depth view of the perspectives of 294 service user participants of their experiences of treatment and service provision in eating disorder

services in the UK and the USA (Escobar-Koch et al. 2010). Service provision ranged from specialist eating disorder services to self-help treatment options. The countries were chosen due to their differing philosophies and ways of delivering healthcare and the study aimed to carry out a cross national comparison to elucidate factors that were considered by service users to be essential for high quality services. Data was gathered using an online questionnaire. A good therapeutic relationship with clinicians was identified as an essential aspect of care and it was suggested that it may have a role equally as important in determining service user satisfaction as the intervention itself. The importance for professionals to receive specialist training was highlighted as well as support to develop their interpersonal skills and the ability to form good therapeutic relationships. A strength of this large scale online survey was that it explored service users' experiences of poor care, an area recognised as often neglected in eating disorder research.

An earlier study by Ramjan (2004) focused on the therapeutic relationship as the primary focus of the research. This qualitative study used semi- structured interviews to explore the experiences of paediatric nurses in establishing a therapeutic relationship with adolescents in acute medical wards in a children's hospital in Australia. Although the participants had up to two years' experience of working with adolescents with anorexia nervosa, they had no formal mental health training. Their lack of training, understanding of anorexia nervosa and subsequent attitudes towards the patients were found to be a barrier in the development of the therapeutic relationship.   In addition, the restrictive environment and subsequent behavioural and interpersonal challenges presented by the patients impacted on the ability of the nurses to form good therapeutic relationships. The findings suggested that the medical ward the adolescents were treated in was not conducive to the development of helpful therapeutic relationships, thus indicating that the therapeutic relationship needs to be considered within the context of the treatment environment.

Building on Ramjan's study, Snell et al. (2010) used grounded theory methods with qualitative interviews, to investigate and theorise about the experiences of seven nurses in

developing a therapeutic relationship in the only specialist eating disorder in-patient service in New Zealand. However, it was not stipulated if this was an adolescent or adult based service. A key difference in this study as compared to Ramjan (2004) is that the nurse participants were all registered psychiatric nurses and therefore there was an assumption that they would have more understanding of the nature of anorexia nervosa specifically. Despite having specialist knowledge of eating disorders, it was still found that the establishment of the therapeutic relationship was difficult due to the resistance that is inherent in the illness. In addition, the role of the nurse as the person who maintains the therapeutic connection in the ward environment was often found to be at odds with the patient due to denial of their illness and resistance towards change (Snell et al. 2010). It was suggested that a controlling therapeutic environment can reproduce negative relationships with staff. However, a strength of this study is that it theorises on the experiences of nurses in their attempts to work with resistance when resistance is part of the illness.

Two other studies also considered the role of the therapeutic alliance regarding treatment adherence. First, Loeb et al. (2005) conducted two randomised controlled trials that investigated the relationship between the therapeutic alliance and treatment adherence in two different intervention programmes for adults with bulimia nervosa. The results demonstrated that the use of cognitive behavioural therapy was associated with higher adherence to therapy than interpersonal psychotherapy and that better adherence was associated with an enhanced therapeutic relationship. In addition, Pereira et al. (2006) examined the role of the therapeutic relationship in predicting treatment drop out with a group of adolescents with anorexia nervosa who were undertaking family based therapy. Weight gain was used as the outcome indicator alongside the semi structured interview - The Eating Disorder Examination (EDE) (Cooper and Fairburn 1987). This original standardised assessment measures change of eating disorder issues such as restraint, eating, shape and weight concerns. To measure the therapeutic relationship, the Working Alliance Inventory (Horvath and Greenberg 1989) was used based on the conceptualisation

of the working alliance (Bordin 1979) as previously detailed. The results supported the view that the therapeutic relationship was important in family based therapy for both the patient and the family. Developing a strong early working alliance with adolescents was associated with early treatment response in terms of weight gain outcomes. In addition, it was found that developing a strong early alliance with their parents prevented dropout from therapy. It was also suggested that the style of therapy underpinning family therapy may encourage adolescents and their parents to work more collaboratively with the therapist and may therefore increase the bond element of the therapeutic alliance.

Finally, Zeeck and Hartmann (2005) used a quantitative methodology to measure therapy process issues as predictors of short term therapy with people with anorexia nervosa using weight gain only as an outcome measure. The results of this study suggested that focusing on the interpersonal aspects of the therapy, i.e. the relationship between the therapist and the patient in the first stages of therapy related to a good outcome. However, it was also acknowledged that no causal relationship could be inferred between the relationship and the therapy outcome due to the exploratory nature of the study and the simplicity of the outcome indicator.

This preliminary review of research focusing on the therapeutic relationship in the treatment of eating disorders suggested that the range of research is diverse and considered the therapeutic relationship from a variety of angles.

Thus, in summary most studies were undertaken with adolescents in an in-patient setting which may or may not be specialist in eating disorder treatment. Findings suggested that nurses within in-patient settings struggle to form and maintain good therapeutic relationships with people with eating disorders due to the nature of the disorders and the therapeutic environments. Studies that have found a tentative association with an early establishment of the therapeutic relationship and therapy outcomes have focused on outcomes such as weight gain and treatment adherence rather than considered the quality of the relationship and factors that helped engagement.

Treatment experiences of practitioners and service users have previously been considered using questionnaires and findings acknowledged that the therapeutic relationship was an important aspect to consider in the process of engaging and working with people with eating disorders. Some aspects of what constituted a good therapeutic relationship from the perspective of service users and practitioners was evident but there was an overall lack of exploration of the detail of what constitutes a good therapeutic relationship.

From the studies reviewed there were a mix of qualitative and quantitative research methodologies employed, utilising a range of methods such as online survey questionnaires the use of standardised symptom based questionnaires to measure outcomes, qualitative semi structured interviews undertaken in the naturalistic environment of the service setting and grounded theory methods aimed to develop a theoretical understanding of participant experiences. Although there was no obvious direction that I could have taken from reviewing these studies in relation to the methodological choice for my study, there was a lack of studies that considered in detail the experience of the therapeutic relationship within therapy from the perspective of adults with eating disorders. The importance of learning from the perspective and experience of the service user with eating disorders is advocated (Jones and Larner 2004, de la Rie et al. 2008). Although previous research confirms the correlation between the quality of the therapeutic relationship and the outcomes of therapy (Horvath and Symonds 1991, Martin et al. 2000) it is also suggested that the client's experience of the therapeutic relationship should still be considered as an important focus for both researchers and clinicians (Hatcher 2010). This therefore became the premise of the ideas for my study.

At this juncture, I would like to note that the eating disorder and therapeutic relationship literature I reviewed in the preparation stage of this project did not include Walker and Lloyd (2011) and most notably Wright (2010). Although these studies were published within the date span of this initial search I did not gain access to them during the application and project development stage. Therefore, due to the nature of the grounded theory methodology that I eventually adopted, when I did access them, I made the decision to put

them aside until after the data analysis was completed (Charmaz 2006, 2014). Thus, their contribution to the theory development are considered in relation to the findings of my study in chapters eight to ten.

2.8. Conclusion

In this chapter, I have considered the approach I undertook when reviewing the literature for the planning stage of my study and justified why I left the further literature review until after the data analysis in keeping with grounded theory methods. When planning this study, it was important for me to acknowledge that I had some prior knowledge of the therapeutic relationship and previous experience in working with people with eating disorders. This knowledge influenced some of the foreshadowing ideas that I had in relation to planning the study, namely that the therapeutic relationship was a complex, dynamic process made up of a set of skills that can be used in different ways with different clients in different situations. I was also aware that I viewed the therapeutic relationship to be a crucial component when working with people with eating disorders.

Considering wider disciplinary conceptualisations of the therapeutic relationship it was clear that it is a shared and generalisable aspect of any therapy encounter and that there are conditions within the therapeutic relationship that can have a healing effect in their own right. It is generally accepted that the quality of the relationship is a good indicator of the therapy outcome regardless of the therapeutic orientation of the treatment approach taken. However, it is also suggested that distinct types of therapy and health conditions may require distinct styles of the therapeutic relationship. This idea resonated with me in regard to people with eating disorders as it is also known that they often have relational difficulties both in therapy and in their wider relationships.

Despite the belief held by clients and therapists that the therapeutic relationship is an important and valued aspect of the quality of treatment, there is still limited knowledge of the

detail of what constitutes a good therapeutic relationship from the perspective of adults with eating disorders. Therefore, I decided that I wanted to examine the experience of the therapeutic relationship for adults with eating disorders in more depth in this study. Investigating the experiences of the individual lent itself to the adoption of a qualitative research methodology. Alongside this, my decision to use constructivist grounded theory methods in conjunction with online research methods is detailed in chapter four.

In keeping with grounded theory methods, the initial aim of this study was broad and set out to explore the nature and process of the therapeutic relationship with adults with any eating disorder and to examine what factors can help develop and maintain it. Over the course of the study, I made a methodological decision to refine this broad aim to focus specifically on adults with anorexia nervosa only (this decision is detailed further in chapter six section 6.4). Thus, the aim of this study became based on the research question:

> What is the nature and context of the therapeutic relationship from the perspective of adults with anorexia nervosa?

Before moving on to consider the specific qualitative methodology and methods chosen for my study in chapter four, the following chapter explains the reasons for ultimately narrowing the focus of the study to adults with anorexia nervosa and introduces the specific eating disorder anorexia nervosa as a contextual discussion to help signpost the reader through the remainder of the thesis.

Chapter 3

Anorexia Nervosa: classification, prevalence and evidence- based practice

3.1. Introduction

As previously detailed, during the planning and preparation of my study I considered a broad sample of background literature that focused firstly, on the therapeutic relationship and secondly, research that considered the therapeutic relationship in respect to a range of eating disorders generally as appropriate to grounded theory methods (Charmaz 2006, 2014). However, in the first phase of data collection and analysis it became apparent that with one exception, all the participants described themselves as having a history of anorexia nervosa. I consequently made the methodological decision to narrow down the collection of data in the second and third phases of the study to adults with anorexia nervosa only (this sampling decision is detailed further in chapter six).

This second literature chapter, therefore, begins with an introduction to the specific eating disorder, anorexia nervosa. I then move on to detail current approaches to evidence based practice in the psychological treatment of adults with anorexia nervosa. This background literature is presented at this stage of the thesis to provide the reader with a contextual understanding. However, akin to grounded theory methods, I did not consider the literature detailed in this chapter until I had completed the final phase of data analysis (Charmaz 2014).

Further consideration of the literature presented in this chapter as well as additional literature pertaining to the findings of my study is subsequently integrated into the findings chapters (eight to ten) where it is related specifically to the theoretical categories in relation to the nature and context of the therapeutic relationship with adults with anorexia nervosa.

3.2. Classification, prevalence and incidence of anorexia nervosa

The term eating disorders is a generic name for a range of clinically significant eating behaviours (Palmer 2000). These conditions are typically classified using diagnostic systems. It is argued that the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association (APA), is generally thought of as the superior formal system due to its use of detailed sub-categories (Palmer 2000). The DSM classification system is commonly used in research, clinical settings and academia and is a conceptual framework to inform clinical thinking. The latest version, the DSM-5 (APA 2013) includes a substantially revised section on feeding and eating disorders. This version takes a life span approach which incorporates eating disorders from childhood, adolescence and adulthood into one cohesive category (Hoek 2013).

The term anorexia nervosa was originally coined by the physician William Gull in his clinical descriptions of patients (Gull 1888, Bruch 1973) Meaning a "nervous loss of appetite", anorexia nervosa is an eating disorder characterised by the individual maintaining their weight as low as possible, however a lack of interest, orientation and desire for food is rarely present (Crisp 1990 p3). Weight loss is generally achieved and maintained through severe dietary restriction. Equally, compensatory behaviours such as increased and often punishing, exercise regimes, purging using laxatives and vomiting and chewing and spitting out food may also be used (NICE 2004, 2017). The incidence and prevalence of anorexia nervosa is difficult to estimate due to the relative rarity of the disorder but also the reluctance of people to admit to or indeed recognise that they have the disorder (Palmer 2014). In accordance with the revised DSM-5 categorisation of feeding and eating disorders, Smink et al. (2012, 2013) reviewed recent epidemiology information indicating the incidence and prevalence of eating disorders. In respect to anorexia nervosa, the incidence or new cases seen in the population per year is estimated to be 8 in 100,00 people with an increase in lifetime prevalence of women diagnosed with anorexia nervosa to approximately 4%. Anorexia nervosa occurs primarily in women; with symptoms typically developing in teenage

years. The peak age of onset is thought to be 14 -19 years (NICE 2017). Although anorexia nervosa is generally considered to be rare in older women, recent research suggests that there is an increase in eating disorders, including anorexia nervosa, in women in their middle age years (Micali et al. 2017). Anorexia nervosa also occurs in men with an estimated incidence of 1 in 100,000 per year (NICE 2017).

Despite relatively low numbers of people with anorexia nervosa in the population, it is nonetheless a serious and enduring mental disorder which often has co-morbidity with other complex mental health conditions such as depression, anxiety and obsessive-compulsive disorder, substance misuse and personality disorder (Palmer and Birchall 2005, Lock and Le Grange 2013, NICE 2017). Anorexia nervosa is also associated with increased mortality in comparison to other mental disorders and in addition, it is recognised that most people with anorexia nervosa do not receive any treatment or have contact with health services (Hoek 2013, Palmer 2014). This presents challenges for service providers in terms of the detection and engagement in treatment of this often-hidden group of individuals.

The current DSM-5 criteria for the diagnosis of anorexia nervosa are:

- Persistent restriction of energy intake leading to significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory, and physical health) (normally 15% lower).
- Either an intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain (even though significantly low weight).
- Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

(APA 2013)

Significant changes to this most recent classification of anorexia nervosa include the following; individuals do not have to articulate a fear of weight gain which is potentially beneficial for young people who may not be able to verbalise their motivations for restrictive eating behaviours (Call et al. 2013). In addition, the presence of amenorrhea (absence of periods) has been eliminated in the revised criteria. This now allows for the diagnosis of post-menarchial women, pre-menstrual girls, women using hormone treatments as well as men.

It has been argued that there is a sub group of individuals that constitute a specific type of anorexia nervosa. Known as severe and enduring eating disorders with anorexia nervosa (SEED-AN) (Robinson 2009) or severe and enduring anorexia nervosa (SE-AN) (Touyz et al. 2013), these individuals present with a severe presentation of symptoms over a prolonged time period; generally, 7-10 years or more. They have often experienced multiple episodes of treatment and have significant impairments in physical, social and psychological domains of their lives such as osteoporosis, lack of social and intimate relationships and depression (Robinson 2009, 2014). The prevalence of SEED in women and men has been estimated at around 1 per 100, 000 of the population in the UK and this prevalence is comparable with other long term medical conditions such as multiple sclerosis. It is also suggested that this group of people are at the highest risk of mortality (Touyz et al. 2013, Robinson 2014).

3.3. The causes and presentation of anorexia nervosa

It is generally agreed by academics and researchers that the causes of anorexia nervosa are multifaceted. Lock and Le Grange (2013) outlined a comprehensive summary of the key risk antecedents to the development of anorexia nervosa as well as current theories and research developments into the aetiology of the disorder. These include the presence of premorbid personality traits, parenting and interaction styles within families; the effects of

cultural influences, and most recently, advances in the investigations into a genetic and biological basis for anorexia nervosa. However, many theories are not empirically tested and are developed from clinical observations. Due to the multiple reasons, why a person may develop anorexia nervosa, Berg et al. (2002) assert that it is important that clinicians do not view people with anorexia nervosa as a homogenised group, but rather view each individual's experience of their condition as unique.

In addition to the above diagnostic criteria for anorexia nervosa, the presentation of someone with the disorder is typically a complex one that encompasses wider physical, psychological and social features.

The physical symptoms experienced in anorexia nervosa can be attributed to the effects of starvation (Keys et al. 1950, NICE 2004, Tucker 2006, NICE 2017). These include gastrointestinal problems, growth of body hair (lanugo), loss of bone density and increased risk of osteoporosis, muscle weakness and wastage including heart muscle and subsequent arrhythmias, low body temperature, immune system changes, anaemia and fertility problems including amenorrhea (Crisp 1997, Freeman 2009, NICE 2004, 2017).

Brain volume has been found to be reduced in anorexia nervosa (NICE 2004). Prolonged starvation impacts the frontal lobe of the brain and thus can affect concentration and memory as well as higher executive cognitive functions such as judgement and decision making. Although many cognitive deficits restore after weight restoration, it has been found that some abnormality in executive functioning can remain such as the ability to set shift; this is the facility to move between tasks or mental sets in response to changing goals or environments (Eating Disorder Glossary 2017). This lack of flexibility or rigidity in cognitive functioning is associated with obsessive and perfectionism traits in the individual and is viewed as a maintaining factor in anorexia nervosa (Freeman 2009, NICE 2004, Treasure and Schmidt 2013).

Rigid, obsessional thinking patterns often lead to controlled behavioural manifestations focused around food and wider daily routines. Disordered thinking is generally not based in reality; indeed, anorexia nervosa has been described as an ego-syntonic condition. That is, the individual holds beliefs, values and feelings that are in keeping with and acceptable to their own sense of self or ideal self-image (Eating Disorders Glossary 2017). Thus, the person with anorexia nervosa believes that the thoughts, beliefs and behaviours that drive the pursuit of thinness and control are acceptable and synonymous with their sense of self. They therefore deny that they are ill and subsequently question that they need to change their behaviour and accept treatment (Crisp 1997, Birmingham and Treasure 2010).

In addition, sleep patterns are often disturbed and symptoms akin to depression, anxiety and obsessional behaviours can be present to the extent where they can be diagnosed as co-morbid conditions (Palmer 2000, 2014). Low self-esteem is recognised as a precursor to the development of anorexia nervosa and the over- evaluation of weight and body shape is viewed as a core psychopathological factor (Fairburn 2008). Self-worth is often linked to the maintenance of the "anorexic identity" in that one source of self-worth is the disorder itself (Garner et al. 1997 p 130) and extreme thinness can be viewed as a sign of discipline and individual control that is indicative of special status (Bowman 2006). Common personality traits are also recognised as present in people with anorexia nervosa such as perfectionism, an excessive need for control and approval and increased emotional sensitivity (Berg et al. 2002).

People with anorexia nervosa often have a sense of unworthiness that can be pervasive throughout wide aspects of their lives (Robinson 2014). This "clinical frugality" can impact on individuals viewing themselves as not deserving of having anything good in their lives including food, clothes, aesthetic goods or experiences (Robinson 2014 p395). In addition, there are typically, wider social impacts of having anorexia nervosa, such as experiencing difficulties in maintaining school or work requirements, interpersonal and relational problems and social isolation. This is due, in part, to the diminished interest and engagement in

premorbid activities as well as disrupted periods of hospitalisation (Berg et al. 2002, Fairburn 2008, Robinson 2009, NICE 2017).

Thus, anorexia nervosa is viewed as a serious mental disorder that is associated with a mortality rate estimated at 9.6 %. This is approximately three times higher than any other psychiatric illness (NICE 2017). Common causes of death being suicide, the effects of starvation and alcohol related diseases, with those with lower weight being at the highest risk as are those aged between 20 - 29 (Robinson 2009, Lock and Le Grange 2013, Smink et al. 2012, 2013, Franko et al. 2013, NICE 2017).

3.4. An overview of treatment for adults with anorexia nervosa

It is suggested that most people with eating disorders including anorexia nervosa do not receive any treatment (Hoek 2013, Smink et al. 2013). This may be, in part, due to denial from the person that they have an illness that requires treatment as previously detailed. In addition, feelings of shame and that they are undeserving of treatment may prevent them from approaching services. Furthermore, a lack of detection and appropriate referral to mental health services may result in people not receiving treatment. As previously mentioned, the ego-syntonic nature of anorexia nervosa is a unique factor in anorexia nervosa in terms of the individual not recognising or acknowledging that they have a problem and therefore, subsequently not seeking or accepting appropriate help. Therefore, it is no wonder that anorexia nervosa is described as the most difficult mental disorder to treat (Bamford and Mountford 2012).

The current premise for the treatment and management of anorexia nervosa in the UK has been informed by clinical guidelines (NICE 2004). At the time of the publication of these guidelines, the recommendations for psychological treatments were generally based on expert clinical experience and opinion due to the lack of accepted randomised controlled trials. Thus, the overall recommendation for the treatment of adults with anorexia nervosa

was that, where possible, service users are treated on an outpatient basis with psychological therapy. This treatment should be delivered through a multidisciplinary team where continuity of care can be maintained through a designated care coordinator (NICE 2004). However, the empirical evidence to support specific types of psychotherapy was sparse at the time of this recommendation, with no evidence to suggest that one specific psychological therapy was more effective than another (NICE 2004). Subsequently, cognitive behavioural therapy (CBT), interpersonal psychotherapy (IPT), cognitive analytic therapy (CAT) and focal psychodynamic therapy were all recommended as acceptable psychological therapies (NICE 2004). (See the glossary of terms for more detail about these therapies).

Following the implementation in practice of these guidelines there was a focus in the following years on research into the efficacy of a range of treatments, including psychological interventions for anorexia nervosa.

In 2012, a comprehensive review updating the medical and psychological treatment of anorexia nervosa across the life span aimed to provide an overview of best practice to guide and support clinical decision making (Watson and Bulik 2012). This review considered evidence from randomized controlled trials (RCTs) published between 1980 and 2011 as well as reviewing clinical practice guidelines and ongoing RCTs. It was concluded that the evidence base for treatment for anorexia nervosa is advancing, but this is more so in respect to treatment for children and adolescents. In regard to adults with anorexia nervosa it was still concluded that there was no one superior treatment approach (Watson and Bulik 2012).

The difficulties in establishing definitive evidence based recommendations is due in part to the problem in establishing the effectiveness of treatments for the complexities of a condition such as anorexia nervosa through RCT based research. Methodological challenges inherent in the recruitment and retention of sufficient participants as well as the difficulties in isolating specific therapeutic factors, within the settings of multi professional team approaches to treatment are highlighted by Watson and Bulik (2012). Due to the high risks associated with the medical complications of anorexia nervosa there is also no option to offer a non-

treatment control comparison. Therefore, isolating specific treatment factors of different approaches is problematic. Thus, it is recommended that clinicians and researchers are appraised of the best evidence available at the time to aid clinical decision making and that this knowledge should be based on a range of evidence sources including RCTs, practice guidelines and clinical recommendations from practice areas. In addition, it is suggested that there is a need for a:

> "Palette or collection of psychotherapies to meet the needs of the full range of individuals who present for anorexia treatment."

> (Watson and Bulik 2012 p20)

Thus, in respect to the treatment of adults with anorexia nervosa, Watson and Bulik (2012) conclude that a combination of nourishment with the restoration of a healthy weight, physical monitoring and specialist psychological treatments are used. Ideally treatment should be implemented on an outpatient basis but there may be times when inpatient treatment is necessary due to the associated physical risks of anorexia nervosa (Watson and Bulik 2012). Thus, psychological treatments such as cognitive behaviour therapy (CBT) cognitive analytical therapy (CAT), interpersonal psychotherapy (IPT) and focal psychodynamic therapy (FPT) are all recommended for adults with anorexia nervosa with a further recommendation that they be delivered for a minimum of six month's duration (NICE 2004, Watson and Bulik 2012).

In 2013, a systematic review also aimed to update the evidence for psychological therapies only for the treatment of a range of eating disorders during the period 2005 - 2012 (Hay 2013). Specifically, regarding the treatment of anorexia nervosa, it was concluded that although the evidence base for psychological therapies for anorexia nervosa had improved in the time frame highlighted, there continued to be no one psychological therapy for adults with anorexia nervosa that had proved to be superior to another (Hay 2013). Highlighted in this review was a follow up study of an RCT previously carried out with adults with anorexia

nervosa. This study compared the use of CBT, IPT and an approach known as Specialist Supportive Clinical Management (SSCM) (McIntosh et al. 2006). SSCM is a specialist education treatment approach developed to focus on eating disorder features whilst simultaneously restoring weight. The long term follow up results (average of 6.7 years' post treatment) demonstrated good global outcomes for anorexia nervosa symptoms in 49% of adult outpatients. These outcomes were found to remain stable over time for CBT, improve over time for IPT but decline over time for SSCM, however overall there was found to be no statistically significant differences between the three treatment approaches (Carter et al. 2011). It was noted in this study that the number of sessions undertaken in the psychological therapy offered was below that recommended for anorexia nervosa by clinical guidelines (20 weeks as opposed to a minimum of 6 months) (NICE 2004), thus it was suggested that this could be too short for the treatment of this condition to effect significant long-term change. In addition, it was suggested that the focus on interpersonal issues in the IPT approach may account for its initial improvements in outcomes as compared to CBT and SSCM (Carter et al. 2011). This is relevant, as previously mentioned in this chapter, relational difficulties have been suggested to be a significant issue for people with anorexia nervosa (Palmer 2014).

In the systematic review by Hay (2013), the only RCT undertaken for the psychological treatment of adults with anorexia nervosa within the 2005 – 2012 time frame was highlighted. Schmidt et al. (2012) compared SSCM with a novel therapy approach: the Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA) (Schmidt and Treasure 2006). The MANTRA approach was developed in response to a lack of efficacy in other psychological treatments for adults with anorexia nervosa. The approach aims to address the pro-anorexic distorted thinking around the functions of the disorder whilst simultaneously addressing the specific socio-emotional deficits that are present in the individual. In addition, the enabling behaviours of parents or partners of the individual are also considered in the programme. The results of this initial trial were inconclusive when

comparing MANTRA with SSCM, with both treatment approaches demonstrating improvements but neither one proving more effective than the other (Schmidt et al. 2012).

A further clinical review of psychological treatments for eating disorders concurred with the reviews undertaken by both Watson and Bulik (2012) and Hay (2013) that there was no conclusive evidence based on RCTs to recommend one psychological treatment approach over another for anorexia nervosa in adults (Kass et al. 2013). However, this clinical review also considered alternative treatments for the sub group of adults with anorexia nervosa who do not respond to or engage with the treatments previously discussed. Based on small scale case studies it is suggested that cognitive remediation therapy has had some positive results with adults with anorexia nervosa including low dropout rates from therapy due to its acceptability as a form of treatment by clients (Tchanturia et al. 2013). This adapted form of CBT aims to encourage a broader, more flexible thinking style in individuals to combat thinking patterns that contribute to the maintenance of anorexia nervosa (Treasure and Schmidt 2013). Preliminary outcomes suggested some improved cognitive flexibility in individuals and it was recommended that cognitive remediation therapy be include in further RCTs.

Kass et al. (2013) also suggested that people with longstanding, severe and enduring anorexia nervosa (SEED-AN) may benefit more from treatments that focus on quality of life and retention in treatment rather than treatments that measure recovery based on weight related outcomes and other symptom based change. Concurrently, an RCT carried out with people with SEED-AN used an adapted form of CBT for anorexia nervosa (CBT-AN) and SSCM that focused on improving quality of life rather than weight recovery (Touyz et al. 2013) The findings demonstrated improved health related quality of life and eating disorder outcomes for both approaches but those who received CBT-AN also demonstrating improved readiness for change as well as better improvements in eating disorder symptoms and social adjustment This study also claimed to have had the highest retention rate of a

treatment trial of adults with severe and enduring anorexia nervosa at the time (Touyz et al. 2013).

To summarise, three key systematic and clinical reviews of both psychological and medical treatments for adults with anorexia nervosa concluded that although there is benefit from specialist psychological treatments, no one approach was found to be superior to another (Watson and Bulik 2012, Hay 2013, Kass et al. 2013). In addition, dropout rates from treatment are still viewed as unacceptable by clinicians and researchers and there is a substantial proportion of individuals who either disengage from treatment, do not respond to treatment offered or relapse within ten years (Smink 2013, Watson and Bulik 2012, Bamford and Mountford 2012). Nevertheless, it is still recognised that adults with anorexia nervosa can benefit from evidence based treatment and that despite the complexities and challenges inherent in providing appropriate treatment, it can extend and save individuals' lives (Watson and Bulik 2012). Thus, the requirement for continued large scale RCTs of a range of treatment approaches for adults with anorexia was recommended (Watson and Bulik 2012, Hay 2013, Kass et al. 2013).

In respect to eating disorder treatments and the significance of the therapeutic relationship on the outcomes of psychological therapies, there have been two studies that have set out to analyse the available evidence. First, a qualitative systematic review aimed to synthesis all qualitative and quantitative research published before 2012 that examined the strength of the therapeutic relationship against treatment outcomes (Antoniou and Cooper 2013). This review considered studies across the life span and all diagnoses of eating disorders according to DSM-IV criteria (APA 1993). Regarding anorexia nervosa only two studies where included in the review. The findings which were drawn from thematic analysis of the studies were inconclusive but suggested that the therapeutic relationship was probably significant for successful treatment outcomes during psychological treatment for anorexia nervosa. However, this claim was based on limited and ambiguous evidence using studies with significant methodological differences. Despite this, a further theme that was highlighted

was that of the therapists' competence. A collaborative, non-judgemental and understanding stance was suggested as being more successful in developing a strong therapeutic relationship when working with people with anorexia nervosa. In addition, it was suggested that the client's sense of feeling accepted rather than criticised by the therapist was important (Antoniou and Cooper 2013). Second, a more recent meta -analysis of the correlation between the therapeutic relationship and the outcomes of psychological therapy has been undertaken (Graves et al. 2017). This study is considered in more detail in section 3.4.

Subsequent to the lack of RCT research into the effectiveness of psychological treatment with anorexia nervosa, the Anorexia Nervosa Treatment of OutPatients (ANTOP) study was developed in Germany. This trial aimed to assess the efficacy of two manualised treatment approaches with adults with anorexia nervosa versus optimised treatment as usual (Zipfel et al. 2014). The two manualised treatment approaches were focal psychodynamic therapy which has a high focus on the therapeutic relationship and associated interpersonal relationships and eating disorder behaviour and an adapted unpublished German version of enhanced CBT for eating disorders as presented by Fairburn (2008). The optimised treatment as usual comprised of medical monitoring and treatment by the family doctor as well as gaining help with accessing outpatient psychotherapy with therapists experienced in treating eating disorders. The primary outcome measured was weight gain as measured by Body Mass Index (BMI) as well as measuring rates of recovery. The results showed that at the end of treatment BMI had increased in all three study groups and it was suggested that optimised treatment as usual can be a solid baseline treatment. However, the use of manualised, specialist approaches were also evidenced as effective with focal psychodynamic therapy showing higher gains in BMI at the 12 month follow up but enhanced CBT showing faster weight gain and more improvement in eating disorder symptomatology (Zipfel et al. 2014).

A further large scale RCT, the MOSIAC Trial compared two psychological therapies (MANTRA and SSCM as previously described) in the outpatient treatment of adults with anorexia nervosa (Schmidt et al. 2015). Both treatment approaches were found to result in significant improvements in weight recovery as well as reductions in a range of eating disorders symptomatology. The results of this trial are of importance due to the high patient retention and completion rates for both treatment approaches. It was found that compared to the SSCM approach, the MANTRA approach had a higher retention and completion rate overall (Schmidt et al. 2015). It was also found to be more acceptable and credible by the patients in respect to how helpful the treatment was perceived regarding the reduction in eating behaviours at 12 month follow up (Zainal et al. 2016). However, it was also suggested that these differences could be due in part to the longer sessions offered within the MANTRA format. Additionally, one of the participant sites was also the same site where this approach was originally developed, therefore it was acknowledged there could have been treatment preference bias on the part of the therapists that may have impacted on the delivery of the MANTRA approach (Schmidt et al. 2015). Despite these cautionary notes, an additional strength of this trial was that patient and therapist evaluation data were also collated to supplement the quantitative outcomes and provide a complete picture of the treatment experience including therapist/client interactions. Indeed, the most commonly mentioned theme in the 12-month qualitative follow up study was the therapeutic relationship (Zainal et al. 2016). Both approaches emphasised the importance of the interpersonal style of the therapist, that is, the need to be supportive and encouraging. In addition, maintaining a hopeful stance, working collaboratively, utilising the individual's strengths and tailoring the approach to the needs of the individual were also highlighted (Schmidt et al. 2013). Feedback from the clients highlighted the importance of the therapeutic relationship in both treatment approaches and outlined therapist characteristics that were perceived as beneficial in the development of the relationship such as trust and empathy. The flexible use and individual tailoring of the MANTRA manual by therapists was viewed by the clients as them having received personalised treatment and impacted positively on the development of

a solid therapeutic relationship (Lose et al. 2014, Zainal et al. 2016).   Although the results of the MOSIAC trial are encouraging for the out-patient treatment of adults with anorexia nervosa, and it is suggested that the MANTRA approach can be recommended over SSCM, it is still recommended that that when choosing one intervention over another three considerations should be made; using the best available research evidence, informed clinical knowledge and patient preference (Zainal et al. 2016).

Hence it is suggested that there should be a range of treatments available that meet the varying needs of the individual. Additionally, considering the complex needs of those with severe and enduring anorexia nervosa, treatments should also focus on quality of life issues and retention of the individual in treatment rather than primarily focusing on weight recovery (Watson and Bulik 2012, Bamford and Mountford 2012, Touyz et al. 2013, Munroe et al. 2014).

With that said, it is acknowledged that there is a lack of consensus in the literature as to what is deemed to mean recovery from anorexia nervosa, both in terms of weight restoration and other physical, psychological and functional impairments (Strober and Lock 2015). Thus, there are examples of clinical practice that draw on a wider theory of recovery from mental illness that does not necessarily mean a remission in symptoms or indeed a return to the normal functioning that was present prior to the onset of the illness (Bamford and Mountford 2012, Munroe et al. 2014, Palmer 2014). This view of recovery suggests that the presenting illness is one aspect of an otherwise whole person and thus the individual is more than just their illness. Therefore, what constitutes recovery may have individual meaning to people and can involve a process of the individual gaining control but also responsibility for their own life through actively participating themselves in the process of recovery. This means that the process of recovery involves acceptance of the illness whilst simultaneously maintaining aspirations and hopes that can be pursued despite the experience of the illness. Over time, it can therefore be possible for the person to build a meaningful and rewarding life

that is built up of the things that are of importance to the person and subsequently the significance of the illness can reduce (Davidson et al. 2005, Palmer 2014).

This ethos of recovery has been incorporated into some specialist outpatient eating disorder services for adults with severe and enduring anorexia nervosa (Bamford and Mountford 2012, Munroe et al. 2014). A primary aim of these services is the engagement and retention in therapy using the therapeutic relationship. Treatment is offered over an extended period, up to 18 months with intensive periods of contact as required by the individual (Munroe et al. 2014). Treatment goals are developed in a collaborative way and individualised to the needs of the person. These may not be focused on eating and weight based goals in the first instance but on quality of life issues. These approaches utilise an adapted form of CBT alongside medical management of the individual and have been found to improve levels of commitment and engagement in therapy. Moreover, reduced levels of premature termination of treatment and improved engagement in wider quality of life domains have been observed (Bamford and Mountford 2012). In addition, Munroe et al. (2014) found that on evaluating this approach there was a high level of satisfaction reported by service users who highlighted that this was a service where they felt understood and perceived the staff to be caring, trustworthy and genuine in their support. They valued the individualised and personal nature of the care they received and viewed the treatment as being holistic and not primarily focused on weight based outcomes. This service also reported a substantial reduction in costs and more importantly a lower rate of mortality of 4% as compared to another study that reported mortality data of 11.5% for a similar population of adults with anorexia nervosa over similar follow up periods of 8 years (Tanaka at al. 2001 cited in Munroe et al. 2014). The differences in mortality rates are suggested to be due to the development of a trusting, long-term therapeutic relationship between the therapists and the clients. Furthermore, it is suggested that the therapeutic relationship is "the key to risk management" (Munroe et al. 2014 p224) as the clients are more likely to be open with their therapist thus allowing for more accurate assessment and agreement to appropriate treatment when necessary.

These community based services aimed to meet the challenging needs of those with long - standing and enduring anorexia nervosa who are at the highest risk of death (Robinson 2014, NICE 2017). Using the therapeutic relationship to engage and improve retention in the service is also viewed as paramount to the process of risk assessment and the reported outcome of reduced mortality. Although the reported outcomes have not been evidenced using clinical trials to date, this recovery based approach appears to have clinical utility as evidenced through expert clinical opinion and service user evaluation (Watson and Bulik 2012).

A final treatment approach that is worthy of note, not primarily as a treatment for anorexia nervosa but due to its focus on the therapeutic relationship is Dialectical Behaviour Therapy (DBT) (Linehan 1993). This therapy was developed for people with borderline personality disorder and it is suggested that this approach may have clinical utility for people with anorexia nervosa and co-morbid borderline personality disorder (Palmer and Birchall 2005). Due to the associated problems of borderline personality disorder, namely emotional instability and impulsiveness, self-harm, chaotic lifestyles and substance misuse, standard outpatient treatment for anorexia nervosa is often unsatisfactory. The therapeutic relationship between the client and therapist often breaks down or is so complex it is difficult to maintain. DBT specifically address and uses the nature of the therapeutic relationship throughout the therapy which is conducted within a clear supportive framework (Palmer and Birchall 2005). A recent study suggests that there is a growing evidence base to support the use of DBT with anorexia nervosa and those with borderline personality disorder (Chen et al. 2015).

3.4.1. The latest evidence for psychological treatment of adults with anorexia nervosa

The 2004 NICE Guideline, Eating Disorders: Core Interventions in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa and Related Eating Disorders has

recently been updated. This will be superseded by the recently published guideline: Eating Disorders: recognition and treatment (NICE 2017). The need to update the 2004 guideline was in recognition that few of the recommendations that were made in 2004 were based on level A or B evidence, that is evidence obtained from a single RCT or meta-analysis of RCTs (A) or evidence obtained from at least one well designed study without randomisation (B) (NICE 2004 p54). In the preceding years, there have been continued RCT research studies as previously detailed. The updated guidelines make recommendations based on the best evidence to date. They are not mandatory and are intended to be used to make clinical decisions that are appropriate to the circumstances of the individual (NICE 2017).

In respect to the psychological treatment for adults with anorexia nervosa the guidelines recognise that although advances have been made through research using RCTs, the quality of the studies remain graded as very low and low. This is due to the continued difficulties inherent in carrying out research with people with anorexia nervosa as previously detailed. Despite this, the following recommendations for the psychological treatment of adults with anorexia nervosa have been made. The first line recommendation is that clinicians should consider using one of the following treatment approaches:

- Individual eating disorder focused CBT (CBT-ED) (Fairburn 2008).
- Specialist Supportive Clinical Management (SSCM) (McIntosh et al. 2006) or
- The Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA) (Schmidt and Treasure 2006).

Based on the clinical evidence available it is suggested that all three treatment approaches have similar clinical benefits and therefore they are not recommended in any order. Rather clients should be given information about each treatment approach for them to choose their preference (NICE 2017).

If any of these individual therapies are not effective, acceptable or contra-indicted, it is recommended that clinicians then consider using:

- Eating disorder focused focal psychodynamic therapy (FPT) (Zipfel et al. 2014).

FPT was downgraded to a second line recommendation (it was initially considered as a first line treatment option in the consultation document). This was in part due to limited numbers of clinicians in the UK trained in its use. In addition, there is currently no English language version of the treatment manual, although this is due to be published in late 2017 (NICE 2017).

The use of self-help, interpersonal psychotherapy (IPT) and family therapy are not recommended for adults with anorexia nervosa in the updated guidelines due to the lack of evidence to support their use.

The guidelines also recommend how the treatments should be delivered. For example, the primary aim of CBT-ED should be to reduce physical risks and other eating disorder symptoms. Thus, up to 40 sessions should be offered over 40 weeks using a CBT-ED manual such as Fairburn (2008). There should be encouragement of restoration of healthy weight and healthy eating patterns. Sessions should cover nutritional advice, relapse planning, cognitive restructuring, mood regulation, social and interpersonal skills, education about the effects of starvation and body image and self-esteem work. Significantly, it is recommended that treatment plans should be personalised and based on the individual processes that maintain the eating disorder (NICE 2017). Key aspects of MANTRA are that it should be delivered typically over 20 sessions, treatment should be in adherence to the MANTRA workbook, but there should be flexibility in how the modules are delivered and emphasised, based on the individual needs of the client. Likewise, SSCM should be delivered over 20 sessions or the number of sessions can be extended depending on the severity of the presentation. The therapist should encourage weight restoration and establish a weight range goal, promote a positive relationship with the client and allow the client to decide what additional factors should be included as part of the therapy.

The guidelines for the use of focal psychodynamic therapy (FPT) recommend that a manual specific to eating disorder treatment is used. An extended period of therapy, again up to 40 sessions delivered over 40 weeks should be offered to the individual. A patient centred focus that is specific to the individual with a focus on what the eating disorder symptoms mean to the individual and how they impact on them specifically is also recommended. Crucially, how the anorexia nervosa symptoms influence the person's relationships including that with the therapist should be considered within the therapy (NICE 2017). Thus, this therapy is essentially relational in nature which as previously detailed is often a key area of difficulty for people with anorexia nervosa. This may go some way to explain its clinical utility in comparison to other psychological therapies as the focus of the therapy is reliant on the development and understanding of the therapeutic relationship as well as relationships with others and how these affect eating behaviours.

Within the NICE (2017) guideline recommendations, the clinical outcomes of studies that have been defined as significant continue to be related to eating disorder symptom change. This is also true of a recent meta-analysis that looked at the relationship between the therapeutic alliance or relationship and treatment outcomes in eating disorders (Graves et al. 2017). In their study, treatment outcomes were defined in terms of improvements of eating disorder symptoms only, for example weight, eating behaviours and cognitions. The study suggests a reciprocal association between symptom change and the therapeutic relationship and that both a focus on early symptom change as well as the development of the therapeutic relationship is necessary. In addition, the study claims to be the first to suggest that the importance of the therapeutic relationship may differ across therapy orientation, client age and eating disorder diagnosis. Thus, in respect to anorexia nervosa, a strong early therapeutic alliance was found to be significantly related to subsequent symptom change for younger clients but not so much for older ones. Subsequently, it is suggested that extra attention may need to be paid to the therapeutic relationship for younger clients across all

therapy orientations to positively effect eating disorder symptom change (Graves et al. 2017).

Despite the continued focus in research into the association between the therapeutic relationship and outcomes related to eating disorder symptom reduction, the NICE (2017) guidelines do acknowledge alternative quality of life outcomes of treatments which may have equal relevance to adults with enduring anorexia. However, as these are rarely measured in RCTs they have not been considered in the research evidence that has informed the recommendations. Similarly, treatment outcomes that are viewed as important to service users such as general functioning and the treatment experience as well as eating disorder psychopathology and family functioning are recognised but have not been considered when making treatment recommendations (NICE 2017).

In summary, the NICE (2017) recommendations offer clear advice regarding the provision of individual psychological therapy for adults with anorexia nervosa. This advice is based on the findings of recent RCTs, albeit these have been downgraded to very low and low evidence rating due to the methodological issues identified in the studies used. Despite this, the recommended first and second line therapies of CBT-ED, MANTRA and SSCM and focal psychodynamic therapy are based on the provision of individualised, patient centred therapy, which is offered over an extended period of time. In the case of focal psychodynamic therapy, the therapeutic relationship is a central aspect of the treatment.

3.5. Conclusion

This chapter detailed the classification and presentation of the eating disorder anorexia nervosa. In addition, an overview of current treatment approaches for adults with anorexia nervosa were considered. This includes recently published clinical guidelines that will shape individual psychological therapies for the foreseeable future. What emerges continues to be a complex and incomplete picture that is indicative of the complexity of the disorder itself.

Consequently, it is challenging to develop high quality evidence based treatments whose efficacy can be researched through RCTs. This is due to various issues including the relatively low prevalence rates of anorexia nervosa in adults; difficulties recruiting people into clinical trials; the reluctance of individuals to engage in treatment in the first place as well as high drop-out rates of individuals from treatment. Moreover, methodological and ethical issues preclude potential research participants being allocated to traditional non-treatment control groups or waiting lists thus making comparisons of different treatment approaches problematic. Despite this, the research to date does demonstrate the potential for adults with anorexia nervosa to benefit from psychological therapy although there continues to be no one treatment modality that is proven superior or more effective than another. However, there are broad commonalities to all four treatment modalities that have been recommended in the recent clinical guidelines. These include:

- Giving individuals choice in the which treatment approach to use.
- An overall aim of weight restoration and healthy eating patterns.
- Extended numbers of treatment sessions.
- Using a relevant eating disorder treatment manual.
- Being flexible in the use of such a manual to accommodate the needs of the individual.
- Creating a personalised treatment plan.
- Developing positive relationships between the therapist and the client.

Anorexia nervosa has been described as the most difficult mental illness to treat and more so those suffering with severe and enduring anorexia nervosa. Due to the lack of RCT based evidence for appropriate treatment and management of this high-risk group of individuals it may therefore be necessary to look to alternative recommendations from clinical practice that include service user evaluation. Reports from clinical practice suggest that services that use a recovery model of mental illness, that does not focus primarily on weight related

treatment outcomes and utilises the therapeutic relationship as a means to engage and retain people in the service can be effective in improving the quality of individuals' lives and reduce rates of mortality.

The therapeutic relationship is a mutual aspect of all psychological therapies and treatment approaches for adults with anorexia nervosa. As previously detailed in chapter two, several exploratory studies have identified that the therapeutic relationship is viewed by service users as being an essential aspect of the quality of treatment they received. However, what constitutes a positive therapeutic relationship with adults with anorexia nervosa and how it can be developed is not always clearly defined. The lack of high quality evidence for any one definitive treatment approach for adults with anorexia nervosa and the emphasis in the approaches on the therapeutic relationship therefore supports the aim of this thesis: that is to investigate the nature and context of the therapeutic relationship from the perspective of adults with anorexia nervosa. The next chapter will discuss what I viewed to be an appropriate research methodology to investigate this phenomenon: constructivist grounded theory.

Chapter Four

Developing a methodology: theoretical underpinnings

4.1. Introduction

This chapter is the first of three methodological chapters. I begin this chapter by presenting my position as a researcher within this study and consider my philosophical stance in respect to my beliefs about the nature and generation of knowledge. I then move on to detail the theoretical foundations of the study and outline the theory and justification for the methodology and research methods I used: constructivist grounded theory (Charmaz 2006, 2014) combined with online research methods (Walker 2013a, 2013b, Hewson et al. 2016). In addition, I also explore the importance of being a reflexive researcher in relation to my own professional background.

As outlined in chapter one, adults with anorexia nervosa were recruited for this study through a UK eating disorder charity. A bespoke website was used to interact asynchronously with the study participants. The primary source of data was comprised of written accounts of participant experiences of the therapeutic relationship. Data were gathered over three phases. In addition, existing written documentation in the form of published autobiographies and online blogs written by people with eating disorders was used both as primary and secondary data.

4.2. Positioning myself as a researcher

During the early planning stage of this study I spent some time considering what my personal and professional philosophical beliefs and position were regarding the nature and construction of knowledge. This was important to consider in light of the research methods I ultimately used in the study to ensure that these were congruent with my own philosophical stance (Birks and Mills 2011, 2015). In addition, it was also important for me to recognise

how my own beliefs about knowledge construction influenced the design and direction that the study took (Creswell 2007).

Working as an occupational therapist in mental health services for many years, I have been privileged to explore the subjective lives of the people I have worked with. I quickly learnt that each of these people had an individual, personal interpretation of the experience of their illness as well as the context of their history and the environment they lived in. Working in collaboration with the individual to understanding the meaning underpinning the experience of their illness is a fundamental element of the problem-solving process of occupational therapy. Moreover, acknowledging the numerous realities of people's lives and experiences and using this knowledge to work in a client centred way is a central tenet of the occupational therapy philosophy (Sumsion 2006, Kielhofner 2008). Thus, undertaking qualitative inquiry in this study was a natural fit that aligned closely to the philosophical background of my profession.

The aim of qualitative research is to "make sense of, or interpret, phenomena in terms of the meanings people bring to them" (Denzin and Lincoln 1994 p 2). In doing so, qualitative inquiry illuminates how individuals construct and attach meaning to their experiences, it elucidates how systems function and explores how context is critical to understanding the phenomena being studied. Using peoples' stories and perspectives allows the qualitative researcher to develop in-depth knowledge and "open a window into the world of the case being studied" (Patton 2015 p13).

Therefore, deciding to undertake a qualitative research study led to me to consider two key philosophical questions about the nature of the qualitative research I intended to undertake. First, what did I consider to be the ontology, or in other words what is the nature of reality for individuals? (Creswell 2007). As mentioned, I have always accepted that reality is subjective and interpreted in diverse ways. Therefore, this means that there are multiple, often conflicting realities experienced by individuals that are also contingent on time and cultural location (Stainton-Rogers 2006). Denzin and Lincoln (1994) describe this as a relativist

ontology. However, despite the differences in realities, there are nonetheless, meaningful constructions of what is real within the minds of individuals (Schwandt 1994). Thus, for me as an occupational therapist as well as an emerging researcher, I believe that the nature of reality is what the individual perceives it to be. This reality is constructed through one's experiences and interactions within the world (Charmaz 2014). Hence, I began the process of planning this study knowing that I wanted to find out about the participants' reality that was based on their knowledge of the topic in question; namely people with anorexia nervosa and their experiences of developing therapeutic relationships with therapists and health care professionals. Therefore, accepting this relativist position about the nature of knowledge underpinned my consideration of the diversity of the participants' experiences and the individual interpretations they placed on their experiences (Finlay 2006a).

The second key philosophical question I considered was in relation to the epistemological stance of this study. In other words, what would be the relationship between myself as the researcher and the participants being researched and how would the nature of the knowledge be developed and justified (Birks and Mills 2011). In answering this, I recognised that it was important for me to understand that I wasn't interpreting the participants' reality of their experience as an objective researcher. Rather, through the process of collecting and analysing data I was, in fact constructing or re-creating an interpretation of the participants' experience. I was therefore not a neutral player in my approach to the study (Charmaz 2006). I brought to it my background knowledge and beliefs of working with people with eating disorders and a prior interest in the therapeutic relationship as a key aspect of therapy. The construction of knowledge was thus developed through the process of interaction between myself and the participants. Using my background knowledge and skills as a therapist as well as those of the researcher, I developed online relationships with the participants, consequently closing the distance between myself and those I based the research on (Creswell 2007).

Thus, the construction of knowledge in this study was an interactive process carried out between the participants and myself and the study design was developed within the context of my own personal and work experience, gender, social and cultural environments (Denzin and Lincoln 1994, Guba and Lincoln 1994, Birks and Mills 2011). For this reason, the need for me to be a reflexive researcher has been paramount throughout the study and is further detailed within this chapter (Birks and Mills 2015).

In addition, by being open about my values, beliefs and prior knowledge in the construction of the theoretical knowledge in this study, I aimed to be clear how this has influenced the interpretation of the participant contributions (Creswell 2007). The intention, therefore, was to develop a consensus construction of knowledge that attempted to explicate an informed and detailed interpretation of the participants' experience (Guba and Lincoln 1994). As such, I would act as a "conduit" for making the voices of my participants heard (Denzin and Lincoln 1994 p15).

Considering my own ontological and epistemological position in relation to this study then led me to consider how these philosophical assumptions influenced my choice of theoretical paradigm and subsequent research methodology and methods. Accordingly, this study is situated within a constructivist paradigm (Denzin and Lincoln 1994). The central principles of the constructivist paradigm are:

- There are multiple realities of knowledge (Denzin and Lincoln 1994)

- Knowledge is co – constructed between the researcher and the participant. This construction of knowledge is subject to continuous revision (Guba and Lincoln 1994).

- Meanings are multiple and varied, thus leading the researcher to examine the complexity of the phenomena under investigation (Creswell 2007).

- Meaning is not created or discovered. It is constructed through the engagement with the world as one interprets it (Crotty 2003).

- Meaning and understanding is developed through interactions with others and are situated within social and cultural contexts (Creswell 2007).

- Theories or patterns of meaning are developed inductively and are generated or grounded in the data that is examined (Creswell 2007).

- Researchers recognise themselves within the research process and how their knowledge, beliefs and values shape the direction and subsequent meaning of the subject of the research (Creswell 2007).

- The quality of the research undertaken in this paradigm is evaluated against the criteria of trustworthiness and authenticity (Guba and Lincoln 1994).

Thus, this constructivist paradigm or "net" contains the ontological and epistemological basis for my study and underpins the beliefs about knowledge construction as previously detailed (Denzin and Lincoln 1994 p13). These beliefs and principles guided the design of the study and my subsequent actions as a researcher. In addition, Birks and Mills (2011) assert the importance of the researcher being aware of their philosophical position to maintain congruence throughout the research process. Hence when considering an appropriate research methodology for this study I was drawn to the writings of Kathy Charmaz and her presentation of constructivist grounded theory (Charmaz 2006, 2014).

4.3. Constructivist grounded theory

The methodology of grounded theory was originally presented in 1967 by Glaser and Strauss in the publication of *The Discovery of Grounded Theory.* In this book, they offered a framework for undertaking a rigorous, systematic and structured approach towards analysing qualitative data. The aim of grounded theory as a research methodology was espoused to discover or develop theoretical understanding of social phenomena that moved beyond description into theories that held analytic and explanatory power (Glaser and Strauss 1967). At the time, grounded theory methodology provided a powerful justification of the

acceptability of qualitative research in its own right rather than primarily as a precursor to developing quantitative measures for research (Charmaz 2006). Table 1 outlines the principle key tenets underpinning grounded theory methodology and its essential research methods.

Key tenets of grounded theory methodology
- A methodology that promotes a systematic and rigorous approach to gathering and analysing qualitative data.   - The development of a theory that is recognisable to those involved with the phenomena and fits with their experience.   - The development of analytic coding and categorisation of data that is derived from the data rather than from preconceived hypotheses.   - The theory is developed iteratively through a concurrent process of data collection and analysis. Emergent concepts are followed up in subsequent phases of the study.   - The theory development is directed through theoretical sampling resulting in the resulting theory that is grounded in the data.   - The identification of a core category that explains the grounded theory in its entirety.   - The degree of the presence of the researcher in grounded theory; theoretical sensitivity (Glaser and Strauss (1967), reflexivity (Charmaz 2006, 2014).
Essential research methods used in grounded theory
Coding of data: a process of identifying and defining the data. The use of gerunds and in vivo coding (participant words) is common.   **The constant comparative method**: a concurrent process of data collection and analysis that compares incidents, codes, categories iteratively across the data set until the grounded theory is fully integrated   **Memo-writing**: a pivotal ongoing writing activity that ultimately constructs into the theoretical findings of the study. They are composed of participant quotes, researcher thinking and analysis and ongoing theoretical development. Writing memos moves description into conceptual analytic development in the process of theory development.   **Theoretical sampling**: the process of seeking to develop the properties of the emerging categories. The researcher seeks people, information and alternative sources of data to provide the richest material to develop the theoretical analysis. The sampling is driven by the categories rather than representation from the sample population.   **Theoretical saturation**: the point at which gathering additional data about a theoretical category does not add any new theoretical insights to the developing theory.

Table 1: Principle tenets and essential methods used in grounded theory. Adapted from: Glaser and Strauss (1967), Charmaz (2006), Creswell (2007), Corbin and Strauss (2008), Birks and Mills (2011), Charmaz (2014), Birks and Mills (2015).

Often known as classical grounded theory, Glaser and Strauss's (1967) original methodology has been described as lying within a post positivist paradigm (Creswell 2007). This methodology has since continued to be debated, refined and developed. Anselm Strauss moved on to work with Juliet Corbin (Strauss and Corbin 1990, 1998, Corbin and Strauss 2008) and within recent years grounded theory researchers such as Kathy Charmaz further developed the methodology to advocate a more constructivist approach to using grounded theory (Charmaz 2003, 2006, Bryant and Charmaz 2007, Charmaz 2009, Charmaz 2014).

The constructivist approach to grounded theory still maintains the key tenets of the original grounded theory methodology, but it is philosophically positioned more overtly in a constructivist approach to qualitative research. Where this approach differs, therefore, is in the assumption that knowledge is not just out there waiting to be *discovered* by the researcher, but is instead *constructed* through the meaning people make of their experiences and their perception of the social world. Therefore, the starting supposition is that the reality of participants is multiple and constructed through the process of the interaction between the researcher and the participants. This means that the presence of the researcher in the design and process of the research as well as the knowledge construction in the form of the theory is an acknowledged and accepted aspect of the process (Charmaz 2006, 2014). A further proposition in using a constructivist approach to grounded theory is that it continues to provide the researcher with a set of skills and methods to use that maintain a structured and systematic approach to the research. Equally, though, it is suggested that the researcher can use these methods more flexibly than suggested by the earlier grounded theorists as presented by Glaser and Strauss in 1967 (Charmaz 2014).

Consequently, deciding to pursue the use of a constructivist grounded theory methodology for the premise of this study was made primarily for two reasons. First, the philosophical

underpinnings of the method fitted with my own beliefs about the nature and construction of knowledge as previously detailed. Additionally, this methodology allowed me to acknowledge and utilise my previous knowledge and beliefs about the phenomenon I wanted to investigate. Second, as I discussed in chapter two, during the planning stages of the study, I undertook a broad review of literature associated with the therapeutic relationship and eating disorders. What I concluded from that review was that although there was research that suggested that the therapeutic relationship was viewed as an important aspect of the experiences of people using eating disorder services, there was little qualitative research that focused specifically on the details of the nature and context of that relationship from the perspective of service users. Therefore, I considered that using a constructivist grounded theory methodology in this study would be appropriate in generating a substantive theoretical understanding of this phenomena in relation to adults with eating disorders and ultimately anorexia nervosa specifically (Birks and Mills 2011, 2015, Charmaz 2006, Corbin and Strauss 2008, Creswell 2007). Nonetheless as part of the justification of the appropriateness of constructivist grounded theory for this study, I felt it was important to consider alternative methodologies and research methods.

4.4. Consideration of alternative qualitative research methodologies

As previously outlined in chapter two there was no one clear methodological direction indicated from the original literature reviewed that I could have pursued in this study. Therefore, although I had clear justification for choosing to use constructivist grounded theory I could have also considered using two alternative qualitative research methods: narrative research and phenomenology.

Narrative research has been described as both a product of qualitative research as well as a method (Creswell 2007). As a method, stories or narratives can be used to develop understanding of a social phenomenon or the experiences and events in people's lives (Flick 2014). Narratives are typically gathered using semi structured interviews from one or two

individuals; the data collected reports on their life or event experiences and is often configured through analysis in a chronological way to explain the meaning of those experiences through the life course. Thus, narrative enquiry is best suited to capturing the detail of individual life stories or events (Creswell 2007). Although I used participant written accounts, arguably stories, as well as autobiographical material and personal online blogs as data in my study, what I set out to do was develop a theoretical understanding of key concepts of the therapeutic relationship. This theoretical understanding developed over the analysis of numerous written accounts that built on the phenomenon of the therapeutic relationship rather than consider the life course of a small number of people with anorexia nervosa and their experiences of relationships with therapists over the course of their illness. Although the participants in my study did in fact write about their life history, particularly how they developed their illness, this data was not used in the analysis and development of the theory in relation to the therapeutic relationship although at times it did provide relevant contextual background to their contributions.

Phenomenology is an umbrella term that describes a philosophical movement as well as a range of research methods (Finlay and Ballinger 2006). It is a methodology that is concerned with the lived experience of the individual. It aims to describe the meaning ascribed to the experiences of a phenomena and to extricate the central meaning or essence of that experience that typifies the experiences of all the participants in the study being undertaken (Creswell 2007). The aim of phenomenology is to provide a "rich, textured experience of the lived experience" (Finlay and Ballinger 2006 p262). There are several approaches to phenomenology, often cited is hermeneutical phenomenology (van Manen 1990 cited in Creswell 2007). Broadly speaking, research is orientated to the lived experience or phenomenology of the texts of life (the hermeneutics). Although description of the phenomena is sought, there is also acknowledgement of the interpretative process that the researcher undertakes in explicating meanings from participants' experiences. The issue of the researcher bracketing out their prior knowledge and experiences of the phenomena

under investigation is highlighted in phenomenology although different approaches to phenomenology emphasises the necessity to do this. Although there are some similarities in the processes of gathering data between phenomenology and grounded theory, such as using broad based open ended questions to gather data that are not based on preconceived ideas, grounded theory methods are not concerned with understanding and explicating the meaning of the lived experience of the individual but rather use the data generated to develop conceptual codes and categories from across the data set in order to develop theoretical understanding of the phenomena under investigation. In contrast to grounded theory, data analysis in phenomenology may be undertaken using a frame of themes or dimensions that act as a lens through which to view the data (Finlay 2006b). Through a process of in-depth description, the researcher aims to bring the lived experience of the individual alive by developing layers of meaning that explore and capture the complexity of the specific experience (Finlay 2006b).

Arguably, I could have legitimately chosen to use either of these qualitative research methodologies for my study. However, returning to the original aims of my study justified my choice of using a grounded theory methodology. I aimed to examine the specific nature and context of the therapeutic relationship that was perceived as helpful by adults with anorexia nervosa, rather than examine the lived experience, meaning or life course of experiencing an eating disorder and working with therapists. Grounded theory offered both a theoretical methodology and system of research methods to develop a concept driven, theoretical understanding of the components and nuances of the therapeutic relationship.

4.5. Reflexivity in constructivist grounded theory

As previously noted, the presence of the researcher and the role they play in the construction of knowledge in constructivist grounded theory is overtly acknowledged (Charmaz 2006, 2014). Indeed, it is suggested that researcher reflexivity in qualitative

research is viewed as an opportunity for the researcher rather than as a problem (Finlay 2006c).

Reflexivity in constructivist grounded theory has been defined as:

"The researcher's scrutiny of his or her research experience, decisions, and interpretations in ways that bring the researcher into the process and allow the reader to assess how and to what extent the researcher's interests, positions and assumptions influenced the inquiry. A reflexive stance informs how the researcher conducts his or her research, relates to the research participants, and represents them in written reports."

(Charmaz 2006 p188)

Due both to the nature of the participants in this study and my background as an occupational therapist, reflexivity was a significant factor for me to consider throughout this study (Birks and Mills 2011, 2015). Thus, I recognised that as a researcher I was not a neutral, value free observer in the research process (Charmaz 2014). Rather, I brought my position, my perspectives and interactions as a researcher as well as an occupational therapist, a female and a member of western culture to this study. Therefore, adopting a reflexive approach throughout the study allowed me to consider the impact that my background as a therapist and my assumptions and beliefs about the nature of the therapeutic relationship in respect to working with people with eating disorders had on the development of the theory I ultimately constructed. In addition, considering the dynamic of the research relationship that developed between myself as a researcher and the participants was vital (Finlay 2006c). This dynamic is considered further in chapter five where I discuss issues that arose during the process of data collection that challenged my beliefs about my role as a researcher versus my role as an occupational therapist.

Thus, to capture the decisions I made throughout the study, and maintain a logical congruence of the methods I used, I kept a detailed written log of each phase of data collection and analysis. This account captured my thoughts, feelings and the reasoning underpinning actions I took, as well as wider theoretical considerations and feedback from my supervisors. This written log is akin to what Birks and Mills (2011) refer to as reflexive memos and I found this process crucial in establishing reflexivity throughout the study. Indeed, it is suggested that writing reflexive memos is the "most truthful and methodologically congruent way" to account for the researcher's actions and decisions when using grounded theory methods (Birks and Mills 2011 p55). The content of these memos is considered further in chapter five where I also discuss how I used grounded theory methods in more detail.

4.6. Choosing an appropriate data collection method

As I previously mentioned, one of the considerations that led me to decide to use constructivist grounded theory methods in this study was due to its use of "systematic, yet flexible guidelines for collecting and analysing qualitative data" (Charmaz 2014 p1). Constructivist grounded theory methods offer a set of general principles, guidelines, strategies and investigative devices rather than prescribe formulaic procedures. Similarly, what constitutes data in grounded theory can be characteristically diverse. Typical sources of data may include transcripts of interviews and focus group discussions, researcher field notes and memos, documents, diaries, literature, music and artwork (Birks and Mills 2015).

When planning this study, I initially assumed that the most appropriate way to gather data from participants with eating disorders would be through face to face interviews. As one of the most common sources of data generation in grounded theory, the value of undertaking in-depth interviewing of participants can be evidenced by this extensive use (Charmaz 2006, Corbin and Strauss 2008, Birks and Mills 2011, 2015). Likewise, it has been suggested that

the best and most powerful way to engage with research participants to construct understanding and knowledge of their worlds is through the interactive face to face encounter between the participant and the researcher (Miller and Glassner 2004, James and Busher 2009). However, I had concerns that because I had previously worked as an occupational therapist in local eating disorder services, I could potentially have knowledge of prospective participants and their therapists working in these areas. This familiarity with the local services worried me as I considered that this could potentially impact on the willingness of people to participate in the study. This suggested to me that I needed to be able to recruit participants from a wider geographical area. In addition, I needed to consider alternative ways of being able to protect the participants' anonymity. I therefore began to consider the possibility of using remote interviewing through Skype, telephone or email as an alternative method of data gathering. It struck me that the typical demographic of people with eating disorders is young and female (NHS Choices 2013) and that using technology based interactions may appeal to them more than face to face interviewing. It is suggested that this age and gender group naturally tend to use technology to communicate and studies show that females, in particular, tend to use the telephone in a more relationship focused way than men (King and Horrocks 2010). Therefore, I made the assumption that they may be more comfortable to undertake an interview through this medium. However, I was also aware that undertaking interviews via skype or telephone would not address the issue of participant anonymity. Thus, I began to consider the use of online research methods as a viable alternative to face to face and telephone or remote interviews. With the increased availability of online social media sites, blogs and discussion forums these online research methods can legitimately be used for data generation in grounded theory (Meho 2006, King and Horrocks 2010, Charmaz 2014, Birks and Mills 2015).

4.7 Generating qualitative data using online research methods

In recent years, technology has transformed communication systems using the internet and the World Wide Web (or the web as it is often referred to). In simple terms, the web is a system of interlinked websites which are located on the internet (Gaiser and Schreiner 2009). In the past three decades, there has been an increased use and availability of the internet across the world and it is now used widely both as a primary source of information as well as a communication system. Indeed, the estimated use of the internet across the world is thought to have grown from several hundred million in 2003 to over two billion in 2013 (Hewson et al. 2016). The potential of the internet for both conducting primary and secondary research has been developing since the 1990s. The most common online research methods being surveys and questionnaires (Hewson et al. 2002). However, in the last decade the potential for using the internet in qualitative research has also been recognised (Markham 2004), although it is still considered to be evolving as a research method (Hewson et al. 2016).

In terms of the potential use of the internet in health-related research it was noted as far back as 2004, that 111 million people in the United States accessed the internet to obtain information about health issues (Hamilton and Bowers 2006). Given the acceleration of internet use in recent years, this figure is likely to be significantly higher today but nonetheless suggests that as well as a source of information, the internet can also provide the forum to develop online information and support groups and communities for those suffering from specific health conditions (Eysenbach et al. 2004, Martin et al. 2011, Gambling and Long 2012, 2013). Moreover, this suggests that the internet can therefore provide an opportunity to be used both as a source of data for health-related research as well being a location for recruiting and communicating with potential research participants (Walstrom 2004, Hamilton and Bowers 2006, Mendelson 2006). In addition, the internet has the potential to enable access to what are known as hard-to-reach or hidden populations or when researchers want to access potentially sensitive issues with participants (Sydor 2013,

Hewson et al. 2016). Arguably, people with eating disorders could be considered as such due to the secretive nature of their disorders and their reluctance to engage with health services (Palmer 2000).

As well as accessing potential participants through the internet, it is suggested that there are many ways to gather research data using internet or online research methods (James and Busher 2009, Hewson et al. 2016). Traditional qualitative research methods have been adapted for online data gathering such as one to one email interviews, online focus groups, email and online surveys and the collection of elicited or solicited texts and personal stories (Mann and Stewart 2000, Charmaz 2006, Gaiser and Schreiner 2009, Long and Bennett 2009, Walker 2013a, Hewson et al. 2016). Each online research method has its own epistemological, methodological and ethical issues and challenges to consider, but this is no different than with other types of qualitative research design. As Hamilton and Bower (2006) discuss face to face interviews can be underpinned by different theoretical philosophies. This can impact on the way questions are constructed and how subsequent knowledge may be constructed. Therefore, they suggest that the same principle is relevant to online communication in research. Indeed, they suggest that the ability of the researcher to transfer these principles to online based data gathering "simply becomes one more skill development in the craftsmanship of interviewing" (Hamilton and Bowers 2006 p 827).

Accordingly, data can be generated through a range of different online research methods. Bryman (2012) makes the distinction between web-based and communication-based systems. Web-based research is a method whereby the research is conducted via a web page. The participant interacts through the web page as opposed to direct e-mail communication with the researcher or other participants. In my study, I have used both methods. First, as mentioned in the beginning of this chapter a dedicated web site called TherRel was developed for participants to use anonymously. Second, the participants were also able to communicate with me directly if they chose to through a dedicated e-mail address. The development of the TherRel website is discussed further in chapter five.

Mann and Stewart (2000) discuss the use of computer-mediated communication in the generation of qualitative data. They define this as the "direct use of a computer in a text based communication process" (p2). The most common forms of computer-mediated communication are synchronous and asynchronous communication methods. Synchronous communication refers to "real time chat" (Mann and Stewart 2000 p2). This is where there is simultaneous exchange between two or more respondents who are logged on to different computer terminals at the same time. An example of this would be an online live chat room discussion or forum. Asynchronous communication refers to written interaction that is transmitted to recipients who then respond in their own time, the most common form being traditional email messaging. The value of asynchronous online communication as a research method is argued by James and Busher (2009 p28)

> "If researchers wish to understand in depth the experiences and identities of individual participants in their voice, then asynchronous modes of online communication such as email interviewing can at the very least generate more considered narratives and rich discourse that is reflective, analytical and creative providing a depth that might be absent in uttered data."

Bearing this assertion in mind, I began to consider the potential of using online asynchronous research methods as the primary source of data generation in this study and specifically considered the relevance of using these methods with people with eating disorders.

As I have previously mentioned, asynchronous communication takes place between individuals at different times but through a shared web space such as a message board on a website or through e-mail exchange. These communications can be carried out on a one to one basis in the form of an interview between the researcher and the participant or as a group discussion amongst online participants. In these cases, discussion is based in non-real time and therefore asynchronous communication methods can generate rich, reflective and considered data as the participants have more time to consider, write and edit their

contributions (Mann and Stewart 2000, James and Busher 2009, Hewson et al. 2016). Thus, online written data can be elicited using semi-structured questions supplemented with probes and follow up questions which help to explore and gain access to more in depth understanding from participants as in face to face interviews (James and Busher 2009, Hewson et al. 2016). Written texts can also be returned to participants and further questions asked, therefore, encouraging an iterative process of revisiting and moving back and forth through narratives as akin to grounded theory methods (Charmaz 2003, 2006).

Furthermore, during the planning stages of this study I became aware of research by Long and Bennett (2009) who had gathered in-depth written accounts from participants in respect to their experiences of living with a chronic health condition. This method of collecting data resonated with me as eating disorder treatments such as cognitive behavioural therapy often utilise written diaries and accounts of patients' experiences, thoughts and feelings (Fairburn 2008). These interventions for eating disorders are also being delivered as internet based treatments. Therefore, using a form of online communication in research can provide a familiar forum for people with eating disorders (Johnston et al. 2010, Dölemeyer et al. 2013, Kendal et al. 2017). In addition, I considered that this method of obtaining in-depth written accounts of participants' experiences could be appropriate to the aims of the study and may also appeal to people with eating disorders as writing may be a preferred medium for sharing their experiences. In the study by Long and Bennett (2009) a website was utilised to advertise the recruitment of participants via a national charity and self-help support group. Guidance as to what was to be included in the written account was given in the form of prompts, although the participants were also encouraged to write about their experiences in any way they wished. This method was successful in gaining an in-depth insight into the lives of people with chronic illness and its strength was viewed as being based on participants own stories as they chose to tell them at that moment in time, thus eliciting its own credibility and truthfulness. The authors however, did recognise that the accounts

elicited only related to those who saw the advertisement for the study and therefore chose to participate (Long and Bennett 2009).

Another example of a study that researched the use of asynchronous online communication methods with people with eating disorders specifically, is described by Walstrom (2004). This study considered participants' experiences of using an online eating disorder support group. The results of the study suggest that participants found the online forum validating of their perspectives and representative of their own voices. Thus, the participants found that their self-understanding was enhanced through the process of writing rich descriptions of their experiences. A further study by Johnstone et al. (2010) utilised email exchange and internet websites to recruit and communicate with people with eating disorders in order to research the effectiveness of the use of therapeutic writing in the remote treatment of bulimia nervosa. From a methodological perspective, they suggested that using internet-based methods may be more acceptable to participants when they are disclosing potentially stressful experiences as they possibly could be in my study. This view is also held by Sydor (2013) and Hewson et al. (2016) who suggest that online research methods can be useful for discussing sensitive issues with hard to reach participants. In addition, responses from the participants in the study by Johnstone at al. (2010) also suggested that undertaking remote writing tasks was a less humiliating experience than disclosing information through face to face contact. A more recent study analysed how young people with eating disorders used an online pro- recovery discussion forum for support with their eating disorders (Kendal et al. 2017). Methodologically, it was concluded that moderated online discussion forums can be a safe, anonymous and trusted environment for young people to offer mutual support and disclosure.

Therefore, although there was limited evidence in using asynchronous online research methods with people with eating disorders, these studies suggested to me that there were some sound methodological benefits for doing so. However, I also felt that it was important to consider the wider benefits and drawbacks of using asynchronous online research

methods before I commenced with this as my primary data collection method in this study. Additional reflections on the application of these methods are also detailed in chapter five.

As I previously outlined I was concerned about accessing potential participants that I may have knowledge of or knowledge of their therapists. Therefore, accessing participants anonymously via the internet from a wide geographical base could be an advantage for recruitment (Hamilton and Bowers 2006, Walker 2013a). It is also suggested that online data gathering is cheaper to carry out and can be potentially less time consuming than face to face interviewing (James and Busher 2009, Bryman 2012). Certainly, travel time and costs as well as the time needed for transcription of audio interviews have been negated in this study, although it is important to note that I have still had to immerse myself in the participant contributions through frequent reading to familiarise myself with the data (Braun and Clarke 2006). On reflection, I have also realised that a further advantage for me as a sole researcher has been the ready availability of access to the equipment and technological support necessary to utilise online research methods in a safe and ethical manner. Gaining access to both the participants and the subsequent data generated was an ongoing and flexible process, managed over a period of three years. This had an additional advantage to me as a part time researcher, as I could manage the data collection and analysis phases in a timely way and it also meant that the participants could dip in and out of the study at their convenience. However, the assumption that gathering online data would take less of my time has not necessarily been true and is discussed further in chapter five where I reflect on managing online research relationships with participants.

A further issue that needed to be considered was that the use of asynchronous internet research methods does assume a level of computer and written literacy from potential participants. The participants also needed to be familiar with the level of technology required, have access to a computer and be willing to write about their experiences. Therefore, I was aware that using these methods may exclude other potential participants who would prefer to talk about their experiences. Hamilton and Bowers (2006) suggest that to develop a

respectful relationship with participants and to acknowledge the time and effort they give in taking part in research it can be helpful to allow participants to have a measure of control in how the data is gathered. Therefore, although online methods may be beneficial to use as a primary data collection method it may be necessary for researchers to be flexible to accommodate participants' individual needs. However, this flexibility would also need to be considered in terms of a study's methodological integrity and congruence (Birks and Mills 2015). In my study, I did not offer an alternative method of data collection, such as face to face interviews. I discuss this decision further in chapter five.

A further deliberation I made when choosing to use online research methods is described by James and Busher (2009) as the consideration of temporal dimensions of online research. This issue contemplates the time frames that the participants and researcher interact within. In face to face research interviews or real time synchronous online communication, interaction is instantaneous with participants having little time to consider their responses to questions, thus contributions may be guarded or be less serious than if the participant is less pressured to answer there and then (Hewson et al. 2016). Using asynchronous methods of communication allows participants more time to consider their responses and write their contributions. They can also re-read, change and edit their texts and reflect on their stories and responses before submission. In my study, several of the participants contacted me through email to ask me further questions about the study and to check out when they could contribute and if it was acceptable to take their time to consider what they wanted to write. Hewson et al. (2002) suggest that having time to prepare and write down answers may be less threatening for participants as their contributions are made in their own time rather than the interviewer's, therefore maintaining a level of control over how they contribute. Although this can be a benefit of using asynchronous online communication, conversely, the disadvantage is that the flow of interaction can be lost which could impact on the development of rapport and the immediacy of response; factors that are viewed as important

in both face to face interviewing and synchronous live time communication online (James and Busher 2009).

Bearing these issues in mind, as a former therapist who relied on the development of rapport in face to face interviews with clients myself, I was initially concerned that I would not be able to re-create these aspects of a face to face interview and that this could potentially impact on the quality of the data collected. However, reflecting now on the three phases of the data gathering, I do not feel this has been the case. The online interactions between myself and the participants have been more individualised and personal than I envisaged they would be. All bar one participant contacted me directly through email prior to contributing to the study, despite the option to participate with complete anonymity via the TherRel web site. We engaged in e-mail communication and some of the participants disclosed information about themselves which was not specifically in the remit of the study, for example, information about their current struggles with their eating disorders and how they were getting on at university. I believe this level of communication impacted positively on the online relationship that I felt I developed with the participants; helped them to engage with the study and subsequently on my interpretation of the written data they disclosed. Nevertheless, the dilemmas of being an objective, faceless researcher and a former therapist working with people with eating disorders has been an issue for me at times during the study: this issue is further considered in chapter five.

In addition to the benefits for the participants in relation to having time to consider and submit their contributions, the time intervals between participant contributions also gave me the opportunity to carry out the analysis in phases. Thus, each contribution was analysed on receipt, subsequently allowing me to return to participants to elicit additional depth around emerging ideas and themes, thus shaping the direction of the study.   In that respect, using asynchronous online methods fitted well with the iterative and comparative methods of grounded theory (Hamilton and Bowers 2006, Charmaz 2006, Charmaz, 2014). How I undertook the analysis of the data is detailed in chapter six.

A further advantage of using online asynchronous research methods is that they may break down barriers in respect to power relations between the researcher and participant (James and Busher 2009). So, for example, the internet can offer a level playing field to participants who may then feel on a more equal footing to the researcher due to their anonymity (Hamilton and Bowers 2006). Issues of control are often central to the maintaining characteristics of anorexia nervosa, therefore I considered that using online research methods could offer the participants an opportunity to enter into a collaborative style of research and enhance their feelings of control in the research process (Hewson et al. 2002, Dölemeyer et al. 2013).

Although there were clear methodological reasons for using online research methods in this study there was also one issue that required further consideration as a potential disadvantage. That was the inability to authenticate the participants and their contributions on a face to face basis (Mann and Stewart 2000, Hamilton and Bowers 2006).

4.8. Considering authenticity of participants in online research

Due to the anonymous nature of contributing to an online research study it has been suggested that this anonymity may also give rise to possible "data fraud" (Hamilton and Bowers (2006 p824). This may take the form of people posing as research participants or representing themselves in ways that are difficult to authenticate (James and Busher 2006). In addition, writing can be seen as the process of creating an identity and writing online can allow the possibility of people to create multiple identities or conversely produce a one-dimensional representation that is lacking in normal interactive processes (James and Busher 2009). In other words, there is the potential for participants to represent themselves online in any way they want to, without the researcher being able to verify who they are or the truthfulness of their contributions. In terms of face to face research relationships, knowing the identity of those who you are communicating with can aid in the understanding

of their story whereas in the "disembodied virtual world, identity can become ambiguous" (James and Busher 2009 p71). However, they also cite Kendall (1999 p72) who contests this view as a legitimate issue, pointing out that "individuals have always engaged in different representations of self and did so before the existence of the virtual world". Similarly, Hamilton and Bowers (2002) assert that this kind of participant misrepresentation can also occur in face to face communication. Indeed, as previously discussed, being able to conceal your identity is also why some people seek to communicate and interact online as it can aid interaction and connect individuals to others, therefore being particularly useful if participants find it difficult to talk about their experiences (Meho 2006, Johnstone et al. 2010, Dölemeyer et al. 2013, Hewson et al. 2016). In fact, it is suggested that being able to mask your identity may lead participants to be more open in their self-disclosure (Charmaz 2006, James and Busher 2006). I considered that this issue of representation of the self may be a factor with people suffering from anorexia nervosa as it is generally a secretive disorder that people often have difficulty in disclosing (Fairburn 2008). Anecdotally, and as I have discovered during the process of carrying out this research study, there are numerous bloggers and people using social networking sites such as Twitter that openly share their experiences of having an eating disorder. The fact that they may do so under an assumed name or hidden identity does not necessarily diminish their experience or put in to question their motivation for communicating in this way. Thus, I considered the advantages to potential participants in using asynchronous online methods outweighed the potential risk of data fraud and may in fact be an advantage to participants to "have the confidence to say more than they would risk in the ad hoc self – representation that is possible face to face" (Mann and Stewart 2000 p 210).

A further consideration in the debate around authenticity of the representation of the self in online research is that of accepting participant narratives at face value in the absence of having supplementary information such as nonverbal cues and communication that may be available through face to face interactions (James and Busher 2006). Therefore, it is argued

that adopting normal methods of triangulation such as observing and participating in the social situations that are being explored, with mutual disclosure and repeated interactions can provide reassurance regarding the authenticity and trustworthiness of participants' written accounts. This process is referred to as the researcher's "investment into the research relationship" (James and Busher 2006 p78). Contrary to this view, Hine (2000), argued that online accounts and identities are valid in themselves and do not need to be verified off line. Indeed, authenticating online data can be no more problematical than authenticating any other data. Therefore, James and Busher (2006) concede that "by working hard to develop research relationships online, researchers can gauge the sincerity; authenticity and individuality of the disembodied research participant" (p79).

In my study, I feel that the investment I made with each participant through e-mail interaction, which involved following up their initial stories with additional questions and gathering data over three phases, was an important process in feeling confident in the authenticity of both the participants and their written contributions. In addition, I gathered multiple accounts from some participants and used existing documentation such as autobiographies and online blogs to supplement and inform the data and emerging analysis. Lee (2006) refers to this collection of additional data to verify online accounts as gathering patterned knowledge. Gathering additional information from participants through e-mail interviewing was not a process I had initially considered but it has been valuable in checking out the meaning of some participants' contributions and augmenting the original stories that were submitted. This process aided the relationship building between myself and the participants, added depth to their written accounts and helped me to feel confident in the credibility of the data that was collected.

Busher and James (2009) also discuss the use of participant and researcher self-disclosure as a way of enhancing the relationship online, which they suggest, can aid the authenticity of the narrative from participants. They propose that the intense sharing of experiences can replace the interpersonal interaction that is the basis of face to face interactions. However,

this stance on self-disclosure from a researcher point of view raises issues about the role of the researcher, particularly in relation to working with potentially vulnerable participants. In the case of my research study, I did not deem it to be appropriate to self-disclose and in fact it was not necessary. I considered that taking a reflexive stance that used my knowledge of people with eating disorders to enhance the quality of the online interactions and subsequent consideration of the credibility of the data that was gathered, was a more appropriate approach to take (Mruck and Mey 2007). I did this through the careful and considered way I communicated with the participants online; this ensured I maintained appropriate research boundaries whilst showing genuine concern and interest in the participants and their contributions.

Therefore, although there is debate regarding the establishment of authenticity and credibility or trustworthiness of online data, it is suggested that further triangulation of findings using offline methods can be useful to aid this process. As mentioned, the use of follow up face to face interviews may be appropriate and the relationship developed through the online interactions can be helpful in gaining confidence in engaging participants to take part in interviews. Nonetheless, it should not be assumed that additional triangulation in this way will simply verify online accounts. Indeed, it is suggested that researchers should in fact accept at face value that online interactions are an authentic experience of the self as would generally be the case in a face to face interview (Hine 2000). Although being flexible to participant requests and preferences in terms of how data is generated can help enhance online relationships and increase ownership of a study, as I previously mentioned, it is also important to maintain methodological congruence within a study. Further considerations of the trustworthiness of the findings and theory that is presented in this study are discussed in chapter six.

Thinking through all the above issues, it seemed apparent to me that the benefits of utilising asynchronous online research methods outweighed the disadvantages and could potentially increase the success in the recruitment of adults with anorexia nervosa for this study. As

previously mentioned this group of individuals could arguably be viewed as a hard-to-reach research population in terms of the potentially sensitive nature of their experiences, the secretive nature of their disorders and their accessibility (Fairburn 2008, Palmer 2014, Sydor 2013, Hewson et al. 2016). In addition, writing about their experiences may be a familiar and preferred media for potential participants, although I was also aware that making this decision would exclude people who would prefer to use verbal interaction. Following the decision to use asynchronous online research methods as the primary method of data collection, I then turned my attention to considering in what form the written data would be collected.

4.9. Using elicited and extant written texts as qualitative data

In grounded theory, the use of written documentation as primary and secondary data is well established. Such data can be in the form of journals, diaries, autobiographies, novels and literature, policy documents, reports and more recently online written material such as blogs, chat room interactions, online discussion boards, email exchange and postings on social networking sites (Corbin and Strauss 2008, Walker 2013a, Walker 2013b, Charmaz 2014, Birks and Mills 2015, Hewson et al. 2016). Written documentation can be elicited or solicited, meaning that it is written in response to the request of the researcher and through the process of the research study. Other forms of written documentation can pre-exist (extant texts). Here, the researcher does not play any role in its construction (Charmaz 2014). In this study, although I used elicited written texts from the participants as the principle source of data, I also supplemented this with existing written autobiographical material in the form of published books and online blogs written by people about their experiences of having anorexia nervosa. I used this extant literature both as an additional source of primary data in the analysis as well as corroborating secondary literature in the theory development (Charmaz 2006).

As mentioned, elicited written texts are constructed both by the author or participant and the researcher through the provision of questions or instructions; the nature of which will be determined by the aims of the study. These texts may not be necessarily viewed as objective truths but are rather constructed from individual's perceptions and memories of experiences and events. Through the process of writing, feelings, thoughts and concerns of the individual can be elicited which is suggested may lead to more forthright and honest disclosure than through a traditional face to face interview as previously detailed (Charmaz 2006). However, the process of writing can also be potentially distressing for participants. This was an important consideration for me in respect to my study, as I asked the participants to write about potentially sensitive subjects; notably their good and bad experiences of working with therapists in respect to the development of a therapeutic relationship (Charmaz 2014). (This issue and wider ethical considerations of using online written research methods are discussed in chapter five).

As aforementioned, the decision to use asynchronous online research methods assumed that the participants would have access to a computer and have reasonable levels of computer literacy. In addition, in asking participants to write elicited accounts I was also assuming that they would be both willing to do this and be able to articulate themselves sufficiently through the written word. This assumption was made, in part, based on my previous work with people with anorexia nervosa. I often found them to be articulate and perceptive individuals; frequently attaining high levels of educational achievement. Coupled with the fact that treatments for anorexia nervosa often use writing for self-expression, I assumed that the use of written elicited texts may in fact appeal to potential participants rather than act as a barrier. However, I was also aware that I was making a broad assumption about a heterogeneous group of individuals. In addition, I also considered that the nature of perfectionism often seen in people with anorexia nervosa may cause issues for participants who could possibly feel that they had to write a textbook account. In fact, I was contacted by two participants who asked me to check and approve their contributions before

they submitted them to the website to make sure they were correct! I therefore had to reassure participants that they were free to write their accounts in any way they wanted, both in the participant guidance that I provided on the website and when they contacted me.

A further issue that was relevant to the use of elicited texts in my study is highlighted by Charmaz (2014). She suggests that "elicited texts work best when participants have a stake in the addressed topics" (Charmaz 2014 p 48). On reflection, I feel this happened in my study. Several of the participants contacted me to express their support of the study; for them it was significant that this aspect of eating disorder treatment was being investigated. In that respect, it could be suggested that the participants were biased in their contributions or indeed had an axe to grind about their experiences. However, on reflection and considering the entirety of the participant data, I think the written accounts submitted were sufficiently balanced in both positive and negative experiences. The fact that participants were interested in the topic led to good levels of recruitment with a wide range and in-depth articulation of the topic. Nonetheless, it was also useful to use supplementary extant documentation as previously mentioned, particularly data gathered from online blogs. Analysing these data in the same way as the participants' written accounts added further depth to the analysis in the second and third phases of the study and provided an additional evidence source that helped me to further develop the analytical and theoretical links in the study findings (Charmaz 2014).

4.10. Conclusion

This chapter presented the philosophical and theoretical underpinnings that influenced the methodological design and the justification of the research methods used in this study. Using constructivist grounded theory in conjunction with online research methods has allowed me to co–construct the knowledge presented in this thesis between myself and the participants. Thus, being a reflexive researcher has been a central consideration within the study and I

have detailed relevant information in the process of considering how my previous background as an occupational therapist working with people with eating disorders impacted on the development of the methods chosen. The use of asynchronous online research methods has been considered and justified as a viable and contemporary method of gathering qualitative research data relevant for a grounded theory study.

To summarise, the participant data used in this study were generated principally through the elicitation of written accounts gathered from adults with anorexia nervosa about their experiences of the therapeutic relationships they had with their therapists. These data were gathered using a dedicated website and analysed alongside additional extant written data in the form of published autobiographies and online blogs written by adults with anorexia nervosa.

The following methodology chapter details the practical development and use of the TherRel website, the process of recruiting the participants as well as the contemplation of wider ethical considerations relevant to the use of online research methods and as they arose in my study.

Chapter Five

Developing a methodology: the practical and ethical application of using online research methods

5.1. Introduction

In the planning stages of this study, I originally considered using the Bristol Online Survey system to gather the participant data. A previous study utilised this method for the collection of similar written data (Gambling and Long 2012). However, in that study, the researchers found that this system was unable to cope with the response level. In addition, it was suggested that this system did not meet the needs of the participants, who tended to revert to direct email communication with the primary researcher. Therefore, following a meeting with a member of the university information technology support team, it was suggested that I use a dedicated, confidential website as an alternative method for collecting online asynchronous written data.

This chapter therefore details the process of developing the website and how I used the website to recruit the participants and collect data over three distinct phases. I also consider the importance of developing online research relationships with participants and how I managed my role as a researcher. I conclude the chapter by outlining the ethical processes inherent in planning and using online research methods and how these issues manifested throughout my study.

5.2. The development of the TherRel website

Working in conjunction with a colleague from Cardiff University information technology service, the bespoke website TherRel was developed:

https://healthcarestudies.cf.ac.uk/therrel/.

This website was designed to be confidential and anonymous, where I could post and update all the information potential participants would need to inform them about the study. This included participant information sheets, consent details and guidance for writing data contributions (appendix 1). Furthermore, it was set up so that participants could upload their written accounts with complete anonymity. However, in addition to this facility, a dedicated, password protected email account was made available, with a link from the website so that participants could contact me directly through email if they chose to do so.

The website was hosted by the School of Healthcare Sciences at Cardiff University however I had personal user access and control. All the documentation on the website was checked and approved by the Cardiff University School of Healthcare Sciences Research and Ethics committee and Beat; a national eating disorder charity based in the United Kingdom (UK) (further information about ethical approval processes are detailed later in this chapter). In addition, I asked a friend who has an eating disorder to check the website and information to gain feedback about the clarity of the information and its visual appeal. Her feedback included suggestions to minimise the use of professional and medical jargon and writing the information directly aimed at potential participants in the first person. Furthermore, I piloted the use of the TherRel website with some work colleagues, my PhD supervisors, as well as some of my family members (who had no understanding or knowledge of the topic area) to ensure that all the website links worked and the information was transparent in preparation for the first phase of participant recruitment.

5.3. Recruiting the participants

A volunteer sampling strategy was used to recruit participants for this study. This recruitment strategy is deemed appropriate for accessing hard-to-reach, and small specialist populations and is commonly used in online qualitative research where broad generalisability of findings is not the aim (Charmaz 2006, Hewson et al. 2016). This recruitment strategy is akin to the

initial purposeful sampling process of potential participants deemed appropriate for a grounded study theory. That is, the researcher accesses participants that can purposefully inform an understanding of the main phenomenon of interest in the study (Charmaz 2006, Creswell 2007, Corbin and Strauss 2008). At the beginning of the study, the aim of the research was to investigate the nature of the therapeutic relationship across the gamut of eating disorders. In keeping with grounded theory methods, the inclusion criteria for the recruitment of participants were kept as broad as possible for the first phase of data collection (Corbin and Strauss 2008). These criteria were that potential participants were aged 18 or over, currently or had previously had an eating disorder of any type and had experience of working with a healthcare professional, therapist or counsellor. Participants did not need to have been formally diagnosed with a specific eating disorder. I made this decision about diagnosis as I did not want to exclude anyone who did not have a formal diagnosis of an eating disorder but may have still have had contact with a health professional or counsellor for problems with their eating.

Throughout the three phases of the study, participants were recruited through Beat, which is, as previously mentioned a UK based national charity for people with eating disorders (formally known as the Eating Disorder Association). Beat is a well-established, credible charity that promotes recovery from eating disorders by offering support and advice for people of all ages with eating disorders as well as their families, carers and professionals. They have an extensive website which provides online information and support to people with eating disorders. In addition, Beat has a research division where people with eating disorders can volunteer to participate in research studies; either those sponsored by Beat or individual researchers such as myself. Beat also advertise research studies to all their members via a monthly newsletter and through social networking sites such as Twitter.

Although Meho (2006) suggests that it can be more effective to solicit participants for online research individually rather than through a mailing list, there were several reasons why I choose to use the Beat resources to advertise my study. Firstly, as I discussed in chapter

four I was previously a therapist who worked in local eating disorder services. I therefore, wanted to be careful not to consciously recruit participants locally that I might know or have knowledge about their therapists. In addition to avoiding potential participants in my local area, I also concluded that using a national online resource would elicit a larger participant response through advertising across a wide geographical area (Walker 2013a). Moreover, it is acknowledged that recruiting specialist, hard to access populations through online sources can be more successful than using offline methods such as advertising in health centres or other public spaces (Hewson et al. 2016). A final advantage of recruiting participants through Beat is the ethical scrutiny that the organisation undertakes before agreeing to advertise the study. This suggests that the highest standards of safeguarding are ensured for the protection of potentially vulnerable research participants.

Therefore, to advertise my study and access potential participants from the Beat research members, I underwent a process of ethical application through the Beat research process (Beat 2017a) as well as my university ethics committee. This included an ethics scrutiny of all documentation including the recruitment flyer and documentation that was displayed on the TherRel website. These approvals and further ethical considerations for online research studies are detailed in section 5.4 of this chapter.

Following this approval processes, the study was then advertised via a recruitment flyer posted on the Beat website as well as through their monthly newsletter (appendix 2). Access to the TherRel website was thus made available via a hyperlink on the recruitment flyer (Hewson et al. 2016).

In the first phase of recruitment some general guidance notes were provided for potential participants that made suggestions as to how they could write about their experiences (Gambling and Long 2012). Although providing detailed questions is generally viewed as being inconsistent with grounded theory methods, Charmaz (2006, 2014) does discuss the use of providing open ended questions and guidelines for participants providing written elicited texts. She suggests that using questions framed in terms of "tell me about, how, what

and when will yield rich data" (p33). I subsequently decided that it was necessary to provide some questions and suggestions to act as a prompt to enable the participants to write about their experiences. Some questions were closed to find out more specific demographic information, whilst others were phrased in an open way to elicit more detailed description. However, the guidance notes provided also suggested that participants should write freely about their experiences in any way they wished (Long and Bennett 2009). Examples of the guidance information given and how this changed over the three phases of the study are detailed further in chapter six and in appendix 4.

The following table summarises details of the range of the participants and the primary methods of data collection employed over the three phases of the study.

	Phase one	Phase two	Phase three
Open time frame	January 2013 – November 2013	January 2014 – September 2014	January 2015 – December 2015
Participants	10 contributors: 9 described themselves as having anorexia nervosa. 1 with bulimia nervosa.	6 new contributors: all described themselves as having anorexia nervosa.	3 past contributors: all described themselves as having anorexia nervosa.
Methods of data collection	Elicited participant written accounts	Elicited participant written accounts plus extant autobiographical accounts	Elicited participant accounts plus extant autobiographical accounts and online blog material.

Table 2. Participant and data information.

In all, fifteen participants contributed to this study. Fourteen were female and one male. The age range of the participants was nineteen to sixty. The average age that participants developed eating problems was fourteen. Over half of the participants had been dealing with their disorder for over nine years and described symptomatology synonymous with a

severe and enduring eating disorder (SEED). Eight existing autobiographies and online blogs written by female adults with anorexia nervosa were also used as primary and secondary data sources. Appendix 8 offers individual demographic information on each participant and outlines which phase/s of the study they contributed to.

Recruitment into phase one of the study was kept open for several months in 2013. During that time, Beat advertised the study twice more on their mailing list and kept the recruitment flyer posted on their website. Overall, recruitment was slow but steady, with ten individuals eventually contributing to the first phase of the study. One participant uploaded a written account of her experiences and provided me with her contact details indicating that she would prefer to talk to me directly in the event of any follow up data collection. I initially considered that it may be appropriate to offer her an alternative method in subsequent phases of the study, for example, a face to face or telephone interview. However, this raised dilemmas of methodological congruence as I mentioned in chapter four. In the end, this participant did not contribute to the further two phases of the study due to her specific diagnosis of bulimia nervosa (see chapter six). A further participant, who was undertaking in-patient treatment at the time she contributed to the study, did not have access to a personal computer and therefore hand wrote her contribution and sent it to me in the post. I subsequently transcribed this document verbatim and treated it in the same way as the other data, concluding that the two forms of data (word processed and handwritten) to be sufficiently alike.

During this time, I began the process of analysing each contribution as it was uploaded to the website (I detail this process and the subsequent two phases of the study in chapter six).

All bar one participant was recruited directly through Beat's advertisements. I recruited one participant following an attendance at a local eating disorder research network forum. At this meeting, she expressed an interest in the study, therefore I directed her to the TherRel website, via Beat and she subsequently contributed as a participant. All the participants except one (who posted her story anonymously) entered into e-mail discussion with me prior

to and following the submission of their experiences. Although the email correspondence has not been analysed as data, this process of developing a research relationship with each participant has been an important aspect of the recruitment process and subsequently helped me to feel confident in the authenticity of each participant as deliberated upon in chapter four.

5.4. Developing research relationships

It is suggested that engaging with individual participants online demonstrates that they are important to the research and thus encourages participation (Meho 2006). Similarly Hunt and McHale (2007) advise that the researcher should make some attempts to establish a relationship with participants prior to conducting online interviews. I had not planned to solicit individual contact with participants directly, as I envisaged that the anonymity of the website would in fact be an attraction to potential participants. However, as stated earlier, a generic email account had been made available for participants to contact me prior to contributing to the study should they wish to. As I have previously mentioned all the participants except one in the study (over the three phases) did in fact contact me via this e-mail account, generally to ask questions about the study or to clarify aspects of the participant guidelines. Despite some participants asking questions about the confidentiality of their information; conceding their anonymity to me (through the provision of their e-mail address and names) did not seem to affect their willingness to engage or participate in the study. Indeed, the participants seemed to value making direct contact with me prior to submitting their written accounts. On reflection, I think the e-mail communications that I had with participants in the initial stages of recruitment were central in developing an online connection with them. Sydor (2013) discussed the importance of developing a rapport in her research with hard-to-reach populations as being a crucial factor in the successful recruitment of participants. Although Sydor's (2013) assertion is not in relation to recruiting participants online, I believe that developing an online communication with my participants prior to their contribution to my study was also crucial in recruitment in my study. This

surprised me as I assumed that the safety of contributing anonymously online without any need for contact with the researcher would appeal to the participants. The ease in which the participants engaged with me online both through e-mail and the TherRel website suggests that these methods of communication are trusted, popular and appropriate to use with people with eating disorders (Woolf 2012, Walker 2013a, Kendal et al. 2017). Nonetheless, I am also aware that using these methods only targeted a specific group of people with eating disorders who were engaged with the online services of Beat and therefore arguably limited the range of participants I might have accessed if I had used alternative methods of recruitment (Gambling and Long 2012, Hewson et al. 2016).

In respect to communicating online with potential participants, it is suggested that it is important for the researcher to respond quickly to participants' queries to strengthen engagement in a study (James and Busher 2009). Conversely, it is also notable that participants are given sufficient time to respond. Bearing this in mind, I developed a spread sheet where I recorded all contacts with participants and thus could keep track of communication and engagement. This helped me to gauge individual participant's response times and then send appropriately timed reminders and prompts. Meho (2006) suggests that online researchers limit the number of reminders to participants to one or two as more than this could be misconstrued as pressure to continue participation. Based on this recommendation, I decided to send two follow up e-mail enquires/reminders when potential participants had contacted me to express interest in the study but who did not then subsequently contribute.

Picking up on participants' e-mail communication styles and patterns was important in the engagement of the participants throughout the three phases of the study. Verbal and non-verbal social signals are often seen as a foundation of face to face interviews and aid the development of rapport between researcher and participant; clearly this form of communication is absent in online communication (Mann and Stewart 2000, Walker 2013b). Although all the participant information on the TherRel website was written in a standard

format, all my e-mail communication with participants was personalised to each participant. This adaptation to the style of the individual and subsequent mirroring of their communication style was the same approach I would have taken had I been carrying out face to face interviewing. Again, I think this helped me to develop an appropriate online rapport with each participant. So, for example, some participants were formal in their e-mail communications, whilst others used more easy-going language, used emoticons and disclosed more personal information about themselves and the process of contributing to the study. I responded accordingly to their communication style in a judicious way.

It was also important for me to acknowledge that the absence of social and verbal signals in online communication can also be of benefit for recruiting participants as it is suggested that the concealment of participants' characteristics can aid self-disclosure. Therefore, online interaction can create a shield which helps to facilitate disclosure and the process of written communication can be less revealing for the individual than face to face contact (Mann and Stewart 2000, Johnstone 2010). Two of my participants disclosed that they had physical disabilities as well as anorexia nervosa and although they did not say that this was a barrier to communication, the convenience of contributing to the study online appeared to be helpful for them. Without the physical representation of self, James and Busher (2009) suggest that the qualitative online researcher needs to employ other ways of building trust and developing a relationship with participants. I did this in several ways: through responding in a timely manner to queries, responding to each participant as an individual, thanking people for their contributions and acknowledging the difficulties some participants had in recalling their experiences and the time they took to write about their experiences.

As a researcher, I was aware of nurturing the online contact with participants as a way of supporting their willingness to contribute. Throughout the three phases of the study the participants were at various stages of their own recovery. Some described themselves as fully recovered, others considered themselves to have severe and enduring anorexia nervosa (Robinson 2009) whereas some participants were clearly going through active

treatment; some as in-patients. I was very aware that these participants could be viewed as being vulnerable due to the acute phase of their illness. It was therefore essential for me to be responsive as a researcher whilst simultaneously maintaining boundaries appropriate to our research relationship. This issue of the nature of the research relationship has been particularly relevant to me due to my background working as an occupational therapist with people with eating disorders. Some of the online contributions and interactions I received were very compelling and moving and I found myself wanting to go beyond my research boundary and respond to the participants as if they were clients. Therefore, several times I had to remind myself what my role was as a researcher and I talked this over with my supervisors throughout the course of the study. Thus, it was essential for me to be reflexive not only due to my prior knowledge and background in eating disorders but also in respect to the feelings and responses that were being evoked in me towards the participants and some of their contributions (Olesen 2007). Thus, as well as the discussions I had with my supervisors, I also considered the questions posed by Birks and Mills (2011) around power differentials between participants and researchers such as, "how is that interaction affecting the course of the research and how is it illuminating or obscuring the research problem?" (p57). This helped me to consider where my role lay and to maintain the boundary of being a researcher while simultaneously using my therapist's skills to demonstrate an empathic and supportive stance during the research whilst not engaging as a therapist with the participants.

In addition to the considered of my role as a researcher and the boundaries of the online relationships developed in the process of carrying out this study, there were several other ethical issues that had to be attended to. The following section details how these were addressed throughout the course of the study.

5.5. Standard ethical considerations in online research

Birks and Mills (2015) acknowledge that the relationship between the researcher and the participants is an important consideration of any grounded theory study and that these relationships should be underpinned by the principle of beneficence, that is, that the researcher should do no harm to the participants. This principle also applies to online research methods and guided me in the planning and execution of this study. What constitutes appropriate online ethical conduct is subject to debate and requires on-going consideration as technology changes and advances (James and Busher 2009, Jones 2011, British Psychological Society 2013, Hewson et al. 2016). There are ambiguities regarding what constitutes private/public space online and this is of relevance in respect to the advances in the development and use of smartphones, social networking sites such as Facebook, Twitter and Instagram and blogging communities (British Psychological Society 2013, Walker 2013a). Similarly, the rules of netiquette and social convention that facilitate interaction through online networks are continuingly being challenged. Nonetheless, although online research may have specific ethical concerns that are different to traditional research methods, in terms of ethical protection for participants and researchers involved in online research, it is suggested that standard procedures for human participants are used (Meho 2006, James and Busher 2009, Jones 2011, British Psychological Society 2013, Hewson et al. 2016). This includes ethical requirements that ensure the protection of privacy, anonymity, confidentiality, data security and gaining informed consent from participants.

As I previously mentioned, ethical approval for carrying out this study was gained through the School of Healthcare Sciences Research and Ethics Committee, Cardiff University as well as Beat (appendix 3). Wider approval from health and social care ethics services such as the Health Research Authority in England or Health and Social Care Research Wales was not deemed necessary as I planned to recruit all the participants via the national eating disorder charity Beat. As detailed earlier, advertising and recruiting participants through Beat involved gaining ethical approval for the initial acceptance of the study (Beat 2017a).

Subsequent changes to the participant information and website updates throughout the further two phases of the study were also scrutinised in accordance with Beat's ethics and safeguarding standards (also see chapter six).

To protect participant anonymity and confidentiality, the TherRel website was developed and hosted by Cardiff University in conjunction with the School of Healthcare Sciences information technology support team. The website offered participants the opportunity to contribute to the study anonymously if they wished to (see chapter four). The TherRel website was located on an encrypted server and offered a secure and private environment which poses less of a threat to security of information than open environments (James and Busher 2009).

Data and contact details of participants were anonymised and stored appropriately to maintain confidentiality (in line with Cardiff University's Confidentiality and Data Protection Policies www.cardiff.ac.uk/govrn/cuconfidentialityguide.doc accessed 02/09/11). I allocated pseudonyms to each participant and these were used throughout the study to protect individuals' identities. All the e-mail communication between myself and the participants was conducted and stored using a password protected system.

Participation in the study was voluntary and the participants could withdraw at any time. Walker (2013a) suggests that informed consent, whether implied or explicit should be obtained before any data are collected. Informed consent for this study was implied through participant contribution rather than through face to face signing of a consent form or being sent a hard copy for signature (Hamilton and Bower 2006, Walker 2013a, Hewson et al. 2016). The consent form was stored on the TherRel website (appendix 1) and potential participants were able to contact me for further information either through my direct work based e-mail or the generic TherRel e-mail address. As previously mentioned, most of the participants did contact me prior to contributing any data. Although some had questions about confidentiality of data, most of the contacts appeared to be in relation to developing a research relationship with me, rather than having specific ethical or consent queries.

The verification of age of participants in an online research study is difficult to authenticate and needs to be balanced against the benefits of providing anonymity (Hewson et al. 2016). As previously detailed in chapter two this study aimed to explore the experiences of adults with anorexia nervosa, therefore my recruitment strategy was to attract adults aged 18 or over. This was made clear in the participant recruitment flyer as well as in the participant information on the TherRel website. In addition, Beat advertised the study within its adult research volunteers. I felt these measures were sufficient for this study although there are ways that further verification of online participants can be made, such as the need to provide credit card information for example (British Psychological Society 2013, Hewson et al. 2016) The second phase of this study was advertised by Beat via Twitter. Arguably using this open social networking forum could have attracted a younger age range to the study due to re-tweeting the advert that Beat would not have had any control over. However, as far as I could tell, based on the demographic data that the participants provided, I was confident that all the participants were over 18.

5.6. Continuing ethical decision making during the study

In the planning stages of this study, my main concerns were centred on the anonymity and confidentiality and consent issues inherent in setting up an online research project (Hewson et al. 2003, 2016). However, these were not issues that appeared to concern the participants. Rather, other issues arose during the three phases of the study that needed to be addressed, such as maintaining boundaries as a researcher versus my professional background as a therapist. As Ballinger and Wiles (2006) discuss, researching potentially difficult and sensitive ethical issues highlights the need for researchers to be aware that they may have to make ethical decisions on an on-going basis throughout the process of a study. This was a pertinent point in my study and the following examples highlight some of the key ethical issues I considered throughout the process of the study and how I adapted the study as they arose.

In phase one of the study, I considered the potential sensitivity of the nature of the topic under investigation. Thus, I deliberated that the process of writing about the experiences of working with therapists could elicit unintended or unexpected emotional responses in the participants. I highlighted this possibility in the participant information on the TherRel website and stated that I would make sure that they had someone to contact for support (appendix 1). In hindsight, I do not think this was realistic or the most useful way to deal with the potential need of a participant to find support as this could have encroached on our researcher/participant relationship as detailed earlier. I think my offer to do this was indicative of the deliberations I was having in establishing what our relationship was and the boundaries I needed to maintain as a researcher. Subsequently, in phase two of the study, I added a hyperlink to the Beat support information on their website. This was done with the approval and knowledge of Beat and on reflection I believe was a more fitting place for the participants to access further support if necessary. In addition, providing information as to where support could be found rather than offering to help participants find this support made it clearer in maintaining the researcher/participant relationship.

Furthermore, I also considered that participants *may* disclose information that could constitute unprofessional behaviour in respect to the therapeutic relationship on the part of a therapist. This consideration was based on my own experiences of working as an occupational therapist with people with eating disorders and being aware of the potential that some therapists may not be regulated by a professional body or have the necessary training and supervision to work with this arguably vulnerable group of people. I therefore decided that it was important to think through what I would need to do if a participant disclosed what could be deemed as unprofessional practice by a therapist. According to the College of Occupational Therapists Code of Ethics and Professional Conduct (College of Occupational Therapists 2015), I am obliged to speak out if I am witness to any malpractice or unprofessional activity from any other professional. Therefore, I included a disclaimer regarding confidentiality in the participant information on the TherRel website. This

disclaimer informed participants that if any information was disclosed that I considered may put themselves or others at risk I may be obliged to act on this information. This therefore gave the participants the opportunity to think about potential disclosure information and in addition protected me if I had to compromise confidentiality (Hewson et al. 2016). In the event, one participant disclosed information about the behaviour of a psychiatrist that she had seen in her past which could be deemed as unprofessional or indeed abusive. However, this participant is the only one who uploaded her contribution anonymously to the TherRel website without communicating with me, and did not give any additional contact information. I was therefore, not able to take any further action on this disclosure.

An unforeseen ethical issue arose in phase two of the study when I was contacted by the research officer from Beat. In response to changes the organisation were making to the requirements for research studies they were advertising on their website, I was asked to amend the participant information on the TherRel website. This amendment was to inform potential participants who were considering contributing to research studies that they should notify their therapist or care team (if they had one) in case they required extra support. This had become a blanket requirement for all the research studies Beat advertised. Although I could appreciate the reasoning behind this safeguard, I also felt that this new requirement could potentially impact on participants' willingness to contribute to my study specifically. Under those circumstances, if a therapist knew that the individual was disclosing information about said therapist, there was the potential that this could affect their relationship and subsequent treatment and/or potentially influence the information the participant may contribute to the study. Therefore, although the intention from Beat was understandable as they were considering the impact of potentially vulnerable people being involved in research, for my study I felt it could be counterproductive. I was therefore able to argue this point and it was agreed that the measures I had put in place were sufficient to ensure that participants could find out about and access support if needed as a consequence of contributing to the study. In reality, I do not know if any participants did have to do this. Two of the participants

did contact me to tell me that they had found it difficult recalling and writing about their experiences and requesting that they had more time to complete their contributions. As there was no set time frame to do so, this was perfectly acceptable and I responded to their requests by reassuring them, redirecting them to the participant information about support and acknowledging the difficulties they were experiencing. They both subsequently contributed very detailed accounts of their experiences. A further participant also contacted me to tell me that she had discussed her contribution to my study with her therapist after she had submitted it and they had used that experience to work on aspects of the therapeutic relationship in their therapy.

Using extant or existing data in the form of online blogs also required ethical considerations. In line with grounded theory methods, in the third phase of the study I began to look at online blogs both as primary and secondary data (Charmaz 2006, 2014). As these data were available in the public domain and were clearly written by anonymous authors, I could not request direct consent to use them. The practice of "harvesting and turning online traces into research data" without the direct consent of the author is increasingly used in online research but careful consideration about what constitutes public and private space in relation to online data needs to be addressed (Hewson et al. 2016 p 114). The principle blog I used was set up and run by a user of eating disorder services. She clearly stated that she was writing under an assumed identity and invited other bloggers to contribute their experiences anonymously. I concluded that by openly making their communications available online (and advertising these on Twitter), the authors were not concerned about this data being accessed (Hewson et al. 2016). However, despite this openness, I still decided that it would be good practice to put in place additional measures to safeguard the anonymity of the contributors in this thesis (British Psychological Society 2013, Hewson et al. 2016). I subsequently gave each author an alternative pseudonym from the one they used on the blog site and have anonymised the name of the blog and withheld the website link, therefore minimising the risks of identifying these individuals online.

A further ethical dilemma also surfaced in the third phase of the study. This arose because at this juncture of the study, I considered altering the primary method of data gathering in the final phase. As outlined in table 2 in this chapter, the method for data collection in the first and second phases of the study was to gather asynchronous online written accounts from individual participants (also see chapter four). In the third phase I considered altering this method to run an open online focus group discussion for participants to discuss the theoretical ideas and themes that were emerging from the analysis of the previous two phases of the study. Although the method would still be online and asynchronous it would open communication between participants rather than just with me as the researcher. From a methodological perspective, I initially considered that this would be a collaborative way of asking participants to contribute to the refinement and elaboration of the theoretical development (Charmaz 2014). Although ultimately, I did not pursue the idea of using an online discussion forum, I detail the unintended ethical issues that arose from contemplating this potential change in data gathering methods as it was a defining learning experience for me in using online research methods.

One of the key issues that arose in respect to contemplating this change in my primary research method was the time lag between gaining the original ethical approval for the study at the beginning of 2012 and the final data collection phase of the study which was at the end of 2015. This time lag amounted to nearly four years. Although the standard ethical issues for the study remained the same over this time frame, aspects of the study changed from the original proposal as would be expected in a grounded theory study (Charmaz 2014). Each phase was developed from the preceding data that was gathered, meaning that the participant information, guidance notes and consent had to be changed accordingly and approved at each stage. This was done through chair's action from the School of Healthcare Sciences Research and Ethics Committee at Cardiff University, who considered these to be minor changes, and directly through the Beat Research Officer. I thought, rather naively, that the same process would stand when I considered making a methodological change for the

final phase of the study. An additional factor that affected this process was the implementation of new and more rigorous ethical guidelines that applied to any study endorsed through advertising by Beat. These was specifically in relation to the use of online discussion forums.

Prior to submitting the changes for ethical approval from the two institutions I spent several weeks researching the methodological, practical and ethical considerations that I thought were relevant to the changes I wished to make. These were submitted and accepted by the School of Healthcare Sciences Research and Ethics Committee but Beat identified an ethical concern that I had not considered. The key issue that arose was the requirement from Beat that any online posts made by the participants in the proposed discussion forum were pre - monitored by myself before being released onto the discussion board. There were sound ethical reasons why Beat insisted that this should occur including the potential vulnerability of the participants in respect to posting 'triggering' comments, that is, comments that could encourage pro-eating disordered behaviours (Beat 2017b).

Although I had thought about what my role as the moderator of the discussion forum would be, namely to provide prompts and questions (Tates et al. 2009), I had not anticipated that I would be required to moderate the posts prior to posting. I felt it raised methodological issues of researcher influence on what may be deemed to be an appropriate or inappropriate post and therefore I was concerned that I may subsequently influence the direction and content of the discussion. There is little research into the effects of moderation into the contributions and discussions in the use of online forums for people with eating disorders, although this issue is highlighted by Kendal et al. (2017). This obstacle led me to reconsider why I was contemplating changing the method of data collection in this final phase of the study. I subsequently debated this from a methodological and ethical perspective with my supervisors and ultimately decided that it was important for me to maintain methodological congruence by using the same data collection method throughout the three phases of the

study. Therefore, I reverted to the original method of gathering individual written contributions for the final phase of the study as detailed in chapter five.

This methodological and ethical debate which I underwent, led me to carefully consider the potential use of online focus groups and discussion forums in qualitative research. On reflection, I believe that Beat were correct in their insistence that pre – monitoring of posts was required as this group of participants could be vulnerable within this type of online forum due to the sensitive nature of their condition and experiences (Hewson et al. 2016). I think at the time I fell into the trap of being over enthusiastic about using this method in the final phase of the study without completely considering all the potential ethical and methodological consequences (Stewart and Williams 2005, Hewson et al. 2016). Thus, although the use of online focus group forums can be a valid and useful way of collecting data with young people (Fox et al. 2007), measures to protect the potential vulnerability of certain groups of participants needs to be very carefully considered before embarking on the use of this online method (Hewson et al. 2016). A further consideration when using any online research methods is the speed in which technology changes. This may subsequently have an impact on the ethical issues inherent in a study. The data collection and analysis in this study took 4 years with ethical approval having been granted a year prior to this. Subsequently the need to continually review ethical consideration as the study has evolved has been highlighted (Ballinger and Wiles 2006).

5.7. Conclusion

The opportunities of the internet and the changing use of online technology for communication offer a relevant and valid method for researchers to access geographically, socially distanced and hard-to-reach populations in qualitative research. This chapter explored the key practical and ethical issues and dilemmas I faced in the process of setting up and using asynchronous online research methods in this study.

I began the chapter by outlining the decision and process of developing and setting up a bespoke website, TherRel, and recruiting participants for the study. This website was used to store and update information for the study and had the facility for participants to upload written accounts of their experiences confidentially and anonymously. Participants also communicated with me through e-mail, subsequently I detailed ethical issues that arose in respect to fostering online relationships with participants and the dilemma I faced that was inherent in my role both as a researcher and therapist.

Standard ethical considerations need to be applied to the use of online research methods as in any research study that uses human participants. These include ensuring participant confidentiality, anonymity and gaining informed consent. In addition to outlining how I achieved these in this study, I also detailed inadvertent ethical and methodological considerations that arose throughout the three phases of data collection. These issues included dealing with sensitive disclosures by participants, verifying the age of participants and utilising existing online written data such as personal blogs. I also explored the ethical implications of considering making a methodological change to the research design in the final data collection phase. This raised important debates about the appropriateness of using online discussion forums with potentially vulnerable participants. It also highlighted the need for researchers to continually review ethical issues throughout the process of a research study. This is of relevance when using online research methods due to the speed with which technology changes and is used. Hence what constitutes appropriate ethical precautions may in fact change; or unintended consequences of using a specific online arise method may arise and need to be attended to.

In this study, accessing participants through a national charity website and using the TherRel website and e-mail to interact asynchronously with participants allowed me to gather in-depth accounts of individuals' experiences. These contributions have been detailed, reflective and considered, perhaps in ways that may not have been possible had their content been gathered through face to face interviews. The following and final

105

methodological chapter details the concurrent, iterative process of data collection and analysis I undertook in the three phases of the study and subsequently how the findings of the study were constructed.

Chapter Six

Collecting and analysing the data

6.1. Introduction

 In this chapter, I draw on the theory of constructivist grounded theory to detail the process of data collection and analysis in this study (Charmaz 2006, 2014). I then move on to explain the method of initial and advanced coding and subsequent memo writing that led to the construction of the theoretical and central categories that are later detailed in the findings chapters. Throughout the chapter I use excerpts from my research diary to demonstrate the reflexive decision-making processes that I made throughout the process of data analysis and theory development.

6.2. The aim of data analysis in constructivist grounded theory

 Corbin and Strauss (2008 p45) describe the analysis of qualitative data as:

> "Examining a substance and its components in order to determine their
> properties and functions, then using the acquired knowledge to make inferences
> about the whole".

This was the premise that guided the process of data analysis that I undertook in this study. My *substance* was the therapeutic relationship. What I set out to examine was the process and nature of the therapeutic relationship and the properties and functions of the relationship from a participant perspective. Therefore, as previously described, rather than providing a description of the participants' lived experience or narrative, the aim of this analysis was to develop a concept driven theoretical framework that provided an overarching explanation of the therapeutic relationship in respect to adults with anorexia nervosa (Corbin and Strauss 2008). This level of theory development is described as substantive, meaning, the theory is

derived from one applicable area, in this case adults with anorexia nervosa. (Glaser and Strauss 1967). Thus, theory can be defined as:

"An explanatory scheme comprising of a set of concepts related to each other through logical patterns of connectivity."

(Birks and Mills 2015 p108)

Despite essentially understanding what a theory was; at the beginning of the data analysis I did not fully grasp what it meant to construct a theory. This understanding developed through the process of gathering and analysing the data over the three phases of the study. What was important for me to consider throughout this process was that the analysis of my data did not just describe the concepts derived from the participant data but rose above the level of description to "construct an explanatory framework" (Corbin and Strauss 2008 p 264). To do this, I closely followed the use of salient grounded theory methods previously outlined in table 1 in chapter four.

Additionally, to develop a process of data analysis that worked for me in this study, I realised that I needed to have a clear grasp of the terminology that is used in grounded theory data analysis. As Birks and Mills (2015) acknowledge this can be a bewildering problem for novice researchers. Although I had read widely on the subject prior to beginning the analysis, I was still confused by the plethora of terms and processes used in the literature. I therefore decided in the first phase of the analysis I would draw on the grounded theory analysis process outlined by Charmaz (2006) whilst also utilising conceptual definitions described by Corbin and Strauss (2008).

At the beginning of the study I also decided that I would undertake the analysis and management of the data manually, rather than use an established analytical computer software package. This decision was made in part following a conversation I had with Kathy Charmaz in 2011 at a workshop on grounded theory analysis. She informed me that rather

than using computerised software herself, she preferred to hand sort her coding and use extensive memo writing in the process of analysis. This was purely a personal decision on my part and although Birks and Mills (2015) suggest the advantages for new researchers of using a combination of manual and computerised coding, once I became comfortable with my own system I decided to continue with it throughout the study.

6.3. The process of data analysis: phase one

The data collection and analysis was carried out in three phases. Diagram 1 below summarises these phases. Supplementary data in the form of published autobiographical books and online blogs was incorporated into phases 2 and 3. This section details the process of analysis through the three phases of the study. In the next chapter, I demonstrate the process of theory development.

Data collection and analysis

Phase 1

Open to anyone with an eating disorder. Participants were asked to write openly about their experiences of working with therapists

Phase 2

Open to people with anorexia nervosa only. Participants were asked to write about aspects of the therapeutic relationship that were developed from the initial and focused coding in phase 1.

Phase 3

Returned to previous participants with anorexia nervosa. Participants were asked to consider questions and statements aimed at testing out emerging theoretical ideas constructed from phase 1 and 2.

Diagram 1: Summary of the three phases of data collection and analysis.

As detailed in chapter five and in keeping with grounded theory methods, in the first phase of the study, the participants were asked to write about their experiences of working with

therapists in an open way (Charmaz 2006). This first data collection phase was open to anyone aged 18 or over, with any form of eating disorder. The participants were provided with broad guidelines about how they could write about their perspectives on the therapeutic relationship but they were also encouraged to write in any way they chose (Charmaz, 2006, Gambling and Long 2012). See appendix 4 (participant guidance).

In grounded theory, the process of data collection/generation and analysis occurs concurrently (Birks and Mills 2015). Thus, on receiving the first written participant account via the TherRel website I began the process of analysis.

Each participant was assigned a pseudonym and each original written contribution was reformatted into a word document similar to a transcript from a face to face interview (Charmaz 2006). This word document template was used to begin the analytic process of coding.

Coding in grounded theory is described as the:

> "Pivotal link between collecting data and developing an emergent theory to explain these data. Through coding, you *define* what is happening in the data and begin to grapple with what it means."

(Charmaz 2006 p 46)

The first stage of coding is typically called initial (Charmaz 2006) or open (Corbin and Strauss 2008) coding. Essentially this involved reading through the first word document several times and then working through it line by line, constructing the initial codes. As suggested, I tried to construct these initial codes with words that replicated actions; using words and phrases of the participant as well as my own. I attempted to think about the meaning behind statements but also tried to work quickly through the first account and not worry too much at this stage how I was naming the codes as initial codes are provisional and can be reworded to find the best fit (Charmaz 2006). In my first attempts at initial coding I attempted to code with gerunds. Gerunds are verbs that are used as nouns that always

finish with an 'ing, such as feeling, needing, worrying (Charmaz 2006, Birks and Mills 2015). Reflecting on the original analysis documents, I realised that I did not always use gerunds in the initial coding of the data in phase one. However, this was a process I became more comfortable using during the initial coding of the analysis of the second phase of data. Although I was aware that I held prior ideas about the therapeutic relationship; as I coded I tried to keep an open mind to what I was reading and not apply pre-existing ideas as codes. I also attempted to keep the codes as close to the data as possible, using participant wording to ensure I was analysing from their perspective rather than from mine (Charmaz 2006). Appendix 5 illustrates an example of initial/open coding that I carried out in phase one of the data collection.

As the written texts came in over several weeks, I repeated this process of initial/open coding with each participant account. I coded for similar initial codes across each new set of data and added new codes as they arose. Thus, I started using constant comparative methods in this first phase of data analysis (Charmaz 2006, Birks and Mills 2015). As I coded each written account, I could see that I was naming codes in similar ways across the developing data set. I kept going back and forth between them, analysing if the codes assigned were similar or different and adjusting the codes accordingly.

After coding several participant contributions, I realised that I had begun to code data that was taking me away from the original aims of the study. Most of the participants had provided a significant amount of background information about the development and nature of their eating disorder in response to the prompts on the participant guidelines. I realised that I had got involved in analysing this background information, despite it not seeming to have any specific relevance to the key phenomenon of the therapeutic relationship. For example, in the analysis of Rebecca's first contribution to the study, I began analysing information about the early development of her eating disorder and her behaviour during this time. Initial codes included getting away with it, being monitored, finding ways to cut down, avoiding parents.

After talking this issue over with my supervisors, I decided that even though it was interesting to code the whole data set for each participant at this early stage, I should be concentrating on the content of the data that linked specifically to the therapeutic relationship and the aims of the study. I therefore set these other codes aside, calling them miscellaneous codes at that stage; knowing that I could return to the data at a different stage of the study if I thought it would be useful to look at the contextual background information that participants had disclosed.

Following the completion of the initial coding of each participant account, I also took time to reflect on each contribution in its entirety and wrote down my impressions and thoughts about each one. This was a useful exercise as it began the process of thinking about potential data that I wanted to collect in the next phase of the study and informed my early attempts at theorising about the emerging codes in terms of whether they had "fit" with the data, were relevant to topic and how relationships between codes may potentially function (Charmaz 2006 p 54). In addition, this process of reflection after the initial analysis of each participant contribution also helped me to consider some of my preconceptions and existing knowledge about the topic (Charmaz 2006). An example of this can been seen in the reflection I carried out after the initial coding of Rebecca's first contribution:

> *"R talks about validation of feelings a lot, also genuineness in the relationship and that the therapist thinks she can improve her situation and get better-instillation of hope. This links to Yalom's curative factors in psychotherapy – I maybe need to find out more about this and look at this from a theoretical viewpoint."*

> (Reflection exert 13/09/13)

Due to my background as a therapist, I used the code "instillation of hope" as an initial code rather than use the words of the participant. I was aware that I was putting my own construction onto this code but equally I realised that I needed to find out more about this

aspect of the therapeutic relationship from the participants' perspective as well as my own interpretation of what that meant.

Subsequently, I wrote follow up questions after each reflection that I sent to the participants in the first phase. All bar one responded with a second set of data based on those questions. However, at that stage I did not analyse that additional data, but stored it on each of the participants' file. I have since questioned why I did this and an entry in my research diary dated six months later highlights some of my uncertainties:

> *"When the first stories came in and I carried out initial coding I also considered follow up Qs straight away before I had finished the phase one– this came out of the initial coding process and also following reflections on that process. I contacted people straight away with follow up Qs and not sure whether this was the right thing to do? The good thing is that I got secondary information which added clarity to their first stories and those who were ever going to respond did so straight away. Others have never responded or contributed to phase 2 even though they indicated they were happy to be contacted again. This raises issues of follow up online, when do you do it? However, did I lose the opportunity to ask people to contribute to 2nd phase as they had already given me two previous contributions?"*

<div align="right">(extract from research diary 27/05/14)</div>

Looking back on my decision to pursue follow up questions straight away with each phase one participant, before I had completed the first phase of analysis over the full data set, raises issues about asynchronous data collection in online research methods that I previously detailed in chapter four. Thus, in a face to face interview or indeed a synchronous online interview, as a researcher, I would have followed up questions in more detail at the time of the interview. When I analysed the data that was gathered asynchronously, I found myself naturally wanting to ask additional questions of the data to clarify meaning and

elaborate on aspects of their responses. Despite these first phase participants responding to the follow up questions, only one of them subsequently contributed to the second phase of the study. The reasons for this are speculative but it does raise the importance of the considerations about the timing of follow up questioning when using online data collection. My experience now tells me that this needs to be done quickly, particularly with hard-to-reach populations (Sydor 2013). I return to this issue later in this chapter.

I now return to the next stage of coding in the first phase of the data analysis. Following the initial coding for each participant I began organising the numerous initial codes that had emerged. For each participant, this involved organising and clustering these codes. I did this by condensing them into groups of similarities and then assigning a focused code to each grouping (Charmaz 2006). Focused codes are more conceptual and analytical than the descriptive initial codes and are used to analyse substantial amounts of data (Charmaz 2006). Moving from initial to focused coding requires the researcher to:

> "Make decisions about which initial codes make the most analytic sense to categorise your data incisively and completely."

> (Charmaz 2006 p 57)

In addition, developing focused codes begins the process of guiding the direction of the next stages of data gathering. I considered the meaning underpinning the clusters of initial codes and the analytic relationship between these codes, thus assigning a focused code that reflected the action or process of the therapist and the therapeutic relationship (Charmaz 2006).

Appendix 6 gives an example of how I condensed the initial codes from the analysis of Rebecca's transcript and assigned focused codes to these clusters.

The process of moving from the initial coding to focused coding was not a linear one. First, I constructed focused codes for each of the participants in the first phase and then compared these focused codes across each transcript. This iterative process of constant comparison

between the data is a crucial procedure in grounded theory and begins the development of a theoretical analysis that has relevance and fits with the data that is presented (Glaser and Strauss 1967, Charmaz 2006, Stern 2009). Second, I decided on what I thought were the most significant and frequent focused codes across the analysis at this point (Charmaz 2006). See appendix 4.

At this stage in the analysis, the focused codes were by no means clearly defined but they were useful for making decisions about the direction for the next stage of data gathering as detailed in section 6.4.

Furthermore, in this first phase of data collection and analysis, I also began the process of memo writing. Memo writing is viewed as a fundamental and essential method in grounded theory as it prompts the researcher to analyse the data and codes early in the research process (Charmaz 2006). It is suggested that writing memos is where the real analysis and thinking occurs; it moves the researcher away from working with raw data and begins the analysis of concepts and theoretical consideration (Corbin and Strauss 2008). I was encouraged to start writing memos in this first stage of analysis by my supervisors and I found it a useful process in beginning to make comparisons between data using the focused codes that I had constructed (Charmaz 2006).

The following extract from my research diary demonstrates my thinking and initial attempt at memo writing:

> *"Do I need to do start writing memos before I gather more data? I think I need to have thought through the data more before I move on to the next stage. Talking this over in supervision I have decided that I will write some short memos based around each of the focused codes that I am considering will inform the next stage of data collection....this will be a lay description initially of what each participant has said about the focused code, maybe include some mapping to make sense of where focused codes fit together?...I found this really useful to*

do. I wrote about what each participant had said about these code, added quotes, my thoughts and pointers to theory. I suppose these are openers for overall themes and categories? Doing this also made me read through the participant accounts again and think about coding again which at this stage is quite fluid. I'm not worrying too much about how I name codes at the moment - I think that will come. Also helped to think about issues to put out there for 2nd phase."

(Extract from research diary 26/11/13)

Thus, my first experience of writing a memo was relatively straightforward, however, my second attempt based on a different focused code had the unintended consequence of making me consider some of my pre – conceived ideas about the data. I chose to write a memo around the focused code of instilling hope:

"Ok so I choose the code – instillation of hope - that really interests me."

(Extract from research diary 27/11/13)

The following extract is taken from the original version of the memo:

"This issue was highlighted in 4 of the original participants' stories. It grabbed me as a code as it relates back to my previous training and experience in analytic group work and is identified by Yalom as a curative factor in group analysis. I recognise that I need to be careful about how I name, explore it as I have a previous knowledge and construct of what it is. So how did the participants describe it?"

Following the process of writing the first draft of the memo I concluded my reflection as follows:

"Mmm – this has been interesting to write up as a memo, there is not actually as much in the data as I thought! Maybe this says more about what I think is

116

important than the participants! It may be that it needs to be part of a wider code

– perhaps trust, acceptance or therapist enablers. I would still like to put it out

there in the next phase of data collection though to see what people say because

it is there but not as much as I thought!"

This was an important process for me to consider in the preliminary stages of the analysis. It illustrated how easily the coding could be forced based on my pre - understanding of concepts grounded in my previous knowledge and practice rather than being in the data itself (Charmaz 2006). Equally, it reinforced the necessity for me to be reflexive and carefully deliberate on my analysis and construction of codes and memos. Charmaz (2006) considers how the researcher can apply discipline based pre-conceived concepts to the analysis but warns that the researcher must make sure that they fit, through questioning their value and their place in the overall understanding of the data.

The following section details how I carried out the second phase of data collection and analysis.

6.4. The process of data analysis: phase two

As I previously detailed, the development of the focused codes across all the data in phase one thus directed the collection of further data in phase two of the study. Rather than pursuing all the focused codes in phase 2, I made the decision to base the second phase of data collection around eight focused codes that had arisen most frequently amongst the participants as highlighted in appendix 7 (Charmaz 2006). These codes were used to develop new participant guidance for the collection of data that aimed to develop the focused codes in terms of understanding more about their specific properties and components. This would add depth to the first phase of analysis and begin the process of analysing potential relationships between the focused codes (Corbin and Strauss 2008). Thus, this process of theoretical sampling seeks to gather relevant data that will develop the

theoretical analysis of the data through refining and elaborating on the emerging theoretical concepts (at this stage, the focused codes) (Charmaz 2006).

At this time, I didn't wholly reject the remaining focused codes that had also emerged from the analysis in phase one, i.e. the focused codes that were not the most frequently seen across the data. This was because during the process of memo writing in the initial stages of the analysis, I could see that some of these focused codes may be amalgamated into future theoretical analysis (Charmaz 2006). Similarly, I did not worry too much about refining what I called the focused codes at this stage as I thought that this would change during the process of analysis.

Subsequently a second set of participant guidelines were posted on the TherRel website. Appendix 4 illustrates how the participant guidelines were adapted between the recruitment of phase one and phase two participants. Thus, in phase one I asked potential participants to write freely about their experiences of the therapeutic relationship and posed open questions for them to consider. In phase two, I highlighted factors that had arisen in the analysis of phase one that were directly derived from the focused codes and asked the participants to write about those factors specifically. However, the participants still had the choice to write freely about their experiences, thus giving them the opportunity to add additional data that may elaborate on existing codes or offer new codes to consider in the analysis of the developing theory (Charmaz 2006).

As in the first phase of data collection, Beat advertised the second phase of the study via their website and on social media as previously detailed in chapter five.

In the second phase I planned to recruit new participants as well as gather further data from the original phase one participants. At this stage, I also made the methodological decision to only recruit adults (over 18) with anorexia nervosa specifically rather than participants with a range of eating disorders as was the remit in phase one (as outlined in table 2 in chapter five). Narrowing the parameters of participant recruitment is not synonymous with theoretical

sampling; which concerns only conceptual or theoretical development (Charmaz 2006). However, the reason for deciding to only recruit people with anorexia nervosa was because all bar one of the participants from the first phase described themselves as having or previously suffering from anorexia nervosa. I therefore, decided that pursuing this specific diagnostic category of eating disorders would have more relevance in the development of a substantive theory (Glaser and Strauss 1967).

Following the second recruitment advertisement, I began to be contacted by potential participants. As soon as I started receiving written accounts via the TherRel website I continued a similar process of data analysis as carried out in phase one. However, this time I concentrated the coding around the content of the focused codes. The aim of the analysis therefore, became centred around developing detail about the content of these codes. Whereas initial coding breaks down the substance of the data, this level of intermediate coding is said to reconnect the data in a conceptual way (Birks and Mills 2011). For example, one of the focused codes that emerged from the first phase of analysis related to the locus of control in the therapeutic relationship. In the second phase of analysis I attempted to unpick what control meant to the participants and how and in what conditions it manifested itself within the therapeutic relationship, thus building specific theoretical understanding and context to the focused code (Corbin and Strauss 2008). Although, the analysis of the data centred around the focused codes, I also kept the analysis open for new codes that had not emerged in the first phase of analysis.

In addition, I simultaneously looked for negative examples in the data (Charmaz 2006, Birks and Mills 2011). Negative examples refer to those that contrast or contradict the foremost patterns and ideas within the analysis of the data. These examples can be useful in refining and refuting emerging theory and providing alternative explanations (Charmaz 2014).

The process of data collection and analysis for the second phase of the study took a period of sixteen months. Looking back at my reflective notes during that time, this involved going through an iterative process of reading and coding the participant data when it was sent in

and using this coding to add to the conceptual depth around each focused code. I did this by drafting and redrafting the initial memos that I had written in phase one. This writing process entailed me defining the properties of the focused codes and comparing these across different participants' descriptions of their experiences. I also used raw data in the form of quotes to explicate and provide substance to the analysis. In addition, I asked questions of the analysis and offered speculations as to the processes and contexts of the focused codes and the relationships between them. These speculations where then used as the basis for testing out the emerging theory in phase three of the data analysis (Charmaz 2006). During this intensive writing phase in the analysis process, I also returned to the original data analysed in phase one and reconsidered this in the light of the phase two analysis. This constant comparison method helped me to build detailed, advanced memos that subsequently became the basis of the theoretical categories and the core category in the emergent theory (Charmaz 2006).

During the second phase of the analysis I also began to read and use existing autobiographical accounts of people with anorexia nervosa as additional primary data. As detailed in chapter four, extant or existing documents such as published autobiographies contrast with elicited written texts as the researcher is not involved in their construction. Nonetheless, autobiographies are used as legitimate data in grounded theory, both as supporting evidence for the researcher's developing theoretical ideas or as primary data (Charmaz 2006, 2014). My reasoning for using extant texts as additional primary data was two-fold. First, I was concerned that I would not be able to gather sufficient data from participants in the second phase as recruitment was limited in respect to numbers of participants. Second, I felt it would be enhance the theory development to include data that I had not specifically elicited (Charmaz 2014). Consequently, where published authors had written explicitly about their experiences of treatment for anorexia nervosa and working with therapists, I analysed their descriptions in the same way as the elicited data gathered from the phase one and two participants. That is, chunks of texts were reproduced into individual

word documents, coded and incorporated with quotes into the ongoing memos and analysis grids.

I found that the process of repeated memo writing to be crucial in the development of memos that moved from being just descriptive accounts from participants to being concept driven. In addition, during the second phase of analysis I began using diagramming as a tool that enabled me to see the data with a conceptual eye. Despite recognising that diagramming and mapping is viewed as an intrinsic aspect of grounded theory analysis (Charmaz 2014); I am not a naturally visual learner (Fleming and Mills 1992) and personally struggle to make sense of visual representations of theory and the relationships between theoretical concepts. However, with some persuasive encouragement from my supervisors I decided to carry out some diagramming of the focused codes to help clarify my thinking:

> *"I need to start diagramming in order to try and connect all the components of the therapeutic relationship that were emerging so far. At this point I am working mainly with four or five key focused codes. The others seem to be more peripheral. What I need to do is understand all the essential properties of these codes and think about how they fit together/cross over and the relationships between them because at the moment I can see that they are all four very closely linked. I also need to check out if these codes and the others from this phase stand up on their own or should they be condensed into others? I've gone back to the study aims again as I need to make sure that I don't go off on a tangent."*
>
> (extract from research diary 11/11/14)

I began this process by taking each of the memos for the main focused codes that I had been working on and using flip charts and post it notes began to explore how they fitted together, and where repetition and crossover of concepts was occurring. This involved breaking the memos apart, reconsidering and defining the properties of each focused code,

exploring the relationships between them and reconstructing them in a way that represented the data. By doing this I felt that I had moved away from the raw, initial codes and was considering the data at a higher conceptual level. Charmaz (2014) describes this analytic process as "raising focused codes to conceptual categories" (p188). Conceptual categories are also sometimes known as themes (Corbin and Strauss 2008). They represent higher level concepts or codes that explain the emerging ideas and processes in the data. Raising the focused codes into tentative conceptual categories moves the analysis from description of the data to a more abstract, theoretical level (Corbin and Strauss 2008, Charmaz 2014). Using the analysis methods of extensive memo-writing and diagramming I refined five key focused codes into four tentative conceptual categories. These became the basis of the third and final phase of data collection and analysis (Charmaz 2006, 2014). Diagram 2 in chapter seven illustrates the development of these conceptual categories and I also specify the process of how I refined them in more detail.

Moving on to collect more data in the third phase was necessary for several reasons. During the preceding analysis, I began to feel that I was reaching a stage of analysis where I was not gaining any further insight in understanding the conceptual categories that I was constructing. In fact, the analysis was raising more questions in my mind than providing explanations. Thus, I concluded that I had reached a stage of "theoretical sufficiency" (Dey 1999 p 257 cited in Charmaz 2006) with the data from phase one and two of the study. I use this term rather than the more widely used theoretical saturation (Charmaz 2006) as it explains more accurately where I was at with the data during this stage of the analysis. Theoretical saturation implies that the analysis is complete and that gathering new data will not provide new theoretical understandings (Charmaz 2006). I felt that the analysis undertaken at this point was not exhaustive; I needed to remain open to new insights into the tentative conceptual categories that I was constructing. In addition, I had questions that I wanted to ask of the data to explicate the gaps in the emerging theoretical ideas.

Consequently, I decided that I needed to undertake an additional phase of data collection (Charmaz 2006, 2014).

6.5. The process of data analysis: phase three

As mentioned earlier I used four conceptual categories for the basis of the data collection in phase three. As also detailed in chapter five, the aim of collecting more data in this final phase of the study was to return to the participants from phase one and two to ask them to elaborate on the theoretical ideas that I was constructing so that I could further refine the emerging theory. This form of participant member checking would give the participants the opportunity to comment on the ideas I had constructed and confirm or deny their relevance in light of their own experiences (Charmaz 2014, Birks and Mills 2015).

It has been suggested that participant member checking is in fact a redundant activity in grounded theory as it is not the aim to develop an:

> "Accurate representation of individuals' lived experience generated through a process of phenomenological interviewing, instead grounded theorists aim for a highly conceptual theorization of process, apparent in relation to a particular substantive area of enquiry."

(Birks and Mills 2015 p 97)

Similarly, they concur with the view that participants' views and beliefs about their experiences are changeable and therefore can be seen as unreliable. However, despite this assertion, Charmaz (2014) suggests that member checking can be useful for the elaboration of theory rather than primarily to achieve verification of that theory from participants. This is what I aimed to achieve by returning to the past participants. In addition, I also felt that they had invested significantly in the study both in terms of providing personal data and in the effort taken to write about their experiences. Thus, I wanted to give the participants an

opportunity to comment on how I had used these accounts and to close the research cycle in a collaborative manner.

In order to write the participant guidelines for phase three, I used the memos that constituted the four conceptual categories. I picked out what seemed to be the most pertinent ideas from each memo and used these to write a set of statements which I developed into revised guidelines for the participants (see appendix 4). The statements were followed by some open questions aimed at prompting the participants to consider them from their own experience and elaborate further on the ideas presented. These revised guidelines were again posted on the TherRel website. The process of returning to the participants with specific theoretical ideas to re-consider reflects the nature of theoretical sampling in grounded theory (Charmaz 2006). Thus, I started this study from a position of inductive data analysis in the first phase and ended with a stage that was abductive in that I was reasoning about "theoretical conjectures" (Charmaz 2014 p 201). Returning to the participants to fill gaps in the emerging theory, helped to clarify the relationships between the theoretical categories as well as adding further depth to the theoretical categories and emerging core category (Charmaz 2006, 2014).

I then e-mailed all the past participants from phase one and two who had indicated that they were willing to be contacted for further contributions. I received three immediate responses on the day the e-mail was sent all indicating an interest in contributing to the final phase. These respondents were from phase two, although one had originally contributed eighteen months previously. Two further participants from phase two of the study also contacted me. There were no responses from phase one participants although some had already contributed multiple responses during that phase. The timing of returning to past participants needs to be carefully considered particularly if data collection occurs in phases over a protracted period of time as was the case in this study. The time taken between the first and third phases (two years) was probably a factor in the low levels of responses in the final phase as well as the nature of the illness of anorexia nervosa. Some original respondents

may have recovered and perhaps would not want to revisit these experiences again, or conversely, they could have relapsed in their recovery. It may also have been just indicative of the sometimes, chaotic lifestyle some people with anorexia nervosa experience. I was also aware that what I was asking for would have involved the respondent in writing a lengthy, considered response, much more so than a short survey or questionnaire. I got the feeling that with the three participants who contributed to the final phase, I had just caught them at the right time with the e-mail. Although they still required a further follow up e-mail, three out of the five people who initially responded again sent detailed responses. Rather than coding this final set of data, I considered the explanations and opinions about the statements and questions I had posed including those which offered a contradictory view. I used the participants' quotes and views to further refine the explanatory theory that was developing in the conceptual categories thus adding more defined analysis (Charmaz 2006, 2014). In addition, I continued to analyse existing data gleaned from autobiographical books and online blogs written by people with anorexia nervosa. Again, the analysis focused on the ideas that had developed through the construction of the four conceptual categories and was guided by the statements and questions asked in the third phase of data collection.

It was during the third phase of data analysis that I began to consider the presence of a central or core category in the data. The central or core category is described by Corbin and Strauss (2008) as the central concept or theme of the research. The central category develops over the course of the study and has the "greatest explanatory relevance and highest potential for linking all the other categories together" (Corbin and Strauss 2008 p104). During the preceding phases of analysis, I had not been conscious of trying to find a central category. However, during the process of developing the four conceptual categories and working out the connections and relationships between them, I became aware that one of the conceptual categories "one size doesn't fit all" did not fit comfortably on its own as an aspect of the therapeutic relationship per se. Despite this, it was still crucial to consider this concept in relation to the therapeutic relationship. Through the analysis in the third phase it

emerged that in fact it held more relevance as a central explanatory category that encapsulated an integrated explanation of the therapeutic relationship with adults with anorexia nervosa (Birks and Mills 2011). I detail the process of the development of the central category further in chapter seven.

The third phase of data collection was also the final phase of collecting written data directly from participants (although I continued to use existing literature and online blogs as data). At this stage, I felt I had sufficient data to construct an in-depth substantive theory about the therapeutic relationship in relation to adults with anorexia nervosa. This decision was based on considering issues of what pertains to quality in grounded theory studies.

6.6. Quality of the data collection and analysis

The evaluation of the quality of a grounded theory study is generally considered by its credibility, relevance and fit (Glaser and Strauss 1967, Charmaz 2006, Corbin and Strauss 2008, Birks and Mills 2015). That is, are the findings believable or plausible? Are they relevant and applicable to the area being investigated? Will they be useful and provide understanding in the field of concern? (Corbin and Strauss 2008).

Charmaz (2014) contends that the credibility of a grounded theory study begins with the quality of the data collected. At the beginning of the first data collection and analysis phase of this study I was concerned about my ability to be able to gather sufficient quantity, depth and range of data using online research methods. On reflection, I believe I was able to gather sufficient data to be able to make systematic comparisons across the participants. The elicited written data collected was in-depth and detailed with several participants offering multiple contributions. This data was also supplemented with additional extant published autobiographical accounts and data from online blogs and the three phases of the study and analysis detailed descriptions of a range of participant views, including variations in cases (Charmaz 2006, Creswell 2007). Thus, over the three phases of the study, I judged that I

had collected enough data to be able to achieve theoretical sufficiency as previously described (Charmaz 2006).

In addition, I established rigorous and systematic methods of data collection and analysis. I have endeavoured to be transparent about these throughout this chapter and provide a clear, detailed explanation of the processes and decisions I made about the use of these methods (Glaser and Strauss 1967, Corbin and Strauss 2008). Moreover, I have adopted a reflexive approach throughout the whole research process so that I could consider my prior knowledge and beliefs and how these impacted on the construction of the theory (Creswell 2007, Alverson and Sköldberg 2000). Charmaz (2014) also considers the issue of originality of findings when considering quality in grounded theory. She asks the questions "are the categories fresh? Do they offer new insights?" (p 182). These were questions I asked myself through the process of analysis as I had concerns that the findings I was constructing were not necessarily new in relation to what is known about the therapeutic relationship generally. However, what the findings do is offer a substantive knowledge to the area of concern; that is the nature of the therapeutic relationship from the perspective of adults with anorexia nervosa. In addition, the findings reveal relevancy and usefulness to the area of clinical practice and portray the experience of the participants (Charmaz 2014). I base this claim on my experiences of presenting the findings at two professional conferences during the analysis phases of the study. Firstly, at the Eating Disorders International Conference in March 2016 in the Institute of Education, London. Secondly, at the London Eating Disorder Conference in March 2017. Attendees at the conferences included academics, clinicians, service users and carers. At both conferences, the findings were well received by the audience as evidenced by their questions and feedback. Furthermore, the findings echoed the key themes that were being discussed in the wider context of the conferences i.e. the therapist stance in the engagement of adults with anorexia nervosa and the need for individuality in the application of therapeutic approaches in the treatment of anorexia nervosa.

I return to the evaluation of the quality of my study in more detail in chapter twelve.

6.7. Conclusion

In this chapter, I have detailed the process of data collection and analysis I undertook in the three phases of this study primarily from a theoretical perspective. Throughout the chapter I also explained pertinent decisions I made during each phase of the study and attempted to demonstrate methodological congruence regarding the use of grounded theory analysis methods. In addition, I have also included excerpts from my research diary as examples of some of the reflexive considerations that arose throughout this process.   The data analysis procedures I undertook in the first phase of the study were extensively influenced by the methods described by Charmaz (2006). Subsequently, in the two phases of data collection and analysis I utilised wider sources of grounded theory to further develop the process undertaken (Corbin and Strauss 2008, Birks and Mills 2011, 2015).

In the following chapter, I detail how I constructed the theory using the grounded theory methods of initial coding; the identification of focused codes and the raising of the focused codes into conceptual categories through memo-writing and diagramming. I also describe how I constructed the central or core category that runs as an explanatory thread throughout the findings of this study. In addition, I detail how and when I returned to the literature to further explicate the development of the theory.

Chapter Seven

The development of the theory and an overview of the findings

<u>7.1. The development of theory in this study</u>

In grounded theory, the process of theorising is an ongoing analytic activity (Charmaz 2014). The first stage of theory development began during the process of initial or open coding of the first written participant contribution. As previously detailed, appendix 5 demonstrates the initial coding of Rebecca's first transcript.

The following diagram 2 illustrates the process of theory development from the establishment of the focused codes at the end of phase one of the data collection through to the identification of the central or core category. I will now explain that process in more detail.

As detailed in the previous chapter in section 6.3 and illustrated in appendix 7, the focused codes were developed through a process of examining all the initial codes for each participant in the first phase of data collection and clustering them into groups of similarities. These clusters were then compared across all the participants in this phase and I selected the clusters that stood out as being significant and the most frequent. These clusters became the focused codes and were assigned a name. Thus, there were ten focused codes that I used to inform the second phase of data collection as previously described.

Phase 2 Focused codes					
The locus of control	Timing in the relationship	Feeling understood	Boundaries	Developing trust	Honesty
Therapist enablers	Impact of the relationship			Instillation of hope	Therapist gender

Phase 2 Key memos					
The locus of control	Being seen as an individual	Therapist enablers		Developing trust and understanding	Instillation of hope

Phase 3 Conceptual categories				
Balancing control	"One size doesn't fit all"		"They just got me"	Developing trust

Phase 3
Central or core category
"one size doesn't fit all": individuality in the therapeutic relationship and the context of the therapy

Diagram 2: The development of the theory.

Subsequently, in the analysis of the data received in phase two, I concentrated the writing and development of memos around five concepts (focused codes) shown above in diagram 2: the locus of control, being seen as an individual, therapist enablers, developing trust and understanding and instillation of hope. These five memos were constructed through a process of considering the properties of the focused codes as detailed by the participants. As mentioned previously the properties are the characteristics and dimensions of specific concepts. Developing the detail of the properties helps to define and describe the concept in more depth (Corbin and Strauss 2008). The following diagram illustrates the properties of the focused code, developing trust in the therapeutic relationship. This was an early diagram that also demonstrates some of the analytic links between the focused codes pertaining to trust, letting go of control and feeling understood by the therapist.
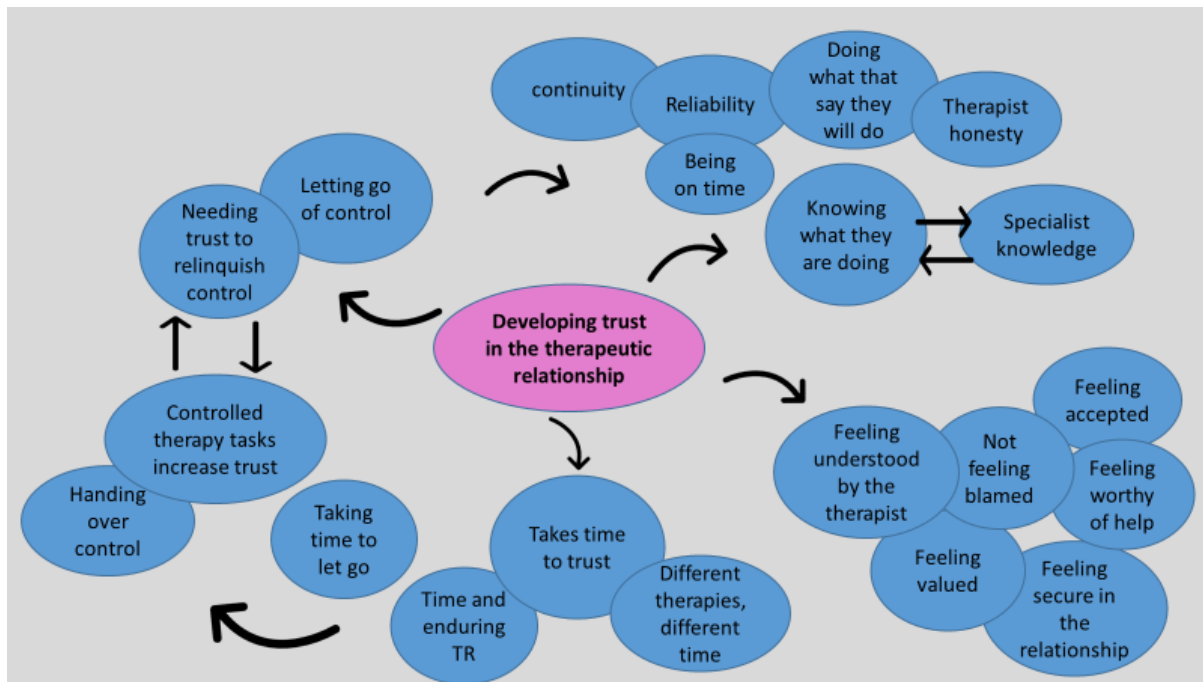
Diagram 3: Early analytic diagram of the properties of the focused code developing trust.

By considering the specific properties of the focused codes I began to see where there was cross over and repetition between the focused codes and where codes could be pursued on their own as potential conceptual categories. Some focused codes appeared to be more peripheral and to fit better if amalgamated with other focused codes (Charmaz 2006). For example, at this stage of the analysis, the focused codes named timing in the relationship, honesty and therapist gender were incorporated into an early memo called developing trust and understanding in the therapeutic relationship.

This second phase of analysis was a fluid process where I moved focused codes and their properties around, through the process of writing memos and diagramming to find the best fit (Charmaz 2006). An example of this is illustrated by considering the focused codes of developing trust and feeling understood. As focused codes, I asked the participants to consider them as distinct codes. However, in the preliminary stages of memo-writing, I amalgamated them together as a key memo: developing trust and understanding in the therapeutic relationship. This was because I could see from the data that they were closely linked as illustrated in diagram 3. However, during the process of analysing the properties of

both focused codes I decided that despite the contextual similarities between them, they also needed to be analysed individually in more depth to understand the relationships between them. Subsequently I considered these concepts of the therapeutic relationship separately as the conceptual categories: "they just got me": feeling understood and developing trust in the therapeutic relationship (see diagram 2).

Two further key decisions I made during phase two of the analysis was to discard the focused code; therapist enablers and the memo; instillation of hope. First, the therapist enablers were too big to maintain as one focused code. On examining the properties of this code further through memo writing it emerged that there was frequent repetition of other focused codes and properties that were being developed in other memos. For example, therapist honesty, feeling cared for by the therapist, being listened to and being seen as an individual were also properties embedded in the memo; developing trust and feeling understood.   Second, as I detailed in chapter six, the focused code instillation of hope did not hold up on its own as a memo or as a potential conceptual category although it was still an important aspect of the therapeutic relationship and present in the data. I consequently made the decision to merge this memo into the memo: developing trust and understanding, by the end of the second phase of analysis.

Thus, during this second stage of theory development, I continued to use memo-writing and diagramming to raise the focused codes to conceptual categories as described in chapter six. The basis of the theory at this stage was captured in the memos and consisted of detailed analysis of the properties of the focused codes, supplementary data from the participants in the form of direct quotes and my own conjectures about the emerging theoretical ideas about the nature and context of the therapeutic relationship. Subsequently, to further refine the theory, the data collection for phase three was directed by four emerging conceptual categories: balancing control, being seen as an individual, developing trust and feeling understood as illustrated in diagram 2.

Phase three of the study was the consolidating stage of theory development. The aim of the final phase was to test out the emergent and tentative theoretical ideas for further refinement of "theoretical adequacy'" in the developing theory (Charmaz 2014 p90). This was achieved in the following ways. First, I collected additional data from the participants to gain their insight into the theoretical conjectures that I was constructing (appendix 4). Second, I undertook a second literature review that was directed by the four emerging conceptual categories. Third, using the final participant data and the existing literature I undertook a final process of memo-writing and diagramming to confirm the final theoretical framework of the therapeutic relationship.

7.2. Using existing literature in theory development

As detailed in chapter two and three, in the planning stages of this study I undertook a limited literature review with the aim to develop and justify the aims of this study. Following that I put that body of literature aside and did not return to consider any further literature until after the final phase of data analysis. Subsequently, the substantive literature review was tailored by the emerging theoretical findings as befits grounded theory methods (Charmaz 2014). First, I returned to the body of literature I had originally gathered for writing the proposal for this study. I thus re-considered this literature by focusing primarily on the findings and compared these in relation to my emerging theory (Charmaz 2014). That is, I considered what had been found in these studies in relation to the concepts of control, being seen as an individual, feeling understood and trust within the therapeutic relationship with people with eating disorders. I narrowed this specifically to literature pertaining to adults with anorexia nervosa as far as possible at this stage to reflect the participants in my study. I then updated the literature review from 2012 – 2017 using the specific search terms: anorexia nervosa, adults, therapeutic relationship, therapeutic alliance, treatment, control, trust and empathy. Subsequently, I used the literature found to compare against the findings in my study and further explicate the theoretical framework that I constructed. I continued to review

and update the literature into the theoretical findings and the overall presentation of the thesis until the final stage of writing up was complete. During this period, the literature used was directed by the ongoing theoretical development and reading that I undertook. Therefore, it was not a systematic review of literature as may be expected in the use of some research methods. Rather it was a more organic process that involved utilising a wide range of literature including peer reviewed research studies, clinical guidelines, practise based academic books, autobiographies and online blogs of people with anorexia nervosa.

Thus, I undertook a literature review process with the aim to engage in the ideas and research that my grounded theory addressed; to evaluate earlier studies in the light of my own findings; to develop the theoretical connections of my own grounded theory against existing theory; to identify gaps in existing knowledge and recognise where my theory may extend knowledge thus clarifying its contribution to the field (Charmaz 2014).

 The final phase of theory development, therefore, consisted of reviewing and incorporating pertinent literature as well as the final participant contributions to the developing theory through the processes of continued memo – writing, diagramming and "just plain thinking" (Corbin and Strauss 2008 p274). This stage in the theory development involved making analytical decisions about the establishment of the conceptual categories that integrated and fully explained the phenomena of the therapeutic relationship as well as ascertaining the relationships between them (Corbin and Strauss 2008).

 7.3. An overview of the theory

As illustrated in diagram 2, the final analysis process began with four potential conceptual categories in phase three. These were finally consolidated in a theoretical framework that was constructed from three conceptual categories and underpinned by a central category as illustrated in the following diagram.
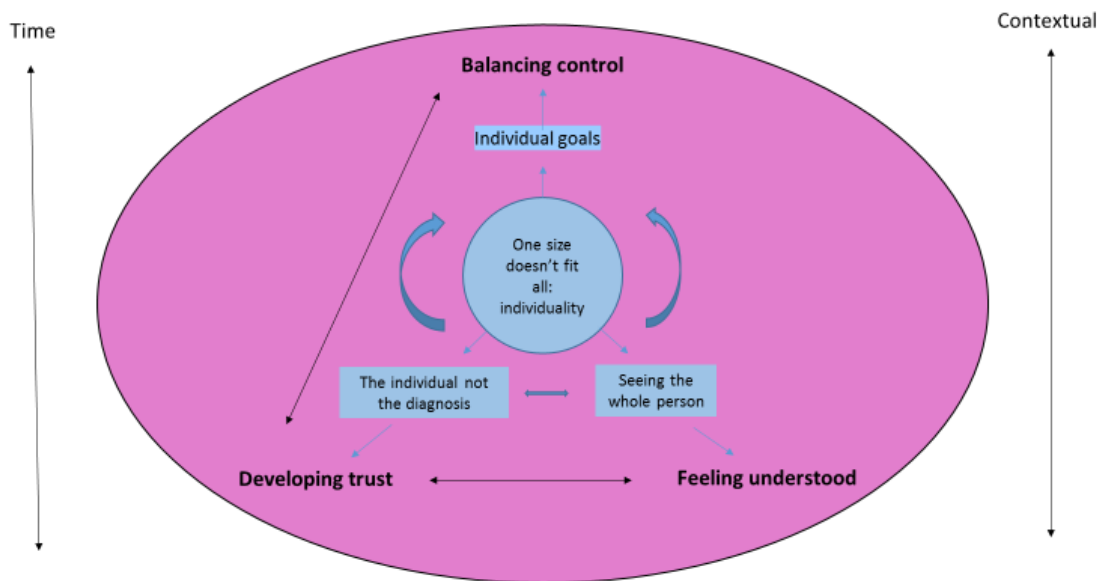
Diagram 4: The framework of the therapeutic relationship for adults with anorexia nervosa.

Firstly, within the diagram, the social process of the therapeutic relationship between the therapist and the client is represented as the purple oval. Making up the therapeutic relationship are three crucial components. These are balancing control; developing trust and feeling understood by the therapist and are depicted in the diagram at the out edges of the circle. These three components have equal weighting in the relationship, but their relevance and importance may be individually interpreted by the client. For example, a client may approach therapy for the first time from a position where developing trust in a therapist may be the most significant factor for them. Once established, this may not hold as much importance but negotiating therapy goals may become more pertinent. Therefore, the nature of the therapeutic relationship is dynamic and contingent on temporal and contextual factors such as the stage and setting of the therapy (represented in the diagram by the two-way arrows set outside of the relationship).

The detailed properties of the three components of the relationship are presented in the following concurrent findings and discussion chapters, eight, nine and ten. In addition, the

relationships between the components are examined, for example, in the diagram the inextricable link between feeling understood and developing trust is represented by a two-way arrow.

However, firstly I present an outline of the central category (Birks and Mills 2015); "one size doesn't fit all" or individuality in the therapeutic relationship as depicted in diagram 4 as a blue circle.

As I discussed in chapter six, the central or core category develops over the course of a study and is the unifying concept of the research with the greatest explanatory power that synthesises the findings in a coherent, theoretical way (Corbin and Strauss 2008). In some grounded theory analyses, the researcher approaches the data analysis with the purpose of finding the core category (Corbin and Strauss 2008). Other writers contend that the identification of a central, explanatory category is not always necessary in grounded theory (Charmaz 2014). On reflection, in the initial stages of the data analysis in this study, I was not aware of consciously looking for a central category, however, the presence of the notion of individuality within the therapeutic relationship was evident throughout the three phases of the theoretical analysis. Initially, it was apparent in the initial and focused coding process where seeing the person as an individual was considered as an aspect of therapist style as an enabler of the therapeutic relationship. Subsequently, as the analysis of phase one developed, the notion of individuality became more defined within the emerging conceptual categories of the therapeutic relationship of control, trust and feeling understood.

However, individuality within the therapeutic relationship also emerged more evidently in the phase two analysis, when I began writing the memo initially titled, being seen as an individual. This memo subsequently developed into the potential conceptual category: "one size doesn't fit all." The use of in vivo codes in grounded theory refers to the employment of significant participant language or terms in analytic coding. In vivo codes can be used to capture and preserve participant meaning whilst simultaneously being readily understood by a wider audience. I felt the phrase "one size doesn't fit all", found frequently in my

participants' accounts, perfectly summed up their concerns and experiences of working with therapists (Charmaz 2014).

However, towards the end of the overall analysis it also became clear to me that this potential conceptual category didn't fit comfortably on its own with the key phenomenon of the research, that was, the nature of the therapeutic relationship. Although individuality was inherent within the nature of the therapeutic relationship as mentioned above, the focus of this category was developing more evidently around the individual context of the treatments that the participants had received rather than as a key component of the therapeutic relationship per se. That said, I still felt that it was an important concept to pursue in the analysis because the therapeutic relationship must be developed within the context of the treatment modality and the treatment setting.

Thus, the central or core category "one size doesn't fit all": individuality, epitomises the main premise of this study and therefore the final theoretical explanation of the therapeutic relationship encompasses individuality as the central explanatory category that elucidates the *nature* of the therapeutic relationship as pertaining to the three key components of the relationship as well as explaining the *context* that the relationship develops within. This central category and the associated concepts that link to the three components of the therapeutic relationship are depicted in diagram 4 as a central blue circle with radial blue boxes. The relationships between these are represented by the blue arrows. For example, a crucial aspect of developing trust is that the therapist sees the individuality of the client first rather than primarily the diagnosis of anorexia nervosa. This may involve the therapist and client developing individualised therapy goals that acknowledge the holistic nature of the client, rather than goals based principally on eating disorder symptomatology. This in turn helps the client feel that the therapist understands them as an individual. These dynamic processes are explored further in the following findings and discussion chapters and returned to in the conclusion in chapter twelve.

7.4. Conclusion

This chapter has provided an explanation of the process of theory development and an overview of the findings of the study. The substantive theory pertaining to the therapeutic relationship with adults with anorexia nervosa was constructed using constructivist grounded theory analysis methods. The refinement or funnelling down of the theoretical ideas was derived through the analysis of the initial codes, followed by the focused codes and subsequent construction of the conceptual categories. These conceptual categories encapsulate the three key components of the therapeutic relationship:

- Balancing control in the therapeutic relationship.

- Developing trust in the therapeutic relationship.

- "They just got me": feeling understood within the therapeutic relationship.

These three crucial components of the therapeutic relationship are underpinned by the central category of "one size doesn't fit all" or individuality. This relates to the necessity to consider the nature of the therapeutic relationship on an individual basis as well as within the context and timing of the treatment modality.

The constructed theory that explains the therapeutic relationship with adults with anorexia nervosa is presented in detail in the following three chapters. Each chapter explicates a key aspect of the therapeutic relationship and is presented as a synthesis of the findings and discussion. The findings derived from the analysis are considered and compared with existing research and enhanced by the participant voice through the presence of direct quotes. The central category of individuality is presented as an explanatory thread throughout each chapter to clarify both the dynamic nature and context of the therapeutic relationship.

Chapter 8: Findings and Discussion

Balancing control in the therapeutic relationship

8.1. Introduction

The first component of the therapeutic relationship relates to issues of control between the therapist and the client. In the first phase of analysis in my study, the initial codes pertaining to control within the therapeutic relationship included: the perceived locus of control, needing control, letting go of control, handing control over to the therapist and having control over therapy. These initial codes subsequently developed into the focused code; the importance of feeling in control within the therapeutic relationship. This focused code was then used to direct the data gathering in the second phase of the study, where the participants were asked to consider control as an aspect of the therapeutic relationship in more depth. Further consideration of how control manifests itself within the therapeutic relationship and what needs to happen within the relationship to achieve a balance of control between the therapist and the client was then undertaken in phase three of the study.

This first findings' chapter therefore considers the conceptual category of control; first, as a defining feature of anorexia nervosa and second; how the concept of control manifests itself within the therapeutic relationship. The chapter concludes with a theoretical explanation of how control impacts on the ability of the client to engage in a therapy process and the conditions necessary for the client to relinquish control. Notably these conditions include; the perception of working in collaboration with the therapist to develop goals that are individually negotiated between the therapist and the client; the need for the client to feel that they have equity within the therapeutic relationship.

8.2. Control as a central feature of anorexia nervosa

In previous eating disorder research, the concept of control has often been examined as a personality trait associated with vulnerability to developing anorexia nervosa (Tan et al. 2003). In my study, control was described by the participants both as a feature of anorexia nervosa as well as a component of the therapeutic relationship. From a therapist's standpoint, issues of control in the person with anorexia nervosa are often seen as a central feature of the problem that needs to be addressed in therapy (Lawrence 1994, Thomas and Schaefer 2013, Palmer 2014). However, in contrast, for the person with anorexia nervosa, maintaining control over eating and maintaining low weight has a positive function in managing psychological distress (Geller at al. 2001, Woolf 2015, Ellie 2016a). In my study participants described sustaining rigid control over their weight and diet as a coping strategy for dealing with life events. For example, one participant, Fay, described her controlled eating behaviour as a method of maintaining order in what she perceived as her out of control life. In addition, she also acknowledged the function this controlled behaviour over her eating had as a self – punishment strategy:

> *"Due to stress I began to lose weight. I liked it and didn't want to stop, so I began restricting my food and making myself sick. This soon became a way of feeling in control. Everything else in my life was falling apart. My eating was the only thing I had control over. Also, I wanted to punish myself for failing my marriage and destroying my children's home life."*

Similarly, Sion described a process of developing control around his weight when life events began to spiral out of his control. His approach was to engage in excessive exercise, develop strict dietary control and avoid social activities:

> *"...my life was now completely engrossed, submerged in a sea of anorexia, I could not see anything else. 24 hours a day, 7 days a week with no rest."*

Despite saying this however, he also recognised that what started as a coping strategy quickly took over his life:

> "I just had to be thinner and it became a war with me, is that the best way to describe it? My thoughts were no longer my own."

Helen also wrote about a controlling/controlled dichotomy of anorexia nervosa and how this ultimately impacted on her wider social engagement in life:

> "*My life is very much dictated by my eating disorder. University has been very challenging as eating is such a social activity and something I cannot engage in. I often suffer from headaches, dizziness, lack of concentration and lethargy due to lack of food. I am very controlling as to when I eat and what I eat. Therefore, if something gets in the way of this, it results in a lot of distress and anxiety. Also because of the tiredness and anxiety from the ED* (eating disorder, her abbreviation)*, I find social things and extra-curricular activities too much which increases my social isolation and social anxiety.*"

Therefore, in the early stages of anorexia nervosa, the participants described a process of controlling their diet as a coping strategy to feel they had control over themselves or aspects of their lives. Ultimately, however this led to the disorder controlling them, and thus they experienced increased isolation in wider domains of their lives and relationships (Bruch 1978, Robinson 2009).

As discussed in chapter three, features of excessive and obsessional control are a defining, indeed central concern in the life of someone with anorexia nervosa (Bruch 1978, Lawrence 1994, Berg et al. 2002, Fairburn 2008). Control is characterised primarily with sufferers maintaining rigid restraint over their diet and eating patterns to maintain low weight. Equally, control may also expand to other aspects of the individual's life such as their relationships and daily routines. Ironically, the struggle involved in maintaining control in their lives can indeed become out of control in itself. Therefore, what starts out as the individual taking

control over their weight and diet, ultimately ends in the resulting illness taking control of the individual (Tan et al. 2003, Palmer 2014). Anxieties about losing control are prominent and individuals will often approach treatment from the standpoint of feeling they need to maintain control over clinical interventions. Fears that they will be forced to make changes that will dismantle or threaten their sense of control are common (Lawrence 1994, Berg et al. 2002, Tierney 2008, Bezance and Holliday 2013, Gulliksen et al. 2015). On the other hand, people with anorexia nervosa can also experience control being taken away from them through engagement in treatment as a relief (Bezance and Holliday 2013).

Despite the obvious problematic consequences of maintaining this cycle of control in anorexia nervosa, sustaining this control often equates to survival in the mind of the individual. Thus, understanding this process can enlighten therapists to the intense fear that people may experience as they contemplate engaging with treatment (Berg et al. 2002). In addition, people with anorexia nervosa tend to regard the control they maintain over their eating with pride and as something that makes them different or special from the average person struggling with weight control (Bowman 2006). Therefore, entering treatment is often viewed with ambivalence and resistance which can adversely affect the development of the therapeutic relationship (Vitousek et al. 1998, Gulliksen et al. 2015).

8.3. How control manifests itself within the therapeutic relationship

8.3.1. Negotiating collaborative treatment goals

Tan et al. (2003) suggest that it is valuable to consider individuals' experiences of how control manifests itself within the therapeutic relationship and the subsequent engagement in therapy for treatment of anorexia nervosa. In my study, the perceptions of the participants' in relation to the development of the therapeutic relationship was often influenced by their experiences in relation to where the locus of control lay when it came to making decisions about treatment. Perceptions about control were particularly heightened in relation to the establishment of weight related goals and were often relative to the treatment setting.

For example, Beth described her experiences of in-patient treatment for anorexia nervosa as a young woman. The treatment was focused on weight recovery and the service used behavioural incentives to encourage weight gain. Although she successfully gained weight during this time, this was not sustained on discharge and the imposition of weight related goals impacted negatively on her ability to develop relationships with any of the staff. As she recounts:

> "*It was essential for me to feel that I had some control over my treatment……*
> *Discussion about diet and weight goals were important as was timescale. When*
> *a target weight was imposed on me I automatically felt it was unreasonable and*
> *would return to a very low weight as soon as I could.*"

Although Beth's experiences of in-patient treatment began in the 1970s, her treatment experiences still resonated with the accounts from younger participants and their experiences of being treated within in-patient settings in more recent years. Fiona recounted her experiences of having treatment for anorexia nervosa in a mixed adolescent unit and being "*forced*" to gain a body mass index (BMI) above 15 as a teenager. She described relationships with ward staff and therapists during this period of her life as being negative.

Ramjan (2004 p 498) described a "struggle for control" between staff and patients in relation to developing helpful therapeutic relationships with young people with anorexia nervosa receiving in-patient treatment. She suggests that the struggle for power and control is generally played out around food choices and the methods used for re-feeding and weight recovery and it is this struggle that is the key impediment to the development of a therapeutic relationship between nurses and people with anorexia nervosa within these types of settings (Ramjan 2004). Similarly, Snell et al. (2010 p 356) suggest that the "integrity of the therapeutic relationship" and the ability of the individual to make meaningful connections with staff is also affected by the nature of control and resistance inherent as a characteristic of anorexia nervosa. Thus, due to the environment and treatment regime often

found within in-patient settings there can then be a re-enactment of the controlling and negative relationship dynamics that the individual may have previously experienced, for example, with a parent or partner (Snell et al. 2010). In addition, it is also suggested that the ego-syntonic nature of anorexia nervosa may elevate the perception of control and coercion often perceived by individuals within in-patient settings (Sly et al. 2013). Therefore, the individual denies that they have an illness and resist any attempts to change the beliefs and behaviours that drive their pursuit for thinness and control (Crisp 1997, Birmingham and Treasure 2010).

However, it is also suggested that good in-patient care that provides a safe and predictable environment can also help the individual, particularly younger people, to be able to let go of some of their internal control processes and behaviours (Pemberton and Fox 2011, Palmer 2014). Thus, in - patient environments with an external control, boundaries and structure can help people to feel safe and contained (Bezance and Holliday 2013). Likewise, it is suggested that it still possible to achieve effective therapeutic relationships between staff and adults with anorexia nervosa within in-patient eating disorder settings. However, the style of relationship may need to be more maternalistic and nurturing than would be found in other therapy encounters and environments (Wright 2010).

Returning to the concept of control in Beth's experiences of being treated for anorexia nervosa, she found that receiving treatment as an out-patient enabled her to be given more control over the pace of weight recovery and the types of foods that she felt were acceptable to include in her diet:

> *"The successful therapist allowed me to increase weight at my own pace and gradually introduce previously 'impossible' foods. We agreed a reasonable weight, which was low but liveable. With regular meetings and discussion about feelings about food and other issues I was able to keep the weight stable for long enough for it to become easily bearable."*

Thus, having this level of control and involvement in her treatment allowed her to engage with the proposed treatment plan; subsequently she perceived the therapeutic relationship with the therapist to be helpful.

In this instance, a successful therapeutic relationship was established because the therapist took the stance of working in collaboration with the individual through planning acceptable goals regarding weight recovery and food choices. This approach helped Beth maintain a sense of control over her treatment, whilst also allowing her to simultaneously relinquish some control to the therapist. Likewise, Fiona described her experience of working with a clinical psychologist as an adult in an out-patient eating disorder setting. In this relationship, she described having some elements of choice and control over the process of therapy where the psychologist agreed to work with her without imposing weight based goals that were *"intolerable to me."*   Taking this approach helped Fiona develop trust in the psychologist which led to the development of what she described as a *"successful therapeutic relationship."* This relationship, was subsequently able to withstand potential ruptures when the psychologist had to recommend compulsory admission for further treatment. Paradoxically, though, despite recognising that she did engage successfully with this therapist, in part because she could continue to control her weight, Fiona also admitted that:

> *"There are times when I'm longing to have control of my eating taken away from*
>
> *me so that I can have a break from the grip that anorexia has over me."*

It must therefore be considered that there is a fine balance for therapists to consider regarding how much negotiation there can be in respect to weight recovery goals as an aspect of therapy and how this negotiation will impact on the development of the therapeutic relationship. It is suggested that a collaborative relationship between the therapist and the individual with anorexia nervosa can maximise the chances of engagement in treatment (Geller et al. 2001, Berg et al. 2002). However, time and patience is generally needed on the part of the therapist, in particular, in the early stages of engagement in order to develop this

style of relationship and to build the trust needed to maintain it (Geller at al. 2001, Berg et al. 2002). It is also recommended that there needs to be a balance achieved between control versus non- control when working with people with anorexia nervosa with some aspects of treatment being non – negotiable (for example the negotiation of an agreed minimum weight that the therapist will work psychologically with the individual) (Berg et al. 2002).

The need to strike a balance between feeling controlled and people having a sense of collaboration with their treatment goals is also highlighted by Offord et al. (2006). In their study, they examined young women's experiences of treatment for anorexia nervosa in an in-patient setting. It was found that although the participants initially experienced the treatment regime as over controlling, they also recognised, in hindsight, that the structure and boundaries the ward provided were a necessary aspect of treatment in their overall recovery. For those participants that received psychological therapy whilst in this setting, it was reported that approaches that were client led and collaborative were generally felt to be the most helpful. However, it is also of importance to note that some participants in their study disagreed with this finding; instead suggesting that trying to adopt a collaborative approach in the early stages of in-patient admission was not necessarily helpful to them and in fact being given choices over treatment options was difficult to deal with (Offord et al. 2006). This suggests that taking an individualised approach to the extent of negotiation over treatment planning is required.

For one of the participants in my study maintaining a sense of control extended to her need to choose her own therapist. In this instance, the therapist she chose worked in private practice:

> "*I had chosen her based on her profile and had been recommended to see her by a few people, I felt prepared to engage and trust her before I met her, as it was in my control who I saw.*"

Accordingly, Helen could negotiate the goals and tasks of the therapy with her therapist (Bordin 1979). Subsequently, she perceived the therapeutic relationship she developed with this therapist as being helpful and productive. The type of relationship she described was based on her feeling that she could be honest with this therapist. This experience contrasted with other relationships in her life where she resisted people becoming involved in her eating problems and hence *"threatening my control".* The therapist, in this instance, used a cognitive behavioural therapy (CBT) treatment approach with Helen and it is suggested that the stance of the therapist when using CBT with people with eating disorders should be that of a coach (Tatham et al. 2012). This approach supports the client to assume the role of being their own therapist. The therapist therefore acts as an agent for encouraging change, but the client assumes the responsibility and control for making this change happen. It is suggested that this approach can help to build a strong therapeutic bond in the early stages of treatment through the process of establishing negotiated, shared goals and tasks (Tatham et al. 2012). Similarly, Evans and Waller (2012) conclude that it is crucial that the person with anorexia nervosa feels that they are part of a collaborative process in CBT. Any attempts to try and control or coerce will increase resistance. Therefore, they suggest that control is discussed openly in the formulation of the individual's problems and therefore any issues that arise within the therapeutic relationship can be examined in the therapy. When considering the process of control, they suggest:

"So, who is in control? The most effective answer is that control over defeating

the illness rests with the patient and the clinician in collaboration."

(Evans and Waller 2012 p 171)

Thus, for Helen, being given choice and responsibility in the process of therapy was important for her to feel she could maintain control over her own treatment. Similarly, Fay described where the balance of control was situated in the relationship with her therapist:

"I feel that he put me in control of my recovery; he was there to assist me. Control is crucial as often eating disorders are about control in one way or another."

Likewise, Daisy described her experience of engaging with CBT for anorexia nervosa. The stance of the therapist was collaborative and individualised to her needs:

"I was always impressed with the way he was able to tailor the sessions to my needs – a person centred approach."

She recalled that his ability to be flexible within the parameters of the therapy, thus individualising the approach, was very important to her. This stance contrasted with a previous experience of therapy where she perceived the therapist to be inflexible and mechanistic in the delivery of therapy.

Likewise, Jo described why she needed to feel in control of her treatment and in her interactions with healthcare staff:

"For me, control is a huge thing. Feeling out of control is a key issue behind my self-harm and anorexia. I have a chronic pain condition which is slowly but surely stripping away my independence and my ability to control the world around me. Because of this, I need to know that I have some control when it comes to interacting with medical professionals including those within a therapeutic relationship. If I don't feel in control, I won't engage as well with the process. I won't feel empowered to make any changes myself and when it comes to recovering from something such as anorexia, self-motivation is vital."

Whilst Jo also associated control with having choices about treatment options, she implied that this process should be a collaboration between herself and the therapist, thus:

"Having some control within therapy means I am able to voice these concerns and we can find alternative options or compromises.....having clear aims feels important and I think the patient has to be involved in determining them. I know that if I feel an aim is unachievable I'd be tempted not to even start working towards it. Equally if I felt an aim was unimportant, I would not engage well. I think that often the goals of the patient and the professional can differ."

Her reference to 'we' suggests that she viewed the relationship with her therapist as a collaborative partnership when making decisions about her treatment goals rather than seeking complete control over the process herself.

However as mentioned earlier having this level of choice and collaboration may not be successful for people at a different stage of their illness (Offord et al. 2006). This indicates that the decision to negotiate the level of choice over goal planning needs to be considered on an individual basis. In addition, focusing on goals that the individual does not view as relevant will impact on the perception of the individual toward the therapeutic relationship and the treatment approach:

"CBT doesn't work for everyone and certainly didn't work for me, they only focused on weight gain and then discharged me...I think the relationship you have with your therapist is paramount to your recovery. You have to believe in the process."

(Maggie)

So far, this section has explored findings from my study regarding aspects of the concept of control that helps to begin to build a theoretical understanding of the impact control has on the development of a helpful therapeutic relationship between adults with anorexia nervosa and their therapists. Issues of control in the therapeutic relationship are often played out around weight and food related matters. Setting initial treatment goals that focus solely on weight recovery and that are *perceived* to be imposed onto the individual were of concern to

149

the participants in this study. Taking this approach, particularly in the initial stages of treatment often impacted negatively on the development of the therapeutic relationship and on the willingness of the participants to engage with therapists and the proposed treatment plans. Therefore, based on the findings in my study I suggest that a collaborative approach to goal planning, where the person with anorexia nervosa is involved in negotiating aspects of their treatment will help them to feel that they are maintaining some control over their treatment. These goals may or may not be related to weight and food but can also incorporate other aspects of the individual's life.

These findings support the approach suggested by Bezance and Holliday (2013 p359):

> "A collaborative approach that addresses the psychological and social elements of the disorder, contrary to the dominant medical view of anorexia may benefit the therapeutic relationship most and indeed promote engagement in the treatment process as a whole."

Regarding the treatment of anorexia nervosa, it is suggested that collaboration between the individual and the therapist can be developed through sharing of control and power and this can promote a sense of self – efficacy in the individual (Berg et al. 2002). Also considering literature on collaborative working from wider areas of therapy, as befits grounded theory development, it is also suggested that supportive therapeutic relationships are more likely where the individual feels that they can negotiate as active participants in their own planning, as well as being involved and having choices in decision making over their treatment (Sumsion 2006).

As well as collaborating on treatment goal planning, goals should be individualised to the person's areas of concern (Bordin 1994). Rebecca recounted two contrasting examples of how therapists approached this process:

> *"With the first therapist, I felt like she delved straight in and didn't bother to try and build any kind of relationship with me. I felt like she had already decided what my problems were and worded all the questions to fit that. I did have a positive experience*

with another therapist. She made an effort to get to know me and allowed me to just speak and tell my story in the first session. Unlike the other therapist, I didn't feel like she was angling questions to get certain answers from me. At the end of the first session she went through the main points we had discussed and asked me what issues I wanted to work on first."

The pan -theoretical conceptualisation of the therapeutic relationship (Bordin 1979, 1994), as described in chapter two, also emphasises the need for negotiation between the therapist and the client when detailing aspects of the goals and tasks of therapy as being crucial in building the therapeutic relationship:

> "I want to emphasize my belief that a careful search with the patient for the change goal that most fully captures the person's struggle with pains and frustration relative to the story of his or her life is a key part of the building of a strong therapeutic alliance. The element of negotiation is an integral part of alliance building."

(Bordin 1994 p14)

This suggests that it is the individualised approach that is fundamental to the development of the therapeutic relationship which allows the client to assume a shared responsibility and control for establishing the goals of the therapy. When discussing the process of establishing these change focused goals, he suggests that through sensitive, careful listening he demonstrates how he takes the clients concerns seriously, raises pertinent questions and focuses on the client being an equal partner in formulating what the goal should be. He recommends that these exchanges in the assessment and engagement phase contribute to the search for a mutually agreed goal and help to forge a bond of trust and respect. He sees this process as being key to "building an initial viable alliance" (Bordin 1994 p21). He reinforces that the change goal should be individually related to the dominant themes in the person's life story.

The importance of approaching the person as an individual, whilst collaborating on goal setting was highlighted by Rebecca:

> *"It's important to acknowledge that patients with the same issues are still different and not to assume things just because you've experienced a similar patient before.....I think it's also important to involve the patient in deciding the aims and goals of the therapy and to compromise with each other on these."*

In my study, I found that the need to working collaboratively to develop individualised goals for therapy was a key aspect of balancing control within the therapeutic relationship. This finding was based in the context of the participants' experiences of engaging with CBT for the treatment of anorexia nervosa (Fairburn 2008). As previously detailed in chapter three, this is a key recommended out - patient psychological treatment approach for adults with anorexia nervosa (NICE 2004, 2017). The participants in my study expressed concerns about the imposition of weight and dietary based goals. In their experiences, this had frequently led to disengagement in therapy and the perception of a poor therapeutic relationship with the therapist. However, previous research has examined the association between the strength of the therapeutic relationship as a predictor of outcomes, including weight gain, in CBT with adults with anorexia nervosa (Waller et al. 2012, Brown et al. 2013, Sly et al. 2013, Brown et al. 2014). The findings of these studies suggest that therapists who believe that the development of the therapeutic relationship should precede weight gain goals and therefore focus on relationship building rather than on structured eating in the early stages of treatment achieve overall poorer outcomes in therapy. However, a recent meta-analysis by Graves et al. (2017) suggests a more complex picture. Across eating disorder diagnoses, they suggest that there is a reciprocal relationship between eating disorder symptom change and the development of the therapeutic relationship. Therefore, focusing treatment on changing eating disorder symptoms, such as weight gain and structured eating as well as attending to the development of the therapeutic relationship is necessary for successful treatment outcomes. However, in respect to people with anorexia

nervosa specifically, a strong early therapeutic relationship has been found to be significantly related to subsequent symptom change in younger clients only (Graves et al. 2017).

According to the participants in my study, developing the therapeutic relationship, in part through balancing the control issues that will be present particularly at the beginning of the therapy, can be achieved through the therapist taking a collaborative approach to setting initial therapy goals. This finding concurs with the assertion of Brown et al. (2014), that it is possible to develop a strong therapeutic relationship specifically within CBT treatment for anorexia nervosa even when the early focus of therapy is on weight recovery. They argue that weight gain needs to remain the overall goal of therapy and it is not enough to rely on the therapeutic relationship to bring about change. This is due to an association with early weight gain and the likelihood of the person remaining in treatment and achieving better outcomes (Brown et al. 2014). It is also advocated however, that a balanced approach should be taken; notably, the development of a therapeutic relationship grounded in empathy and firmness whilst simultaneously encouraging changes in eating patterns from the beginning of therapy (Waller et al. 2012).

Additionally, the findings of my study suggest that an approach to weight recovery based on collaborative negotiation of individualised goal setting is important. This enables the individual to have a say and sense of control and choice in how that weight recovery is achieved. In addition, the goals of therapy should be formulated around the individual's unique presentation resulting in a personalised treatment plan (Evans and Waller 2012, NICE 2017). This approach subsequently leads to the perception of a good therapeutic relationship on the part of the client, a factor that has been found to be predictive of better outcomes of therapy (Horvath 2000, Martin et al. 2000).

8.3.2. Achieving a balance of control and equity in the therapeutic relationship

According to the participants in my study, the process of maintaining a feeling of control through the negotiation of treatment goals was not the only aspect of the concept of control that was key in the therapeutic relationship. As Beth recognised, although maintaining control within the therapy process was necessary for her to engage with a therapist, this was not her only concern:

"It was essential for me to feel that I had some control over my treatment although I was aware that control was one of the problems that had to be addressed".

It is suggested that recognising the need to let go of control is the key step towards recovery for people with anorexia nervosa (Woolf 2015). However, letting go of control is often incongruent with the beliefs people with anorexia nervosa hold about themselves (Crisp 1997, Birmingham and Treasure 2010). This presents the client with a paradoxical dilemma and goes some way to explain why letting go of control within therapy is so difficult to achieve. Therefore, to gain more control over therapeutic decisions, the individual with anorexia nervosa must simultaneously relinquish control to the therapy team or therapist. Once this can be achieved it can become a self- perpetuating process as Beth described:

"As I demonstrated increased control over my eating behaviour the sessions became more relaxed and I was able to be more open with the therapist."

Subsequently, as she assumed greater responsibility for her eating behaviours (in a positive way) the interactions and therapeutic relationship with the therapist improved allowing for the balance of treatment decisions to move further in her control.

In Fay's account of her experiences of working with a psychologist, she suggested that the nature of their relationship was based more on achieving equality in the therapeutic relationship, rather than her needing to establish control within the relationship:

"For me, I think it's not so much a case of needing to be 'in control' but more a case of being equal. If I had complete control we may well have got no-where, after all I allowed the eating disorder to control me. He gave me a certain amount of 'responsibility' for the progress I made, he allowed me to lead sessions when I felt inclined but, also dragged me kicking and screaming when I wasn't feeling particularly co-operative. It felt as if we were a team, trying to reach the same goal. I think this feeling of mutual respect allowed me to feel as 'in control' as I needed to be."

She therefore described a flexible process in relation to who holds power and control within their relationship. At times, she recognised that her therapist needed to exert more control but equally she felt she had as much control over the process as she needed due to feeling respected and on an equal footing within the therapeutic relationship. The importance of the perception of an equal therapeutic relationship from the perspective of the individual with anorexia nervosa is also highlighted by Sly et al. (2014). In this study of adult women receiving specialist eating disorder treatment, the therapeutic relationships between the women and the therapists were viewed as a core component of treatment. Good therapeutic relationships were described as those where neither the client nor therapist tried to control the other, but rather, worked together, in a "give and take" style (Sly et al. 2014 p238) where mutual expectations were shared and a balance in the relationship was achieved. This style of the therapist's stance is supported by the findings in my study.

Developing a sense of equality within the therapeutic relationship also resonates with the approach to therapy know as client or person-centred practice. Parker (2006) refers to the process of an "absence of a struggle for power and control" as being, "one of the most tangible indicators of how it feels to be with a client centred therapist" (p201). She also considers that the process of empowerment in the therapeutic relationship needs to be shared and that a process of mutual interdependency and partnership is developed (Parker 2006). In addition, supporting clients to develop personal control over their own health needs

rather than developing reliance on professionals can also help to foster empowerment (Taylor 2008). In my study, Fay's experience of a mutual balance of power sharing seems to have been achieved in the therapeutic relationship between herself and her psychologist, thus enabling her to feel that she was on an equal footing with the therapist.

Power differences are an inherent aspect of any therapeutic or professional relationship and it is the transfer of this power that can move the interaction from being therapist led to one that is focused on the needs of the individual (Sumsion 2006). It must be remembered though, when considering issues uniquely pertinent to anorexia nervosa, that medical, ethical and professional responsibilities of the therapist may mean that completely handing over power and decision making during the process of the therapy may not serve the best interests of the individual (Sumsion 2006). In the treatment of anorexia nervosa, it is not recommended that the wishes of the client are completely accepted but rather a middle ground is sought between the client and therapist in the majority of cases (Vitousek et al. 1998). In fact, this stance is one that the participants in my study *did* recognise and appeared to advocate; although they considered that having control of their own treatment was important to them, there was also a recognition that it was actually achieving a balance of control within the relationship that was important.

The issue of equality and control in the relationship between therapist and client is also discussed in the autobiographical book, *In and out of anorexia* (Ronen and Ayelet 2001). Following numerous unsuccessful in-patient admissions as an adolescent, Ayelet (the client) discussed the nature of the therapeutic relationship between her and a therapist she worked with as an adult. In this situation, the therapist was able to engage her in therapy through the process of negotiating mutually agreed goals and intervention tasks. Through this negotiation, Ayelet's cooperation in the therapy process was achieved as she felt her wishes were being considered and she had equal control in the process. Her experiences are therefore similar to those of the participants in my study. That is, having control in the therapy process was not focused around struggling for complete control; rather the

156

development of a more equal relationship was seen as being more effective. Being able to negotiate and agree the goals and tasks of therapy through the process of a negotiated contract led to the development of trust and openness in the therapeutic relationship with her therapist Tammie:

"Immediately she (Tammie) *recruited my cooperation. I also appreciated the fact that Tammie wanted the two of us to make a treatment contract, considering my wishes and cooperation. Unlike other therapies, it was not Tammie deciding and me needing to comply. Neither was there a coalition between my therapist and my parents against my wishes. Here, for the first time, I would receive a mutual, equal contract. I felt I could trust her and open up to her."*

(Ronen and Ayelet 2001 p188)

Although a therapeutic relationship that is built on shared collaboration and equality may be desirable, Maggie, another participant in my study, also reflected on the reality of being able to achieve this due to the psychopathology of anorexia nervosa:

"It is important to recognise that although you are both equally in control of what happens in therapy you need to recognise that sometimes a patient cannot always be right, especially with regard to advice around food."

She also highlighted the complexities in achieving a balance of control and choice as being due to the differences in agendas between the staff and patients in an in-patient unit:

"At the end of the day a patient's safety is more important to them (staff) *than giving a patient choice. There is some choice over likes/dislikes with foods but then that can be portrayed as an eating disorder behaviour not liking cream, butter etc. Within therapy I wish I had told the therapist what I wanted to speak about or what was important to me but I didn't have the confidence to. All we*

ever got told was we can do what we like when we are well and discharged."

(Maggie)

Bearing in mind the challenges inherent in attempting to balance issues of control between therapist and clients, it is still suggested that a collaborative stance should be taken when working with people with anorexia nervosa (Vitousek et al. 1998, Geller et al. 2001, Berg et al. 2002). Vitousek et al. (1998 p 402) present a style of "active collaboration" between the client and the therapist that encourages feedback about the therapist's approach and places, "emphasis on client choice rather than therapist control" (p 402). More recent research based on clients' experiences of treatment for anorexia nervosa found that being involved in treatment decisions and having an element of control over aspects of their recovery enabled people to feel empowered in making changes and confronting aspects of anorexia nervosa (Fogarty and Ramjan 2016). However, although it is also acknowledged that despite the client being an authority on their own experiences of having anorexia nervosa, it is also suggested that they may not be an expert on the psychological and physiological effects of starvation (Vitousek et al. 1998). This means that due to the effects of starvation on cognitive functioning and the physical risks posed by low weight it is not always possible and indeed it could be construed as unethical and irresponsible to allow the client with anorexia nervosa to fully dictate the goals of therapy.

Maggie also offered this additional insight into the challenges of therapists being able to work collaboratively to offer a balance of control over the negotiation of weight related goals in therapy specifically. This explanation of her own experience needs to be considered in the context of her being at a very low weight when she started working with her therapist. In her own words, she recognised that she wasn't cognitively able at the time to make rational decisions about weight related goals in the early stages of therapy. In retrospect, therefore, she understands that this was an area of therapy where negotiation between herself and her therapist was not possible:

"*The treatment I am receiving is about letting go of control altogether so 'negotiating' weight goals is not an option for me. As this is still seen as anorexic ways and holding onto anorexia by giving it power. To concentrate on my weight was something that was needed to begin with as I could not concentrate properly or speak coherently. Now I have started to increase my diet I am able to focus more on the issues that really matter to me, making sure my problems do not lead to restriction or other anorexic behaviours. I am taught that full recovery is not possible if you are still trying to control your weight, what you eat, instead trust the process and use other coping mechanisms such as mindfulness, journaling, painting/drawing when you feel the urge to follow through with an anorexic behaviour. There is always time made to speak about how I feel so the focus is not about food. I feel it is ok to say to my therapist I need to speak about XYZ as well as food.*"

Therefore, Maggie suggested that in her case, she needed to relinquish complete control of food and weight related goals to her therapist in the first stages of the therapy and could do this because she had developed some trust in her therapist. What the therapist also offered her was the space for her to talk about wider issues apart from weight recovery and this impacted positively on the development of their therapeutic relationship.

In contrast Anna still felt that having an element of control and choice was important to her, even as an in-patient.

"*When someone is an inpatient and their weight is dangerously low they still need to feel some control no matter what or they will not want help. Give them control, say in the foods they like to eat at least or talk to them as much as possible. It is so important, as a patient I felt to have some say and some control.*

My dietician gave me a meal plan without any say from me on what I liked to eat

or if I could eat it and I did not stick to it."

In support of this, Vitousek et al. (1998) suggest that through paying attention to the client's wishes and agenda, the therapist can achieve a balanced approach that serves the needs of the client and simultaneously encourages change. In addition, Fogarty and Ramjan (2016) also found that treatment for anorexia nervosa that is viewed as suitable by recipients of the service needs to be individualised to the person. The contrasting experiences of the participants in my study suggest that people need to be considered individually when negotiating goals of therapy and these goals will depend on the stage of treatment, where the treatment is being carried out, for example in an in-patient or out-patient setting as well as the individual physiological and psychological state of the person with anorexia nervosa at the time of treatment.

8.4. Conclusion: a theoretical explanation of control within the therapeutic relationship

The conceptual category presented in this chapter was constructed over three phases of data collection. Achieving a balance of control is a key concept in the development and maintenance of the therapeutic relationship pertaining to adults with anorexia nervosa.   As a defining feature of anorexia nervosa, control also manifests itself in the dynamic of the relationship between the client and therapist. A perceived struggle for control can often be played out over issues related to food and weight; this is predominantly more so within in-patient treatment settings where the aim of treatment is typically focused on weight restoration.

Based on the experiences of the participants in my study, I suggest that using a collaborative approach to goal setting, that promotes choice and responsibility, can help the development of the therapeutic relationship. These choices may or may not be related to food and weight

based goals but need to reflect the core concerns of the individual. What is important is that clients feel that they can contribute to a treatment plan that is individual to them and their unique needs. Through the negotiation and agreement of goals of treatment, resistance by the client can be reduced. This can enable the individual to feel that they have an equal role within the therapeutic relationship and thus maintain an element of control within the therapy process. This approach seems more likely to result in the individual engaging in the therapeutic process and can foster a perceived helpful therapeutic relationship. The perception of a helpful therapeutic relationship by the client is significant as this has been found to be a factor that can impact on the improvement of treatment outcomes.

However, the reality is more complex than this approach would suggest and needs to be considered on an individual basis within the context of the therapy setting and the individual risks posed by the client regarding their physical and psychological presentation.

What has also emerged is the recognition that to develop a positive therapeutic relationship and engage in the therapy, the person with anorexia nervosa must also relinquish some elements of control, whether that be related to weight and diet or other aspects of their lives. This presents as a paradoxical dilemma for the individual but can be achieved through the dynamic and support of the therapeutic relationship. This in turn can lead to the balance of control for treatment decisions to shift more towards the client, thus effecting equality within a collaborative relationship.   To enable this, a high level of trust is required between the client and their therapist to achieve a balance of control.

Developing this style of therapeutic relationship is challenging both for the person with anorexia nervosa and for the health professionals working with them, as the client often approaches therapy from a position of mistrust and ambivalence towards the common goals of therapy, which are typically focused on weight recovery in the initial stages of treatment. In the next chapter, I present the second conceptual concept of the therapeutic relationship: developing trust and how this can be established between the therapist and client.

Chapter 9: Findings and Discussion

Developing trust in the therapeutic relationship

9.1. Introduction

The second key conceptual category of the therapeutic relationship examines issues pertaining to trust within the therapeutic relationship and considers how trust can be developed between the therapist and the client. In the first phase of data analysis, there were numerous initial codes related to trust that were subsequently clustered to construct the focused code: developing trust. In the first phase of data analysis I initially examined the concept of trust in relation to both the process of control within the therapeutic relationship and feeling understood by the therapist (the third conceptual category of the therapeutic relationship) as previously detailed in chapter seven.

However, despite the close links between the three concepts, I ultimately made the decision to pursue each concept separately. Thus, in the second and third phases of the data collection I asked the participants to elucidate in more detail what they viewed as being the crucial properties that define and describe trust within the therapeutic relationship. My reasons for doing this was that in the participant accounts they frequently mentioned trust as being important within the therapeutic relationship, but what therapists did to develop that trust was still unclear.

Trust is a fundamental requirement of any therapeutic relationship (Beck et al.1979, Bordin 1979, Meissner 2007). It is known that the development of trust is based on the client having faith that the therapist is competent, believing that the therapist is acting in their best interest and that the therapist is viewed as being inherently trustworthy (Ackerman and Hilsenroth 2003, Castonguay et al. 2010, Palmer 2014). In addition, Bordin (1979) suggests that deeper bonds of trust may be necessary for different types of therapeutic relationships. Due to the ambivalence of people with anorexia nervosa to engage with therapy and the need for them to maintain a sense of control within therapy, it could be surmised that specific issues related

to trust may have significance for the development of the therapeutic relationship between adults with anorexia nervosa and their therapists. This chapter therefore details how therapists can develop trust with their clients: first, through their actions, second, through the interpersonal stance they adopt, and third, how they convey their knowledge of anorexia nervosa to the client. In addition, I consider temporal issues in relation to the development of a trusting therapeutic relationship between the therapist and client. Finally, running through this conceptual category is the central category of individuality which manifests itself within the therapeutic relationship through the ability of the therapist to see the individual beyond the eating disorder. Thus, how this therapist stance impacts on the development of trust within the relationship is also examined.

9.2. Understanding how trust develops in the therapeutic relationship: therapist actions

Firstly, a cluster of the constituent properties of trust emerged in the data analysis that I named therapist actions.   These actions by the therapist were viewed as important by the participants in the initial stages of the development of the therapeutic relationship development and were perceived to be crucial in establishing trust in their early meetings. Examples of basic actions that therapists undertook that helped to develop the foundations of trust within the therapeutic relationship included: the therapist keeping pre - arranged appointments, punctuality and reliability in following through on agreed actions and plans.

Accordingly, Sue, in her account, emphasised the importance of trust within the therapeutic relationship she had with her therapist. She highlighted specific details of how he enabled her to build up this sense of trust:

> *"I think the key thing for me in this relationship was "**trust**"* (her emphasis). *And very simple things helped to build trust: he always turned up on time and always followed up the things he said he would. He had a fantastic memory and remembered the smallest details of what I had told him. He took time to prepare*

for our sessions and spent much time reading the things that I had written (or diagrams I had drawn) in between sessions."

In contrast, Helen wrote about how the unreliable actions of her therapist impacted negatively on the development of their therapeutic relationship:

"*Since I last wrote, I've unfortunately had a bad experience with a therapist. A key part of that was her cancelling most of my appointments just before or just after they were due to start. She would turn up for the rearranged appointment but we didn't build a rapport. It felt like she had a clear agenda but wasn't prepared to listen to my concerns."*

Similarly, Jo discussed her experience of working with a student counsellor at university. She disengaged prematurely in the process, thus inhibiting any chance of a trusting relationship to develop. This appears to be in part due to the therapist's unreliability around keeping appointments as well as not doing things she said she would do:

"*My first experience of therapy was when I was 18 and at university……She cancelled on me twice and rescheduled me once. As we only got 6 appointments I gave up."*

She also experienced "*feeling a little unanchored"* when she perceived the therapist to be unreliable by not following up on a suggestion for referral to group work. However, a further example from her demonstrates how a practice nurse in a primary care setting inspired trust through her approach to making appointments:

"*If she can get me in any earlier she will (my appointments are at the start of my working day so the quicker I'm seen, the quicker I'm back in work). I also know that she'll book the appointments in just as soon as they're available. I know she will do this because she has proven it to me. She also makes me feel like my appointments are important to her. She recently changed shift patterns and when she was telling me this she said her first thoughts were, but what about*

Jo's appointments? It feels like this was genuine and she's always tried her best
to ensure my appointments are convenient."

<div align="right">(Jo)</div>

Thus, to begin to develop trust in the early stages of engagement in therapy, it is crucial that the therapist should demonstrate that they are reliable in regard to fundamental aspects of the therapy process such as making and keeping appointments. This is important as it is suggested that in the treatment of anorexia nervosa, the impression of trust in the therapist should be established within one or two assessment meetings (Palmer 2014).

In addition, when considering how the therapist can develop basic trust in cognitive therapy, it is also suggested that in the early stages of therapy the therapist should be actively involved in providing structure to the sessions, moreover citing the importance of the therapist to be dependable, punctual and responsive to the individual. Whilst client autonomy is equally viewed as important, providing structure and a sense of stability in the first instance can therefore help to develop basic trust in the early stages of therapy (Beck et al.1979).

On the surface, the issue of therapist reliability and consistency may seem to be an obvious necessary condition for the development of trust in the therapeutic relationship. However, my data suggest that it is important to understand the meaning and interpretation people with anorexia nervosa place on therapist's actions such as these.

These findings are similar to those of Lose et al. (2014). In their study with adults receiving out-patient treatment for anorexia nervosa, the provision of regular, predictable appointments was viewed by clients as important in the development of a solid therapeutic relationship. In my study, the perception of the therapist of being reliable as demonstrated through their actions conveyed to the participants the impression that they were important, they were valued by the therapist and that their concerns are being taken seriously. Thus, suggesting that they are worthy of engaging in the therapy process.

It is known that people with anorexia nervosa are often ambivalent and reluctance to engage in therapy (Geller and Dunn 2011). Subsequently, any actions by the therapist that reinforce to the client that they are not worthy of therapy or treatment will lead to a lack of trust in the therapist and rapid disengagement by the client. Feeling worthy of treatment is often a challenge for people with anorexia nervosa who frequently experience feelings of low self-esteem and consider that they are undeserving of seeking and receiving help (Woodrow et al. 2010). Indeed, Robinson (2014 p 395) describes this as "treatment unworthiness" and views it as a pervasive characteristic seen in people with anorexia nervosa, particularly in those with a long-term condition.

In addition to feeling unworthy or undeserving of treatment, Waller et al. (2012) also found that a sub group of adults with eating disorders including anorexia nervosa scored highly on paranoid personality cognitions when presenting for CBT treatment for eating disorders. They suggest that this group of people experience low trust which is indicative as a predictor of poor therapeutic relationship development. Therefore, it can be surmised that people with high paranoid personality levels are more likely to interpret therapist actions in ways that interfere with the development of trust. So, for example, if the individual perceives the therapist to be unreliable and therefore untrustworthy early in the development of the therapeutic relationship, they may be less likely to engage in the therapy process. This suggestion is borne out in the findings of my study.

Thus, the actions of the therapist that are perceived to be inherently trustworthy such as being consistent and reliable will help the person to feel worthy of treatment, develop a foundation of trust and are therefore important to consider in the engagement of adults with anorexia nervosa particularly in the early stages of treatment.

The next section moves on from considering the therapist's actions in relation to the development of trust in the therapeutic relationship to look at key aspects of the therapist's approach or stance (Geller et al. 2001, Geller and Dunn 2011).

9.3. Understanding how trust develops in the therapeutic relationship: therapist stance

The processes of the therapist's stance that impact on the development of trust in the therapeutic relationship were derived from the initial codes that denoted therapists' interpersonal styles. These processes appeared to have helped the participants to feel understood, secure, accepted and valued as an individual, thus instilling a sense of trust between the client and therapist.

Jenny considered some of these issues in her recollections of two in-patient admissions.

> *"During the torturous admission in 2010 I was transferred nearer home to a wonderful unit at xxxxx which unbelievably was only open little over a year. The care was genuine and treatment was positive. I had gone from a place which reinforced the idea that 'it was my fault' I was anorexic to a place where I could for the first time admit I was anorexic. I needed to trust the staff I worked with, to feel that there's no shame in being anorexic and that I didn't need to be punished for my problems."*

A sense of shame and feeling blamed for having an eating disorder was a common experience for participants in my study and is also evident in other accounts from people with anorexia nervosa:

> *"Not so long ago I couldn't even say the words anorexia or eating disorder without feeling overwhelmed, ashamed and guilty....I don't know if anyone actually gets how embarrassed I feel every time I try to ask for help, help I don't think I should need..."*

> (Ellie 2016b)

Walker and Lloyd (2011) and Gale et al. (2014) discuss how people with anorexia nervosa often experience feelings of shame as well as feeling that they are stigmatised and blamed for having the disorder. It is suggested that this is in part due to the perceived lack of

understanding of anorexia nervosa from both health care providers as well as the general public, who frequently hold the view that people with anorexia nervosa are responsible for their condition (Robinson 2009, 2014). For Jenny, feeling accepted by the staff despite having anorexia nervosa was an important step in the process of her being able to start trusting the people she was working with. She went on to describe herself as having now achieved a stable weight and having been discharged from specialist eating disorder services. However, she continues to work with a CBT therapist and described her experience of being able to trust him:

"I trust my therapist who is understanding of all my issues and treats me as a person who has worth."

Similarly, Fay articulated how the stance taken by her therapist led her to develop trust in him:

"Trust was probably one of the most powerful aspects of my therapy. It is a scary word and not one I find very easy. When you suffer from an eating disorder your world becomes a web of deceit and lies. Somehow this warps your ability to trust others. You feel so rubbish about yourself that you can't imagine why anyone would want to help you, other than to try and make you put on weight! At first I expected very little from my sessions with my therapist but gradually I realised that a relationship was building between us. I would think of things I wanted to tell him and save them for him because I felt he was the only person who would understand properly. Gradually I understood that I trusted him and this was quite a revelation for me and incredibly important. I feel he achieved this due to his genuine nature, his acceptance of me and his ability to judge my character and mood, week to week. On a bigger scale, actually having felt that trust has made it a lot easier for me to move on and let in other people."

Feeling valued and understood by the therapist resonates with Carl Roger's original conjectures about client centred therapy and the necessary conditions that need to be provided by the therapist to affect change in the therapeutic encounter. In 1951 Rogers asked the fundamental question "do we tend to treat individuals as persons of worth, or do we subtly devaluate them by our attitudes and behaviour?" (p20). He subscribed that positive regard and acceptance should be experienced by the client as unconditional (Rogers 1957). Due to the inherent relational and behavioural challenges of people with anorexia nervosa, health care professionals often experience ambivalence and negative attitudes towards people with anorexia nervosa that can be played out within therapy (Palmer 2000, Jones and Larner 2004). Thus, experiencing unconditional acceptance and regard by their therapist is therefore relevant due to the client's prevalent feeling that they are not worthy of treatment (Woodrow et al. 2010, Robinson 2014). Thus, to feel accepted and valued as an individual by a therapist, despite having anorexia nervosa, can be a powerful experience for a client. This process can help to engender trust. The therapist can convey to the client that they are a person of worth through their interpersonal approach or stance, this includes expressions of warmth, respect, acceptance, caring and understanding towards their clients (Farber and Lane 2002).

As Maggie described in my study:

> *"She shows that she understands my physical needs as a have a disability as well as anorexia nervosa, so she helps to hold me on the scales and carries my bag etc. This has all proved to me that she genuinely cares and sees me as an individual with individual needs."*

Thus, in my study, feeling valued and cared for was an important condition in being able to develop the foundations of trust for the participants. So not only is it important for therapists to convey that clients are worthy of treatment through their actions as previously detailed but also in their stance towards the individual.

In previous studies people with eating disorders have highly rated the value of having trust in their therapist and being taken seriously by them (de la Rie et al. 2008, Escobar – Koch et al. 2010). In addition, Gulliksen et al. (2012) highlight client's preferred therapist characteristics in the treatment experiences of adults with anorexia nervosa specifically. The experience of feeling cared for by the therapist was identified as a factor that helped participants to feel that they were themselves trustworthy and that they were taken seriously by the therapist. These characteristics were perceived as "generosity" in the therapist and were seen to be a significant aspect of the key construct of "acceptance" that was highly preferred as a therapist characteristic by adults with anorexia nervosa (Gullikson et al. 2012 p 939). These findings are also evident in the study by Wright (2013) who considered trust to be an important component in the "authenticity" of the therapeutic relationship (p 225). In her study, adults with anorexia nervosa in a specialist eating disorder in-patient unit, also described the experience of feeling cared for as an individual by the nursing staff. This perception helped them to develop mutual trust between the staff and patients. Similarly, Kirsh and Tate (2006) found that building and developing a sense of trust was a key ingredient of the therapeutic relationship in their study with people serious mental illness living in the community. Although not specifically people with anorexia nervosa, these service user participants also identified feeling cared for and accepted by their workers as being a fundamental component of the development of a genuine therapeutic relationship.

Although I did not name codes specifically as feeling cared for, this aspect of the therapist's stance in the development of trust in the therapeutic relationship relates closely to what I identified as 'feeling valued' by the therapist.

This finding also resonates with that described in a further study by Gulliksen et al. (2015). In their study, a group of adult women with anorexia nervosa were interviewed about their first experience of help seeking from health professionals. It was suggested that the communication style, both in the body language and what was said by the health professional in the first conversation was important in how the patient felt about engaging in

future help. The participants highlighted that feeling valued and safe and being taken seriously by the health professional were all aspects of the interaction that were important and contributed to the participants feeling that they were receiving "authentic attention" (Gulliksen et al. 2015 p216). These participants also described experiences where they had felt that they were being disrespected and treated "like a baby" (Gulliksen et al. 2015 p216). They contended that these experiences made them feel ashamed and subsequently they lost hope about the possibilities of future recovery and any potential value of treatment.

In addition, a user of eating disorder services described on a mental health blog the initial contact she had with her general practitioner:

> *"He took me seriously, listened to what I had to say, and was adamant that I was not wasting his time despite me protestations otherwise"* (Caitlin 2016).

According to the findings of my study it appears that a therapist who can convey to the individual feelings of understanding and that they are a person of worth, is then able to instil a sense of trust that helps to underpin the therapeutic relationship. As previously mentioned, this style of therapist interaction resonates with client centred approaches to therapy. Parker (2006) recognises that being able to show respect, to listen and demonstrate empathy forms the basis of a trusting relationship with the client.

The concepts of feeling valued and feeling understood by a therapist are closely linked to the development of trust between the therapist and the client. In the initial phases of analysis, I considered these concepts together as previously noted in chapter seven. Consideration of the experience of feeling understood and the role of empathy within the therapeutic relationship and how they link to the development of trust is considered in further detail in chapter ten.

To summarise, in my study I found that the stance of the therapist that can inspire the development of trust from the perspective of the person with anorexia nervosa is akin to that previously described in client centred, collaborative therapies (Rogers 1951, 1957, Geller et

al. 2001, Parker 2006, Geller and Dunn 2011, Gulliksen et al. 2012, 2015). Through their interactions, therapists can foster trust in the therapeutic relationship with their clients by conveying that they are valued and accepted as an individual and seen as worthy of help. In addition, demonstrating curiosity and interest in the client's perspective of their illness can demonstrate that the therapist is taking the person seriously and can help cultivate trust between the therapist and client (Geller et al. 2001).

The findings of my study in relation to therapist stance also concur with that of Walker and Lloyd (2011). They suggested that trust was a core aspect of the therapeutic relationship with people with eating disorders. To develop trust, they speculated that experiencing an accepting, non-judgmental approach by the therapist is a key determinant in developing a trusting relationship that can help to alleviate feelings of shame and self -blame in people with anorexia nervosa. Feeling understood is a concept that people with anorexia nervosa rarely experience and how this impacts on the development of the therapeutic relationship is explored in more detail in chapter ten. Before that, I examine other factors found in this study that had an impact on the development of trust in the therapeutic relationship.

9.4. Therapist's knowledge of eating disorders

In the first phase of data analysis there were codes pertaining to therapist knowledge of eating disorders in relation to the development of trust in the therapeutic relationship. This finding concurs with other service user studies where health professionals who are perceived to be knowledgeable about eating disorders are valued by clients (Tierney 2008, Zainal et al. 2016).

Indeed, for Beth, the professional's knowledge of eating disorders was the defining factor when considering the concept of trust as a foundation of the therapeutic relationship:

"Trust is the result of demonstration of knowledge. It is possible to like a therapist who has empathy but only a therapist who understands every aspect of the illness and gives realistic advice will inspire real trust."

In her account, she referred to an endocrinologist who worked with her in the earlier days of her eating disorder. His specialist knowledge of eating disorders was important to her and inspired in her a belief that he could help her. Although she emphasised that it was his knowledge that inspired this trust she also recognised that his ability to demonstrate empathy was evident:

"I believed he could really help me, I thought he knew what I was suffering…….he was reassuring and I had absolute trust that he would be able to help me".

In contrast, another participant, Natalie described her process of transition from adolescent specialist services to adult community mental health team services (CMHT). Her allocated worker in the CMHT was a newly qualified occupational therapist:

"My CMHT worker was a newly qualified OT and had only worked with psychosis in the past. She felt more comfortable working with the things that she was trained to do, such as working with my anxiety and social anxiety, such as in food situation like cafes or the supermarket, but with emotional, feelings stuff, I gathered she wasn't trained. She didn't 'get' or understand the rationality behind the eating disorder and used to explain how food is a 'nice and pleasurable' thing for her. When I tried to talk about what was going on in my head she would say to me that it wasn't in her capacity and that I should speak with someone who is trained to do so [a therapist]."

Natalie subsequently relapsed during this transition phase and didn't re-engage with adult community mental health services. This matter of therapist expertise in eating disorders is also highlighted by Gulliksen et al. (2012). In their study, they describe two constructs of

preferred therapist characteristics by people with anorexia nervosa in relation to therapist knowledge. First, they describe "experienced knowledge" and second the "authoritativeness" of the therapist (Gulliksen et al. 2012 p938). Therapist knowledge refers to how the therapist uses their knowledge of anorexia nervosa to better understand the individual. Thus, the consequences of this knowledge and the understanding demonstrated by the therapist helps people with anorexia nervosa to accept themselves and subsequently reduce feelings of shame about their illness. In addition, they highlight that people with anorexia nervosa prefer therapists who convey confidence and a sense of authority in their expertise; this was viewed as helping people feel more secure within the therapeutic relationship. The authors do clarify, however that this sense of authority should not be misplaced as over confidence but rather patients value therapists who are secure and comfortable in the treatment setting (Gulliksen at al. 2012).

Evans and Waller (2012) also consider a similar therapist style in CBT with eating disorders that is beneficial in the initial stages of the development of a strong therapeutic relationship. They suggest that the therapist needs to be authoritative about their knowledge without being authoritarian in their behaviour and attitude regarding imparting advice, giving directions and having expectations of the individual to be compliant in the therapeutic encounter. In addition, Gulliksen et al (2012) raised an interesting point that the therapist who is confident in demonstrating self-awareness and imperfection can be an important role model for someone with anorexia nervosa and who is likely to be overly perfectionist in regard to themselves. This is suggestive again of the type of authentic therapeutic relationship as described by Wright (2013). In their further study, Gulliksen et al. (2015) also suggest that the way health professionals convey their knowledge of eating disorders in the initial meeting can effectively change what might be an ambivalent experience for the client into a positive interpersonal encounter. They found that people who experienced a first meeting with a health professional who did not have sufficient knowledge of eating disorders could in fact trigger negative reactions in the person with anorexia nervosa and suggest that

174

general practitioners specifically would benefit from strengthening their knowledge of eating disorders generally.

Walker and Lloyd (2011) also found that the participants in their study lacked trust in their healthcare providers due to their lack of understanding and knowledge about eating disorders. This lack of trust led to poor relationship building and subsequent motivation to stay in treatment. They therefore highlight the importance of the therapeutic relationship in terms of engaging and staying in therapy and call for increased access to specialist services for people with eating disorders and more access to training and support for health care providers. This issue was also highlighted by Escobar – Koch et al. (2010) who suggest that eating disorder professionals should be provided with training and support to develop their interpersonal skills and to be able to form strong therapeutic relationships with clients.

9.5. The time needed to develop trust in the therapist

As previously detailed, the distinctive clinical and personal presentation of people with anorexia nervosa suggests that they may need extended time within therapy to develop a trusting therapeutic relationship. Indeed, this supposition was borne out by most of the participants who contributed to my study. For example:

> *"In terms of short term therapy, I find it really hard to build up a relationship with someone I know will disappear. I don't feel I can trust anyone when I've only known them a few weeks, they've had no time to prove to me that they are trustworthy and will do what they say and there's no way they can see me as an individual."*

<div align="right">(Jo)</div>

Seeing and treating people primarily as part of a diagnostic group rather than as an individual has previously been highlighted as a factor that can reinforce distrust between therapists and people with anorexia nervosa (Pemberton and Fox 2011).

As well as needing time to reveal themselves to therapists, it has also been found that consistency, regularity and predictability of therapists over time periods of interventions are necessary in the development of therapeutic relationships for adults with anorexia nervosa undertaking therapy in both in-patient and out-patient settings who also expressed dissatisfaction with changes in therapists and disruptions in episodes of care (McKnight and Boughton 2009, Ross and Green 2011, Lose et al. 2014, Zainal et al. 2016). Similarly, in her study of young people's experiences of being treated for anorexia nervosa, Tierney (2008) highlights the importance and impact of consistency of therapists over time regarding the development of trust and subsequent engagement between the client and therapist.

In my study, Fiona's story was written from the context of having severe and enduring anorexia nervosa as previously detailed. She made the point that when an eating disorder persists over a period of years and gets to the stage where maintenance is really the primary goal, the significance of the therapeutic relationship becomes greater. She discussed needing time to open up and learn that she could trust her psychologist.

Likewise, Rebecca highlighted time as a factor in being able to build up a trusting relationship with her student counsellor:

> *"I think short term counselling can work for some people/ issues as I think the relationship is more to do with the people involved rather than orientation of therapy. Having said that, I think it can be difficult to build trust etc. in such a short time. For me personally, I don't think the 6 sessions were enough as I had so many issues I wanted to work through but I didn't feel that comfortable with the counsellor. I think that was a combination of our personalities and only having 6 sessions to build up that trust."*

In addition, Jo discussed her own relational problems and highlighted the time that she needed to open up with people as a barrier to developing trust in the therapeutic relationship:

"I take time to build relationships. In therapy and my personal life I rarely meet someone and tell them things about me. I'm a private person and you have to earn anything you know about me. It takes time".

Similarly, the study by Ross and Green (2011) found that due to the difficulties people with anorexia nervosa purported to have in trusting others, they valued having time in long term psychotherapy to develop trust in the therapist.

The issue of time and the development of the therapeutic relationship is also contemplated in a study by Stiles – Shields at al. (2013). They considered the therapeutic alliance (relationship) in two types of treatments for adults with severe and enduring anorexia nervosa; Cognitive Behavioural Therapy for Anorexia Nervosa (CBT – AN) and Specialist Supportive Clinical Management (SSCM). Both treatment types were found to be able to promote moderate ratings of the therapeutic alliance in the early stages of treatment, increasing to a strong therapeutic alliance in the later treatment stages. There was no significant difference between the two treatment types in relation to the presence of the therapeutic relationship. However, it is suggested that the predictive benefits of the therapeutic relationship in relation to clinical outcomes such as weight gain and the reduction in depressive symptoms may be associated with a stronger therapeutic relationship developed over a longer length of time. They suggest that this may be because these outcomes are more resistive to change, therefore a longer period of treatment and a stronger relationship is required. Although the issue of trust is not explicitly considered in the Stiles-Shields et al. 2013 study; my study suggests that longer periods of treatment can also lead to the development of a trusting therapeutic relationship that has positive connotations for the client. This is valuable as has previously been noted, better therapy outcomes are linked to improved perceptions of the therapeutic relationship by the client.

However, in contrast, another study found that patients who reported a stronger sense of alliance with their key nurse at the start of treatment were more likely to stay in treatment until the planned end and had significant weight increases in comparison to those who terminated treatment prematurely (Sly et al. 2013). They suggest, therefore that "first impressions count" (p122) in relation to the development of the therapeutic relationship and suggest that although it is generally regarded that a stronger therapeutic alliance develops over time this may not necessarily be so thus supporting the notion that a trusting relationship should and can be formed in the initial assessment meetings (Palmer 2014).

Although studies that consider the relationship between time, the development of the therapeutic relationship and clinical outcomes of treatment are somewhat contested; what emerged in the findings from my study was that individual consideration of the time required to develop trust between the individual and the therapist was of concern to the participants in my study. This seems important to consider as often people are offered short term treatment, particularly in primary care settings such as student counselling services. In addition, the participants in my study often reported a lack of continuity of therapists that made the development of trust difficult. What is encouraging, is that in the recently revised NICE guidelines for eating disorders (NICE 2017), it is recommended that individual psychological therapies for adults with anorexia nervosa are delivered over an extended time period of 40 treatment sessions. This recognises the unique needs and difficulties experienced by people with anorexia nervosa both in terms of the resistive nature of eating disorder symptoms and the relational trust issues inherent in the illness and subsequent therapeutic relationship.

9.6. Mutual trust and distrust

When considering trust as a concept integral to the development of the therapeutic relationship, the participants in my study also suggested that trust has to be perceived as a

two-way process. Thus, just as the person with anorexia nervosa needs to develop trust with the therapist, a reciprocal process of the therapist needing to develop trust in the person is required to develop a strong therapeutic relationship. Anna didn't feel trusted or believed by her therapist:

> *"In trying to explain the reasons for my eating disorder I felt that they did not believe me as they constantly offered other reasons that were not true. I also felt that they did not trust me which strongly hindered my treatment as due to blood test results they believed me to be bulimic which was not true and arranged a test to find this without my knowledge...In order to give the best therapy the client needs to be made to feel understood and trusted in what they say."*

As previously mentioned, Pemberton and Fox (2011) found that there was a significant amount of distrust felt towards staff by people with anorexia nervosa in their study. This distrust was mutual. It was suggested that this distrust seem to be derived from the patients feeling that they were being defined primarily by their eating disorder and that staff where attributing all their behaviour and emotional expression to their illness. Thus, the participants did not perceive that they were viewed as individuals but rather as identical members of a diagnostic group.

Similarly, Ramjan (2004) highlighted the presence of mutual distrust between nurses and adolescents with anorexia nervosa in an in-patient setting. As previously detailed in chapter eight there was a power struggle between nurses and patients over the control of food which was attributed to the distrust between the nurses and patients with anorexia nervosa. Subsequently, the adolescents in this setting were viewed by the nurses as being manipulative and less deserving in comparison to other children on the unit. Indeed, the nurses acknowledged that they did not even try to establish trust with them. Labelling the person with anorexia nervosa as being manipulative and therefore inherently untrustworthy in their self-reporting and behaviour can be a barrier to being able to develop mutual trust required to develop a good therapeutic relationship. Rather, being able to reframe the

behaviours that are viewed as manipulative as having a function for the individual, such as a coping or survival strategy can help staff develop understanding which can then lead to the development of trust (Ramjan 2004). The findings in Ramjan's study need to be viewed in the context that it was set in a paediatric medical ward where the nurses had very little, if any mental health training or knowledge. However, similar findings were noted in the Pemberton and Fox (2011) study which was set in an adolescent mental health in-patient setting where nurses and therapists would have had specialist training in mental disorders as well as eating disorders. A key issue appears to be that people, both adolescents and adults with anorexia nervosa are viewed by health professionals as essentially untrustworthy (Colton and Pistrang 2004, Jones and Larner 2004, Bezance and Holliday 2013). Indeed, it has been said that "you can't trust an anorexic" (Colton and Pistrang 2004 p312). In addition, they are often seen and treated primarily as a diagnosis rather than as an individual, which undermines the development of mutual trust between the therapist and the client. As Amy, a participant in my study highlighted:

> "My therapist spent a lot of time weighing and monitoring me and his first action in any appointment was to weigh me. Also when my weight was going up and down and I had no explanation he accused me of making myself sick. This did not encourage trust from me. I think therapists can be too quick to try and pigeon hole their patients and do everything by the book."

Similarly, Jenny explained:

> "I can't bear to be seen as an anorexic with my weight being the only important thing. I believe there isn't a 'typical anorexic'. It develops for different reasons and everyone experiences it differently...like any other person, we're all different, we are all individuals."

Fay also described her experience in therapy:

> *"The counsellor never got a good idea of who I was. It was more like she treated me from a one size fits all type of approach."*

Likewise, Anna emphasised the importance of being treated as an individual:

> *"I was put on a particular pathway due to my low weight which meant a certain treatment plan. I don't feel this should be done as every case is different and so an individual care plan needs to be made so it is personalised to you and therefore more beneficial. You can't learn about eating disorders from a text book; everyone is unique; everyone has different reasons and different ways of recovering. It's so important to treat every case as individual."*

The supposition that people with anorexia nervosa need to be viewed as individuals rather than as a homogenous diagnostic group concurs with findings from other studies where clients with eating disorders have expressed dissatisfaction with how treatment was delivered (Colton and Pistrang 2004, Tierney 2008, Pemberton and Fox 2011, Sly et al. 2014). Conversely, Wright (2013) found that women with anorexia nervosa in an in-patient setting defined their identity primarily through their anorexia nervosa. However, it was the ability of the staff to convey care and empathy on an individual basis that inspired trust in the women. Wright (2013 p226) therefore suggests that trust is fundamental in the transition to recovery in anorexia nervosa:

> *"Trusting a worker meant agreeing to engage in therapy that would cause weight gain and re-align their sense of identity from anorexic to recovered anorexia."*

Though it is known that people with anorexia nervosa can attribute great importance to their own identity as being 'an anorexic', in my study the participants were less concerned with being defined in relation to their illness. Rather, they preferred to be seen as an individual outside of the anorexia nervosa. This is a central tenet to the nature and context of the therapeutic relationship. As Kate described:

> *"My psychotherapist always saw me and treated me as a person, **an individual**
> (participant emphasis) not in terms of my eating disorder or defined by my
> problems."*

Specifically, being viewed by the therapist as an individual first, with unique strengths, needs and experiences fosters trust within the relationship.

During the second phase of data analysis I began to consider that the participants in my study tended to approach services and therapists from an initial position of distrust of the therapist and the goals of the therapy. Indeed, Berg et al. (2002) suggest that people with anorexia nervosa often enter the treatment process with a fear of the clinical interventions and subsequently view practitioners with distrust.

This means that trust must be gained by the therapist to progress with therapy. In the beginning of this chapter I defined trust as being the faith that the client has that the therapist is competent, inherently trustworthy themselves and is acting in their best interests of the client (Ackerman and Hilsenroth 2003, Castonguay et al. 2010, Palmer 2014). What struck me during the data analysis is that people with anorexia nervosa do not naturally approach treatment with these beliefs. This is due to the ego – syntonic nature of their illness as well as their perceived negative beliefs about how they are viewed by health professionals, which may or may not be based in reality. This would seem to be a unique position for the person with anorexia nervosa seeking help. It is reasonable to assume to make that most people approach health services for treatment having faith in those services and staff. Accordingly, during the theory development in this study, I returned to the participants to ask them about these emerging ideas in regard to trust and the therapeutic relationship.

Specifically, I asked:

> "I have found that people are often ambivalent about treatment, and seem to
> initially approach the relationship with new therapists from a position of mistrust.
> What do you think about this, how might this impact on your expectations of the

therapeutic relationship that might develop and how you might engage in the therapy being offered?" (see appendix 4)

Although only two participants responded to this question, what they contributed was valuable in considering this unique aspect of trust:

First, Amy replied

"In terms of issues of mistrust towards new therapists I think that when you suffer from an eating disorder it's hard to engage with someone whose job is in principal to support you through putting on weight which in your mind is the last thing you want to do. I think you are fighting yourself and what is in your head when dealing with an eating disorder which some therapists don't seem to understand. You are not necessarily fighting or not trusting them but instead your own thoughts and feelings."

Maggie was unable to write down the word trust in her response. She explained that this was due to feeling so let down by previous therapists and services. She has therefore used the code Trt in her answer to the question about approaching therapy from a position of mistrust:

"This is correct. As a client is often passed from one person to another, often told they are unable to help them so you believe this to be the same for any other therapist you see. This in turn leads to disbelief that any therapist can help even if they are using a different approach. There is an expectation that they will also tell you, you cannot be helped, you are too complex or your time is up. You start to believe that you will never get better. If professionals have let you down, or have said unhelpful insensitive comments this can also lead to mistrust in further treatments. Personally it took me many months to (trt) that my current therapist would not do this, I would constantly be asking what she thought of me and even asked her directly if she has ever given up on helping clients. I now feel more stable within the therapeutic relationship. I think it is the little things the therapist

does for you or goes out of their way to make sure you are ok that helps build

that relationship. Also when a therapist shows genuine empathy makes you feel

like they want to help and care about your wellbeing. This enabled me to (trt) her

more".

Thus, the responses from Amy and Maggie appear to support my supposition which offers some explanation as to why developing trust in the initial stages of seeking help can be so difficult but equally crucial to the development of the therapeutic relationship. Bordin (1979) suggested that some therapies require different approaches to the therapeutic relationship. I suggest that this is a relevant factor in the treatment of anorexia nervosa and that attention to the development of trust is significant. Meissner (2007) also suggests that because some people enter therapy without a sense of trust in the therapist, extra support is needed to resolve this concern to establish a trusting therapeutic relationship. This process can require an extended time to allow security in the relationship to develop.

9.7. Conclusion: a theoretical explanation of trust within the therapeutic relationship

Trust is a core component of any therapeutic relationship. This chapter presents an explanation of the specific conditions necessary for the development of trust with adults with anorexia nervosa. Due to the nature of the illness and the presence of personality traits synonymous with anorexia nervosa, it is reasonable to surmise that individuals tend to approach therapy from a position of mistrust of both therapists and the aims of therapies for eating disorders; primarily the restoration of weight. Thus, as a component of developing a therapeutic relationship, special attention needs to be placed by the therapist on developing trust with the client from the outset of therapy.

Therapists' actions such as being reliable and consistent in the initial stages of relationship building can be significant in providing positive first impressions with clients and conveying that the individual is valued and worthy of engaging in treatment. In addition, the

interpersonal stance or approach of the therapist, namely the ability to convey positive regard and acceptance of the individual as well as not creating the impression that the person is somehow to blame for their condition helps to reduce feelings of shame and fosters trust. Specialist knowledge of eating disorders is also favoured by clients as it inspires confidence in clients that the therapist is going to be able to help them. However, the way this knowledge is conveyed by the therapist is critical. Thus, an authoritative but not authoritarian approach is required. Moreover, using specialist knowledge of anorexia nervosa to convey understanding on an individual basis for each client is central to the development of trust on the part of the client. Thus, one size does not fit all and it is crucial in the experience of the client that they are appreciated as a unique person outside of their illness; taking this approach nurtures the development of a trusting therapeutic relationship.

The context of therapy that the participants have described in a favourable light in relation to being able to develop trust with their therapist have tended to be those working with therapists in out-patient specialist eating disorder services within the National Health Service (NHS) as well as private specialist eating disorder therapists. These services and therapists are often able to offer longer term treatment options than those found in primary care or alternative counselling services such as those found in university based student support. Due to the unique difficulties presented by people with anorexia nervosa, in terms of issues related to trust as well as the resistive nature of the symptomatology, individuals generally respond better to longer term treatments. However, this does need to be considered on an individual basis. It has been suggested that clients who present to therapy with specific trust issues such as those with anorexia nervosa require extra support to establish a trusting therapeutic relationship. This proposal is borne out in the findings of my study.

In the following chapter, I present the final theoretical category of the therapeutic relationship pertaining to adults with anorexia nervosa: feeling understood within the relationship.

Chapter 10: Findings and Discussion

"They just got me" – feeling understood within the therapeutic relationship

10.1. Introduction

This chapter presents the third key conceptual category necessary in the therapeutic relationship. This relates to the client experience of feeling understood by the therapist. I have used the in vivo code "they just got me" as a prefix for this category as this phrase was used by a participant in the first phase of this study. Throughout the analysis, I felt it clearly articulated how the participant experienced the understanding and empathy present in the therapeutic relationship with her therapist and closely captured the essence of this category (Charmaz 2014).

Empathic understanding is viewed as one of the characteristics of a helpful therapeutic relationship and has been suggested to be an essential constituent of the relationship that is necessary to facilitate therapeutic change and foster client and therapist collaboration (Rogers 1951, 1957, 1961, Beck et al. 1979, Ackerman et al. 2003, Meissner 2007). Empathy relates to the therapist being able to understand the client's world and subsequent feelings; communicate this understanding accurately, without judgement or contamination of the therapist's own feelings and responses (Rogers 1957). Furthermore, empathy has been described as:

> "The therapist's sensitive ability and willingness to understand the client's thoughts, feelings and struggles from the client's point of view. It is this ability to see completely through the client's eyes, to adopt his frame of reference."

> (Rogers 1957 p85).

Being empathic therefore means entering the private world of the individual and being sensitive to changing meanings throughout the process of the therapeutic interaction (Rogers 1957). Empathy can therefore be viewed as a high order, complex construct that

manifests in the manner that the therapist communicates within the therapeutic relationship (Bohort et al. 2002).

Anorexia nervosa has been described as a condition that is "beyond understanding" (Lawrence 1995 p 15) and lies outside of most people's experience. Equally, it has been found that health professionals also misunderstand the causes and maintaining factors that drive anorexia nervosa (Jones and Larner 2004). Thus, clinicians and in particular those with limited experience report feelings of hopelessness, incompetence, frustration and worry associated when working with people with eating disorders (Thompson-Brenner et al. 2012). In addition to these feelings, it is also suggested that in comparison to other mental health disorders, people with anorexia nervosa rarely induce feelings of compassion and empathy in others (Walker and Lloyd 2011). Therefore, it can be surmised that being able to demonstrate and maintain accurate empathy for those with anorexia nervosa is especially challenging for therapists. Nonetheless, Vitousek et al. (1998) suggest that conveying empathy is vital and it is important for therapists to gain a frame of reference for anorexia nervosa through attending to the experiences of those with the condition. Previous studies undertaken with users of eating disorder services have identified the need for therapists to have personal qualities of empathy, understanding, a non-judgemental approach and the ability to stand beside the individual in relation to the therapeutic relationship (de la Rie 2008, Escobar-Koch et al 2010, Walker and Lloyd 2011, Fogarty and Ramjan 2016).

In my study, feeling understood by the therapist also emerged as a key component in the development of what was perceived to be a good therapeutic relationship by the participants. This chapter, therefore, details how empathy manifests between the client and the therapist. This includes understanding the association between feeling understood and valued by the therapist and the subsequent impact this can have on the instillation of hope for recovery; feeling understood and accepted as a whole person, rather than primarily as a diagnosis and experiencing a non- judgemental stance from the therapist. Finally, the potential impact of the gender of the therapist regarding feeling understood is explored.

10.2. Feeling understood and valued by the therapist

As detailed in chapter seven, in the initial phases of the data analysis, I considered the focused codes of feeling understood and developing trust together. However, as the analysis progressed these concepts were subsequently analysed separately to explicate the unique properties of these two concepts as well as further explore the relationship between them. However, a shared property of feeling understood and developing trust was the ability of the therapist to convey to the individual that they were a person of value. The experience of feeling valued was also highlighted in chapter eight as being fundamental to the development of trust between participants and their therapists.

As Jenny described, in her experience of working with a CBT therapist:

> "*I trust my therapist who is understanding of all my issues and treats me as a person who has worth.*"

Similarly, Sue felt that her therapist generally understood her well; he was interested in her and demonstrated that he valued her thoughts and feelings by taking the time to read her:

> "*Insights and thoughts in between sessions.*"

Describing the therapeutic relationship with her psychodynamic therapist, Kate stated:

> "*He made me feel **valuable** (her emphasis) and worth listening to and taken seriously.*"

For Jo, feeling understood by a therapist for the first time was:

> "*A powerful moment. I had never felt like that before and I didn't realise that I ever would. It really makes you feel like someone is on your side and that you aren't alone in whatever it is you are going through.*"

According to people with anorexia nervosa, **feeling understood** is a significant factor in their recovery process (Tozzi et al. 2003). Key elements of demonstrating

understanding or empathy have been identified as therapist warmth and affirmation. These aspects of empathy are suggested to positively influence the development and maintenance of the therapeutic relationship (Ackerman and Hilsenroth 2003). Kate experienced this with her therapist:

"His warmth, compassion and evident positive regard for me made all the difference."

Similarly, an online blogger with anorexia nervosa described meeting her community psychiatric nurses from the local eating disorder service for the first time:

"They were humorous and human and they made a difficult conversation bearable, the whole meeting was filled with respect and compassion."

(Alice 2016)

Rogers (1957) identified what he called therapist unconditional positive regard as being a necessary condition for therapeutic change. He described this as the therapist experiencing:

".....warm acceptance of each aspect of the client's experience as being part of that client….it means a "prizing" of the person"

(Rogers 1957 p 98).

Prizing is akin to what I have identified in my study as the therapist valuing and accepting the client. Assuming this stance enables the client to have their own feelings and perspective, thus conveying to the client that their experience is "fully accepted and valued without judgement" (Watson and Kalogerakos 2010 p193).

Farber and Lane (2002) suggest that the concepts of unconditional positive regard and empathy in human interaction are very closely and perhaps inextricably linked. Therefore, experiencing positive regard for the client can only be achieved through empathic identification or understanding of that client Thus, for the person with anorexia nervosa

experiencing therapist understanding as well as warm regard can be a potent combination that can lead to change (Watson and Kalogerakos 2010).

In the autobiographical account of her treatment for anorexia nervosa, Ayelet experienced her therapist working from a position of empathic identification:

"Finally, I found myself accepting different behaviours, different ways of thinking and feeling and believing. I cannot tell exactly when it happened. It was a very slow, gradual process of acceptance. Tammie helped me achieve our goals in the treatment by learning to know who I was, learning my kind of language, and becoming part of my belief system. Only then could she help me change and chose another way to live."

(Ronen and Ayelet 2001 p188)

In my study, Natalie described her experience and the impact of feeling that her therapist understood and accepted all aspects of herself:

"She just got me, she understood that there were certain things that I found hard to explain or say – she filled in the gap for me to let me know that she understood – and didn't say the words she knew I couldn't bear to hear...... My preconceived perceptions that no-one and no-where was safe were challenged, I could say what I wanted or didn't without judgement or harshness. I was accepted for all I was and all that I am. I was able to find me, and understand me."

Watson and Kalogerakos (2010) argue that the communication of unconditional positive regard by the therapist as an antidote to clients' feelings of worthlessness. In addition, they suggest that this is of particularly important where clients' feelings and thoughts have previously been ignored or discounted. This is often the experience of people with anorexia nervosa and evident in the experiences of the participants in my study. For example, Jo described an encounter with a general practitioner. He told her:

"Don't worry, we'll get you back to being good and pudgy soon."

He then went on to inform her that she was too heavy to have anorexia nervosa, thus contradicting and invalidating her experience.

Helen described the impact of feeling judged during an experience of treatment for her eating disorder:

"During my time as an inpatient on an eating disorder ward, a lot of the mental health nurses were very judgmental about my self-harm. They would openly express their disgust to me about the self-harm. They had a rule where if I self-harmed, then I would not be allowed any one to one support for 24 hours. Therapists and people generally in the mental health profession should understand that self-harm is very common within sufferers of EDs (eating disorders - her abbreviation) *and making them feel bad and shameful reinforces the need to punish oneself through whatever means is possible e.g. self-harm, restriction/purging, exercise."*

Likewise, Jenny experienced a lack of understanding and feeling judged regarding receiving in-patient treatment for anorexia nervosa:

"Maybe you think anorexia is something young girls do for attention? It's their decision to be anorexic? You just need to have a few sandwiches, eat a banana, you should go rowing – that's what I've been told. You are wasting your life, an out of order judgemental member of staff on a ward told me. A consultant called me childish for self -harming. Professionals should listen to the patient, not judge or punish."

Ellie is a health professional as well as a user of eating disorder services for the treatment of anorexia nervosa. In an online blog, she wrote about her fears of feeling judged by her own colleagues in mental health services:

"I've pretty much given up thinking of excuses when I bump into colleagues on my way to therapy. I don't actually want to lie. Yes, I have issues with eating. Yes, I'm trying to address them. But the truth is that there are people who if they knew, would view me differently, gossip, or see me as less than. I don't want people to judge...well would you want to advertise at work that you are receiving help for a problem often misunderstood as narcissistic, self-inflicted or selfish? I doubt it."

Ellie (2016c)

Although Ellie's fears may not manifest, as previously mentioned, health professionals do often misunderstand and indeed blame the individual for their illness (Jones and Larner 2004, Walker and Lloyd 2011). In addition, it has been found that nurses can believe that young people with anorexia nervosa are less deserving of treatment than other patients (Ramjan 2004).

Due to the nature of anorexia nervosa and a lack of knowledge and misconception about the illness, demonstrating non- judgemental positive regard and empathy for someone with anorexia nervosa can be challenging for health professionals, particularly if they lack experience in this area. In my own practice as an occupational therapist, I experienced my colleagues within secondary care community mental health services often avoiding or refusing to accept referrals for people with anorexia nervosa. In addition, this refusal was often accompanied with blatantly ignorant and condemnatory remarks that would not be made about other people with serious mental health conditions.

Despite the negative cases that demonstrate some of the difficulties experienced by health professionals to demonstrate non-judgemental understanding towards people with anorexia nervosa, Wright (2010) has recognised that nurses do use "genuineness, empathy and authenticity" within the therapeutic relationship (p157). She highlights that the nature of the therapeutic relationship with adults with anorexia nervosa in specialist eating disorder

services may be fundamentally different to those in other therapeutic encounters. However, trust, empathy and understanding the experience of the individual without judgement is required (Wright 2010). More recently, adults with anorexia nervosa have again highlighted that they favour the following qualities in therapists: non – judgemental, understanding, kind, compassionate and intuitive. Feeling listened to and understood helps adults with anorexia nervosa to feel validated and worthy of support (Fogarty and Ramjan 2016, Zainal et al. 2016).

This section has explored the relationship between feeling understood by the therapist and feeling valued. Prizing or valuing the client can be demonstrated by acceptance and identification of the client's experience. Manifested by the therapist's warmth, non - judgemental and unconditional regard, this stance can counter against the feelings of worthlessness that are experienced by those with anorexia nervosa. These components of empathy can positively influence the development and maintenance of the therapeutic relationship.

I now move on to explore how feeling understood by the therapist impacts on the client's perception of hope for recovery.

10.3. Feeling understood and the instillation of hope for recovery

A further aspect of the experience of feeling understood by the therapist within the therapeutic relationship was the conveyance of hope by the therapist. In the early phases of the analysis in my study, I wrote a memo about the instillation of hope as a key aspect of the therapeutic relationship (as previously detailed in chapter 6). Subsequently, I then asked the participants in phase two of the study to comment on this focused code further. However, in the process of advanced memo-writing, I made the analytical decision that this aspect of the therapeutic relationship did not develop significantly enough to warrant being considered as a full conceptual category (Charmaz 2014). Nonetheless, I decided that the conveyance of

hope by the therapist was still a noteworthy aspect of the therapeutic relationship. As Maggie said:

> "Encourage us by telling us we are capable and that you believe in us and want us to get well, as we often don't get this."

I therefore reconsidered this code in the light of feeling understood by the therapist as this is where the best fit seemed to be within the data and theory development (Charmaz 2014).

For example, Jenny felt that her therapist had belief in her:

> "He doesn't judge me or look down on me. I feel like he really cares about me and has faith in my ability to change even when I don't."

Natalie observed that:

> "The therapeutic relationship we had also gave me hope – that there are people out there who are genuine and who truly do care."

Kate also recognised that her therapist felt hopeful for her:

> "I trusted that he was there for me and was hopeful for me even at times when I couldn't feel hopeful."

In these accounts, hope is linked to feeling cared for and valued by the therapists in an unconditional, non-judgemental way as previously described (Rogers 1957, Watson and Kalogerakos 2010, Walker and Lloyd 2011, Zainal et al. 2016).

A common factor that emerged from the participants in my study regarding hope was that they tended to approach therapy believing they were not capable of change. The belief in the possibility for change and recovery came initially from the therapist. For example, although Rebecca did not have the belief that she could modify her eating behaviour herself, her therapist did:

"The relationship I had was really important to me because I felt like if I couldn't work through my issues this time, that I would always have them. Even though I know I will never be completely normal with food and weight, the therapist made me feel like I could always improve my situation and things would be better."

Subsequently, in phase two of the data analysis Rebecca further expanded on this issue by reflecting on what the therapist did to convey hope for change and what impact this had on her. She wrote:

"The therapist helped me believe I could change. I would often say that "it's just the way I am" and that I'd been like it for too long to change and I still believe that to a certain extent.... But when I would say things like that she would remind me of how I was- what I was doing and how I was thinking at the beginning of counselling and the steps I had taken since. I also respected her for agreeing with me that I probably would always have some issues with food and my body, instead of telling me that I would be completely 'normal' again."

Sue also considered how her therapist conveyed hope within the process of their relationship:

"I think my therapist did communicate hope for recovery/change. He was certainly encouraging and helped me to see the positives in the changes I had made."

In addition, Fay recalled how her therapist combined hope and empowerment in his approach:

"Whilst he was always positive and optimistic about hopes for recovery and change, he very much allowed me to make those decisions myself. It was him enabling me to see those hopes for myself that made my sessions so effective."

The instillation and maintenance of hope is a vital component of any therapy. Not only does it help maintain the individual in therapy but it is said to have curative properties in its own right (Yalom and Leszcz 2005). In a previous study of health professionals and patients in a specialist eating disorder service it was found that the hope and optimism that was conveyed by the staff was recognised as a significant factor within the experience of developing an authentic therapeutic relationship (Wright 2012, 2013). Similarly, Fogarty and Ramjan (2016) found that hope for future recovery can be fostered through the experiences of treatment for anorexia nervosa.

In my study, the conveyance of hope for recovery appeared to be provided through the therapist in the first instance. This finding corresponds with the nature of anorexia nervosa where clients are generally reluctant to engage in therapy or have experienced unsuccessful episodes of treatment and therapy in the past and thus often feel hopeless about the potential for change (Evans and Waller 2012). Having belief in a treatment mode has been found to be therapeutically effective and moreover, positive outcomes of psychotherapy are more likely where the client and therapist have similar expectations of the therapy (Yalom and Leszcz 2005). Therefore, it is crucial for the therapist to convey to the client in the early stages of therapy that the treatment approach will be beneficial. Equally, the goals of therapy need to be achievable and agreed collaboratively between the therapist and client as previously detailed in chapter eight. Furthermore, setting achievable goals and reflecting on progress will help the client feel hopeful for recovery themselves. That said, my findings also suggest that it is important that the therapist is realistic about the extent for potential recovery. This issue was recognised by Beth as being significant to her:

> *"The therapist who was of most help to me agreed that I would not recover from anorexia but that she would help me manage the condition…....it was a relief to me when I came across a psychiatrist who had a genuine interest in SEED (*severe and enduring eating disorder*) and was able to help me manage my illness without attempting to change my behaviour."*

In this instance, therefore, it was important that the therapist worked from the position that Beth was at, thus accepting and validating her experience. This arguably demonstrates unconditional positive regard and understanding of her unique situation. However, an alternative perspective is offered by Evans and Waller (2012). They suggest that instilling hope about the potential usefulness of therapy is a crucial factor in the engagement of people with eating disorders and can help to prevent them sinking into a trap of helplessness. Nonetheless, they also recognise that balancing optimism and a realistic view of potential outcomes is equally important to acknowledge.

Snell et al. (2010), considered the concept of 'pacing' as a therapeutic strategy to develop a therapeutic connection with the person with anorexia nervosa. They described pacing as "being alongside the patient as they moved towards recovery" (p354). In their study, they detailed a process whereby the nurse endeavoured to get into the world of the client and worked alongside them from a position of where they were at, rather than pushing them towards recovery too quickly. Thus, it was suggested that developing a therapeutic relationship requires working at a pace dictated by the patient to fully understand their individual experience of anorexia nervosa, whilst concurrently maintaining a "hopeful presence" for recovery (Snell et al. p354). This therapeutic stance was used to overcome resistance from the clients and encourage engagement in the treatment programme. This approach utilises both understanding and empathy of the person with anorexia nervosa whilst also conveying hope for recovery.

10.4. Feeling understood and the therapist's stance

In my study, the ability of the therapist to demonstrate accurate understanding of the individual was a powerful experience for the participants and had a positive function in the development of the therapeutic relationship. However, the manner in which empathy was

conveyed was also important. For example, Sue interpreted her therapist's attempts to validate her experiences as collusive:

"*Unfortunately, I feel he was probably too lenient with me… he often appeared to validate and "accept" difficult behaviours rather than trying to get me to change or stop them. e.g. 'I can see why you would want to binge/purge in that situation.' In hindsight, I don't think this was particularly helpful.*"

However, Sion described a different stance taken by his social worker:

"*I have a lot to be thankful for especially that first meeting with my therapist, she was so caring, kind and very open to my feelings, but most of all honest about my illness, straight talking in her mannerism which came across in her voice. At that point, I needed to be told how emaciated I looked and unwell. This opened my eyes to what I had done or become. I believe to this day no one else could have put that to me. Her professional understanding and manner shone through to my inner self that unlocked a door of trust which allowed me to feel relaxed enough to open up my heart and for the first time in my life I was free. This was an all-new experience for me. At a tender age and with no real coping method with life I had found a single person that now knew and shared my most best kept secret of anorexia.*"

Likewise, in an online blog entry, Lisa described the stance that was taken by her mental health advisor at university:

"*He completely understood how I felt and while he always challenged me in my behaviours, he was always there for me.*"

(Lisa 2016)

In addition, a further contribution by an online blogger described how a general practitioner approached her:

"He took a calculated approach – painfully honest and blunt at times, but understanding and sensitive to the complexities of what we were dealing with. He certainly didn't pussyfoot around the issue and that was what I needed – someone to sit me down and tell me the truth."

(Caitlin 2016)

As has been formerly described in relation to working with people with anorexia nervosa, "the ideal therapist is a judicious blend of empathy and firmness" (Vitousek et al. 1998 p 400). Thus, a combination of demonstrating understanding of the individual whilst simultaneously being able to confront the seriousness of the illness and the situation is vital. This finding concurs with that of Gulliksen at al. (2012) who found that a combination of the therapist's ability to convey understanding and their willingness to challenge are viewed as preferred characteristics of therapists by people with anorexia nervosa. In addition, and as previously detailed in chapter nine it has been suggested that the style of therapist stance that combines understanding with authoritativeness, and a willingness to challenge also helps to develop trust within the therapeutic relationship (Vitousek et al. 1998, Walker and Lloyd 2011, Evans and Waller 2012, Gulliksen et al. 2012).

I know move on to detail how understanding the person with anorexia nervosa as an individual is a crucial factor in the development of the relationship between the therapist and client.

10.5. Demonstrating understanding of the whole individual

Being viewed as a complete individual and not primarily as 'an anorexic' was a further factor in the experience of feeling understood within the context of the therapeutic relationship. As Kate described:

> "*He* (her therapist) *always saw me and treated me as a person, an individual not in terms of my eating disorder or just defined by my problems.*"

Likewise, Fay described her specialist eating disorder CBT therapist as being fully understanding of her unique issues. She felt:

> "*He had a fantastic gauge of me as a person (not just as a patient who needed fixing). He understood me and what made me tick.*"

Jo described her relationship with a practice nurse. Although the focus of the nurse's intervention was medical, she took the time and effort to get to know Jo outside of her diagnosis of anorexia nervosa. The outcome of this was the development of a good therapeutic relationship that kept her engaged in the process of medical monitoring. The nurse achieved this by simply finding out more about Jo as an individual and thus:

> "*It also feels like she sees me as a person and she's gaining an understanding about me.*"

She went on to suggest that she finds it helpful when therapists pick up on some of the personal things that make her an individual outside of her eating disorder:.

> "*Find out what interests someone or what pet they have, it lets you make a little bit of small talk whilst you are taking off your coat and is so important for relationship building.*"

Anna described that despite her therapist trying to find out about her personally, the focus of treatment still focused primarily on her medical needs, thus she didn't feel listened to or understood:

> "*Although the therapist asked me personal questions about my life to try and develop a relationship most of the time I spent in treatment was focused on medical rather than personal......although the therapist tried to tell me the advantages to gaining weight and eating properly they also made a focus on how*

I would feel if this happened. In order to give the best therapy, the client needs to be made to feel understood and trusted in what they say. Although when suffering with an eating disorder the medical intervention is extremely vital so is listening to their thoughts and feelings which I believe was neglected during my treatment".

Maggie also highlighted the need for therapists to be aware of the whole person to understand the uniqueness of their lived experience. Her experience resonates with Parker's (2006) clinical discussion of the concept of contextual congruence as a component of client centred practice. This means seeing the person as an individual rather than as a medical diagnosis and understanding the situation and environment the person lives in and the individuality of the persons, interests and roles. Thus, as someone with a physical disability as well as suffering with anorexia nervosa, she described feeling that her life experiences and beliefs were not understood by therapists. This drove her to find a specialist eating disorder therapist in the private sector where the therapy offered was based on a holistic psychodynamic therapy approach.

"My current therapist has always told me that I am worth more and am more than my anorexia. She is interested in me and what I want to do in my life outside of my eating disorder and I think this is how a positive relationship develops. Asking about things I have mentioned the week before is a nice thing to do and shows interest.....if I get upset she gives me time to explain how I am feeling and tells me she wants to understand why I think a certain way so that she can help me. All of this has enabled me to feel like I have been treated like an individual, building a positive relationship."

Describing the relationship with her therapist, Maggie highlighted that this was the first time she had felt understood by a therapist. Due to this, the therapeutic relationship was one of openness and honesty that allowed differences in their opinions about her treatment to be worked through:

"Sometimes there is difference of opinion and that is inevitable but I know that I am able to discuss that openly, something I have never felt able to do before because I felt nobody understood me. I now know having found the right therapist and the right therapy that full recovery is possible and one day I will be free from my eating disorder."

In the autobiographical account by Ayelet, being treated primarily as a diagnosis rather than as an individual first was highlighted as impacting negatively on her willingness to engage in treatment. Thus, by failing to engage with her strengths and talents she felt misunderstood and as she recalls did not cooperate with the treatment offered or develop a therapeutic relationship with the staff.

"A short time after my 16th birthday I started individual therapy with a therapist…this treatment did not help me. I did not cooperate. The therapist did not understand me and concentrated mainly on trying to make me eat. No one treated me as a person, that is to say, as a normal person…. I was treated as a diagnosis, not as a human being. No one cared about my hobbies, my joys, my writings, and my expectations. Nobody tried to enlist my positive strengths. Except for my assigned nurse therapist, not one member of the staff ever tried to get involved with the things that I liked: writing, reading and drawing. None of them tried to get inside my world, my preferences. I had to conform to theirs."

(Ronen and Ayelet 2001 p81)

Feeling understood as an individual was also a key factor in Daisy's relationship with her psychologist. Although she recounted finding the use of cognitive behavioural therapy as too mechanistic, her therapist was also able to work in a flexible *"person centred"* way. Subsequently, she described a therapeutic relationship with her therapist that appeared to have been able to instil a feeling of understanding and was adapted to her unique needs:

"The therapist was very comforting. He honestly was the most sympathetic, empathetic, caring person I have ever happened across. His eyes told of genuine understanding of me and a willingness to share my pain and frustration. He was ever so understanding and willing to adapt the sessions to my current needs."

This contrasted with a previous experience where she felt that the therapist did not understand her as an individual and delivered the treatment in an inflexible way, thus impacting on the development of the therapeutic relationship:

"The relationship with a therapist is very important, as you have to genuinely like them. I know this from seeing the other therapist who I got nowhere with. We didn't click and she didn't understand me, and was unwilling to flex the rigidity around rules."

The association between understanding the whole person beyond the diagnosis of anorexia nervosa has been observed in other studies. Colton and Pistrang (2004 p311) highlighted the theme "being an individual vs just another anorexic" in their participant's descriptions of in-patient treatment for eating disorders. Thus, being viewed and treated as a unique individual with differing needs by staff was seen as being helpful. Staff who were described as good by the participants were those who could see beyond the diagnosis of anorexia nervosa and did not attribute everything just to the illness. Similarly, Pemberton and Fox (2011) specifically looked at the experience and management of emotions of people with anorexia nervosa on an in-patient unit. A lack of knowledge was recognised as a factor in the staffs' lack of understanding of anorexia nervosa and the subsequent emotions experienced and expressed by the participants. It was found that the way these emotions were responded to by the staff equated to whether the participants felt understood and validated. Therefore, the ability of the staff to respond in an empathic manner through the accurate identification and acknowledgement of the emotional trigger and their subsequent response was found to be helpful in the development of the therapeutic relationship. In

addition, defining the individual in terms of the illness and thus pathologising all their interactions and emotions as aspects of the illness impacted negatively on the development of trust between the staff and participants as they felt that they were being treated under an assumed group identity rather than as an individual.

Feeling understood as an individual was also highlighted in Tierney's (2008) qualitative investigation into the experiences of adolescents being treated for anorexia nervosa in in-patient services. In this study, it was found that staff who treated people as 'anorexic cases' rather than as individuals were condemned by the participants as not being understanding of their individual problems. Therefore, therapists who can demonstrate understanding of anorexia nervosa through listening to the individual rather than treating everyone as a homogenous group are most valued by people with anorexia nervosa (Tierney 2008). As previously detailed in chapter nine, Evans and Waller (2012) also discuss how they formulate the person's problems with eating in CBT for anorexia nervosa in an individualised way, thus validating the person by conveying understanding of their unique experiences, beliefs and actions. They suggest that through feeling understood as an individual the person is more likely to accept that change in their situation is necessary. Likewise, it has been highlighted in more recent studies that individual therapy delivered by an understanding, compassionate and non-judgemental therapist who can consider the individual needs of the person is viewed as important by adults with anorexia nervosa (Fogarty and Ramjan 2016, Zainal et al. 2016).

In my study, there was a close link between feeling understood by the therapist as an individual and the development of trust in the therapeutic relationship. Thus, to inspire trust, it is necessary for the therapist to recognise the unique experience of anorexia nervosa for everyone they work with. Likewise, to demonstrate understanding the therapist must take into account the whole person behind the anorexia nervosa through engaging with their individual strengths, talents, interests and beliefs. These links between feeling understood by the therapist, the establishment of trust and being viewed as an individual are also

acknowledged by Gulliksen et al. (2012) who identified preferred therapist attributes from the perspective of adult women with anorexia nervosa. The construct of therapist "acceptance" (p 935) related to therapists being viewed as understanding by the clients. This in turn led clients to believe that these therapists were also trustworthy. It was also found that therapists who could listen and accept the patient's perspective in a non-judgmental way were highly valued. The participants in this study reported that they subsequently felt that they were viewed as unique individuals and were participating in an equal therapeutic relationship (Gulliksen et al. 2012). The findings of my study concur with this conclusion.

Finally, in the explication of the association between feeling understood as an individual and developing trust in the therapeutic relationship, I refer to theory by Fonagy and Allison (2014). They postulate that the process of mentalizing in therapy is a generic process that can help to establish trust between the therapist and client. Mentalizing is an approach used in therapy that works in a way to help the client relinquish inflexibility in thinking. This is a feature that is prominent in people with anorexia nervosa (Schmidt and Treasure 2006). Through relearning flexibility in thinking, the client can move on to learn from new social relationships; both about themselves and their own cognitions and behaviours as well as other people.

The development of epistemic trust is described by Fonagy and Allison (2014 p4) as:

> "The willingness of the individual to consider new knowledge from another person as being trustworthy and relevant to the individual."

As I detailed in chapter nine, people with anorexia nervosa often approach therapy from an initial position of mistrust of the therapist and the therapy. In other words, they have "epistemic hypervigilance" (Fonagy and Allison 2014 p 15). That is, they view the therapist with suspicion and do not put trust in the information that they may be given about their illness or indeed see it as having any relevance to their individual situation (Fonagy and Allison 2014). What is suggested is that epistemic trust can be developed between the

therapist and client through the realisation that the therapist has understood the crucial things about the individual. Therefore, it is not a case of the therapist conveying generalised knowledge about anorexia nervosa, but rather relating this to how the individual experiences their own condition. Thus, the message the client receives from the therapist, through their communication, is that they have noticed and understood what it is like to be that person in their unique situation. In other words, as Natalie wrote about her therapist: *"they just got me."* The result of feeling understood as a unique being subsequently helps the individual to develop epistemic trust and gives the person the opportunity to begin to think about themselves in an alternative way as described by Fonagy and Allison (2014 p14):

> "Establishing epistemic trust in the creation of a collaboration between the patient and therapist, through the explicit effort of seeing the world from the patient's standpoint, serves to open the patient's mind to the therapist's communication."

Although the processes of mentalization and the development of epistemic trust are suggested to be generic processes in therapy, based on the findings of my study I suggest that they have specific relevance to adults with anorexia nervosa. Thus, feeling understood by the therapist as a unique individual, acts as a prerequisite for the development of trust in the therapist and a belief in their expertise and ability to help. Consequently, the therapeutic relationship offers a milieu in which the client can explore and learn about alternative understandings of themselves and others.

I now move on to consider the question of whether the gender of the therapist impacts on the client feeling that they are understood within the therapeutic relationship.

During the early phases of the data analysis, the gender of the therapist was a further factor that was evident in some participants' stories in relation to feeling understood by their therapist.

For example, Anna described her relationship with a male psychologist as being a struggle:

> *"Due to the person I saw most being a man I found this very difficult as I did not feel they would understand me the way a woman would. I think having a male therapist did not help me as I think it is much harder for a man to understand how a woman sees their body image."*

The assumption that a male therapist cannot understand a female's experience of having anorexia nervosa as well as a female therapist was also raised by Kate who disclosed that she deliberately chose to work with a male therapist:

> *"I knew they would probably know less about AN/EDs* (anorexia nervosa/eating disorders, her abbreviation) *generally and therefore I could get away with talking about everything under the sun apart from the actual eating patterns."*

That said, she also went on to describe some of the complexity of the gender issues that arose for her when she subsequently worked with a female therapist. Initially, she reflected that because the therapist was female, this would be a barrier to the development of the therapeutic relationship. She attributed this belief to the comparisons she made between herself and the therapist, which in her perception, left her wanting. For example, she viewed the therapist in an idealised way, seeing her in terms of being a high achieving and successful individual. However, through the process of working together she began to change this view and began to see the therapist as a positive role model:

> *"Working with a female therapist who was obviously at a very normal weight and who I could see was very feminine and curvy in a very attractive way was*

reassuring and helpful. Also her being very open about what she ate on a typical day or meal as opposed to how badly I was under estimating my requirements was a really helpful (and shame lessening!) challenge to my fears of being greedy."

In contrast, Fay did not think that the gender of the therapist made any difference to feeling understood or the development of the therapeutic relationship:

"I don't think that the gender of the therapist would make any difference to me personally. It purely depends on the relationship you manage to build."

As a participant in the final stage of the analysis, I asked Maggie to comment on the issue of gender:

"This is very important especially where abuse has taken place, also some service users just feel it is easier to talk about sensitive issues if the therapist has the same gender."

The issue of the gender of the therapist in relation to the development of the therapeutic relationship in eating disorder treatment is an area of consideration that is lacking in the literature. However, in a study by Walker and Lloyd (2011), it was found that participants generally believed that women could better understand the pressures experienced by other women regarding body image and weight. They also reported that issues were raised about the appearance of female therapists about their weight and size. Some participants thought that they would find a thin therapist "triggering" of their own eating disorder (Walker and Lloyd 2011 p 544). In addition, other participants thought that they could not connect to a therapist who did not take care of their appearance. Further research undertaken with people with eating disorders on the impact of therapist's physical attributes on the establishment of the therapeutic relationship found that clients held beliefs about the therapist's appearance and gender. These beliefs did impact on clients' views about the credibility of the therapist in regard to their ability to be able to understand their perspective

(Lawson 2016). These beliefs also influenced the speed of engagement with a therapist as well as the willingness to disclose within the therapy and adhere to the treatment plan. It was thus recommended that therapists recognise and be aware of the potential impact of their appearance on the development of the therapeutic relationship and be willing and confident to process potential reactions from clients within the therapy (Lawson 2016).

The findings in my study about gender and its impact on the therapeutic relationship do appear to concur with the findings of Lawson's 2016 study. What seems to be important to consider is that the gender of the therapist impacts on people in a very individual way. For some people, the gender and physical appearance of the therapist can act as a point of identification and offer a model for recovery; for others, gender can be a barrier due to comparison or the belief that the therapist will not understand their experiences. Although in my study, it was only female participants who commented on their beliefs about the gender of the therapist, it cannot be assumed that these beliefs are not also held by male clients too. Therefore, as both Walker and Lloyd (2011) and Lawson (2016) suggest, it is helpful for therapists to be aware that their gender and appearance may be a factor in the development of the therapeutic relationship. Consequently, clients may hold beliefs about the therapist's credibility and their ability to understand their unique experience that are not necessarily voiced by the client. It may, therefore be an issue that needs to be raised by the therapist.

10.7. Conclusion: a theoretical explanation of feeling understood by the therapist within the therapeutic relationship

Feeling understood by the therapist is the third conceptual component of the therapeutic relationship. Although it has long been recognised as an essential aspect of any psychological therapy, for people with anorexia nervosa the recognition that the therapist 'just got me' is particularly powerful and is rarely achieved. The ability of the therapist to convey empathy and understanding of the individual and their unique experience of their illness is thus crucial in the development of the therapeutic relationship.

To do this the therapist needs to demonstrate that the individual is of value and worth. This is of relevance to people with anorexia nervosa as they frequently feel undeserving about themselves and the need for treatment. What has previously been described as a prizing of the person can be achieved through listening and attending to the individual's concerns and experiences whilst simultaneously assuming a non – judgmental and warm approach. However, accurate empathy alone is not enough when working with someone with anorexia nervosa. An understanding but firm stance is required; this approach needs to be conveyed with knowledgeable authority and the willingness to confront the reality of the illness.

Adults with anorexia nervosa can also feel that they are beyond help and unable to change. By understanding the unique circumstances of the individual, the therapist can begin to instil hope and optimism for change and recovery. Reflecting on positive changes regularly with the client, can in turn instil hope for progress in the person with anorexia nervosa. However, this means that realistic therapy goals, that are tailored to the person's individual needs must be agreed in collaboration with the client. Therefore, the understanding that the therapist gains of the individual should be reflected in these goals, utilising the individual's strengths, interests, talents and beliefs.

Understanding the whole person and their exclusive experience of anorexia nervosa is fundamentally associated with the development of trust in the therapist. To feel understood the individual needs to be seen in the totality of their experience and environment and not assumed to be the same as anyone else with anorexia nervosa. Theory on epistemic trust helps to identify why the conveyance of individual understanding of the person is a crucial prerequisite to the development of trust in the therapeutic relationship with adults with anorexia nervosa.

Finally, it is also important for the therapist to consider how their gender may impact on the client's engagement in the therapeutic relationship. Although this aspect of feeling understood by the therapist is under developed theoretically, beliefs held about therapist gender or indeed their appearance may act as a barrier to the development of the

relationship. It is likely that these assumptions may never be voiced by the client. Being open about this possibility could be beneficial in understanding the individual perspective of the client.

The ability to demonstrate understanding of the client is complex and particularly challenging when working with people with anorexia nervosa. Nonetheless the ideas raised in this final conceptual category demonstrate that the conveyance of accurate empathy is a crucial aspect of the therapeutic relationship. Indeed, it has previously been suggested that:

> "Despite the current zeitgeist emphasising more technical (technique-orientated, manually driven) therapeutic approaches it is difficult to envisage the future of psychotherapy without imagining therapists who are deeply caring, compassionate, supportive and affirming of their patients."

> (Farber and Lane 2002 p192)

This assertion is relevant when considering how the therapeutic relationship with adults with anorexia nervosa needs to be established within the context of contemporary recommended psychological treatments for anorexia nervosa.

In the preceding three chapters I have detailed the three theoretical categories that formulate the framework of the therapeutic relationship for adults with anorexia nervosa: "one size doesn't fit all". Before concluding these findings and making recommendations for practice, I reflect on the research design and quality of the theory constructed in this thesis in the following chapter.

Chapter 11

Evaluation of the research methods and quality of this study

In chapter six, section 6.6. I outlined an initial evaluation of the quality of the data collection and analysis undertaken in this study based upon the criteria of credibility, relevance and fit (Glaser and Strauss 1967, Charmaz 2006, Corbin and Strauss 2008, Birks and Mills 2015). In this chapter, I return to critically reflect on the study design and the use of the research methods utilised in this study: constructivist grounded theory and online research methods. I then evaluate myself as a reflective researcher in the construction of the theory presented in this thesis.

11.2. Evaluation of the research methods and quality of this study

It is said that many research studies using grounded theory methodology do not actually result in theory development (Corbin and Strauss 2008, Nayar 2015). This can be due to a lack of aim of purpose by the researcher as well as poor or partial application of grounded theory methods (Corbin and Strauss 2008). In chapter four, I clearly argued that I set out in this study to examine the specific nature and context of the therapeutic relationship that was perceived as helpful by adults with anorexia nervosa. Subsequently, the use of grounded theory offered me both a theoretical methodology and system of research methods that helped me to develop a concept driven, theoretical understanding of the components and nuances of the therapeutic relationship in the substantive area of adults with anorexia nervosa. In addition to the collection of quality data (Charmaz 2014), the credibility of the theory developed in a grounded theory study is also contingent on the researcher maintaining methodological congruency and consistency (Corbin and Strauss 2008, Birks and Mills 2015). In chapter four I laid out my position as a researcher and my philosophical stance in relation to the nature and construction of knowledge. Thus, choosing to use the

methodology of constructivist grounded theory gave me a framework of methods to utilise that ensured that the way I carried out the data collection and analysis in the construction of the theory was congruent with the philosophical stance I had declared. As a developing researcher who had not used grounded theory methods before, I followed the process and methods outlined by Charmaz (2006, 2014) closely, in a systematic way as detailed in chapter six. Thus, I can assert that I used the essential grounded theory methods of coding, theoretical sampling, constant comparative analysis methods as well as extensive memo writing, diagramming and the identification of a core or central category in the construction of the resultant theory. I have evidenced this throughout the thesis to demonstrate clarity of the research process as well as the construction of the theory (Corbin and Strauss 2008, Nayar 2015). On reflection, the most difficult aspect of maintaining congruency with grounded theory methods was my engagement with the literature used to compare my findings against in the construction of the theory. In chapters two and three I detailed the theoretical reasoning that underpinned my approach to considering the literature in this study. Practically, throughout the phases of data analysis, I was eager to engage with relevant literature and found it hard not to do so. This was due, in part, to my interest and prior knowledge of eating disorder theory as well as my ongoing involvement in an eating disorder specialist interest group for occupational therapists. For example, I was aware that the recommended clinical guidelines for the treatment of anorexia nervosa were being updated. Thus, I made the decision not to involve myself in the consultation process, as I did not want to be unduly influenced by what was being considered for recommendation. Likewise, I presented a paper on the methods of my study at an international eating disorder conference before the final phase of analysis was completed. Attending other presentations at the conference again sparked my interest in following up specific literature. However, I held out doing this until after the analysis was complete. Subsequently, I underestimated the time it would take to investigate and integrate relevant literature into the development of the theory and in hindsight, I question whether I have fully captured the range and depth of literature that I could have utilised within the theory development. That said, I am confident that I

maintained my distance from the literature to the extent that I limited my prior knowledge of anorexia nervosa and the therapeutic relationship to a minimum in the theory development.

In chapter six, section 6.6. I also highlighted my early concerns that using online research methods would not provide sufficient quantity, depth and range of data to develop a credible theory. However, on reflection, I believe I gathered adequate in - depth and detailed written data to be able to make systematic comparisons across the participants, identify conditions and consequences in the conceptual categories and demonstrate variation in the theory (Charmaz 2006, Creswell 2007, Corbin and Strauss 2008). The most limited phase of data collection was the third and final phase. Only three participants contributed at this stage. Ideally, it would have been beneficial to have had more participants to add to and further clarify the emerging theory I was constructing at this stage of the analysis. However, I supplemented this phase with additional data in the form of published autobiographical accounts and data from online blogs from adults with anorexia nervosa (Charmaz 2014). Despite this, I recognise, that there are aspects of the theory that are under developed and I have subsequently acknowledged these in the findings and conclusion. That said, I have also identified where these more limited concepts are present in other research and literature (Corbin and Strauss 2008).   Overall, I contend that using a combination of online research methods to gather elicited written data as well as existing written data, in particular, the use of online blogs allowed me to be able to achieve theoretical sufficiency in this study (Charmaz 2006).

Although websites are frequently used to advertise and recruit participants for eating disorder research, using asynchronous online research methods in conjunction with grounded theory methods to gather in-depth written qualitative data with adults with anorexia nervosa was a novel methodological strength of this study. To the best of my knowledge it is the only study to have done so to date. As previously detailed in chapter four, I justified the use of using elicited written accounts as the primary source of data with arguably, hard-to-

reach participants. Although successful as a recruitment and data collection method, the limitations are clear. This method excluded anyone who did not want to or indeed could write about their experiences or had access to the Beat website or Twitter. Overall, however, the use of online methods both as a recruitment tool and as a method for gathering data has utility for people with eating disorders and arguably other hidden health populations (Kendal et al. 2017).

In chapter six, I also asked the question of the originality of the theory that I had constructed (Charmaz 2014). It could be argued that the concepts and categories within the theory are not new in relation to the essential components of any therapeutic relationship, for example, trust and empathy. What the theory does however, is offer a comprehensive way to think about how the theory relates specifically to the therapeutic relationship with adults with anorexia nervosa. The theory builds on concepts identified in previous research but also adds new insights and understanding of the significance of the relationship between the categories of balancing control, developing trust and feeling understood (Corbin and Strauss 2008). Although, previously acknowledged as necessary in the therapeutic relationship, the theory further explicates the detail of the categories that are often accepted as a given in therapists. This suggests that the theory offers an interpretation of generic processes that can be useful in everyday situations when working with people with anorexia nervosa (Charmaz 2014). The core category of individuality or "one size doesn't fit all" has explanatory relevance throughout the conceptual categories and fits with current thinking about the context of personalised treatment for adults with anorexia nervosa (NICE 2017). The resonance of the theory is evident in the experiences of the participants of this study. In addition, following the presentation of the findings at two professional conferences as detailed in chapter six, feedback and discussion generated by clinicians and service users indicated to me that the theory makes sense in the real-world context of eating disorder treatment (Charmaz 2014).

In this section, I have evaluated the use of the research methods and the resultant theory in relation to drawing out the strengths and limitations of this study. Finally, I evaluate myself as a reflexive researcher in the construction of the theory (Alverson and Sköldberg 2000, Creswell 2007, Charmaz 2014).

11.3. Reflecting on my presence as a researcher in the development of the theory

Throughout the entire process of this study I have been acutely aware of the need to be reflexive about my prior knowledge and interest in both the therapeutic relationship and eating disorders as detailed previously in chapters two and four. In relation to how this may have unwittingly impacted on the analysis and development of the theory, I now reflect on some of the preconceptions about the therapeutic relationship and anorexia nervosa that I held prior to the commencement of the analysis and theory development (Charmaz 2014).

Naturally, I started this research with preconceived ideas. I have never claimed to be a neutral, value free researcher and have attempted to use my prior knowledge and understanding of the subject area as an advantage in this study (Finlay 2006c). However, it was during the analysis and theory construction that the acknowledgement and examination of my preconceptions were essential.

From the outset of this study I was aware that I believed that the therapeutic relationship was as important or indeed more so than the treatment approaches used with people with anorexia nervosa. My background in psychodynamic therapy has also led me to concur with the adage "It is the relationship that heals, the relationship that heals, the relationship that heals" (Yalom 1989 p91). Likewise, the philosophy of occupational therapy is underpinned by tenets of client centred therapy (Rogers 1957, Law et al. 1995, Townsend et al 2002, Sumsion 2006, Townsend and Polatajko 2007). Thus, being aware of how the theoretical background of my profession as well as my personal experience of working with adults with anorexia nervosa could influence the analysis of the data was crucial. It would be naïve to

216

think that this did not have any bearing at all on the analysis and theory construction. Thus, I have attempted to be transparent within the thesis by giving examples where I reflected on this issue. Throughout the construction of the theory I was mainly concerned about forcing the data into my preconceptions of what I thought were important aspects of the therapeutic relationship. Thus, to avoid or minimise this I adopted the following analytical strategies:

- I used broad, open participant guidelines in the initial phase of data collection to encourage the participants to write about the therapeutic relationship in any way they wished (see appendix 1).

- I coded closely to the participants accounts, including using their words and phrases as in vivo codes. This was to ensure that the codes reflected the participants' concerns rather than mine.

- Following the coding of each participant's contribution, I wrote a reflection on my initial thoughts. When appropriate I returned to participants to ask further questions to clarify my understanding of their contribution in relation to my initial analysis.

- The participant guidelines for each phase of data collection were developed using the analysis of the previous phase thus giving participants the opportunity to develop the emerging analysis.

- I asked my academic supervisors to code one set of data each to compare my coding with others who had limited knowledge of eating disorders. Ultimately our coding was similar.

On reflection, being aware of my preconceptions about the therapeutic relationship was essential throughout the process of analysis. It forced me to think carefully about my initial coding and subsequent analysis data. I therefore undertook extensive memo writing and constantly compared the emerging theoretical concepts across the whole data set. If anything, being aware of my prior ideas made me more tentative in naming the categories. For example, the core category "one size doesn't fit all" was originally formulated around

ideas pertaining to client centred occupational therapy (Sumsion 2006). Recognising that this was a theoretical framework that could lead me down a particular analytic route required me to carefully analyse the central component of the core category in relation to the data and not merely my own interpretation of it. Using reflexivity throughout the analysis gives me confidence that the theory I have presented in this thesis is a co - construction between myself and the study participants. In addition, I have recognised that over the course of carrying out this study, the preconceptions I had about the therapeutic relationship in relation to adults with anorexia nervosa have changed. It is clear that the relationship between therapists and clients is important and does have a therapeutic effect. But it is not enough on its own. The relationship must be developed within the context of the treatment approach, both of which need equal attention.

11.4. Conclusion

The purpose of this chapter was to reflect on the research process and my presence as a researcher in the construction of the theoretical explanation of the therapeutic relationship that was constructed through this research study. Doing so highlights the strengths and limitations of this study. In the next chapter, I present the key conclusions based on the findings of my study.

Chapter 12

Conclusion and Recommendations

12.1 Introduction

In this concluding chapter, I return to detail the theoretical framework of the therapeutic relationship with adults with anorexia nervosa: "one size doesn't fit all" and make recommendations for the potential use of this theory in practice. I also consider how this framework adds to existing knowledge and suggest how it could be taken forward into further research.

12.2. The theoretical framework of the therapeutic relationship with adults with anorexia nervosa

In chapter seven I offered the overview of the theoretical framework of the therapeutic relationship with adults with anorexia nervosa as a diagrammatical representation. I now present this framework again below (diagram 4).
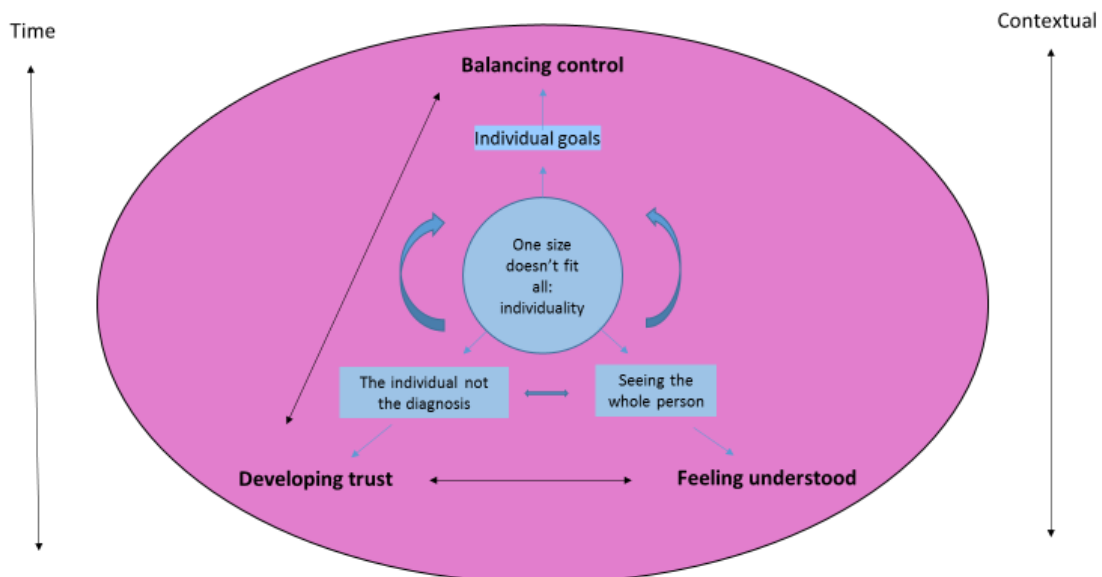
To reiterate the findings from this study, there are three key components that need to be present in the therapeutic relationship with adults with anorexia nervosa. These are: balancing control in the relationship; developing trust and feeling understood by the therapist. Each component of the therapeutic relationship is linked but may not be equally relevant in all therapist/client relationships. Therefore, the dynamic and individual nature of the therapeutic relationship needs to be considered by the therapist and adapted to accordingly. This will be contingent on the timing and the treatment modality and setting.

Consequently, the central or core category of individuality or "one size doesn't fit all" underpins the three key components of the therapeutic relationship. The ability of the therapist to recognise and accommodate the individuality needed within the therapeutic relationship as well applying this to the individuality of the client is essential to how the client perceives the therapeutic relationship to be.

Taking the first component of the therapeutic relationship, balancing control through working collaboratively towards mutually agreed and individualised goals of therapy will enable the person with anorexia nervosa to assume some aspects of control and responsibility for their own treatment. This helps the client to feel that they are working in partnership with the therapist. Arguably, power imbalances are inherent in all client-therapist relationships, but are particularly present in those between therapists and people with anorexia nervosa. Therefore, facilitating collaborative decision making and problem solving can help to readjust these imbalances, reduce resistance toward therapy, encourage active participation and help the client feel that they are part of the therapy process and not just a passive recipient of treatment. Treatment choices may or may not be related to food and weight-based goals but they do need to reflect the core concerns of the individual. A key factor is that the clients feel that they can contribute to a treatment plan that is individual to them and their unique needs. The findings from this study are endorsed by the publication of the latest recommendations for psychological therapies for adults with anorexia nervosa (NICE 2017). In these, although helping people to achieve a healthy weight is the primary goal of

treatment, it is recommended that treatment plans should be personalised and the individual should be involved in deciding what additional goals should be included in their therapy (NICE 2017). A second factor in relation to control is the paradoxical dilemma facing clients with anorexia nervosa that to develop a positive therapeutic relationship and engage in therapy they must relinquish aspects of their own control, whether that be related to weight restoration goals or other aspects of their lives. However, by doing so, control can then be shifted in favour towards the client, thus effecting more equality within a collaborative therapeutic relationship. To enable this to happen, high levels of trust are required between the therapist and client.

The second component of the therapeutic relationship is the development of trust. Adults with anorexia nervosa generally approach therapy from an initial position of mistrust towards the therapist as well as to the goals of therapy. Therefore, special attention needs to be placed by the therapist on developing trust with the client from the outset of therapy. Therapists who are reliable and consistent in the initial stages of a client's approach for help, give a positive first impression which is important for clients to feel they are valued and worthy of engaging in treatment. Trust can also be fostered through the therapist assuming a stance that conveys positive regard and acceptance of the individual. This helps to reduce the shame and self-blame frequently experienced by people with anorexia nervosa. In this study, it was found that therapists who convey specialist knowledge of anorexia nervosa inspire trust and confidence that the therapist is going to be able to help them. But crucially, as previously described, specialist knowledge needs to be conveyed in an authoritative but not authoritarian way (Gulliksen et al. 2012, Evans and Waller 2012). Building on this, using specialist knowledge of anorexia nervosa to convey understanding of how the illness is experienced on an individual basis for each client is central to the development of epistemic trust (Fonagy and Allison 2014). Thus, it is critical for the development of trust in the therapeutic relationship that the client perceives that they are understood and accepted as a unique person outside of their illness. An additional aspect to consider in the development of

trust is the time it takes to develop this within the therapeutic relationship. Based on my study I found that adults with anorexia nervosa generally require extended time to develop trust with their therapists. Again, this finding is endorsed within the recommendations for extended psychological treatment approaches for anorexia nervosa (NICE 2017).

The third component of the therapeutic relationship framework is feeling understood by the therapist ("they just got me"). Adults with anorexia nervosa frequently feel misunderstood, judged and undeserving of treatment. Therefore, the therapist needs to demonstrate that the individual is of value and worth. This can be achieved through taking time to allow the client to tell their individual story and attending to their concerns and experiences. Simultaneously demonstrating warmth, care, interest and a non – judgmental approach will help the client feel they are understood by the therapist. However, this approach needs to be conveyed with knowledgeable authority and the willingness to confront the reality of the illness. Adults with anorexia nervosa often feel that they are beyond help and unable to change. By demonstrating understanding of the unique circumstances of the individual, the therapist can help to instil hope and optimism for change and recovery. Reflecting on positive changes within therapy can instil hope for progress for the client. However, treatment goals need to be realistic, agreed collaboratively and tailored to the individual's needs. Treatment goals should thus capture the strengths and needs of the whole individual that are based on an accurate understanding of the client and reflect their wider interests, inspirations and hopes for the future. Demonstrating understanding of the whole person and their exclusive experience of anorexia nervosa is a crucial prerequisite to the development of trust in the therapeutic relationship. To feel understood the individual needs to be seen by the therapist in the totality of their experience and environment and not assumed to be the same as anyone else with anorexia nervosa.

In this section, I have reiterated and summarised the theoretical framework of the therapeutic relationship for adults with anorexia nervosa constructed in my study. This

framework "one size doesn't fit all" relates to both the nature of the therapeutic relationship and the context of recommended treatment approaches. It has clinical utility and enhances the perceptions of the therapeutic relationship by adults with anorexia nervosa. A positive perception of the therapeutic relationship on the part of the client is important in respect to the overall outcome of therapy (Horvath 2000, Martin et al. 2000).

12.3. What the study adds to existing knowledge and clinical practice

There has been and continues to be an interest in research regarding the therapeutic relationship in the treatment of anorexia nervosa. Previous studies have highlighted the value placed on the therapeutic relationship from service user perspectives in eating disorder service evaluations and have examined aspects of treatment experiences associated with the therapeutic relationship (de la Rie et al. 2008, Escobar – Koch et al. 2010, Reid at al. 2010, Fogarty and Ramjan 2016). Other studies have considered the role of the therapeutic relationship with adolescents with anorexia nervosa (Ramjan 2004, Tierney 2008, Pereira et al. 2006) or considered the therapeutic relationship from the perspective of the therapist (for example Woodrow et al. 2010). In addition, there has been a substantial focus of research on the predictive nature of the therapeutic relationship on the outcomes of therapy, for example, Waller et al. (2012), Sly et al. (2013), Brown et al. (2013, 2014), Graves et al. (2017).

To my knowledge two previous studies have considered the therapeutic relationship as the primary focus of the research from the perspective of adults with anorexia nervosa. First, a phenomenological study examined the relationships between women with anorexia nervosa and healthcare professionals in a specialist eating disorder day care and in-patient setting in the UK (Wright 2010, 2012, 2013). Second, a Norwegian study examined preferred characteristics and communication style in therapists from the perspective of women with anorexia nervosa (Gulliksen et al. 2012).

My study offers a substantive theoretical explanation of the nature and context of the therapeutic relationship with adults with anorexia nervosa and adds to existing knowledge in the following ways:

The theoretical framework of the therapeutic relationship is derived from the experiences of adults with anorexia nervosa and represents their perspective of the therapeutic relationship.

The study focus is on the nature of the therapeutic relationship as a tool for engagement and maintenance in treatment, rather than as an outcome measure of treatment. The framework has utility for practice by those working with adults with anorexia nervosa and offers additional understanding for therapists of the complexities of the process of developing a helpful therapeutic relationship.

The framework is applicable across a range of therapy approaches and has potential relevance to all healthcare and counselling disciplines. It is known that a large number of people with anorexia nervosa will be seen in primary and secondary care services where health professionals have the least training and support in working with people with eating disorders. Poor communication skills and not taking individual concerns seriously have previously been highlighted as a barrier when people with anorexia nervosa first approach health professionals for help (Gulliksen et al. 2015). It is reasonable to surmise that the concepts that make up the framework of the therapeutic relationship for adults with anorexia nervosa could be of specific value to practitioners to consider in these settings. The concepts are not aligned to any treatment approach and can be considered in conjunction with other assessment and treatment guidelines in relation to anorexia nervosa.

The findings have fit and relevance (Charmaz 2014) with the approaches espoused in the first line recommended psychological treatment for adults with anorexia nervosa (NICE 2017). For example, working collaboratively, developing a strong trusting relationship, encouraging realistic hope for recovery, using expert knowledge in an authoritative way, being reliable and consistent through the therapy, demonstrating understanding of the

individual and personalising the use of treatment manuals by tailoring the content to the individual (Fairburn 2008, Evans and Waller 2012, Lose et al. 2014, Fogarty and Ramjan 2016, Zainal et al. 2016). The framework constructed in my study offers detailed insights into how these components of the therapeutic relationship can be achieved.

The concepts presented in the findings' framework also concur closely to clinical descriptions of specialist eating disorder services for adults for severe and enduring eating disorders (SEED-AN). Although the term SEED-AN has not been formally adopted in the updated eating disorder guidelines due to a lack of differential treatment outcomes in studies (NICE 2017), in the real world there are significant numbers of adults that present to services with a long-term presentation of anorexia nervosa as previously detailed in chapter three. Service settings that adopt a recovery model and utilise the therapeutic relationship as a vehicle for engagement and risk management, report success in reduced hospital stays, reduced mortality rates and increased service user satisfaction (Bamford and Mountford 2012, Munroe et al. 2014). The nature of the therapeutic relationship is described in these settings as needing to be long term and trusting, treatment goals are developed collaboratively, individualised and focused on a holistic view of the client. The findings of my study support the style of therapeutic relationship previously outlined in service descriptions with adults with severe and enduring anorexia nervosa and offers detail into how this style of therapeutic relationship can be developed.

The theoretical concepts of developing trust and feeling understood concur and build on findings specifically identified by Gulliksen et al. (2012), and Wright (2012). The findings from my study explicate detailed characteristics of these key concepts and offer suggestions as how they can be implemented in practice as outlined in section 12.2. in this chapter. In addition, the findings examine the relationship between feeling understood from an individual perspective and the development of epistemic trust with the therapist. This supports theory postulated by Fonagy and Allison (2014) regarding the role the therapeutic relationship has in offering an environment whereby the client can feel understood by the therapist. This in

turn fosters the development of epistemic trust in the client which helps them to learn through their own social interactions both in and outside of the therapy environment. The findings of my study demonstrate that accurate understanding of the client, which resonates with their individual experience of anorexia nervosa is a necessary prerequisite for the development of trust between the therapist and the client.

The concept of instilling of hope for recovery through the therapeutic relationship was noteworthy in my study. Similarly, Wright (2012) also identified "the power of hope and optimism" (p112) in the findings of her study into the relationships between women with anorexia nervosa and their care workers. In addition, qualitative data derived from the recent study by Fogarty and Ramjan (2016) identified the importance of imbuing hope in the treatment experiences of adults with anorexia nervosa. We all agree that hope stems initially from the therapist. In my study, I found that hope can be transferred to the client through regular review and feedback to the client, however it is important that treatment goals are developed collaboratively, are individualised and realistic for the client to achieve.

In my study, I found that it was the explicit negotiation of acceptable and collaborative goals that enhanced the bond element of the therapeutic relationship between the client and the therapist as described in Bordin's (1979, 1994) conceptualisation of the therapeutic relationship. It has previously been suggested that in the treatment of eating disorders there is little agreement between clients and therapists around the primary goals of treatment, therefore the therapeutic relationship is built primarily on the development of the bond (Wright 2010, 2012). Where the primary goal of eating disorder treatments is weight recovery, such as in in-patient and day patient settings, I suggest that agreeing wider goals alongside weight restoration that reflect the individual interests and hopes of the client will help to enhance the bond aspect of the therapeutic relationship. This recommendation is also endorsed in the NICE (2017) guidelines for the psychological treatment of adults with anorexia nervosa where it is suggested that clients should include additional goals to weight recovery as part of their therapy.

Central to my framework of the therapeutic relationship is the core category of individuality or "one size doesn't fit all". Being treated as an individual rather than as an anorexic has previously been acknowledged as a concern to people with anorexia nervosa, for example Gulliksen et al. (2012). Equally, encouraging the individual to develop a non – anorexic identity is now recommended as a goal of treatment for anorexia nervosa (NICE 2017).

Recently, the question has also been asked regarding future eating disorder research priorities: "What patient and disorder- related features can be used to provide more personalised treatment" (van Furth et al. 2016). The theoretical framework developed in my study, "one size doesn't fit all", provides an understanding of the components of the therapeutic relationship that can be utilised to promote individuality and personalisation in the treatment of adults with anorexia nervosa.

12.4. Suggestions for further research

The level of theory of the therapeutic relationship constructed in this thesis is substantive in relation to adults with anorexia nervosa (Glaser and Strauss 1967, Charmaz 2014, Birks and Mills 2015). I make no claims that the theory can be applied across other substantive areas of eating disorders. However, it would be of interest to further develop the theory by exploring its relevancy in other diagnostic categories of eating disorders, such as bulimia nervosa. Further generalisation of the concepts and higher abstraction of the theory would move the theory from a substantive to a formal theory of the therapeutic relationship. It could arguably be applicable to other areas of therapy where the therapeutic relationship is central to the therapy as well as other diagnostic classifications, for example, personality disorder.

Further aspects of the theory that could be developed in relation to anorexia nervosa could be:

- Further investigation of the association between feeling understood by the therapist within the therapeutic relationship and the development of epistemic trust in adults with anorexia nervosa.

- Refinement of the concept of instilling hope for recovery within the therapeutic relationship.

- Examining the impact of the therapist's gender in the development of feeling understood by the therapist. This aspect of the therapeutic relationship has had limited attention paid to it in previous research (Walker and Lloyd 2011, Lawson 2016). Although it emerged in the findings of my study as an area of concern, it is an aspect of the therapeutic relationship that is underdeveloped theoretically. Similarly, consideration of the impact of the therapist's appearance on the development of the therapeutic relationship would be worthy of further research. This may also be linked to the gender of the therapist.

- Investigating the utility of the framework with men with anorexia nervosa.

- Evaluate the use of the framework concepts with a range of practitioners in primary and secondary healthcare and other services where specialist knowledge of anorexia nervosa is limited but who are likely to be the first contact for people seeking help.

- Evaluate the utility of the concepts imbedded in the framework in respect to the NICE (2017) recommended psychological therapies for the treatment of adults with anorexia nervosa. For example, the second line recommended treatment approach for adults with anorexia nervosa is focal psychodynamic therapy (FPT) (NICE 2017). In this approach, the first phase of treatment focuses in part on the therapeutic relationship. What this means in practice is currently not available as the treatment manual is not due to be published in English until the end of 2017. Comparing the findings of my research to the FPT approach to the therapeutic relationship would be of interest.

12.5. Conclusion

In this chapter, I have summarised the key theoretical findings from this study as constructed into the framework of the therapeutic relationship for adults with anorexia nervosa: "one size doesn't fit all". I have also made recommendations for the use of the concepts embedded in the framework in clinical practice. I have then considered how the theory builds on existing knowledge and made suggestions where directions for future research could lie.

From the outset of this study I aimed to develop a theoretical understanding of the nature and context of the therapeutic relationship in relation to adults with anorexia nervosa. The resultant substantive theory has been drawn from the experiences of people with anorexia nervosa who have partaken in a range of therapies and interactions with health professionals that were underpinned by a variety of theoretical approaches. Thus, the theoretical framework that I have constructed using grounded theory methods is not aligned to one treatment approach, but rather can be viewed as a pan-theoretical framework of the therapeutic relationship that can have utility across a range of recommended therapies for the treatment of adults with anorexia nervosa. In addition, the recommendations that have been drawn from the findings could be usefully deployed by any health, social care or education professionals who may be the first person the individual approaches in seeking help. How the individual perceives themselves to be treated and the first impressions the professional makes is critical in engaging someone with anorexia nervosa in the process of treatment. It has previously been suggested that different clinical conditions may require different types of therapeutic relationships; this study has illuminated the critical factors that are fundamental to the therapeutic relationship for adults with anorexia nervosa.

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Appendix 1

Initial participant information and consent details on the TherRel Website

A project to find out about the therapeutic relationship between people with eating disorders and their therapists

Who am I?

My name is Alison Seymour and I am a PhD student at Cardiff University. I am also an Occupational Therapist and previously worked with people with eating disorders. I am interested in finding out more about the therapeutic relationships between people with eating disorders and the therapists who work with them and how this may impact on treatment.

What is the purpose of this project?

The therapeutic relationship between people with eating disorders and their therapists is seen as important to how the individual manages their eating problems. Current research does not really explain very well the best way to develop the relationship and this project aims to understand this process better. The findings of the project could then be used to improve the services people with eating disorders receive and to help students and therapists learn the best way to work with somebody who has difficulties with their eating behaviours. For the purposes of this project I am looking for volunteers to participate who are aged 18 or over.

What will happen if I take part?

Firstly I would ask you to give me some background information about your eating problems and then write about your experiences of working with therapists. Therapists may include nurses, doctors, psychologists, occupational therapists, counsellors or anyone else who has worked with you in a professional capacity with your eating problems. To help you do this I will provide you with some guidance notes (How to Write Your Story) but I would like you to write about your experiences in any way you wish. I will then read your account closely and use it to develop themes and ideas which will inform a further stage of the project. I may wish to contact you again to ask you to elaborate on aspects of your story or check that I have interpreted your experiences in the way you meant. However it would be entirely your choice if you wanted me to do this.

Will the information I give be kept confidential and securely stored?

All information which is collected about you during the course of the project will be kept strictly confidential. All data collected will be made anonymous and the stories will not be individually identifiable. A pseudonym (made up name) will be used in any verbal or written reports or presentations from the project, including any direct quotations from your story. All electronic data will be kept on a password-protected encrypted server at Cardiff University. Any paper-based material will be kept in a locked filing cabinet. The original data will be kept securely in accordance with the Data Protection Act, and will only be accessible to myself and my supervisors. Data will be kept for 5 years and then disposed of securely.

What happens if I change my mind about taking part?

You can withdraw your consent at any time and you do not have to give a reason. Just let me know through TherRel@cardiff.ac.uk If you do decide at a later date to withdraw from the project any data collected up to point of withdrawal will continue to be used unless you ask me not to.

Are there any disadvantages/risks in taking part?

Sometimes when people think about their experiences they find that they become upset about things that may have happened to them in the past. This is quite normal and if you decided to be involved in this project and this happened I would try to help you identify someone to contact for support if you wanted me to. If you disclosed any information that put yourself or anyone else at risk it may be necessary to act upon this in accordance with my professional code of conduct.

What are the benefits?

By taking part you would be giving information about your experiences of having an eating disorder and the things that have helped or hindered your progress of recovery. This information could then be used to inform the experiences of other people who have similar problems to you.

What will happen to the findings of the project?

The findings will be written up as a PhD thesis and will be stored at Cardiff University. I will also present the findings through writing research articles in academic and professional

journals and through conference presentations. However, all the data will be made anonymous so that you will not be able to be identified.

Who is monitoring and reviewing the project?

The project is being monitored and supervised through the School of Healthcare Studies at Cardiff University. I have two supervisors, Dr Tina Gambling and Dr Gail Boniface who I meet regularly. The project has been given ethical approval by the Research Ethics Committee of the School of Healthcare Studies, Cardiff University and has also been accepted by the B-eat research process.

If having agreed to take part, you have any concerns the project, you should firstly contact me, Alison Seymour or one of my supervisors, Dr Tina Gambling or Dr Gail Boniface through TherRel@cardiff.ac.uk We will try to allay your concerns and answer your questions. If you remain unhappy and wish to complain formally, you can do this through the Cardiff University Complaints Procedure. Details can be obtained from Governance and Complaints Division, Cardiff University, 4th Floor, McKenzie House, 30-36 Newport Road, Cardiff CF24 ODE

What do I do now if I want to take part in the study?

Before agreeing to take part please read all the information on the website carefully (Giving Consent and How to Write Your Story).This information informs you what you are agreeing to do by participating and what to do next.

If you would like any further information to help you decide whether or not to take part please feel free to contact me direct through TherRel@cardiff.ac.uk

Giving Consent

A project to find out about the therapeutic relationship between people with eating disorders and their therapists

Please read carefully

- I have read and understood the information provided about the project and have had the opportunity to ask questions.

- I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

- I understand that, if I withdraw from the project, any data collected up to that point will be included in the research unless I specifically request that it is not used.

- I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in any verbal or written material arising from the project.

- I give permission for the researcher to use anonymous direct quotes in future research publications and professional presentations.

- By sending in my story I understand that I give informed consent for the above points

Appendix 2

Initial participant recruitment flyer

Hello, my name is Alison Seymour and I am a PhD student at Cardiff University. I am looking for volunteers to take part in my research.

The project involves exploring the therapeutic relationship between you and your therapist (this may be any professional who has been involved in helping you with your eating problems e.g. doctor, counsellor or nurse). The therapeutic relationship can be seen as the interpersonal processes that occur between you. In other words how you relate to each other. I am interested in finding out about your experiences as it may be that this relationship can have an effect on the therapy process.

Would you be prepared to take part?

I am looking for volunteers who are aged 18 or over and either currently have or have had problems with eating in the past. You do not need to have been formally diagnosed with an eating disorder.

Taking part in the project would involve you writing about your experiences of working with professionals. I would also like to find out a little about yourself, for example how long you have had problems with your eating? What sort of eating problems you have and what type of therapies you may have had? To help you write about your experiences, I will provide you with some guidance notes, but you can write your story in any way that you wish.

If you would like to take part and to find out more information please click on the following link
https://healthcarestudies.cf.ac.uk/therrel

Thank you for your interest in this project.

I hope that you will take part and look forward to hearing from you.

Appendix 3

Ethics Approval

School of Healthcare Studies
Department of Administration
Research Administrator Liz Harmer BSc(Hons)
Ysgol Astudiaethau Gofal Iechyd
Adran Weinyddu
Gweinyddwr Ymchwil Liz Harmer BSc(Hons)

Alison Seymour
Department of Occupational Therapy
SOHCS

24 February 2012

Dear Alison

Understanding the Therapeutic Relationship between People with Eating Disorders and their Practitioners

At its meeting of 23 February the School's Research Ethics Committee considered your research proposal. The decision of the Committee is:

Pass - Proceed with Research

The Committee felt that this was a worthwhile study that has been well considered but it suggests that you, and you supervisors, may wish to consider your interview schedule in the light of grounded theory. The Committee is not expecting you to respond to this comment.

Please note that if there are any major amendments to the project you will be required to submit a revised proposal form. You are advised to contact me if this situation arises. In addition, in line with the University requirements, the project will be monitored on an annual basis by the Committee and an annual monitoring form will be despatched to you in approximately 11 months time. If the project is completed before this time you should contact me to obtain a form for completion.

Please do not hesitate to contact me if you have any questions.

Yours sincerely

Mrs Liz Harmer - Griebel

Appendix 4

Participant guidance across the three phase of data collection

Phase one	Phase two	Phase three
Feel free to write your personal experiences in any way that you wish. You may find it helpful to think of it as a letter to a member of your family, or to a friend who you would like to share these experiences with. Below I have listed some open questions you might find useful to use. Your experiences may have been positive and helpful but they may also have been negative or difficult in some ways. Please write about both the positive and the negative. • Thinking about a therapist you have worked please describe how that relationship was? • What aspects of this relationship (if any) were important to you? In what way? • What did the therapist do to develop a relationship with you? • What did the therapist do that was helpful in developing this relationship? • Was there anything they did or said that got in the way of developing the relationship? • How important to you was the relationship you had/have with this	I have carefully examined all the stories sent to me and have noticed that there are some similarities in peoples' experiences. These factors appear to have either had a positive or negative impact on how the therapeutic relationship develops and how this then impacts on people's progress in dealing with their eating problems. I have listed the main factors below and would be grateful if you could write about these from your own experience of working with therapists: • The importance of feeling in control within the relationship/therapy process • Developing trust • Feeling understood by the therapist • The therapist's style - things they did that helped or were a barrier to the development of the relationship • Honesty • The impact the relationship had on you • The gender of the therapist • The boundaries of the relationship • The therapist communicating hope for recovery/change Rather than ask you specific questions I would like you to write freely about **any or all** of these factors. Your experiences may have been positive and helpful	In the previous phases of this project, you wrote about your individual experiences of working with therapists. I have carefully examined all the written accounts which were sent to me and have noticed that there are some similar factors in peoples' experiences. These factors appear to have either had a positive or negative impact on how the therapeutic relationship develops and how this then impacts on people's progress in dealing with their eating problems. In this 3rd and final phase of this project I am inviting you to consider these ideas and tell me what you think about them. For example, do they make sense based on your experiences? How can these ideas be put into practice by health professionals? There are no right or wrong responses; all your opinions are valid and will contribute to my understanding of the ideas I have developed so far. Please feel free to comment on any of the ideas below: **Trust** • I have found that people are often ambivalent about treatment, and seem to initially approach

therapist? • How do you think the relationship impacts on the progress or success of the therapy? • How was this relationship different from other relationships in your life at that time?	but they may also have been negative or difficult in some ways. I would be interested to hear about both your positive and negative experiences. If there are any other factors that have been important to you in regards to the relationship between you and your therapist, please feel free to write about these too.	the relationship with new therapists from a position of mistrust. *What do you think about this? How might this impact on your expectations of the therapeutic relationship that might develop and how you might engage in the therapy being offered.* **Control** • It has also been suggested that a more collaborative approach to treatment planning where service users feel that some locus of control stays with them and where they are able to negotiate, be involved in decision making and have choices is more successful. What this approach seems to do is make the service user feel empowered and encourages the development of trust and engagement in the relationship and therapy process. *What do you think about this?* **Feeling understood** • Some people thought that the gender of the therapist was important in regard to feeling understood by the therapist. *What is your opinion of this issue?*

Appendix 5

An example of initial/open coding of data in phase one

Rebecca: Aged 25, eating problems started at age 14. Anorexia nervosa.	Initial/open coding
With one therapist I worked with I felt really awkward. I felt like she delved straight in and didn't bother to try and build up any kind of relationship/ trust with me. I felt like she had already decided what my problems were and worded all of the questions to fit that. She was also very persistent with questions about my parents but pushed it so much during the first session I felt really uncomfortable. The relationship differed from any others in my life at that time as I couldn't/ wouldn't speak so honestly about 'that time' and my eating problems with anyone else. That probably put more pressure on my relationship with the therapist as I relied on her for everything to do with my issues and wanted her to magically fix me and the problems I had caused. I also wanted her to tell me why I was the way I was and what had caused me to do that to myself rather than accepting it happened/ responsibility and being able to move on. I think the fact that I didn't feel comfortable with the therapist was detrimental to the 'success' of therapy as I wouldn't really open up to her and I felt a bit like I didn't feel she deserved to know what I was thinking- even though it was me who sought help! The relationship didn't really change through the sessions- I didn't feel like she particularly made any effort to understand me and I think I had decided from the first session that I wouldn't really be honest about my thoughts etc almost as a protective action.	Feeling awkward with therapist Delving in too quickly Needing time to build trust Feeling pre judged Therapist pre- empting responses Delving too deep Persistence Feeling uncomfortable Only relationship where could speak openly about eating problems Relying on therapist Putting pressure on therapist to 'fix me' Wanting to find answers Difficulty accepting responsibility to change Feeling comfortable with therapist Detrimental to being able to open up Feeling understood? Being honest with the therapist Protecting self

Appendix 6

An example of moving from initial to focused codes

Participant: Rebecca

Initial/open codes	Potential focused codes (most significant, and or frequent. Use to analyse large amounts of data (Charmaz 2006)
Feeling awkward with therapist Delving in too quickly Time needed to build trust Feeling pre judged Therapist pre- empting responses Delving too deep Persistence Feeling uncomfortable Didn't feel understood Didn't feel she could be honest Protecting self Lacked faith in therapist and therapy - Interfered with engagement Therapist presumption as a barrier to therapy	Therapist approach – barriers to relationship development and engagement in therapy
Felt given time to tell story Got to know me Given freedom to say what she wanted to say Open questioning style Felt respected Given time to talk about difficult issues Collaborating in goal setting Therapist not avoiding difficult areas Belief in getting help she needed Feeling could be honest Not feeling judged Therapist accepted views Validating Therapist gently pushed about difficult issues Asking useful Qs Feeling listened to	Therapist approach – enablers to relationship and engagement

Feeling cared about Positive relationship needed to see whole picture Being authentic in relationship Not feeling judged Recognising each person is different/unique experience of their eating disorder Working collaboratively Feeling comfortable with therapist Comprising over food behaviours and goals Collaborative target setting Structure but not therapist's agenda Validating of thoughts and beliefs	
Belief in being able to change Instilling hope and belief in change	Instillation of hope by therapist
Relying on therapist Putting pressure on therapist to 'fix me' Wanting to find answers Accepting responsibility to change	Responsibility in relationship Locus of control in therapy
Only relationship where could speak openly about eating problems valued relationship Impact of TR on success of therapy Therapy space valued to talk through anything – not just weight and eating Feeling respected Being honest	Impact of relationship

Appendix 7

Frequency of focused codes across data set in phase one

Clustered focused codes:	Participant frequency
Perceived locus of control in therapy Control of therapy on relationship development Needing/having control in therapy Control - importance of having control in therapy.	Beth, Kate, Rebecca Fiona Natalie Helen
Trust in therapist Trusting relationship Trust and openness in relationship Trust and safety within relationship Trust as an enabler Time needed to develop trust Aspects which impacted on ability to trust therapists	Beth, Kate Fiona Sara Sion Helen
Instillation of hope by therapist Being realistic about outcomes	Beth, Kate, Natalie, Rebecca
Feeling understood Feeling understood and accepted Feeling cared for Feeling worthy of help Being taken seriously	Beth Natalie Sion Kate
Therapist knowledge of eating disorders Use of theory in therapy	Beth, Kate
Therapist approach – barrier to relationship Barrier to relationship development – therapist making assumptions Impact of therapists being judgemental Therapist approach – enabler to relationship Needing to understand rational of treatment – openness, collaborative decision making Individual intervention planning	Beth Helen Beth, Fiona, Kate, Natalie, Rebecca, Sara, Sion, Helen Beth Helen
Therapist's gender	Kate, Sion
Temporal nature of relationship Length of therapy relationship Time it takes to trust	Beth, Fiona, Rebecca, Sion Beth Helen
Boundaries of therapist Impact of giving support outside of therapy session Therapist as a boundary issue	Kate Natalie, Sara Sara
Impact of the relationship Impact of the relationship on view of self Perceived importance of the relationship Impact of positive relationship Impact of therapists being judgemental Value of relationship Value of relationship over ED Therapy process and outcome contingent on relationships developed	Fiona, Kate, Rebecca Natalie Sara Sion Helen Beth Natalie Natalie

Appendix 8

Participant demographic data

Phase one participants	Phase two participants	Phase three participants	Extant autobiographical accounts/online blogs
Fiona: Female aged 25. Developed eating problems aged 14. Anorexia nervosa	Anna: Female aged 20. Developed eating problems aged 16. Anorexia nervosa	Anna: As phase two	Ayelet
Kate: Female aged 35. Developed eating problems aged 7. Anorexia nervosa	Jenny: Female aged 30. Developed eating problems aged 19. Anorexia nervosa	Jo: As phase two	Grace
Sion: Male age not stated. Developed eating problems aged 14. Anorexia nervosa	Fay: As phase one. Contributed in phase two but also wrote an additional open account for phase one.	Maggie: As phase two	Emma
Rebecca: Female aged 25. Developed eating problems aged 14. Anorexia nervosa	Sue: Female aged 30. Developed eating problems aged 15. Anorexia nervosa		Lisa
Natalie: Female aged 19. Developed eating problems aged 13. Anorexia nervosa	Jo: Female aged 28. Developed eating problems aged 14. Anorexia nervosa		Ellie
Beth: Female aged 60. Developed eating problems aged 18. Anorexia nervosa	Maggie: Female aged 32. Developed eating problems aged 21. Anorexia nervosa		Caitlin
Sara: Female aged 19. Developed eating problems aged 10. Anorexia nervosa			Alice
Daisy: Female aged 27. Developed eating problems aged 15 -16. Bulimia Nervosa			Zoe
Helen: Female aged 20. Developed eating problems aged 14. Anorexia nervosa			
Fay: Female aged 33. Developed eating problems aged 14. Anorexia nervosa			