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UNIVERSITY OF NORTHERN COLORADO

Greeley, Colorado

The Graduate School

UNDERSTANDING THE WORKING ALLIANCE BETWEEN CLIENTS
DIAGNOSED WITH ANOREXIA NERVOSA AND THERAPISTS IN
INDIVIDUAL PSYCHOTHERAPY: A PHENOMENOLOGICAL
APPROACH

A Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy

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College of Education and Behavioral Sciences
Department of Counseling Psychology

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This Dissertation by: Laura M. Oyer

Entitled: *Understanding the Working Alliance between Clients Diagnosed with Anorexia Nervosa and Therapists in Individual Psychotherapy: A Phenomenological Approach*

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in College of Education and Behavioral Sciences in Department of Counseling
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ABSTRACT

Oyer, Laura M. *Understanding the Working Alliance Between Clients Diagnosed with Anorexia Nervosa and Therapists in Individual Psychotherapy: A Phenomenological Approach*. Published Doctor of Philosophy dissertation, University of Northern Colorado, 2013.

The therapeutic working alliance is a vital ingredient to psychotherapy, specifically with clients diagnosed with Anorexia Nervosa (AN) as progress is often slow and treatment difficult. This phenomenological study investigated the experiences of eight clients with AN and seven therapists who work with this population regarding how the working alliance was formed and challenged in the process of individual psychotherapy. Data were gathered through semi-structured interviews. Findings revealed overarching themes among all the participants as well as themes unique to clients and therapists. The findings are discussed in the context of working alliance theory. Implications for therapists when forming the working alliance with clients with AN include remain patient while clients develop trust and motivation, maintain awareness of personal reactions and seek consultation/supervision, be active and directive at the beginning of treatment, use caution when creating therapy goals, collaborate with other treatment providers and family, implement basic counseling skills (e.g., unconditional positive regard, validation, authenticity), utilize appropriate self-disclosure, balance setting boundaries and portraying care, create a warm office environment, and have/gain experience treating this population. Additionally, implications for clients are discussed.

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CHAPTER I

INTRODUCTION TO THE RESEARCH PROBLEM

Introduction

Through this phenomenological study, I sought to explore perceptions and experiences of clients diagnosed with Anorexia Nervosa (AN) and therapists who work with AN with regard to how the working alliance was formed and challenged during the process of individual psychotherapy. Through this exploration, I identified the essence or essences of the working alliance in therapy with clients diagnosed with AN as well as discovered factors that influenced its formation. Participants in this study included eight clients diagnosed with AN and seven therapists who provided individual psychotherapy to clients diagnosed with AN, resulting in 15 total participants.

In this chapter, I provide an overview of the background and context for the current study, the statement of the problem, purpose of the study, and research questions. Additionally, I present the research approach, assumptions, and a discussion of the rationale and significance of the current study.

Background and Context

Researchers have investigated the process and outcome of psychotherapy for many decades. While some researchers focused on specific techniques or theoretical orientations with regard to therapeutic outcome, other researchers investigated elements common to all types of therapy, also known as common factors (Lambert & Ogles,

2004). The most frequently mentioned common factor in the psychotherapy literature was the relationship, or alliance, between the client and therapist (Wampold, 2001).

Several terms were used in the psychotherapy literature to refer to the relationship between the client and therapist: *therapeutic alliance*, *working alliance*, *helping alliance*, and *therapeutic relationship* (Horvath & Luborsky, 1993). For the purpose of this study, the relationship between the client and therapist is referred to as the working alliance or alliance. The most commonly used conceptualization of the working alliance was defined by Bordin (1979). He described it as a collaborative relationship between the client and therapist comprised of three different components: agreement on the goals of therapy, agreement on the tasks of therapy, and the relational bond between client and therapist. Prior definitions of the alliance were conceptualized from a primarily psychoanalytic perspective, whereas Bordin's definition was proposed as a pantheoretical definition common to all forms of therapy.

Since Bordin (1979) offered this pantheoretical definition, researchers have investigated how the alliance affects therapeutic outcome and have used a variety of measures to evaluate these constructs. For example, in a recent meta-analysis on alliance and outcome, Horvath, Del Re, Flückiger, and Symonds (2011) analyzed 201 outcome studies using over 30 different types of alliance measures. Additionally, when measuring outcome, researchers have used a variety of constructs, e.g., global ratings of satisfaction and improvement, target complaints and symptom checklists, pre-and post-counseling changes, and session evaluations (Horvath & Luborsky, 1993; Kivlighan, 2007). Although there is much variability among the assessments used to measure alliance and outcome, researchers found alliance to correlate moderately with outcome. Furthermore,

it is one of the most robust predictors of outcome (Safran, Muran, Samstag, & Stevens, 2002).

Researchers discovered therapist and client ratings of the working alliance often differed, particularly early in therapy (Horvath & Bedi, 2002; Horvath et al., 2011; Horvath & Symonds, 1991). Many researchers found clients' ratings of the working alliance were better predictors of outcome compared to therapists' ratings on various alliance measures (Hersoug, Høglend, Monsen, & Havik, 2001; Horvath & Luborsky, 1993; Horvath & Symonds, 1991). Bedi, Davis, and Williams (2005) and Bedi (2006) highlighted that due to differences in therapist and client ratings, further research is needed on the client's subjective understanding of the working alliance.

In both studies, Bedi et al. (2005) and Bedi (2006) interviewed clients regarding their experiences in therapy and asked them to identify what was helpful in forming and strengthening the working alliance. Their results indicated that participants often viewed the alliance formation differently than the current proposed theories, e.g., Bordin's (1979) conceptualization of goals, tasks, and bond. For example, the participants highlighted their therapists' personal characteristics and the therapeutic environment as influential in alliance formation. Bedi argued, "If investigators wish to claim to measure a client's subjective experience of the alliance, then constructs that reflect the client's perspective need to be included into future measures" (p. 33). Additionally, Bedi et al. stated future research should replicate their study in different diagnosed populations. I believed a similar study was needed to investigate the perspectives of clients diagnosed with AN with regard to the formation of the working alliance. Specific to clients with AN, Westwood and Kendal (2012) put forth that improving the understanding of clients'

perspectives is an important step toward improving client engagement in treatment and treatment outcome.

One reason the working alliance should be investigated in clients diagnosed with AN is because therapeutic progress is often slow and prognosis poor with this population (Franko & Rolfe, 1996). In a meta-analysis investigating treatment outcomes using 119 studies on clients diagnosed with AN, Steinhausen (2002) found 46.9% of clients fully recovered from all essential clinical symptoms, 33.5% improved with some residual symptoms, and 20.8% developed a chronic course of the disorder. Furthermore, because this disorder involves a reduced intake of food, medical complications and even death can be an outcome if the disorder is not treated. Steinhausen estimated the crude mortality rate of this population is 5%; however, the American Psychiatric Association (APA; 2000) concluded the long-term mortality rate for those diagnosed with AN is over 10%.

Another reason the working alliance should be investigated with clients diagnosed with AN is because research indicates that forming a working alliance is often difficult with this population. To illustrate, Warren, Crowley, Olivardia, and Schoen (2009) found that clients with eating disorders might have difficulty trusting their therapist as well as sharing power and control during therapy. Additionally, researchers discovered that many clients diagnosed with AN have insecure attachment styles that can negatively impact the client's ability to form a therapeutic relationship with his/her therapist (Wechselblatt, Gurnick, & Simon, 2000). Since these client characteristics can challenge the formation of the working alliance, researchers observed that therapists frequently have negative reactions or a negative view when treating clients diagnosed with AN. For example, Franko and Rolfe (1996) investigated therapists' experience working with

different diagnosed populations and discovered clients diagnosed with AN evoked considerable negative emotional reactions, more so than clients diagnosed with bulimia nervosa (BN) or depression. These negative reactions were likely to create countertransference, and thus be detrimental to the alliance and, potentially, therapy outcome.

Statement of the Problem

There is a dearth of research on clients' subjective understanding of the working alliance (Bedi, 2006; Bedi et al., 2005). This is problematic because researchers found that client ratings of the working alliance are a better predictor of outcome than therapist ratings (Hersoug et al., 2001; Horvath & Luborsky, 1993; Horvath & Symonds, 1991); however, researchers who created the measures, e.g., the Working Alliance Inventory (Horvath & Greenberg, 1989), did not take into account factors clients viewed as important in forming or challenging the working alliance. Specifically, researching the working alliance in the population diagnosed with AN is needed because treatment outcome is usually poor with this population--poor outcomes can ultimately lead to death (Franko & Rolfe, 1996). By illuminating factors both therapists and clients diagnosed with AN view as beneficial and problematic in forming the working alliance, future research can then investigate the factors and identify if they do, in fact, improve the relationship and thus therapeutic outcome.

Purpose of the Study

The purpose of this phenomenological study was to explore perceptions and experiences of clients diagnosed with AN as they form an alliance with their therapist and therapists who work with this population regarding how the working alliance was formed

and challenged in the process of individual psychotherapy. The overall goals of this research were to identify the essence or essences of the working alliance in therapy with clients diagnosed with AN and identify factors that influenced its formation.

Primary Research Questions

- Q1   How do clients diagnosed with Anorexia Nervosa experience the working alliance in individual psychotherapy?
- Q2   How do therapists who work with clients diagnosed with Anorexia Nervosa experience the working alliance in individual psychotherapy?
- Q3   What factors influence the working alliance between therapists and clients diagnosed with Anorexia Nervosa?

Research Approach

After my proposal of this study was approved by my doctoral dissertation committee and my university's Institutional Review Board (see Appendix A), I began my investigation of understanding the phenomenon of the working alliance in individual psychotherapy between clients diagnosed with AN and therapists who work with these clients. To investigate and understand this phenomenon, I utilized a qualitative research paradigm and a phenomenological methodology.

Fifteen participants contributed to this study: eight clients and seven therapists. Interviews were conducted until the point of saturation. Out of the eight client participants, seven were female and one was male. Their ages ranged from 20 to 63 years old; the average age was 43 years old. All clients had a diagnosis of Anorexia Nervosa as reported by the clients and their referring therapist and did not fit the criteria of an Axis II diagnosis as reported by their referring therapist. Additionally, the clients were seeking individual therapy at the time of the study; the number of sessions they had with their

therapists ranged from 30 to over 500 sessions with the average number of sessions being 205.

Of the seven therapist participants, six were female and one was male. Their ages ranged from 28 years to 63 years old; the average age was 43 years old. The average number of years the therapists had worked with clients with AN was 12.57, ranging from two years to 30 years. Additionally, the therapists worked with an average of 258 clients with AN, ranging from 20 to “well over 1,000.” At the time of this study, three therapists worked at a private practice, one worked at an outpatient treatment facility for eating disorders, and three worked at an inpatient treatment facility for eating disorders. All acknowledged they had worked with clients with AN in an outpatient setting at one time or another.

Semi-structured interviews directed by an interview guide served as the primary source of data collection. After each participant agreed to be interviewed, I asked him or her to bring to the interview an object or objects that symbolized or represented the relationship he or she had with their therapist/clients diagnosed with AN. The object(s) could be in the form of drawings, poems, songs, pictures, or artifacts, and served as a visual elicitation of data at the start of the interview. Visual elicitation approaches are appropriate “when the nature of the subject matter of interest is especially difficult to characterize in linguistic terms” (Johnson & Weller, 2002). The interviews were digitally audio-recorded and transcribed verbatim.

After data were collected, I analyzed it using Moustakas’ (1994) steps, which are a modification of van Kaam’s (as cited in Moustakas, 1994) steps: identifying what participants experienced (textural description), how they experienced it (structural

description), and a combination of the two, which is the essence of the phenomenon (invariant structure). The ultimate goal of this approach was to identify the shared essence or essences of the phenomenon--the working alliance--among participants.

In an effort to enhance the trustworthiness of this study, I conducted interviews with participants until the data were saturated (Lincoln & Guba, 1985) and no new information or themes emerged. I also utilized triangulation (Lincoln & Guba, 1985) by collecting data from multiple participants, from multiple perspectives (clients and therapists), and used multiple researchers (another doctoral student and myself) to analyze the data. Additional techniques--member/participant checks, peer checks, and expert checks--were used to enhance trustworthiness (Guba & Lincoln, 1989). Additionally, I utilized researcher reflexivity (Morrow, 2005) and kept a reflexive journal to identify ways in which I influenced the data collection and analysis. Using an audit trail also helped identify my bias and explained my decisions in the data collection and analysis process. In the written report, I used thick descriptions (Morrow, 2005) of the participants' experiences and the contexts in which their experiences occurred.

Assumptions

Based on my experience working with clients diagnosed with AN, speaking with therapists who provided individual therapy to this population, and reading and reviewing research investigations in which researchers studied the working alliance, it is important that I identify several assumptions that guided the current study. The first assumption was the working alliance was a phenomenon experienced by both clients diagnosed with AN and the therapists who worked with them. Although a poor working alliance might have formed or a rupture might have occurred in the therapeutic relationship, it was

assumed all participants experienced a type (e.g., strong, poor) of alliance, and thus, could be interviewed as experiencing this phenomenon. A second assumption was clients and therapists had differing views on some of the aspects they believed influenced the formation of the alliance, hence the reason for interviewing both therapists and clients. This assumption was based on research that found clients' and therapists' ratings often differed regarding the strength of the working alliance. The last assumption was that working alliance theories had not taken into account clients' subjective experiences of the working alliance and, therefore, were not represented in the current conceptualizations.

Rationale and Significance

Researchers investigated the working alliance in therapy as it impacted therapy outcome and identified it as a significant common factor in therapy. However, fewer researchers have studied its formation and development, as well as factors influencing its creation. Furthermore, even less research has attempted to understand the client's subjective understanding of this phenomenon. By qualitatively investigating clients' subjective experiences with and understandings of the working alliance, future research could investigate the client-identified factors and assess if they improved the therapeutic relationship. In addition, this could lead to the creation of new theories and/or measurements that include clients' perspectives, aiding in consensus among alliance measurements, and better predicting of therapeutic outcome.

Additionally, investigating this phenomenon with clients diagnosed with AN is important. By investigating experiences of clients diagnosed with AN with regard to the working alliance in therapy, professionals can obtain a better understanding of the factors or experiences clients view as helpful and harmful in the formation of the working

alliance. As Bedi (2006) noted, just because clients identify certain factors or experiences as helpful in the alliance formation does not necessarily mean therapists should unconditionally provide clients with whatever they desire; there are ethical and clinical implications to consider. However, by further understanding the experience from clients, researchers can then explore if these factors are helpful and ethical when building a therapeutic relationship. Interviewing therapists regarding their perspectives of this phenomenon is also important because they can provide a richer description and deeper understanding regarding alliance formation with clients diagnosed with AN. Identifying how therapists' and clients' perspectives converge and diverge might shed light on the difficulties in alliance formation often experienced with the AN population.

CHAPTER II

LITERATURE REVIEW

Overview

The purpose of this chapter is to discuss a history of the working alliance, research regarding its impact on therapy outcome, how it is formed and challenged, and clients' subjective understanding of the construct. I then present a review of the disorder -Anorexia Nervosa, followed by research regarding the etiology, treatment, and outcome of this disorder. Additionally, I outline the working alliance in the population diagnosed with eating disorders and challenges often encountered. I conclude with implications for future directions.

Common Factors

Researchers and theorists have investigated the process and outcome of psychotherapy for many decades. Many studied the utilization of specific theories and techniques, compared them to other theories and techniques, and found little evidence that one type of technique or therapy was better than another with regard to therapeutic outcome (Horvath & Luborsky, 1993; Lambert & Ogles, 2004; Wampold et al., 1997). This finding initiated researchers' and theorists' investigations regarding common elements, or common factors, among different types of therapies (Horvath, 2000).

Common factors are "dimensions of the treatment setting (therapist, therapy, client) that are not specific to any particular technique" (Lambert & Ogles, 2004, p. 151)

and are present in many, if not all, therapy approaches. Four specific common factors were identified in the outcome literature: relationship factors, therapeutic models or techniques, expectancy factors, and extratherapeutic factors (Lambert, 1992; Wampold, 2001). Meta-analyses and outcome literature discovered that approximately 30% of the outcome variance in psychotherapy was attributed to relationship factors, 15% was to the use of therapeutic models or techniques, 15% was to expectancy factors, and 40% was to extratherapeutic factors (Lambert & Barley, 2002; Lambert & Ogles, 2004). Although several different common factors were identified, the most frequently mentioned common factor in the psychotherapy literature was the relationship, or alliance, between the client and therapist (Lambert & Ogles, 2004; Wampold, 2001).

The Working Alliance

History of the Working Alliance

Several terms have been used to define the construct describing the relationship between the client and therapist: *therapeutic alliance*, *working alliance*, and *helping alliance* (Horvath & Luborsky, 1993). Although these various terms are used in psychotherapy literature to describe a similar construct, they actually describe a slightly different phenomenon between the client and therapist. To comprehend these constructs and understand the context in which they were developed, it is important to explore the multifaceted history of the alliance.

The alliance construct has its roots in psychoanalysis. In one of Freud's (1912/1958) seminal writings on transference, he discussed a type that was non-neurotic in nature; rather, it was friendly, affectionate, necessary for success, and kept the client in therapy when exploring difficult, unconscious material. He proposed the analyst should

not interpret this type of positive transference; instead, he/should use it to assist in interpreting the neurotic transferences causing the client's problems. Horvath and Luborsky (1993) observed that later in his career, Freud modified his view of positive transference and viewed it as a beneficial attachment between the client and therapist and grounded in reality.

Freud's (1912/1958) concept of positive transference led other psychoanalysts to further investigate the idea of non-neurotic transference. Sterba (1934) provided the term *ego alliance*, in which the client's ego-observing process exchanges with the transference process. Fenichel (1945) referred to this as *rational transference*. Zetzel (1956) coined the term *therapeutic alliance* and described it as the linking between the analyst and the healthy part of the client's ego. She also asserted that a therapeutic alliance is helpful in accomplishing therapeutic tasks. In a similar fashion, Stone (1961) referred to a similar aspect of psychoanalysis and called it *mature transference*. Greenson (1965) further elaborated on this construct of a rational, reality-based relationship between the therapist and client and put forth the term *working alliance*. According to Greenson, the term working alliance was the joining of the therapist and client to further the work of therapy; it was different than transference and the real relationship. Although psychoanalysts were beginning to highlight the therapeutic relationship as a dimension in the therapeutic process, their attention to it was minimal; it was viewed strictly through a psychoanalytic lens. Carl Rogers (1951) was also influential in highlighting this helping relationship between the therapist and client; however, he sought to investigate it from a humanistic perspective, quite different than the psychoanalytic point of view.

Rogers (1951) proposed that therapist-offered conditions, e.g., empathy, congruence, and unconditional positive regard, were in and of themselves sufficient for a client's therapeutic change. He suggested the helping relationship between the client and therapist had a positive and healing function; it was the therapist's responsibility to provide these relational conditions (Horvath, 2000). This was a shift in the current thinking; many theorists at the time believed specific techniques or theories, such as psychoanalysis, were responsible for client change. However, Rogers asserted that client change, in part, resulted from therapist-offered conditions (Horvath, 2000) such as the therapist's ability to be empathic, congruent, and accept clients unconditionally (Horvath & Luborsky, 1993). This new proposition moved the construct of the therapeutic relationship to the forefront of research (Horvath et al., 2011). Since Rogers' novel declaration, research has generally found the therapist-offered conditions were not sufficient and, at times, not necessary (Gelso & Carter, 1985). Furthermore, Roger's conceptualization of therapist-offered conditions did not take into account client-offered conditions, thus only highlighting one side of the therapeutic relationship. Two theorists--Luborsky (1976) and Bordin (1979)--attempted to conceptualize the therapeutic relationship, or the alliance, and took into account contributions from both the therapist and client.

Luborsky (1976) suggested that the relationship between the client and therapist is a dynamic rather than static entity--it changes with the different phases of therapy. He identified two phases in which an alliance is formed or defined: Type I alliance and Type II alliance. Type I alliance is described as the client viewing and experiencing the therapist as supportive and warm, thereby providing a foundation in which the work of

therapy can proceed. Type II alliance involves an investment from the client and therapist for a commitment to the process as well as a shared responsibility and working together toward common goals. He further explained that a Type I alliance is more pronounced in the beginning of therapy and a Type II alliance is typical in the later phases of treatment (Horvath & Luborsky, 1993). In this model, Luborsky extended the alliance concept from its psychodynamic roots to include relational components found in many therapeutic perspectives.

Bordin (1979) proposed a somewhat different pantheoretical conceptualization of the alliance. In a seminal article, he identified a broader definition of the effective ingredients of the therapeutic relationship, which he termed the *working alliance*. His definition builds on Greenson's (1965) conceptualization. Coming from a psychoanalytic perspective, Greenson highlighted the difference between transference--the client's unconscious projections onto the therapist and the working alliance--the reality-based collaboration between the client and therapist. Bordin used Greenson's explanation of the working alliance and broadened it to encompass all forms of therapy. He suggested all theories and approaches to psychotherapy have embedded alliances and the working alliance "is one of the keys, if not *the* key, to the change process" (Bordin, 1979, p. 252). He presented the working alliance as a collaborative relationship between the client and therapist and comprised of three different components: agreement on the goals of therapy, agreement on the tasks of therapy, and the relational bond between client and therapist. Although his conceptualization might at first appear simplistic, it is important to understand each component in further detail.

Goals of therapy. The goals of therapy are discovered through “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” (Bordin, 1994, p. 15). The process of uncovering a goal or goals in therapy is collaborative in nature and creates a direction for therapy to progress. It is also important to note Bordin (1979) discussed *actual* agreement between the therapist and client on change goals (e.g., the client verbalizing his or her goal[s] and coming to an agreement with the therapist) versus *perceived* agreement (e.g., the client assuming the therapist has the same goal[s] although they might have never actually discussed and agreed upon them). Mackrill (2011) built on Bordin’s (1979) idea of goals and recommended that it is important for the therapist to help the client differentiate between life goals and therapy goals; although they may overlap, they may also be quite different.

Agreement on tasks. When describing the second component of the working alliance-- agreement on tasks, Bordin (1994) described tasks as the specific activities the client and therapist engage in during therapy to produce therapeutic change. He further explained that depending on the therapist’s theoretical orientation, the tasks of therapy often looked quite different from therapist to therapist. Also, tasks could take place outside of the therapy room, e.g., the therapist assigning homework to the client. Whatever task(s) used, Bordin (1979) stated there should be actual agreement on therapy tasks between the therapist and client rather than perceived agreement as previously described in the goals section.

Relational bond. The last component of the working alliance is the bond between the therapist and client. Bordin (1994) described the bond as “expressed and felt

in terms of liking, trusting, respect for each other, and a sense of common commitment and shared understanding” (p. 16). The bond between the therapist and client has been conceptualized as forming and growing while agreeing on the goals and tasks of therapy. Bordin (1979) further suggested the bond also develops and is required when unearthing and working through the client’s problems and difficulties.

Conceptualizations of the Working Alliance

Hersoug, Høglend, Havik, and Monsen (2010) stated that Bordin’s (1979) pantheoretical definition of the working alliance is the definition and conceptualization most researchers utilize because of its applicability across different therapies and techniques. Therefore, it is useful to understand how the working alliance relates to other constructs, e.g., transference, the real relationship, and attachment, as well as how it is understood through different theoretical lenses. By understanding how others conceptualize and integrate the working alliance into their theories, one can better understand this construct and its importance in the therapeutic process.

The unreal relationship, the real relationship, and the working alliance.

Greenson (1965) put forth the term working alliance and stated that it was different than transference and the real relationship. Because his definitions and conceptualization of these terms were from a psychoanalysis lens, Gelso and Carter (1985) elaborated on these terms and presented them in a pantheoretical nature. The first component they described was the “unreal relationship.”

The “unreal relationship,” or the transference configuration, is comprised of transference and countertransference. Although transference and countertransference are rooted in the psychoanalytic theory, Gelso and Carter (1985) proposed they have a

significant impact on the therapeutic relationship regardless of the therapist's theoretical orientation. Transference is described as the client's schemas created from past relationships that are used to anticipate interactions in future relationships and produce unconscious reactions toward the therapist (Sexton & Whiston, 1994).

Countertransference is described similarly; however, this type of transference comes from the therapist and is considered detrimental to the therapeutic relationship (Sexton & Whiston, 1994). Both transference and countertransference are considered unreal aspects of the relationship because both are based upon past relational experiences and are different than the current real relationship between the therapist and client.

Gelso and Carter (1985) described the real relationship as "something that exists and develops between counselor and client as a result of the feelings, perceptions, attitudes, and actions of each toward and with the other" (p. 185). The real relationship has two defining features: genuineness and realistic perceptions (Gelso & Carter, 1994). Therefore, the real relationship is different from the unreal relationship--it is based on a genuine, undistorted view of the other person in therapy (Sexton & Whiston, 1994). Moore and Gelso (2011) noted the real relationship is theorized to form in the first moments of the first session and is related to therapy outcome.

To understand the working alliance, Gelso and Carter (1985) used Bordin's (1979) goals, tasks, and bond conceptualization of this construct. They suggested that the transference configuration, the real relationship, and the working alliance interact and, at times, overlap throughout the course of therapy. For example, Sexton and Whiston (1994) posited the real relationship overlaps significantly with Bordin's bond aspect of the working alliance. The transference-based reactions give the working alliance shape

and depth, and a strong, positive, real relationship provides a better working alliance. Although the transference configuration and the real relationship influence the working alliance, the working alliance is more than simply the sum of these two constructs (Gelso & Carter, 1994).

Attachment and object-relations theory. It is important to investigate how the working alliance relates with theories, e.g., attachment and object-relations theory, given that the working alliance represents an attachment between two people (Gelso & Hayes, 1998). Horvath (2000) indicated theorists such as Sullivan, Greenson, and Bowlby were influential in identifying the importance of the social context of therapy. Horvath and Luborsky (1993) also highlighted that therapy represents a new object relationship between the therapist and client. Furthermore, since the working alliance is composed of a bond construct, Bordin (1994) and Horvath and Luborsky hypothesized that both the clients' and therapists' relational histories of attachment would influence their ability to form a working alliance.

Literature and research in the area of adult attachment and psychotherapy process variables (i.e., the working alliance) are quite recent (Slade, 2008). Research has shown that a client's early relationship experiences correlate modestly but reliably with the ability to form a working alliance early in therapy (Horvath, 2000). For example, Slade reviewed several studies that found client secure attachment facilitated positive alliance in therapy; anxiously attached clients produced lower alliance ratings than clients who were secure or avoidant. Furthermore, additional researchers discovered that secure clients reported fewer shifts in the alliance over the course of treatment as compared to clients with preoccupied attachment (Slade, 2008). Due to growing evidence that

attachment correlates with the working alliance, Gelso and Hayes (1998) emphasized the importance of the therapist providing a secure base for clients when developing and strengthening the working alliance.

Differing theoretical orientations. Another important aspect to explore is how different counseling theoretical orientations conceptualize the working alliance. Several authors (Gelso & Carter, 1985; Horvath, 2000; Horvath & Luborsky, 1993) proposed that the working alliance, using Bordin's (1979) conceptualization, is similar in its early phases of development among all theoretical orientations and necessary for therapy to occur. Horvath and Luborsky (1993) asserted that a strong working alliance makes a positive contribution in behavioral, cognitive, gestalt, and psychodynamic therapies.

In a study of master therapists, Jennings and Skovholt (1999) interviewed 10 peer-nominated master therapists as defined by their involvement in training other therapists, long-standing involvement with the local mental health community, and reputation for being well-regarded. The therapists utilized a variety of disciplines and counseling theoretical orientations. Researchers found that all agreed on the necessity of establishing a strong working alliance. Most believed that the alliance was the foundation for therapeutic change.

Although most believed a working alliance is necessary across all theoretical orientations, Bordin (1979) suggested that different kinds of working alliances might be essential for different theoretical perspectives. Gelso and Carter (1985) expanded this idea and proposed how the working alliance is viewed through three broad theoretical orientations: psychoanalysis, humanism, and learning theories. They proposed that the different theoretical camps view the alliance differently on three dimensions: the real-

unreal dimension, the centrality dimension, and the means or means-end dimension.

Their argument suggested that how alliance is viewed, its purpose, and the amount of focus it is given differs among the three broad orientations.

In summary, defining and conceptualizing the working alliance is not a simple or easy task. It is composed of different parts (i.e., goals, tasks, and bond) that interact, overlap, and affect one another as well as external constructs and theories (e.g., the real and unreal relationship, attachment, object-relations) that interact and affect its strength and formation. To quantify the working alliance, researchers created measurements to better understand and investigate this extremely important construct in the therapeutic process.

Working Alliance Measures

Due to the disagreement among researchers and theorists about the definition for and conceptualization of the working alliance, multiple empirical alliance measures have emerged. In 1993, Horvath and Luborsky stated there were at least 11 different alliance assessment methods. Less than 10 years later, Horvath and Bedi (2002) reported there were more than 24 alliance scales used by researchers. Finally, Horvath et al. (2011) identified over 30 different alliance measures, not including different versions of the same instrument (e.g., short form versus long form, client's perspective versus therapist's perspective). The growth in the number of alliance measures makes it difficult to know what concept is actually being measured in the various alliance studies (Sexton & Whiston, 1994) as most measures do not share a clear, common point of reference (Horvath et al., 2011).

In a meta-analysis conducted by Horvath et al. (2011), the authors identified four core alliance measures that accounted for approximately two-thirds of their data: the California Psychotherapy Alliance Scale (CALPAS), the Helping Alliance Questionnaire (HAQ), the Vanderbilt Psychotherapy Process Scale (VPPS), and the Working Alliance Inventory (WAI). The WAI was developed and validated by Horvath and Greenberg (1989) and based on Bordin's (1979) definition and conceptualization of the working alliance. It is composed of three subscales: Goal, Task, and Bond. The measurement is also pantheoretical in nature, making it an attractive instrument since it can be used in any type of therapy or treatment setting. The WAI was originally developed in two versions to assess client and therapist perspectives of the alliance. Horvath and Bedi (2002) also reviewed other WAI measures that have been developed by various researchers based on the original WAI: an observer version, a short-form version, and a couples/family version.

Current alliance measures have several limitations. Some authors (Busseri & Tyler, 2004; Kivlighan, 2007; Long, 2001) proposed that the WAI, as well as most other alliance measurements, measure *perceptions* of agreement on goals and tasks versus *actual* agreement. This is problematic because Bordin's (1979) original definition of the working alliance is composed of actual agreement on goals and tasks and not perceived agreement. Long (2001) provides the example that a client and therapist might both rank a statement such as "My therapist (client) and I agree on the goals of therapy" (p. 220) as "very high" on an alliance measure; however, if they were asked to write down the goal(s) of therapy, the actual agreement might be quite different.

Busseri and Tyler (2004) suggested the alliance measurements might need to include both actual and perceived aspects of the client-therapist agreement. In part, this might also explain why clients' and therapists' alliance ratings early in treatment often do not correlate with one another (Horvath & Bedi, 2002; Horvath et al., 2011; Horvath & Symonds, 1991) and have a shared variance of only 14% to 18% (Hersoug et al., 2001). Also, clients' ratings are on average higher than therapists' ratings (Hersoug et al., 2001). Another limitation is the variety of measurements used in alliance research, which makes it difficult to understand what component of the working alliance is being investigated. However, several authors (Horvath et al., 2001; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000) reported that regardless of what instrument is used to measure alliance, it still impacts and predicts psychotherapy outcome.

Research on Working Alliance and Outcome

One of the strongest arguments for studying the working alliance in therapy is its correlation with client outcome. In measuring outcome, researchers (Horvath & Luborsky, 1993; Kivlighan, 2007) have used a variety of constructs including but not limited to premature termination, global ratings of satisfaction and improvement, target complaints, symptom checklists, pre-and post-counseling changes, and session evaluations. Of these outcome studies now numbering in the thousands, researchers have generally found that a good therapeutic relationship correlates with a positive outcome (Horvath, 2000). Meta-analyses of many of these studies also support this finding (Horvath et al., 2011; Horvath & Symonds, 1991; Martin et al., 2000).

In a recent meta-analysis, Horvath et al. (2011) analyzed 201 outcome studies that used over 30 different alliance measures. The authors utilized previous analyses

(Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin et al., 2000) to identify studies published between 1973 and 2000; however, they recalculated the effect sizes using a more up-to-date method. They also searched electronic databases to identify studies from 2000 to 2009 and used both published and unpublished research. The researchers found an overall effect size of .275; the alliance accounted for approximately 7.5 % of the variance in treatment outcome. The results provided evidence that there is “a moderate but highly reliable relation between alliance and psychotherapy outcome” (Horvath et al., 2011, p. 13). The effect size and variance calculated in this study are similar to other meta-analyses (Horvath & Symonds, 1991). Horvath and Bedi (2002) proposed that although the size of the correlation might not appear large, it is robust and the effect size is significant for a variable being measured within a multifaceted process such as psychotherapy.

Sexton and Whiston (1994) hypothesized that because of the variety of alliance measures used in the meta-analysis studies, it is difficult to know what construct of the alliance was measured and, therefore, might account for the relatively low effect size. Horvath et al. (2011) also noted this effect size (although moderate) was calculated using studies that employed different instruments and perspectives to measure alliance and outcome, different diagnosed populations, different testing times, and different theoretical orientations and treatment approaches. However, given this variability, the alliance was still correlated with outcome and is one of the most robust predictors (Safran et al., 2002).

Luborsky (1994) also reviewed factors that influence researchers’ results regarding the predictive success of the working alliance: type of measure; type of treatment; patients’, therapists’, or observers’ views; positive vs. negative alliance as a

predictor; overlap between the alliance and outcome measures; overlap between alliance and prior improvement; facilitation of the alliance by the therapist; facilitation of the alliance by mental health and quality of object relations; facilitation by basic similarities between patient and therapist; time course from early to late in psychotherapy; and size of sample of sessions needed. These studies provided evidence that focusing on the alliance is an important component of quality treatment; not giving it the proper attention during therapy and/or supervision might be viewed as unethical (Castonguay, Constantino, & Holtforth, 2006).

Differing alliance perspectives and outcome. Since researchers found the strength of the working alliance is a predictor of outcome, many have then asked, “Whose perception of the working alliance (client, therapist, or outside observer) better predicts outcome?” Many researchers (Hersoug et al., 2001; Horvath & Luborsky, 1993; Horvath & Symonds, 1991) discovered client measures of the working alliance were a better predictor of outcome than therapist measures. Sexton and Whiston (1994) suggested these findings were not unanticipated as Bordin’s (1979) original conceptualization of the alliance was intended to identify client’s collaboration in psychotherapy where the client appears to be the best judge of his or her collaboration and change.

Researchers (Horvath & Luborsky, 1993; Horvath & Symonds, 1991) also found that observer measures of the working alliance predicted outcomes better than therapist measures. Hersoug et al. (2001) discovered when client and therapist alliance ratings were similar late in treatment, they were also positively related to outcome. Therefore, even though client’s and therapist’s alliance ratings might differ at the beginning of

treatment, which is often the case (Horvath & Bedi, 2002; Horvath et al., 2011; Horvath & Symonds, 1991), as the alliance develops and grows, the client and therapist might come to see the alliance from a similar viewpoint, possibly due to the stronger bond developed between them. Researchers also investigated the earliest one could measure or assess the working alliance. Most researchers (Gelso & Carter, 1985; Horvath & Bedi, 2002) agreed that measures given as early as the third session were consistent predictors of therapy outcome.

Working alliance to predict dropout. Just as the working alliance is a predictor of outcome, it is also a predictor of psychotherapy dropout (Horvath et al., 2011; Horvath & Luborsky, 1993). Reis and Brown (1999) reviewed several studies and found 20 to 50% of clients did not return after the first therapy session and 37 to 45% attended only one or two sessions. They also suggested that although some theoretical orientations (e.g., solution-focused) might not view dropout as negative or problematic, studies have shown that dropout is related to poor outcome.

In a meta-analysis, Sharf, Primavera, and Diener (2010) reviewed 11 studies in which the authors investigated the relationship between alliance and dropout and found a moderately strong relationship (weighted mean $d = .55$) between psychotherapy dropout and therapeutic alliance. They reported that clients with weaker alliances were more likely to drop out of psychotherapy. They also compared their results with another meta-analysis on dropout in which Wierzbicki and Pekarik (1993) identified three client variables to be predictive of dropout: client socioeconomic status, minority racial status, and low education. Sharf et al. concluded that the therapeutic alliance was a stronger predictor of dropout than all client variables found in the previous study. In a qualitative

case study investigating therapy failure, Strupp (1990) also found that not forming a therapeutic alliance early in therapy caused the client to drop out of treatment prematurely. These studies, as well as others, showcased the importance of developing a working alliance early in psychotherapy and how it could potentially protect against client dropout.

Working alliance associated with other constructs. While most of the research on the working alliance investigated its ability to predict outcome, some researchers have investigated other constructs associated with the working alliance. Webb et al. (2011) investigated depressive symptoms and found that a stronger therapeutic alliance was associated with greater depressive symptom reduction. Fitzpatrick, Iwakabe, and Stalikas (2005) used the WAI to assess working alliance and found client alliance ratings on the Task and Goal subscales were positively correlated with positive sessions. Investigators also examined the construct of client secret keeping in psychotherapy and found that secret keeping was negatively correlated with a strong working alliance (Kelly & Yuan, 2009).

Since several constructs have been associated with the working alliance, researchers have begun to investigate whether the working alliance or other correlated variables are better predictors of outcome. For example, alliance measures correlate with measures of empathy--one of the therapist-offered conditions proposed by Rogers (1951). However, when comparing which of the two variables better predicted outcome, many studies found alliance to be a better predictor than empathy (Horvath & Luborsky, 1993) regardless of the measurement used. Others also investigated and reported that alliance is a better predictor of outcome than specialized therapy techniques, specific client

characteristics, specific therapist characteristics, and therapy procedures (Lambert & Barley, 2002; Sexton & Whiston, 1994).

Formation of the Working Alliance

Much research on the working alliance has demonstrated the importance of a strong therapeutic relationship and how it relates to positive outcome; however, surprisingly little is known about the development of the working alliance (Bedi & Richards, 2011), the conditions that lay the ground work for its formation (Taber, Leibert, & Agaskar, 2011), and empirically supported strategies and interventions therapists can use to form the relationship (Castonguay et al., 2006). Horvath and Greenberg (1994) discussed the development of a positive alliance, or what they called a “good enough” alliance, as needing to develop by the third to fifth session. They drew a picture for the reader and stated, “...think of alliance development in the first phase of therapy as a series of windows of opportunity, decreasing in size with each session” (Horvath & Greenberg, 1994, p. 3). This picture conveyed the message that therapists have a limited time frame in which to form an alliance with clients. Bordin (1994) stated that the formation of the working alliance with clients who are “...deprived in their object relations capacities... [is] critical, extended, and [a] painful process” (p. 27). Therefore, these clients might require more than three to five sessions to form a working alliance.

Gelso and Hayes (1998) asserted that using Rogers’ (1951) therapist-offered conditions, e.g., empathy, unconditional positive regard, and congruence could assist in building the working alliance early in therapy. This would intuitively make sense as these were conditions Rogers put forth to build the relationship with the client as well as conditions he believed were sufficient to create therapeutic change. Horvath et al. (2011)

also directed therapists in the early phases of therapy to adapt the tasks or methods of therapy to suit the specific needs and expectations of the client to build a positive relationship. He and his colleagues also stated that alliance is formed when client's expectations and personal resources are bridged with what the therapist believes is the most important interventions and tasks. Additionally, Gelso and Hayes emphasized the idea of using tasks or techniques the client views as helpful in forming and maintaining a positive working alliance.

Patterns of Working Alliance Throughout Therapy

Although alliance formation research is sparse, more researchers have investigated patterns of alliance formation and maintenance across the psychotherapy process. Once the working alliance has formed between the therapist and client, it is often not constant over time (Horvath, 2000). Horvath et al. (2011) proposed that the strength of the alliance might fluctuate within or between sessions due to a variety of factors: the therapist challenging the client, misunderstandings between the client and therapist, and transference/countertransference. Therefore, Kivlighan and Shaughnessy (2000) suggested that measuring the working alliance at different points during therapy and averaging the alliance scores may be misleading. Several researchers investigated the working alliance across different points of therapy and have identified different patterns alliance scores create when plotted over time.

Kivlighan and Shaughnessy (2000) investigated clients' working alliance ratings using the WAI over the course of four therapy sessions. They identified three different patterns of development in their data: stable alliance (when plotted produced a horizontal line), linear growth (increasing line), and quadratic growth (U-shape or high-low-high).

Another result they discovered was clients who produced a quadratic growth pattern also produced better outcome scores. At first, this might seem counter-intuitive--one would likely assume the linear growth pattern of alliance as a better predictor of outcome as it would grow and develop over time. However, the authors suggested that Bordin's (1979) conceptualization of the working alliance included the idea of a tear-and-repair process created by the client's pathology: "activities involved in repairing the alliance are the essence of therapy" (Kivlighan & Shaughnessy, 2000, p. 369). Bordin even said that if the tear-and-repair process did not occur, then therapy could not take place.

Stiles et al. (2004) attempted to replicate Kivlighan and Shaughnessy's (2000) investigation; however, they investigated the working alliance using a different measurement (the Agnew Relationship Measure [ARM]), extended the amount of therapy sessions (8 and 16 sessions), and did not measure the working alliance at every session. Their findings were different compared to Kivlighan and Shaughnessy--they found brief V-shaped alliance patterns (interpreted as rupture-repair sequences) to be associated with better outcomes than U-shaped alliance patterns. The authors reported that it was better to have a V-shape rather than a U-shape because one would not want several sessions in a row to have low alliance scores; rather, a briefer rupture and repair would be more productive than several low alliance-rated sessions. Castonguay et al. (2006) proposed the mixed results between the two studies "... may be partly due to the fluctuating nature of some process of change" (p. 273).

In a more recent study with a larger sample size than the previously mentioned studies ($n = 201$), Hersoug et al. (2010) examined working alliance patterns during long-term therapy (mean number of sessions = 60.7). Using the WAI short version to measure

alliance at sessions 3, 12, 20, and every 20th session thereafter, they found three working alliance patterns: stable alliance (70.1% of participants), improving alliance (23.4%), and deteriorating alliance (5.5%). Results furthered portrayed that clients in the deteriorating alliance group had more severe pre-therapy target complaints and lower expectation to change scores than did clients in the improving alliance group. They also found that the improving alliance group had better outcome scores than did the deteriorating group. According to these findings, the authors proposed that initial client severity might be associated with the pattern, direction, and development of the working alliance.

The reviewed studies suggested that different working alliance patterns formed during the process of therapy. The mixed findings also suggested factors such as the type of therapy (e.g., short-term vs. long-term), when the alliance was measured, how frequently it was measured, and severity of clients' target complaints might affect the portrayed pattern of the working alliance during the course of therapy. Further research in this area might help identify other patterns of alliance and/or identify patterns more frequently associated with successful outcomes. Because of the theoretical conceptualization and research finding that a rupture-repair process of the working alliance is associated with positive outcome, it is important to review ways in which the alliance might rupture or be challenged as well as possible ways to repair it.

Challenges to the Working Alliance: Rupture and Repair

Once a working alliance has developed between a client and therapist, it often recedes to the background of treatment (Samstag, 2006) and becomes a backdrop in which the work of therapy can occur. Hausner (2000) stated, "The therapeutic alliance is often 'silent,' becoming more audible as certain resistances are encountered" (p. 167).

Often in cases of extreme working alliance ruptures, the client will drop out of therapy and the issue of the working alliance is not considered further (Samstag, 2006); however, if the therapist can identify the alliance rupture prior to client drop out, this represents a prime opportunity for client change to occur (Bordin, 1994). Safran, Muran, and Samstag (1994) recommended improving problematic alliances should be an important focus of therapy and repaired for the client's benefit. Investigating both therapist and client factors that challenge and/or rupture the working alliance is important as these can assist in unveiling and potentially predicting ruptures and negative alliance formation.

Therapist factors. Therapist factors can, unfortunately, have a negative impact on the working alliance. Safran et al. (1994) discovered that lapses in the therapist's empathic attunement might produce ruptures in the alliance. Ackerman and Hilsenroth (2001) reviewed studies in which the researchers investigated therapists' characteristics and techniques that negatively impacted the working alliance. They found therapist characteristics--being rigid, uncertain, critical, distant, tense, and distracted--negatively impacted the therapeutic relationship. Additionally, they discovered specific therapeutic techniques--over-structuring the therapy session, inappropriate self-disclosure, excessive use of transference interpretation, and inappropriate silence--also negatively influenced the working alliance.

Furthermore, Hersoug et al. (2001) and Hersoug, Høglend, Havik, von der Lippe, and Monsen (2009) asserted that therapists' cold/detached scores on the Inventory of Interpersonal Problems-64 (IIP-64), as rated by both clients and therapists, had the most consistent and strongest negative impact on the working alliance. Another finding from Hersoug et al. (2009) was clients who had therapists with more professional training (i.e.,

years of formal postgraduate training in psychotherapy and supervision) rated the working alliance as poorer than therapists with less professional training. The authors hypothesized that therapists with more interpersonal problems might stay in training longer or seek more training. However, Sexton and Whiston (1994) reviewed several studies that discovered as a therapist's experience increased, so did the working alliance. These mixed results indicate more research is needed in this area.

In a laboratory analogue study, Myers and Hayes (2006) investigated how therapists' self-disclosure, countertransference disclosure, and no self-disclosure in the context of a strong or weak working alliance impacted observers' ratings of the therapist's expertness and session depth scores through the use of observers watching recorded role-plays of therapy sessions. The data suggested when the working alliance was weak, therapist self-disclosures and countertransference disclosures led observers to rate the therapist as less expert and the session as more shallow. Conversely, when the working alliance was strong, the therapist's general self-disclosure led observers to rate the therapist as more expert and the session as having more depth. This suggested that when the working alliance was weak, therapists' self-disclosure and countertransference disclosures might negatively impact the already weak alliance. Although this study had several limitations, such as the laboratory design, it did allow the researchers to manipulate the working alliance, which the authors note in a field study would be considered unethical since alliance is associated with outcome. Sexton and Whiston (1994) also reviewed a number of studies that examined therapist self-disclosure and self-involving statements. They found mixed results: some studies found that participants rated disclosing therapists better than non-disclosing therapists and the disclosures

strengthened client involvement, whereas others found that self-disclosure did not have a positive or negative effect. Further research on the therapist's self-disclosure and countertransference disclosures is necessary to conclude if it does or does not negatively impact the working alliance.

Client factors. Since the working alliance is collaborative in nature, client factors can also negatively impact the working alliance. Sexton and Whiston (1994) reviewed several studies and found higher initial ratings of clients' symptomology resulted in a negative contribution to the therapeutic relationship. This is similar to Bordin's (1994) hypothesis wherein he proposed that different groups of clients, in terms of symptom severity, impact the formation and maintenance of the working alliance. For the group he termed "so severely deprived in their object relations capacities--psychotic, schizophrenic, and borderline..." change will occur "...on the utilization of strain and rupture episodes to foster the work of an individual overcoming firmly established inner obstacles toward change" (Bordin, 1994, p. 27). However, Horvath (2000) stated that most studies indicated clients' symptom severity did not have a strong impact on the working alliance development.

Furthermore, Sexton and Whiston (1994) discovered clients with higher ratings of rigidity also had weaker working alliances. Kelly and Yuan (2009) also found clients who reported keeping relevant secrets from their therapists rated the working alliance as weaker than those who were not keeping a secret. The authors proposed this finding suggested clients tended to keep secrets when the working alliance was weak or the working alliance was weakened when clients kept secrets. Castonguay et al. (2006) reviewed other client characteristics that were negatively associated with the therapeutic

relationship: client avoidance, interpersonal difficulties, and depressogenic cognitions. Investigating client factors and characteristics that negatively impact the working alliance might allow therapists to forecast clients with whom forming a working alliance might be difficult to establish and maintain (Castonguay et al., 2006).

Repairing ruptures in the working alliance. Once the working alliance has ruptured, it is important the therapist takes steps to repair it with the client. Safran et al. (2002) defined therapeutic alliance rupture as “a tension or breakdown in the collaborative relationship between patient and therapist” (p. 236). They also conceptualized a rupture in the working alliance according to Bordin’s (1979) conceptualization; therefore, a rupture could be a disagreement in goals or tasks, or a strain in the therapeutic bond. According to Castonguay et al. (2006), one indicator that a working alliance rupture has occurred is client anger or hostility toward the therapist. Horvath et al. (2011) and Safran et al. directed therapists to respond non-defensively when this occurs and accept their own potential contribution to the rupture.

In reviewing several studies investigating working alliance rupture and repair, Safran et al. (2002) identified interventions therapists can utilize to help in the repair process: provide a therapeutic rationale, explore core relational themes, reframe the meaning of tasks and goals, change tasks and goals, clarify misunderstandings at the surface level, ally with the resistance, and create new relational experiences (i.e., corrective emotional experience). Safran and Muran (1996) also suggested that therapist self-disclosure and a discussion of countertransference might help repair a ruptured alliance. Since this suggestion is in opposition with Myers and Hayes’ (2006) conclusion

that therapist self-disclosure when the working alliance is weak might portray the therapist as less expert and the session as more shallow, more research is necessary.

Predictors of a Good Working Alliance

Just as it is important to investigate factors that negatively impact or predict the working alliance, it is also valuable to uncover factors that positively impact or predict it. Gelso and Hayes (1998) established that certain client and therapist factors were related to the strength of the alliance. These factors could enhance its formation and maintenance, thereby impacting the client's outcome in therapy.

Therapist factors. The client-centered, therapist-offered conditions of empathy, genuineness, respect, and unconditional positive regard have been associated with developing and maintaining a positive working alliance (Gelso & Carter, 1985; Lambert & Barley, 2002). Therapists who were compassionate and portrayed a willingness to help their client face his or her problems also produced better therapeutic relationships (Gelso & Carter, 1985). Wei and Heppner (2005) reviewed several studies and concluded therapist flexibility and credibility were associated with the strength of the alliance. Additionally, therapists who were more challenging, thematically focused, and here-and-now oriented had stronger alliance ratings than did therapists who attempted to clarify or obtain information, explored feelings, or offered support and encouragement (Sexton & Whiston, 1994). Sexton and Whiston (1994) asserted that because the alliance is collaborative in nature and support and encouragement put the client in a passive role, this might explain the findings. Other therapist characteristics that encouraged a strong working alliance included trustworthiness, warmth, honesty, integrity, confidence, and openness (Hersoug et al., 2009). Hersoug et al. (2001, 2009) found that therapists who

had more perceived social support and a higher degree of comfort in close interpersonal relationships also had higher-rated working alliances.

Client factors. One of the most frequently discussed client factors in psychotherapy literature that impacts the working alliance is the client's ability or capacity to form a relationship with the therapist. Gelso and Carter (1985) stated the client "needs to possess a capacity to trust so that a healthy bonding can occur...[and] must be able to form attachments to people, to invest energy and caring in relationships" (p. 163). Gelso and Hayes (1998) reviewed several studies in which the authors found clients' styles of attachment as children and adults were similar to their attachment to their therapist; the type of attachment was associated with the strength of the working alliance. For example, anxiously attached clients produced lower alliance ratings than did clients who had a secure or avoidant style (Slade, 2008). The quality of the client's relationship with family and friends was also related to the formation of the working alliance (Sexton & Whiston, 1994). Furthermore, Gelso and Carter suggested that the client likely needs to have a similar world-view to their therapist's theoretical stance, in which case the goals and tasks of therapy (proposed by the therapist) would make sense to the client.

Other client characteristics and behaviors that have correlated positively with the working alliance include psychological mindedness, positive expectation for change (Castonguay et al., 2006), and personal commitment (Patterson, Uhlin, & Anderson, 2008). Emmerling and Whelton (2009) investigated stages of change and working alliance and found that alliance scores were higher for clients who had progressed during therapy to the action stage of change versus those who stayed in the contemplation stage.

In another study, Constantino et al. (2010) discovered an unexpected finding in which clients diagnosed with depression who were taking psychotropic medication reported better working alliances measured at session three than clients who were not taking medication. Another unanticipated finding by Patterson et al. (2008) was clients who had prior counseling rated the Goals and Bonds subscales on the WAI (Horvath & Greenberg, 1989) higher than did clients who had not received prior counseling.

Research on both therapist and client factors provided useful information in understanding characteristics that are correlated and/or predict a strong working alliance. With many of the studies in this section, as well as many of the investigations reviewed thus far, most of the researchers utilized alliance measures that were created from a professional's (e.g., theorist, therapist, researcher) definition and conceptualization. This could be problematic because the working alliance is created collaboratively between the therapist and client. However, most researchers appeared to only use the professional's perspective to define, conceptualize, and ultimately measure this phenomenon.

Differing Working Alliance Perspectives

Therapist and client ratings of the working alliance often differ, particularly early in therapy (Horvath & Bedi, 2002; Horvath et al., 2011; Horvath & Symonds, 1991). Horvath (2000) asserted, "The therapist's assessment can only reflect a normative perspective, whereas the client's knowledge is entirely subjective and individualized" (p. 168). He further proposed that given differences in ratings between the therapist and client and the finding that a good working alliance impacts positive therapeutic outcome, "then the reasons for differences between how therapists see the relationship and the factors impacting on their assessment, as contrasted to the clients' more 'naïve'

perspective, is an important question for practice and research alike” (p. 168). Because much of the literature on the conceptualization of the working alliance is from the professional’s (e.g., therapist, theorist, researcher) perspective, it is important to investigate the client’s point of view to better understand where these perspectives diverge.

Client’s Perspective on the Working Alliance

Bedi et al. (2005) and Bedi (2006) stated that there is limited research investigating the client’s subjective understanding of what forms and impacts a strong working alliance in therapy. Given that clients’ ratings of the working alliance are stronger predictors of outcome (Horvath & Bedi, 2002), they proposed that it is important to investigate how clients subjectively view alliance formation. To explore the paucity of research, Bedi et al. (2005) used a qualitative approach and interviewed 40 clients seeking treatment for a variety of presenting concerns (e.g., anxiety-stress, relationship issues, depression, anger, eating-related issues, educational concerns) and were previously or currently in therapy. The authors sought to investigate critical incidents in forming the working alliance with their therapist. They asked the clients to recall incidents during therapy that were helpful in forming and strengthening the therapeutic relationship. Their findings diverged from several of the widely used conceptualizations of the working alliance by professionals. For example, out of the 40 participants, only 33% mentioned their own contributions to the formation of the working alliance, suggesting the participants viewed the therapist as responsible for its creation. This deviated from the previous conceptualizations and definitions of the working alliance:

that it is collaborative in nature between the client and therapist and agreement on goals and tasks must occur.

The participants in the study (Bedi et al., 2005) identified several elements that impacted the working alliance that have not often been researched in the context of forming a therapeutic relationship: the therapist's personal characteristics (e.g., clothing, body type) and the therapeutic environment (e.g., office size, lighting, decorations, color schemes, types of books in the therapist's office). These external factors did not align with the conceptualization of the working alliance that focused on goals, tasks, and bond. Another difference the authors discovered was that 72.5% of the participants recalled a therapeutic technique or intervention that was influential in forming the working alliance. For example, one participant recalled their therapist teaching them a grounding technique. Bedi (2006) also replicated the finding that clients perceived techniques to influence the working alliance. Although Bordin's (1979) conceptualization established that agreement on tasks is important in forming a working alliance, it did not declare that a task or technique in and of itself formed the alliance. Most of the research on techniques and tasks often investigated their impact on therapy outcome, not on the working alliance.

Bedi (2006) also discovered other themes when interviewing clients with regard to their perceptions of alliance formation that have not been discussed in existing theories: session administration, setting, therapist's education, referrals given by the therapist, recommended materials, and guidance. He also found that the participants often viewed the therapist's microskills, e.g., empathic listening and nonverbal gestures, as important in alliance formation. Additionally, Bedi and Richards (2011) interviewed

37 men regarding what they viewed as helpful in alliance formation. The participants stated it was important their therapist balance conventional relationship-building techniques (e.g., empathy, paraphrasing, validating) with asking questions and providing suggestions. Bedi et al. (2005) noted that although these variables were identified by participants as useful in building the therapeutic relationship, it was beyond the scope of their study to establish whether they had a measurable impact on alliance formation. Furthermore, Bedi (2006) asserted that therapists “should not unconditionally provide clients with whatever type of alliance they desire. There are clinical (e.g., transference) and ethical considerations” (p. 33).

In all three studies, the authors proposed further research was necessary to fully investigate the process of alliance formation from the client’s subjective perspective (Bedi, 2006; Bedi et al., 2005; Bedi & Richards, 2011). They also concluded that present alliance measures might not measure many of the variables their participants, and potentially other clients, judged as important in forming a working alliance. Bedi (2006) further states, “If investigators wish to claim to measure a client’s subjective experience of the alliance, then constructs that reflect the client’s perspective need to be included into future measures” (p. 33). Also, all three studies suggested future researchers should perform similar studies in different populations (e.g., geriatric, traumatized clients, inpatients) to better understand the client’s subjective perspective of this process as well as possible constructs and variables current theories were missing. One population that would be useful to investigate is clients diagnosed with Anorexia Nervosa. Westwood and Kendal (2012) indicated that better understanding of the perspectives of clients with

AN would be an important step toward improving client engagement in treatment and treatment outcome.

Anorexia Nervosa

Overview of Anorexia Nervosa

In 1689, Richard Morton first wrote about characteristics of the disorder we now call Anorexia Nervosa (Kracke, 1999). Later in 1873, W. W. Gull coined the term *Anorexia Nervosa* (AN) as well as provided many of the major diagnostic criteria that are still used today (Kracke, 1999). Although the term *anorexia* means loss of appetite, loss of appetite is actually rare in individuals with this disorder. In the early stages of AN, individuals do have an appetite and have signs of hunger; however, individuals ignore these signs in an attempt to lose weight and be thin. Furthermore, it is rare for these individuals to complain of weight loss; they are often in denial that a problem exists (APA, 2000). Currently, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; APA, 2000) provides the diagnostic criteria used for diagnosing individuals with AN. The criteria one must meet are listed below as well as two subtypes:

- A. Refusal to maintain bodyweight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).
  - B. Intense fear of gaining weight or becoming fat, even though underweight.
  - C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
  - D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)
- Restricting Type: during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)
- Binge-Eating/Purging Type: during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging

behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). (p. 589)

According to APA (2000), the lifetime prevalence rate of AN is approximately 0.5%; the prevalence among males is approximately one-tenth that of females. Rumney (2009) reported that one in 100 females in the United States develops this disorder. Although some researchers have proposed AN often begins in adolescence (APA, 2000), recent research has suggested eating disorders can also begin in middle-aged women (Midlarsky & Nitzburg, 2008). Anorexia Nervosa is most common in industrialized societies where being considered attractive is associated with being thin; therefore, it is common in countries such as the United States, Canada, Europe, Australia, Japan, New Zealand, and South Africa (APA, 2000), to name a few.

Because AN is a disorder involving a reduced intake of food, semi-starvation characteristics such as problems with the individual's major organ systems, anemia, dehydration, osteoporosis, cardiovascular and gastrointestinal abnormalities, and even death can affect these individuals (APA, 2000; Wright, 2010). In a meta-analysis using 119 outcome studies on clients diagnosed with AN, Steinhausen (2002) estimated the crude mortality rate of this population was 5%; however, APA (2000) concluded the long-term mortality rate was over 10%. Steinhausen utilized studies that included both adolescence and adults and concluded lower mortality rates were associated with onset of the disorder during adolescence. Rumney (2009) stated that the death rate for those with AN was "twelve times higher than the death rate from *all* other causes of death for females from fifteen to twenty four years old" (p. 17). Additionally, individuals with AN have a 58 times greater suicide rate than do healthy females; 3% to 20% of those with AN attempt suicide (Warren et al., 2009). Due to the increased rate of death and suicide,

it is clear that AN is a very serious disorder. To understand this disorder more clearly, the etiology of AN is explored.

Etiology of Anorexia Nervosa

Currently, there is no single identified cause of AN; rather, researchers and theorists have identified several multidimensional factors that interact to develop this disorder (Rumney, 2009; Steinhausen, 2002). These factors have aided in the development of a biopsychosocial etiology. Some predisposing factors of AN might be due to a genetic or biological component (Kracke, 1999; Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2003). Rumney (2009) reviewed several studies that investigated identical twins raised in separate families and found if one twin developed AN, the other twin had a 50% to 60% chance of developing the disorder. Furthermore, if someone in a family was diagnosed with AN, family members were 12 times more likely than the general population to develop the disorder (Rumney, 2009). Researchers also investigated specific chromosomes and found a susceptibility gene on chromosome 1 (Rumney, 2009), as well as abnormal functioning of the hypothalamus (Kracke, 1999) and two neurotransmitters: serotonin (Klein & Walsh, 2004) and dopamine (Rumney, 2009).

Psychological factors also influence the development of AN. As previously mentioned, researchers discovered AN often begins in mid-to late adolescent development, usually around the ages of 14 to 18 years (APA, 2000). This is also during the developmental phase of separation and individuation (Rumney, 2009). Rumney (2009) proposed that for some individuals with AN, it might be their attempt to remain child-like; by controlling their intake of food, they can acquire a sense of security,

competence, and achievement. Individuals with AN are often perfectionistic (APA, 2000) and might never meet their own perfect standards. Therefore, the individual diagnosed with AN often uses starvation to punish “herself [or himself] and her [or his] body for perceived failures and imperfections” (Rumney, 2009, p. 20).

Social factors are also involved in the development of AN. Researchers discovered industrialized societies have a greater prevalence of eating disorders than do non-industrialized societies (APA, 2002; Becker, Burwell, Herzog, Hamburg, & Gilman, 2002); therefore, researchers concluded that culture likely plays an important role. Tozzi et al. (2003) suggested that cultural pressures to be thin might be necessary, but not sufficient, for the development of eating disorders.

In a study conducted by Becker et al. (2002), the researchers investigated eating behaviors and attitudes of Fijian adolescent girls in 1995 within a few weeks after the introduction of television and three years later in 1998. Using quantitative and qualitative methods, they found participants’ scores on the Eating Attitudes Test (EAT-26; Garner & Garfield, 1979) increased 12.7% and induced vomiting increased by 11.3% from 1995 to 1998. Furthermore, in 1998, 77% reported that television had influenced their body image. The authors noted that this culture primarily encouraged “robust appetites...[and] efforts to reshape the body by dieting or exercise thus traditionally have been discouraged” (p. 509). Because the researchers had a small sample size ($n = 63$ in 1995 and $n = 65$ in 1998), it is difficult to generalize these findings and conclude that media or Western culture created or caused higher eating disorder behavior in the participants. However, it did suggest that media and culture likely played a part in creating an environment in which eating disorders might cultivate and evolve.

Other factors associated with the development of AN included family dynamics, dieting, and spirituality. Early in the conceptualization of AN, many researchers, theorists, and practitioners believed clients' parents were responsible for the creation of eating disorders; however, although specific family characteristics are related to AN, researchers now understand many factors can contribute to the development of AN, not just family or parental factors. Some family characteristics that have been investigated in clients with AN include enmeshment, overprotection, rigidity, lack of conflict resolution (Kracke, 1999), excessive control, marital discord (Tozzi et al., 2003), perfectionism, and emphasis on appearance and/or weight (Rumney, 2009), to name a few. Dieting has also been associated with the development of AN (Tozzi et al., 2003). Often times, individuals with AN report going on a diet, limiting the type and/or amount of food they eat, and slowly reducing this amount to almost nothing, leading to the development of AN. Spirituality might also play a role. For example, some individuals believe that excessive fasting is a display of spirituality and, historically, a standard for sainthood (Hepworth, 1999). These beliefs might propel individuals to take fasting to an extreme and develop AN.

A stressful life event or events can trigger the onset of AN (Tozzi et al., 2003). Rumney (2009) stated, "Biochemical imbalances, psychological problems, family issues and cultural milieu create a backdrop for anorexia. Each is important, but there is usually a triggering event or series of events that acts as catalyst" (p. 23). These events might be, but not limited to, parental divorce, puberty, death of a family member or friend, pressure to achieve, external comments about weight or body shape, changing environments, or feelings of loneliness or isolation (Rumney, 2009).

Anorexia Nervosa and Comorbidity

Researchers found that individuals with AN often are diagnosed with other psychiatric disorders. One disorder often seen among individuals with AN is Obsessive-Compulsive Disorder (OCD), obsessive-compulsive features (APA, 2000; Steinhausen, 2002), or Obsessive-Compulsive Personality Disorder (Satir et al., 2011). Although persons with AN are usually obsessed with thoughts of food, weight, and body image, they often exhibit other obsessions and compulsions. For example, many individuals described as perfectionists frequently obsess over getting good grades or keeping their room/home meticulously neat (Kracke, 1999). They might also obsess over things that are not symmetrical. Anxiety disorders, phobias, substance use disorders, and affective disorders are also found among individuals with AN (Steinhausen, 2002). As individuals become underweight, they might manifest symptoms similar to depression such as irritability, insomnia, social withdrawal, depressed mood, and diminished interests (APA, 2000).

Other characteristics associated with AN include a strong need to control one's environment, limited emotional expression, inflexibility, fear of eating in public, and low self-esteem (APA, 2000; Tozzi et al., 2003). Furthermore, a large portion of individuals with AN also have a diagnosis of at least one personality disorder including borderline states (APA, 2000; Steinhausen, 2002). Researchers suggested individuals diagnosed with the binge-eating/purging type are more likely to have problems with impulse control, abuse alcohol or drugs, portray mood changes, have several suicide attempts, be sexually active, and may meet criteria for Borderline Personality Disorder (APA, 2000). Since an individual diagnosed with AN might present with comorbid diagnoses and

severe physical and psychological symptomatology, treatment for those with AN often requires a complex approach.

Outcome and Treatment of Anorexia Nervosa

Outcome. For therapists working with this population, progress is often slow and prognosis is usually poor (Franko & Rolfe, 1996). Researchers found that outcome is better and mortality rates are lower if the onset of AN occurs during early adolescence versus having a late onset of the disorder (APA, 2000; Steinhausen, 2002). In a meta-analysis, Steinhausen (2002) utilized 119 outcome studies composed of 5,590 clients diagnosed with AN. The diagnostic categories for AN changed over the period of the studies with the earliest study using no official criteria and the latest using the DSM-IV. Furthermore, the studies were grouped by participant age (i.e., no older than 17 years at onset, both younger and older patients) as well as duration of follow-up (i.e., one year to 29 years). Using these studies, Steinhausen found that 46.9% of clients fully recovered, 33.5% improved, and 20.8% developed a chronic course of the disorder. Herzog and Eddy (2007) also estimated similar recovery statistics and suggested about 33% of clients diagnosed with AN who did recover, relapsed. Additionally, researchers identified that clients who had comorbid diagnoses such as depression, anxiety disorders, and/or personality disorders had less favorable outcomes (Steinhausen, 2002). Although a variety of treatments were used in the meta-analysis, it appeared clients diagnosed with AN had a relatively poor outcome--roughly half fully recovered.

Treatment. Prior to the second half of the 20th century, individuals with AN were treated from a strictly medical model. During the 1960s, a shift occurred and these clients were provided treatment that emphasized psychotherapy (Steinhausen, 2002).

Because many of these clients were forced or strongly persuaded to enter psychotherapy (Franko & Rolfe, 1996) by parents, family members, or friends, treatment was often difficult. Bruch (1988) stated, “Anorexic patients resist treatment and remain uncommitted to therapy for a long time. They do not complain about their condition; on the contrary, they glory in it” (p. 7).

Besides many clients’ unwillingness to begin treatment, treatment is further complicated because of the multifaceted etiology and various symptomatology. Before psychotherapy can begin, some clients diagnosed with AN must first restore weight and possibly be hospitalized to treat their physical symptoms. Once clients are physically stable and have gone through the refeeding process (if necessary), then psychotherapy can begin. Psychotherapy can occur in a number of settings including inpatient hospitalization, partial hospitalization/day hospital program, residential treatment program, intensive outpatient treatment, and outpatient treatment (Rumney, 2009).

Unfortunately, scientific research on the effectiveness and quality of treatments for eating disorders, specifically AN, is limited (de la Rie, Noordenbos, Donker, & van Furth, 2008). Some researchers and practitioners suggest several types of treatment including but not limited to “medical maintenance, nutritional counseling, individual therapy, family therapy, behavior therapy, rational-emotive therapy, or group therapy in order to address those factors that predisposed, precipitated, or are functioning to sustain the disorder” (Kracke, 1999, p. 85). Hollon and Beck (2004) reviewed several studies and found that conventional cognitive-behavior therapy (CBT) has shown no great benefit for clients diagnosed with restricting type AN. They further reviewed that

cognitive analytic therapy was as effective as behavior therapy in an outpatient setting in keeping clients from being hospitalized.

In another study, Ricca et al. (2010) investigated the use of CBT with 53 participants diagnosed with AN and 50 participants with sub-threshold AN (met all DSM-IV criteria except underweight or amenorrhea) in individual psychotherapy. The researchers measured the participants' body mass index (BMI) and gave the participants the Eating Disorder Examination Questionnaire, Body Uneasiness Test, Symptom Checklist, Beck Depression Inventory, and State-Trait Anxiety Inventory at the beginning of treatment, the end of treatment, and three years after the end of treatment. The authors found that no deaths occurred during treatment and the follow-up period, and 34 participants (33%) obtained a full recovery (i.e., the participant did not meet the criteria for any eating disorder in the DSM-IV including eating disorder not otherwise specified [EDNOS]). Because the authors did not use a control group, it is difficult to identify the specific effectiveness of CBT; however, the authors highlighted that both significant weight gain and reduction in general and eating-specific psychopathology variables were observed in both groups. Similarly, Satir et al. (2011) reviewed several preliminary studies that indicated CBT might be an effective treatment for AN.

Hollon and Beck (2004) also suggested the use of treatments that highlighted and used motivational aspects might prove useful in future research. Wade, Frayne, Edwards, Robertson, and Gilchrist (2009) investigated if motivational interviewing (MI) would influence clients with AN's dropout rates and/or eating pathology as compared to treatment as usual in an inpatient setting. They found that the group of participants randomly assigned to the MI group had less dropout rates than did the treatment as usual

group; however, the MI group did not decrease in their eating pathology. Further research is necessary to evaluate if MI is useful when treating clients diagnosed with AN. Rumney (2009) also reviewed types of treatments that were used with this population: behavior modification, dialectical behavior therapy (DBT), psychodynamic therapy, family therapy, psychopharmacology, and experiential modalities such as hypnotherapy, guided imagery, art therapy, music therapy, poetry therapy, movement therapy, and psychodrama.

When treating clients diagnosed with AN in individual psychotherapy, therapists often highlight the importance of balancing encouragement and assertiveness by setting clear boundaries (Warren et al., 2009). Firm boundaries are necessary because of the “potentially life- and treatment-threatening states of despair and destructiveness” (Golan, Yaroslavski, & Stein, 2009, p. 214). De la Rie et al. (2008) investigated eating disorder clients’ and therapists’ views of important components in the therapy process, structure, and outcome. They found that therapists often focused on eating disorder symptoms and changing those behaviors, whereas clients often focused on the importance of the therapeutic relationship and addressing the underlying problems of their eating disorder.

In a similar study focusing on clients’ evaluations of their eating disorder treatment, de la Rie, Noordenbos, Donker, and van Furth (2006) discovered helpful components of treatment included factors such as feeling understood, gaining insight, telling their story, and having a good working alliance with their therapist. Tozzi et al. (2003) also found a similar result when interviewing clients diagnosed with AN about perceived factors related to recovery; participants viewed supportive relationships from either a partner or therapist as the driving force assisting them in treatment and recovery.

Therefore, investigating the working alliance in psychotherapy between clients diagnosed with AN and their therapist might prove beneficial.

Working Alliance and Eating Disorders

Some studies investigated the working alliance specifically with clients diagnosed with eating disorders. Loeb et al. (2005) explored how alliance and treatment adherence in cognitive-behavioral therapy (CBT) and interpersonal psychotherapy (IPT) would impact outcome in 220 women with BN purging type over 19 therapy sessions. Outcome was defined as the frequency of purging derived from the Eating Disorder Examination (EDE) and measured at the first session and one week after the final session. The therapeutic alliance was measured using a modified version of the Vanderbilt Therapeutic Alliance Scale (VTAS) and completed by independent raters who listened to three full-length sessions per client at sessions 6, 12, and 18. The researchers found that early session alliance ratings (session 6) predicted final outcome; however, the treatment group assigned (CBT or IPT) was a stronger predictor of outcome than alliance.

In another study, Toman (2002) investigated how the BMI of 18 females diagnosed with BN or AN of the bulimic subtype impacted the therapeutic alliance. To explore the alliance, Toman conducted interviews with the therapists and identified several types of transference or countertransference experienced in therapy. For example, some of the categories included fear of the patient, anxiety toward the patient, emotional closeness to the patient, and emotional distance to the patient. Toman discovered that the thinner the client, the more likely the therapist presented a “close-protective” attitude toward the client and the heavier the client, the greater probability the therapist would have a “distant-demanding” attitude. Although the findings were

interesting, the researcher did not investigate if these therapist attitudes impacted client outcome or how the clients viewed the alliance with their therapist. Furthermore, Toman acknowledged the limited number of participants and identified this as a limitation when generalizing the findings.

Only a few researchers have investigated the working alliance among clients diagnosed with AN. In one study, Gallop, Kennedy, and Stern (1994) studied how 31 anorexic clients' ratings on the Working Alliance Inventory (WAI) predicted treatment dropout on an inpatient unit for eating disorders. Since the clients interacted and built relationships with several different staff members (e.g., nurse, psychiatric resident, nutritionist, occupational therapist), they were asked to complete multiple WAIs--one per relevant staff member. The clients completed the WAIs three to four weeks after admission and again between the seventh and eighth week. The researchers also had the relevant staff members fill out the WAI in relation to the client(s) with whom they worked. Results conveyed that the client participants who completed the program ($n = 21$) rated the therapeutic alliance with staff stronger than did clients who prematurely left the program ($n = 10$). Little correlation was found between client and staff alliance ratings.

In another study, Zeeck and Hartmann (2005) explored if process aspects of psychotherapy were associated with a positive or negative outcome as measured by BMI at discharge for 38 clients diagnosed with AN. After each of the 12 individual therapy sessions, clients filled out the *Stundenbogen* to evaluate their experience in the session and their therapists filled out the *Heuristikskalen*--a German instrument used to assess interventions the therapist might have used in the session. The researchers discovered

that a focus in therapy on the relationship with the therapist and/or with others in the client's life during the first stage of therapy was related to positive outcome (i.e., weight gain). Additionally, Pereira, Lock, and Oggins (2006) investigated the working alliance in family therapy with 41 adolescent clients diagnosed with AN and their families. The researchers watched two full-length videotaped sessions of each of the 41 families and used the WAI Observer-Rater version to rate the working alliance between the adolescent and therapist, and parent(s) and therapist. They also documented the adolescent's weight during sessions one and six, at six months, and at 12 months after the start of therapy. The researchers discovered that a strong alliance with the adolescent was associated with weight gain and a strong alliance with the client's parents was associated with lower rates of therapy dropout.

There were several limitations to the studies investigating the AN population. For example, Gallop et al. (1994) and Zeeck and Hartmann (2005) utilized clients in an inpatient setting, and Pereira et al. (2006) investigated adolescent clients in family therapy. The varying treatment modalities made it difficult to generalize the findings to outpatient, individual psychotherapy. Additionally, all three studies had small sample sizes and utilized different criteria to measure outcome (e.g., weight gain, BMI, treatment dropout), also making it difficult to generalize the findings. Out of these studies, only one (Gallop et al., 1994) utilized the clients' ratings of the working alliance; however, they investigated multiple alliances with staff members rather than with the client's primary therapist. This also made it complicated to assess if the client's rating of the working alliance with their primary therapist in individual psychotherapy impacted treatment outcome.

Although few studies investigated the working alliance in the eating disorder population, much research has investigated the working alliance in general and found the working alliance to impact therapy outcome. Therefore, it would seem appropriate to suggest the working alliance is important in the treatment of clients diagnosed with AN. Furthermore, because of the nature of the disorder, building a working alliance might prove difficult in this population. Client and therapist factors that could influence or challenge the formation of the working alliance are reviewed in the following section.

Client factors. Often, clients diagnosed with AN present with difficult characteristics that challenge the formation of the working alliance. These individuals often have trouble with regard to relating and forming attachments with others including their therapist. Warren et al. (2009) reported clients with eating disorders often find it hard to trust their therapist as well as share power and control during therapy. Additionally, they suggest that these clients often retreat from relationships; this challenges the formation of the working alliance.

Attachment styles can also impact the formation of the working alliance. Wechselblatt et al. (2000) proposed that many clients diagnosed with AN have an insecure attachment style; therefore, the client's ability, or inability, to form an attachment with the therapist might significantly impact the therapeutic relationship. Additionally, clients diagnosed with AN can be quite competitive; Golan et al. (2009) suggested this competitiveness likely interferes with a strong alliance. Lowell and Meader (2005) furthered this thought in their proposition that a therapist's body might create competitive, "strong, complex feelings in eating disordered patients" (p. 256), which might also interfere with the therapeutic bond.

Another characteristic that could challenge the creation of alliance is the client's denial that he/she has an illness and/or the lack of motivation to change and work toward recovery. Additionally, clients diagnosed with AN might want to maintain their disorder so they can stay thin. Wright (2010) asserted that Bordin's (1979) three-part model of the working alliance included agreement on goals and tasks and a therapeutic bond.

Therefore, an agreement on goals and tasks in therapy between the client with AN and the therapist might be difficult, especially when the client does not see a problem and the therapist is worried about treating a potentially life-threatening disorder. Other client characteristics that might challenge the working alliance include the degree of the client's rigidity (Sexton & Whiston, 1994) and the amount of client perceived controllability and curability of his/her disorder (de la Rie et al., 2006). Also the possibility that the client needs hospitalization during therapy might negatively influence the formation or maintenance of a working alliance.

Therapist factors. Unfortunately, therapists often find "patients with eating disorders have a notorious reputation for being difficult to treat and undesirable as patients" (Warren et al., 2009, p. 28). Some of the words used to describe therapists' feelings or experiences when working with clients from this population include worry, anxiety, angst, fatigue, sadness (Warren et al., 2009), frustration, idealization, inadequacy, hopelessness/helplessness, anger, hate, despair, devaluation, and rejection (Golan et al., 2009). In one study, Franko and Rolfe (1996) recruited 71 therapists who specialized in treating eating disorders and investigated their emotional reactions to clients diagnosed with AN, BN, and depression. Their participants reported that clients diagnosed with AN evoked considerable negative emotional reactions, more so than did

clients diagnosed with BN or depression. These findings might be explained by Warren et al.'s (2009) investigative results. They asked treatment providers to write about the hardest aspects of working with clients with eating disorders. Some themes included low readiness to change, chronic symptomatology, poor prognosis, slow recovery, medical complications, and high rates of relapse, suicide, and death. Although these were client factors, they in turn affected the therapist and could generate countertransference that might negatively influence the working alliance. Golan et al. (2009) indicated that strains in the alliance when treating clients with eating disorders were inevitable and therapists and treatment providers alike need to acquire skills to be aware of and deal with their own countertransference reactions.

Literature Summary and Conclusions

A strong working alliance between the client and therapist has been found to be an important ingredient in the process and outcome of psychotherapy. Researchers have investigated alliance using a number of measures and scales, various perspectives (e.g., client, therapist, observer), and in many different diagnosed populations; they found that a strong working alliance predicted therapeutic outcomes (Horvath et al., 2011). Studies in which the researchers investigated alliance formation, as well as factors that influenced the relationship, were much smaller in number compared to outcome studies; therefore, practitioners were left with little guidance in how to form and maintain a working alliance with their clients. Furthermore, many studies that investigated the working alliance used measures conceived by theorists and researchers, thereby neglecting clients' definition and conceptualization of the working alliance. This is problematic--research is investigating a collaborative phenomenon only using one person's (the professional's)

conceptualization. Also, recent research discovered that clients might view the definition of and contributing factors to the working alliance differently than the current conceptualizations (Bedi, 2006; Bedi et al., 2005).

Research investigating the working alliance in specific diagnosed populations was also limited. A small number of studies (Gallop et al., 1994; Pereira et al., 2006; Zeeck & Hartmann, 2005) reported that a strong working alliance in treating clients diagnosed with AN was correlated to positive outcomes (i.e., weight gain, lower rates of premature dropout); conversely, a negative working alliance was correlated with poor outcomes.

These findings are useful because prognosis is often poor in this population.

Furthermore, it might be difficult to form a working alliance with clients diagnosed with AN because they often present with strong characteristics that challenge the alliance, which can then create countertransference reactions from the therapist.

Implications and Future Directions

A number of researchers investigated the working alliance and found it to be a predictor of outcome; however, the number of studies that investigated the process by which the working alliance was formed was limited (Castonguay et al., 2006; Safran et al., 1994; Steinhausen, 2002). Other investigators concluded that it is important for future research to explore factors that enhance the working alliance (Sharf et al., 2010), aid in the repair of therapeutic ruptures (Safran et al., 2010), and aid in the formation of poor working alliances (Samstag, 2006). Authors also suggested that current measures of the working alliance are created based on researchers' and theorists' perspectives, which might exclude factors clients view as important in defining, conceptualizing, and

measuring this construct (Bedi, 2006; Bedi et al., 2005). Therefore, more research is needed to investigate the client's understanding and conceptualization.

Furthermore, investigators identified the need to identify alliance formation and rupture factors within specific diagnosed populations (Bedi et al., 2005; Castonguay et al., 2006; Hersoug et al., 2010). Clients diagnosed with AN would be a useful population to investigate as they often have poor treatment prognosis. Poor outcome in this population is often associated with medical complications, hospitalizations, and/or death. Some clients diagnosed with AN do not believe they have a problem and/or are not ready to change; therefore, Geller, Williams, and Srikameswaran (2001) asserted that understanding how alliance is established and maintained with this population would be of great use. Tozzi et al. (2003) stated that little attention has been paid to clients with eating disorder perspectives on the factors that contribute to recovery. Westwood and Kendal (2012) indicated that improving the understanding of clients' perspectives is an important step toward improving client engagement in treatment and treatment outcome. Therefore, investigating perceptions of clients diagnosed with AN with regard to factors that influence alliance formation is needed. Researchers also suggested that because the working alliance is collaborative between client and therapist, data should be gathered from both the therapist and client (Kivlighan, 2007; Råbu, Halvorsen, & Haavind, 2011) to create "a more complete and useful picture of the alliance" (Kivlighan, 2007, p. 431). Thus, investigating the therapists' perspectives regarding the formation of the working alliance would provide useful information about the actual, not assumed, agreement about this phenomenon. De la Rie et al. (2008) suggested that converging available

evidence, clients' views, and therapists' views would optimize treatment of eating disorders.

When investigating the working alliance, many studies used a quantitative empirical approach. Sexton and Whiston (1994) argued that these studies decontextualized the very process they were investigating. Furthermore, they proposed that in order to understand the relationship between the therapist and client, a paradigm shift is necessary and requires a different mode of inquiry and level of reduction, e.g., a qualitative approach. Using a qualitative approach to investigate the working alliance with clients diagnosed with AN from the therapists' and clients' perspectives would allow the phenomenon to remain context based and client and therapist differences to be "the focus, not the unfortunate outcome" (Sexton & Whiston, 1994, p. 68).

CHAPTER III

METHODOLOGY

Introduction

The purpose of this chapter is to outline the rationale of the study, state the research questions, identify my stance as a researcher, and discuss the underlying principles for the methodology, research model, methods, and paradigm. Additionally, I present issues related to rigor, trustworthiness, and ethical considerations of the current study.

The purpose of this phenomenological study was to explore perceptions and experiences of clients diagnosed with Anorexia Nervosa (AN) and therapists who work with AN with regard to how the working alliance was formed and challenged in the process of individual psychotherapy. The following research questions guided the current study:

- Q1   How do clients diagnosed with Anorexia Nervosa experience the working alliance in individual psychotherapy?
- Q2   How do therapists who work with clients diagnosed with Anorexia Nervosa experience the working alliance in individual psychotherapy?
- Q3   What factors influence the working alliance between therapists and clients diagnosed with Anorexia Nervosa?

Researcher's Stance

Description of the Researcher

I am a 28-year-old female Caucasian married graduate student currently working toward a doctoral degree in Counseling Psychology. My previous education included obtaining a bachelor's degree in Elementary Education and a master's degree in Rehabilitation Counseling. During high school and my undergraduate studies, I aspired to work with children; however, after completing an internship while working on a master's degree at a residential treatment facility for adult women with eating disorders, I realized working with this population was a strong interest of mine. Therefore, my personal and professional experiences contributed to the development of this study.

For the purpose of being reflexive, as is the practice of qualitative researchers "to inform their audiences about their perspectives as well as to manage their subjectivities" (Morrow, 2005, p. 250), it was important to state that my interest in studying eating disorders stemmed more from a professional interest and less from a personal interest. I have never been diagnosed or struggled with an eating disorder; nor has anyone in my immediate family. However, as a female growing up in the United States, I felt many societal pressures regarding weight and body shape. Furthermore, I was an athlete in high school and college and felt pressure to maintain a certain body size "appropriate" for my sport, which was gymnastics. Although I never developed an eating disorder, I personally experienced the pressures many women and men experience in Western culture.

When providing individual psychotherapy, I utilize an interpersonal, theoretical orientation (guided by interpersonal theorist Teyber) and, therefore, place high value on

the therapeutic relationship, or working alliance, between the client and therapist.

Although many theories identify the relationship as an important aspect of therapy, my orientation views client change as occurring in the context of the alliance when the therapist responds to the client in a new, adaptive way. This belief guided my choice to study the working alliance.

Choice of Research Topic

During my master's internship at the treatment facility, I was fortunate enough to participate and co-lead many group counseling sessions and psychoeducational groups with several full-time staff members. Their degrees and certifications varied from eating disorder specialist and marriage and family counselor to social worker, dietician, and registered nurse. When interacting with the staff, I quietly observed that many had strong, often negative reactions to clients diagnosed with AN when compared to the women diagnosed with Bulimia Nervosa (BN) or Eating-Disorder Not Otherwise Specified (EDNOS). It appeared that staff members had more difficulty communicating and building relationships with the AN-diagnosed population. I also observed that clients diagnosed with AN were often the ones discussed during staff group supervision.

After working at this site for about two months and becoming more active in co-leading therapy groups, I had one interaction with a client diagnosed with AN that greatly impacted me. During a group therapy session, the client became triggered by something that was being discussed and stormed out of the room. When I went to speak with her, she began yelling and telling me she did not trust someone so young and incompetent and, therefore, would not work with me during her treatment. As a novice counselor, this was a difficult situation to encounter; however, it allowed me an opportunity to reflect on

the process of building relationships with clients and factors that might challenge the relationship between client and therapist.

Although this is just one example I experienced in building a relationship with a client, I have heard and read many accounts of therapists experiencing similar incidents in therapy. Researchers have investigated therapists' perspectives of working with clients diagnosed with AN and found these clients evoked more negative reactions than did clients diagnosed with BN or depression (Franko & Rolfe, 1996). After reading research on therapists' negative responses to this population, hearing mental health workers' personal experiences, and experiencing a negative reaction of my own, I began thinking about how the working alliance formation between a therapist and client with AN is affected; if clients diagnosed with AN present with characteristics that evoke negative reactions in therapists, then how is the working alliance formed between the client and therapist? Furthermore, what factors influence its formation? I continued to ponder these questions, thought about clients' perspectives on this phenomenon, and how similar or different they were from therapists' perspectives.

Previous research examined the working alliance in relation to therapy outcome and most studies investigated the phenomenon in a quantitative manner. Much of this research has shed light on the therapeutic relationship and highlighted its importance in therapy and research. Fewer studies explored factors that influenced alliance formation and even fewer studies researched alliance in therapy with individuals diagnosed with AN. Therefore, I investigated the lived experiences of the working alliance formation in therapy with therapists and clients diagnosed with AN.

Research Model and Paradigm

Researchers highlighted that although there were various theories on the working alliance in psychotherapy, there was an “absence of theorizing and empirical research that represents clients’ subjective understandings” (Bedi, 2006, p. 26) of this phenomenon (Bedi, 2006; Bedi et al., 2005). Bedi (2006) further proposed that because past research found clients often understood the working alliance differently than did their therapists, further elucidation of the client’s perspective might help promote better counseling outcomes. Therefore, I proposed the most useful way to grasp the clients’ and therapists’ understanding of this phenomenon and how it was experienced in individual psychotherapy was to use a qualitative research paradigm. Qualitative researchers are interested in understanding how individuals “interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences” (Merriam, 2009, p. 5). Qualitative research also provides a complex and detailed description of the issue being investigated (Creswell, 2007) and the product is richly descriptive (Merriam, 2009). To direct the qualitative research process, Crotty (1998) outlined four elements to guide the ontology, philosophy, process, and procedures of a study: epistemology, theoretical perspective, methodology, and methods. Figure 1 displays these elements of the current study.

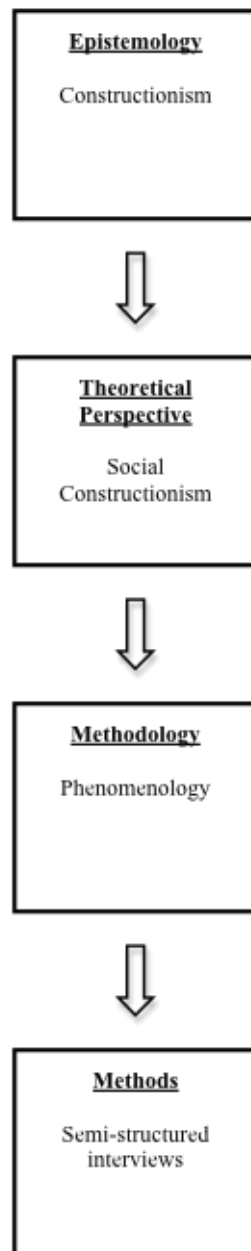


Figure 1. Elements of research (Adapted from Crotty, 1998).

Epistemology and Theoretical Perspective

Epistemology is described as “a way of understanding and explaining how we know what we know” (Crotty, 1998, p. 3). Guba and Lincoln (1989) defined it as the relationship of the knower to the known or the knowledgeable. To guide this study, I chose to use constructionism. Constructionists assume there is no objective truth; truth is created in and out of individuals’ engagement with the world (Crotty, 1998). Therefore, truth or meaning is not discovered, rather constructed. Crotty (1998) stated that constructionists also assume that different individuals construct meaning in different ways, even in relation to the same phenomenon. Because this study investigates the phenomenon of the working alliance in psychotherapy, it is assumed that different participants would construct the meaning of the working alliance differently and, therefore, provide multiple *truths* or *realities* of the same phenomenon. In addition, each participant’s “way of making sense of the world is as valid and worthy of respect as any other” (Crotty, 1998, p. 58). Therefore, participants’ constructed realities of the working alliance can enhance our understanding of this socially constructed phenomenon.

The theoretical perspective is a philosophical stance that aids one in understanding and explaining society and the human world; it provides a set of assumptions that guide the methodology (Crotty, 1998). To guide this research study, I employed a social constructionist theoretical perspective. Constructionism is defined as

the view that all knowledge, and therefore, all meaningful reality as such, is contingent upon human practices being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context. (Crotty, 1998, p. 42)

Therefore, social constructionists not only look at the ways in which individuals engage with and make sense of their world but also how this understanding is set in and guided by historical and social contexts (Crotty, 1998). Furthermore, this theory assumes that culture teaches individuals what to notice in the world and how to make meaning of it.

Methodology

The methodology of a study provides a strategy, process, or plan that guides the choice of particular methods and links the methods to the desired outcome (Crotty, 1998). The methodology I used in this study was phenomenology, specifically transcendental phenomenology. There are several types of phenomenology; however, all approaches share a common focus: “exploring how human beings make sense of experience and transform experience into consciousness, both individually and as shared meaning” (Patton, 2002, p. 104). Furthermore, phenomenologists investigate what people experience, how they experience it, and assume there is not one objective reality for all individuals. As a method of analysis, Patton (2002) stated that phenomenology seeks to identify and illuminate the meaning, structure, and essence of a phenomenon for a person or group of people. To do this, the researcher must capture how individuals experience a phenomenon: “how they perceive it, judge it, remember it, make sense of it, and talk about it with others” (Patton, 2002, p. 104). The assumption that delineates phenomenology from other methodological approaches is that a shared essence or essences exist among individuals who experience a phenomenon (Patton, 2002). Therefore, in this research study, I investigated the shared meaning or essence of the working alliance in psychotherapy between therapists and clients diagnosed with AN.

Philosopher Husserl employed phenomenology as a rigorous science to investigate how people described and understood their experiences (Patton, 2002). Inspired by the work of Husserl, Moustakas (1994) developed transcendental phenomenology. Transcendental phenomenology focuses less on the researcher's interpretations of the phenomenon and more on the participants' descriptions of the phenomenon (Creswell, 2007). To do this, the researcher must employ *epoche*. Epoche is a Greek word that means to refrain from judgment or abstain from the ordinary way of viewing things (Moustakas, 1994). Moustakas stated, "In epoche, the everyday understandings, judgments, and knowings are set aside, and phenomena are revisited, freshly, naively, in a wide open sense, from the vantage point of a pure or transcendental ego" (p. 33). Since epoche is the first step in phenomenological analysis (Patton, 2002), it is further discussed in the data analysis section.

Research Methods

In this section, I review aspects of the research methods including Institutional Review Board approval, research participants, participant recruitment, and the setting. In addition, methods for data collection and procedures for data analysis are also outlined.

Institutional Review Board approval. After the proposal of this study was approved by my dissertation committee, I submitted the appropriate paperwork reviewing my research study to the university's Institutional Review Board (IRB). Once the study was approved by the IRB (see Appendix A), I began participant recruitment. Throughout the study, I also submitted two changes to the IRB. The first change included interviewing participants via Skype or phone as several participants who were interested could not complete the interviews in person. The participants interviewed via Skype

were not visually recorded, only audio recorded. This included changes to the consent form and the recruitment letter. The second change included providing a monetary incentive for the client participants: a raffle for one of two \$50.00 Visa gift cards. This change was made to encourage participation and included changes to the consent form and the recruitment letter.

Research participants. When using a phenomenological methodology to guide a research study, Creswell (2007) recommended using criterion sampling when choosing research participants. Criterion sampling is used when the researcher identifies specific criteria participants must meet in order to take part in a study. This type of sampling works well in a phenomenological study because participants need to have *lived experience* as opposed to *secondhand experience* of the phenomenon in question (Creswell, 2007; Patton, 2002).

In this study, 15 participants were interviewed, all of whom had experienced the working alliance in individual psychotherapy. The number of participants was determined by saturation of the data. Saturation occurs when data are gathered to the point of redundancy (Lincoln & Guba, 1985) and new themes no longer emerge (Creswell, 2007). After each interview, Elizabeth Legg (a co-researcher and doctoral student) and I analyzed the data independently, which contributed to determining the point at which themes were repetitive.

The first set of participants included eight clients who met the following criteria at the time of the study: 18 years of age or older, diagnosed with AN by a physician or licensed mental health provider, not diagnosed with a DSM-IV-TR (APA, 2000) Axis II diagnosis (e.g., Borderline Personality Disorder), and attending individual psychotherapy

to treat their eating disorder. Previous research found that a working alliance could be measured as early as the third session (Gelso & Carter, 1985; Horvath & Bedi, 2002); however, clients diagnosed with AN often present with characteristics (e.g., difficulty sharing power, lacking motivation, rigidity) that make it more difficult to form a working alliance. Therefore, participants needed to have met with their individual therapist for at least five therapy sessions. In the current study, the client participants had well over five sessions, the least number of sessions being 30 and the most being well over 500. Additionally, clients were asked not to participate or discontinue their participation if they felt it would negatively impact their ongoing psychotherapy. Table 1 portrays the demographic information for the client participants.

The second set of participants included seven therapists who worked with clients diagnosed with AN at the time of the study. The therapists did not provide individual psychotherapy to the client participants. This decision was made to maintain participant confidentiality as well as avoid a potentially negative impact on the client's ongoing individual psychotherapy. Similar to the previous criteria set forth for the client participants, therapists needed to have at least five individual therapy sessions with a client diagnosed with AN; however, the therapist participants had much more than this--the lowest number of clients a therapist worked with being 20. Table 2 portrays the demographic information for the therapist participants.

Table 1

Demographics of Client Participants

Participant Pseudonym	Age	Gender	Race	Highest level of education	Occupation	Years diagnosed with AN	Sessions with current therapist	Previous treatment
Jessica	20	Female	White/Caucasian	Completed 2 years of Bachelor's degree	Student; part-time at jewelry store	7	150	Hospitalization and outpatient therapy
Snow	45	Female	White/Caucasian	Bachelor's degree; few courses short of Master's degree	Vice president of a consulting firm	28	200	Inpatient, 4 week residential program, intensive outpatient
Cody	53	Male	White/Caucasian	Bachelor's degree	Banking consultant	1.5	30	Inpatient, group therapy, and 'Celebrate Recovery'
Melissa	30	Female	White/Caucasian	Bachelor's and Master's degree	Social Worker	14	300	Intensive outpatient/day program and group therapy
Laura-Leigh	54	Female	White/Caucasian	Associate's degree	Bank teller	31	500	Two hospitalizations
Emily	23	Female	White/Caucasian	Bachelor's degree	Graduate student	1.5	100	Residential
Kelly	26	Female	White/Caucasian	Associate's degree	Student; part-time at hotel	9	60	Inpatient and group therapy
Jamie	63	Female	White/Caucasian	Bachelor's degree and several graduate courses	Substitute teacher and part-time nanny	10	300	Inpatient and group therapy

Table 2

Demographics of Therapist Participants

Participant Pseudonym	Age	Gender	Race	Highest level of education	Occupation	Years working with clients with AN	Approximate number of clients with AN provided treatment to
Stacey	63	Female	White/Caucasian	Master's degree	Outpatient therapist; unlicensed	12	300
Bridgett	30	Female	White/Caucasian	Master's degree	Therapist at a private practice	5	20
Tim	38	Male	White/Caucasian	Master's degree and several PhD courses	Therapist at a treatment facility for eating disorders	5	200
Sally	28	Female	White/Caucasian	Master's degree	Social Worker at a treatment facility for eating disorders	2	40
Mary	53	Female	White/Caucasian	Doctoral degree	Psychologist at a private practice	25	125
Jane	59	Female	White/Caucasian	Doctoral degree	Psychologist and Clinical Director at a treatment facility for eating disorders	30	1,000
Kathy	32	Female	White/Caucasian	Master's degree	Therapist at a treatment facility for eating disorders	9	150

Procedures

Participant recruitment. To recruit therapist participants, I identified two national organizations, the National Eating Disorders Association (NEDA) and National Association of Anorexia Nervosa and Associated Disorders (ANAD), in which their members, or therapists on their website, worked with clients diagnosed with AN. Both organizations' websites included a referral list of treatment providers including their email addresses. I then contacted therapists via email and briefly explained my study (see Appendix B). If they were interested in participating and met the inclusion criteria, I asked that they respond to the email. When the participants replied to my email, we set up a time to conduct the interview.

To recruit client participants, I utilized similar methods above to identify therapists who worked with this population and sent them an email explaining the study (see Appendix B) and the criteria for clients to participate (e.g., over 18 years-of-age, currently diagnosed with AN, not diagnosed with a DSM-IV-TR Axis II disorder, currently in treatment, and had at least five therapy sessions with the same therapist). I asked that they give their clients who met the criteria a recruitment letter (see Appendix C) explaining the study and asking the client to contact me privately via email or phone. After a client contacted me, I set up a time to conduct the interview.

Setting. Interviews were conducted in three formats: Skype, phone, or in person. Two clients and one therapist completed their interviews via Skype, six clients and two therapists utilized phone, and four therapists' interviews were in person. Skype and phone were utilized as a means of interviewing participants who lived far away or were

unable to meet in person due to scheduling conflicts. The four interviews completed in person were held in the therapist's office or a public library.

Informed consent. Prior to the start of the interview and audio recording, I reviewed the informed consent with participants and obtained written consent. The informed consent documents (see Appendix D for in person therapist interviews, Appendix E for Skype or phone therapist interviews, and Appendix F for Skype or phone client interviews) included my and my supervisor's contact information, a description of the study, information regarding the participant's right to withdraw from the study at any time, measures taken to ensure confidentiality, the use of a research team to aid in transcribing the audio recordings and assisting in analyzing the data, potential benefits and risks of participation, and notification that I might contact them in the future for further information and/or verification of data findings (member/participant checks). Additionally, in the client participant's consent form, I included information about the monetary incentive: a chance to win one of two \$50.00 Visa gift cards. After reviewing the informed consent form and answering participant questions, the participant signed the consent form. For those who conducted their interviews via Skype or phone, they typed their name and emailed it as an electronic signature. I also provided all participants with an additional copy of the consent form for future reference.

Prior to starting the interview, I asked the participant to choose a pseudonym that I could use for him or her throughout the interview, in the transcript, and throughout the Discussion and Results portion of this paper. Participants also filled out a demographic form (see Appendix G) after the interview. All client participants were provided referral information for mental health services (see Appendix H) in the unlikely event an

interview provoked feelings of discomfort or distress requiring outside support; however, none of the participants verbally reported discomfort or distress during or after the interview.

Data Collection

The primary method of data collection was semi-structured interviews.

Moustakas (1994) stated that when using a phenomenological approach, evidence is derived from first-person reports of the lived experience; through these, the researcher can obtain descriptions of the experience. To gain these reports, Moustakas described the interview as being the method through which data are collected; it should be informal, interactive, and utilize open-ended comments and questions. This type of interview is described as a semi-structured interview and is directed by an interview guide. Appendix I contains the interview guide I used for the participants' interviews.

To enhance the data, I used a visual elicitation technique. This technique is appropriate "when the nature of the subject matter of interest is especially difficult to characterize in linguistic terms" (Johnson & Weller, 2002, p. 510). I asked participants to bring to the interview an object that symbolized or represented the relationship they had with their therapist/clients diagnosed with AN. The object could be in the form of drawings, poems, songs, pictures, or artifacts. At the beginning of the interview, I invited participants to tell me about the object they brought and describe it for the audio recording. I also asked them to explain how the object represented or characterized the relationship between themselves and their clients/therapist. This technique aided in eliciting rich information about how the participants viewed their relationship in therapy.

The term *working alliance* was not used during the interview as this term might be “unfamiliar or confusing to participants” (Bedi et al., 2005, p. 313). Therefore, I used the terms *relationship*, *working relationship*, or *therapy relationship* during the interviews. Bedi et al. (2005) also used these terms in their qualitative study when interviewing clients about the working alliance in psychotherapy. The interviews lasted 60 to 90 minutes in length.

All interviews were digitally recorded on two password-protected audio recording devices. To maintain confidentiality, participants were referred to using their pseudonym on the audio recording and in the written report. The audio recordings were stored on the primary researcher’s password-protected computer and deleted once transcribed.

Members of the research team transcribed 13 audio recordings verbatim and I transcribed two. The research team was composed of six master’s-level students currently working toward a degree in Counseling. Their participation was voluntary and provided them with an experience in qualitative research. Prior to transcription, I conducted a training session and reviewed confidentiality, ethics, and steps for transcription to ensure the team members had the proper knowledge to assist in data collection. The audio-recordings were passed between the research team and me; therefore, the audio-recordings were not left unattended. After a team member transcribed the interview, I read it while listening to the audio recording to ensure proper transcription. Additionally, I removed any identifying information in the transcript. The printed transcripts, my reflexive journal, notes, and signed consent forms were stored in a locked filing cabinet in my home; the consent forms will be kept for three years.

After the interviews were transcribed, I contacted the participant via email and attached their transcribed interview, requesting that he/she review it and provide feedback regarding its accuracy to allow for participant checks. Data were gathered until the point of saturation and no new themes emerged. Throughout the analysis, I also contacted the participants via email to discuss and confirm their textural-structural description and the composite description.

Data Analysis

The first step in phenomenological analysis is to take part in epoche or setting aside judgments (Moustakas, 1994). In qualitative research, the researcher is the primary instrument for data collection and analysis (Merriam, 2009); thus, it is important for the researcher to be aware of his or her biases and how they might influence data collection and analysis. Researchers using a phenomenological approach use the term *bracketing*, which is similar to epoche in that the researcher suspends or sets aside his or her own pre-understandings and assumptions of the phenomenon prior to data collection (Vagle, Hughes, & Durbin, 2009). However, I found it difficult to argue that one could completely set aside his or her biases. Although most qualitative researchers would agree that bracketing can never completely do this, the term provides a picture--that one can put a "bracket" around his or her bias and neatly separate it from the phenomenon. This term does not fit well with my own philosophical beliefs that one can separate personal bias from the phenomenon being studied. Thus, I prefer to use Dahlberg's (2006) term: *bridling*. Dahlberg coined this term through her experiences on a horse ranch and suggested that researchers could use the term "bridling" in place of the word "bracketing." However, bridling has a different philosophical meaning:

Bridling means a reflective stance that helps us “slacken” the firm intentional threads that tie us to the world (Merleau-Ponty, 1995). We do not want to cut them off and we *cannot* even cut them off as long as we live, but we must, as Merleau-Ponty encourages us to, loose them up in order to give us that elbow room that we need to see what is happening when we understand phenomena and their meanings. (Dahlberg, 2006, p. 16)

Dahlberg further argued that by bridling, we do not understand too quickly or carelessly and do not make definite what is indefinite. Therefore, the primary issue is not whether we are influencing the phenomenon or not as in bracketing, rather “in what ways we are influencing the phenomenon and in what ways we might bridle our influence” (Vagle et al., 2009, p. 348).

To bridle my bias, I have previously described my personal background with regard to the working alliance with clients diagnosed with AN as well as my personal interest in the phenomenon. Throughout data collection and analysis, I also kept a reflexive journal and noted ways in which I believed I influenced the data collection and analysis of the phenomenon, as well as how the data collection and analysis influenced me as a researcher.

After the interviews were transcribed, I analyzed the data using Moustakas’ (1994) method of analysis. Moustakas’ approach is a modification of van Kaam’s (as cited in Moustakas, 1994) and involves seven steps:

1. *Listing and Preliminary Grouping*: List every expression relevant to the experience (horizontalization).
2. *Reduction and Elimination*: To determine the Invariant Constituents, test each expression for two requirements:
  - a. Does it contain a moment of the experience that is a necessary and sufficient constituent for understanding it?
  - b. Is it possible to abstract and label it? If so, it is a horizon of the experience. Expressions not meeting the above requirement are eliminated. Overlapping, repetitive, and vague expressions are also

eliminated or presented in more exact descriptive terms. The horizons that remain are the invariant constituents of the experience.

3. *Clustering and Thematizing the Invariant Constituents*: Cluster the invariant constituents of the experience that are related into a thematic label. The clustered and labeled constituents are the core themes of the experience.
4. *Final Identification of the Invariant Constituents and Themes by Application Validation*: Check the invariant constituents and their accompanying theme against the complete record of the research participant. (1) Are they expressed explicitly in the complete transcription? (2) Are they compatible if not explicitly expressed? (3) If they are not explicit or compatible, they are not relevant to the co-researcher's experience and should be deleted.
5. Using the relevant, validated invariant constituents and themes, construct for each co-researcher an *Individual Textural Description* of the experience. Include verbatim examples from the transcribed interviews.
6. Construct for each co-researcher an *Individual Structural Description* of the experience based on the Individual Textural Description and Imaginative Variation.
7. Construct for each research participant a *Textural-Structural Description* of the meanings and essences of the experience, incorporating the invariant constituents and themes.

From the Individual Textural-Structural Descriptions, develop a Composite Description of the meanings and essences of the experience, representing the group as a whole. (Moustakas, 1994, pp. 120-121)

To summarize, I first examined each participant's transcript and highlighted significant statements or quotes to better understand how the participants experienced the phenomenon. This step is known as horizontalization. Next, I developed clusters of meaning from the significant statements from which themes were developed. These themes were then used to write a textural description or what the participants experienced. Next, a structural description, sometimes called the imaginative variation, was created to describe the context or the setting in which the participants experienced the phenomenon or how they experienced it (Creswell, 2007). Finally, I combined the textural and structural descriptions and constructed the essence or invariant structure for

all participants. The primary goal for this analysis was for the reader to comprehend the phenomenon and say, “I understand better what it is like for someone to experience that” (Polkinghorne, 1989, p. 46).

Trustworthiness

Lincoln and Guba (1985) and Guba and Lincoln (1989) described trustworthiness as criteria used to judge the rigor of a qualitative study. To increase trustworthiness, four elements must be met: credibility, dependability, confirmability, and transferability. These elements are carefully considered at every stage of the research process including the design, data collection, analysis, and presentation of the findings (Merriam, 2009).

Credibility

When striving for credibility in a study, the researcher attempts to create a match between the participants’ constructed realities and the realities represented by the researcher (Lincoln & Guba, 1985). I enhanced the credibility of this study in several ways: prolonged engagement/saturation, triangulation, and member checks. I also used progressive subjectivity/researcher reflexivity and thick descriptions.

Prolonged engagement, as described by Guba and Lincoln (1989), is having substantial involvement at the site of inquiry, which can discourage misinformation or distortion. Although there was not an actual site of inquiry, rather a phenomenon under investigation, I made sure I had an adequate number of interviews that reached the point of saturation. Another way I enhanced the credibility was through triangulation-- obtaining and analyzing the data from multiple sources, multiple methods, multiple investigators, and/or multiple theories (Lincoln & Guba, 1985).

For this study, I chose to interview multiple participants (both clients and therapists) and used multiple investigators. Another doctoral student served as my co-researcher and we independently analyzed each transcript, identifying the textural-structural description (individual themes) and the composite description (overarching themes). We then compared our independent findings and identified the similarities and differences, discussing the differences until an agreement was made to incorporate the theme or not. Additionally, my research advisor read all the transcripts, textural-structural description, and composite description to aid in peer/expert check.

Member checks, sometimes called participant checks, were used to enhance the credibility and thus the trustworthiness. Member checks are described as “the process of testing hypotheses, data, preliminary categories, and interpretations with members...from whom the original constructions were collected” (Guba & Lincoln, 1989, pp. 238-239). To do this, I returned the participant’s transcription back to him or her to ensure its accuracy and inquired if any information was missing. Additionally, after preliminary findings emerged from the data analysis, I contacted the participants and inquired if the findings fit their experience.

The last two ways I enhanced the credibility included progressive subjectivity/researcher reflexivity and thick descriptions. Progressive subjectivity (Guba & Lincoln, 1989) or researcher reflexivity (Morrow, 2005) highlights the process of the researcher monitoring his or her bias. To do this, I kept a reflexive journal through the process of data collection and analysis. I also used thick descriptions in the written report; Morrow (2005) describes this as “descriptions not only of participants’ experiences of phenomena but also of the contexts in which those experiences occur...the

descriptions relate to the multiple layers of culture and context in which the experiences are embedded” (p. 252).

Dependability

Dependability is described as the stability, or consistency, of how the researcher conducted the study and analyzed the data (Guba & Lincoln, 1989; Morrow, 2005).

Guba and Lincoln (1989) identified that a mature and successful qualitative inquiry would likely experience methodological changes and shifts throughout the course of the study and that these would not be threats to dependability. However, changes and shifts must be tracked and documented so others can understand, evaluate, and judge the decisions made by the researcher(s). The technique used for documenting this process of logic is called a dependability audit (Guba & Lincoln, 1989) or an audit trail (Morrow, 2005). Morrow (2005) described the audit trail as “a detailed chronology of research activities and process; influences on the data collection and analysis; emerging themes, categories, or models; and analytic memos” (p. 252). Therefore, I kept an audit trail throughout the course of the study.

Confirmability

Guba and Lincoln (1989) proposed that confirmability is concerned with assuring data interpretations are “rooted in contexts and persons apart from the evaluator and are not simply figments of the evaluator’s imagination” (p. 243). I established confirmability in several ways. The first way was to keep a confirmability audit or an audit trail (Guba & Lincoln, 1989; Morrow, 2005). Another way included triangulation (Lincoln & Guba, 1985): using multiple participants, perspectives, and researchers. Furthermore, I used reflexivity (Morrow, 2005) through the process of keeping a reflexive journal, comparing

the themes I developed with my co-researcher's themes, and having my chair, Dr. O'Halloran, review the transcripts and themes. These techniques helped illuminate my biases and track how they did or did not influence the data collection and analysis.

Transferability

Transferability is a criterion of trustworthiness that parallels external validity or generalizability (Guba & Lincoln, 1989). However, both Lincoln and Guba (1985) and Morrow (2005) highlighted that qualitative data cannot be generalizable in the conventional sense and that the naturalist, as compared to the conventionalist, cannot specify the external validity of a study. Instead, the qualitative researcher can provide a thick description "to enable someone interested in making a transfer to reach a conclusion about whether transfer can be contemplated as a possibility" (Lincoln & Guba, 1985, p. 316). Therefore, I utilized thick descriptions of the participants, contexts, and data in the written report while maintaining participant confidentiality.

Ethical Considerations

It is important to highlight the precautions and decisions made to create an ethical research study. First, it was essential to be cognizant of the power imbalance that could be created between the participants and the investigator and not exploit the participants because of this power imbalance (Creswell, 2007). To do this, during the informed consent, I explained to participants that their involvement was voluntary; they could cease their participation at any time and would not lose benefits to which they were otherwise entitled. There was also no form of deception in the study; the participants knew the general content discussed during the interviews. Giving the participants the

right to select the format, the location of the interview, and their own pseudonym aided in the power imbalance they might have felt.

I also took steps to maintain confidentiality of the participants: storing audio data in a locked filing cabinet and electronic data on a password protected computer, using only the pseudonym of the participants on the audio recordings and transcripts, training the research team members on confidentiality and ethics, and not using information in the written report that could identify the participants. Moustakas (1994) also noted that allowing the participants to review, confirm, and/or alter the research data with his or her perception of the phenomenon is considered an ethical principle. Therefore, I provided participants with opportunities throughout the study to do this, e.g., reviewing their transcripts and confirming the emerging themes.

Merriam (2009) highlighted that both risks and benefits are inherent when using interviews to collect data: participants might feel their privacy has been invaded, they might feel embarrassed, and/or they might tell things they did not intend to discuss. For example, in my study, one participant disclosed identifying information he asked I take out of the transcript; therefore, I assented. Additionally, to minimize this risk, I reminded participants of their right to discontinue the study at any time and all participants were provided mental health referrals in the case they needed additional support after the interview.

CHAPTER IV

FINDINGS: CLIENTS' AND THERAPISTS' EXPERIENCES

In this study, I explored how clients diagnosed with Anorexia Nervosa (AN) and therapists who work with this population experienced the working alliance in individual psychotherapy. I sought to understand the participants' experiences of the working alliance, what factors influenced its formation, and the essence of this phenomenon. I collected data through semi-structured interviews with eight client and seven therapist participants.

I utilized phenomenology methodology to guide this study. This approach helps the researcher explore “how human beings make sense of experience and transform experience into consciousness, both individually and as shared meaning” (Patton, 2002, p. 104). According to Moustakas' (1994) method of analyzing data using a phenomenological approach, one must first understand the participants' individual experiences, called the individual textural-structural descriptions, prior to understanding the shared meanings, referred to as the composite description. Therefore, in this chapter, I review the textural-structural descriptions for each participant beginning with the client participants and followed by the therapist participants. I first provide background information for each participant followed by his or her description of the therapeutic working alliance. I then review each participant's identified factors that were helpful and unhelpful in building the therapeutic working alliance.

To enhance the trustworthiness of the findings, I employed member checks and emailed the participants their individual textural-structural descriptions. I asked that they review my interpretations and provide feedback. Four therapists and two clients replied about their individual textural-structural description; all stated that my interpretations were accurate and no new information was provided.

Individual Client Participants

Jessica

Background. Jessica is a 20-year-old, Caucasian female of Greek descent. She is currently a full-time college student and works part-time at a jewelry store. We met via Skype to conduct the interview; she was interested and willing to share her experience about her individual therapy and the process of building a relationship with her therapist. Jessica was diagnosed with AN approximately seven years ago at age 13. During the past seven years, she was hospitalized four times and had two different outpatient therapists. She has worked with her current therapist, Dr. Jones, for the last four years with the exception of a short time period when she “left” and saw another therapist; however, she eventually returned to her.

At the beginning of her work with Dr. Jones, they met twice weekly. At the time of the study, they were meeting once per week, totaling over 150 sessions together. At first, Jessica did not want to be in treatment; however, because she was a minor, her mother made her attend therapy sessions and the hospitalization treatment program. Currently, she is seeking treatment of her own volition. I sent Jessica her transcript, individual themes, and composite description (i.e., overarching themes among client participants) and invited her feedback. She provided feedback about her transcript,

stating it was accurate, and made minor edits where the audio recording was inaudible; however, she did not have feedback on her individual themes or composite description.

Description of the alliance. Prior to the interview, I asked Jessica to think about an object or artifact that represented the relationship she has with Dr. Jones. During the interview, Jessica described the object as a little, heart-shaped rock. She stated Dr. Jones gave her this rock during a therapy session and told her to use it during times of difficulty. Jessica shared she kept it in her pocket and pulled it out when she went through a difficult time, e.g., trying to complete eating a meal: “She [Dr. Jones] would say that it was like her being with me and helping me complete that.”

When describing the relationship at the beginning of therapy four years ago, Jessica stated she was “really, really cautious,” “didn’t like her [Dr. Jones],” and “didn’t open up with her.” Furthermore, she stated, “[it was] one hour that I had to get through to make my mom happy.” Over time, she took ownership of her recovery and began to trust and open up to Dr. Jones. She explained it took two or three years until she could fully disclose about her past trauma. Currently, she believes Dr. Jones cares about her; she said she really cares about Dr. Jones. She also described their current relationship as a friendship even though “she’s the therapist and I’m the client.”

Helpful therapist factors.

Care. Jessica explained that it was important to know Dr. Jones cared about her. One way Dr. Jones conveyed her care was being available via phone or text any time of the day or night. Jessica stated, “Not only does she allow me to text her and call her, but she wants me to.” She also relayed Dr. Jones’ response helped build their relationship and trust. Another way in which Dr. Jones conveyed care was when she hospitalized

Jessica. When doing this, Dr. Jones explained her decision in a way that helped Jessica understand she was not trying to “save herself from the liability issues. I guess she really cared about my well-being.”

Holding the client accountable. Another therapist factor was that Dr. Jones always followed through with what she said she was going to do. For example, she stated previous therapists threatened to hospitalize her but did not follow through. Dr. Jones was different in that “she really does what she says she’s going to do. And while I hate that, I kind of appreciate that because it makes me realize that she does care.” Jessica also described how this helped her trust Dr. Jones and feel safe: “I was literally dying in front of my other therapists... and [they] accepted all the lies that I was saying to them. But Dr. Jones, she won’t let me fall too far.” When Dr. Jones followed through, Jessica recalled having a negative response; however, given time, it helped create a predictable environment in which she felt safe.

Empathy and genuineness. Jessica relayed it was meaningful when Dr. Jones presented herself as a person with feelings, who could connect, versus a detached, disconnected doctor. Jessica described this as “more of a human interaction as opposed to something so textbook.” Dr. Jones did this when she showed genuine emotion and cried with her during one of their sessions; it helped Jessica see she was a human being who cared. Dr. Jones self-disclosed about personal information, e.g., what her favorite color was or what types of food she liked or did not like. Once, she asked Dr. Jones about her personal history with an eating disorder; however, Dr. Jones told her she was not sure if she should disclose that information and asked Jessica if she could think about it for a while. Jessica explained Dr. Jones did not disclose this piece of her personal life;

however, it did not really matter nor did it impact their relationship. Jessica appreciated her flexibility with self-disclosure as it helped create a genuine relationship.

Helpful client factors.

Readiness for change. When Jessica transitioned from being forced to go to therapy to choosing to go to therapy, her relationship with Dr. Jones shifted. She described after her last hospitalization as she told herself, “Something has to change.” She stated once she took ownership of her treatment and recovery, it positively affected the relationship.

Honesty. Jessica explained that at the beginning of treatment, she was not honest and open with Dr. Jones about her eating disorder behaviors. She told her everything was “fine and obviously it wasn’t.” Over time, she was more open with her and told her if she restricted her food intake or started losing weight. She stated this helped build trust between them and created an environment in which she could disclose about her struggles.

Unhelpful therapist factors.

Lack of accountability. Jessica described several therapy relationships prior to that with Dr. Jones in which she was able to “get away with so much.” She explained her mother told her therapist she was not eating lunch at school. When the therapist questioned it, she lied to her and told her she was eating it. However, Jessica stated it was apparent she drastically lost weight and her therapist said, “Oh, okay. Alright,” and did not question it further. She also described a situation in which a previous therapist questioned her weight loss. However, she made up a story about when one starts eating more food, his or her metabolism starts speeding up. Since she was increasing her caloric

intake, she was probably burning more calories and losing weight. She remembered her therapist saying, “Well, okay,” and Jessica thought, “Oh my God. I can’t believe she’s running with this information.” While she stated her eating disorder loved these types of therapists, it made her second-guess her therapist’s skill level and trust her less. In turn, this lack of trust negatively impacted the alliance.

Lack of physical responsiveness. Another unhelpful factor Jessica described was when Dr. Jones did not physically console her (i.e., give her a hug). She recalled several occasions when she cried, struggled, and had a difficult time during a session. Dr. Jones “would sit back and watch me struggle.” Occasionally, Dr. Jones handed her a box of tissues; however, Jessica thought, “Damn it. If you cry, you go up to them and give them a hug and console them.” Furthermore, when Dr. Jones did not offer a hug during these times, Jessica wondered, “Maybe she doesn’t care about me,” and pondered if she was “cold” and not a “warm person.”

Focusing too much on the eating disorder. Several times, Jessica recalled that Dr. Jones focused too much on the eating disorder behaviors and too little on other things. For example, Jessica described a session in which she told Dr. Jones about a difficult week she had as she did not follow her meal plan. She stated, “That was ALL she wanted to talk about; me not following my meal plan! And she wouldn’t want to address anything else.” While Jessica understood this was a serious disorder and restricting was a necessary discussion, she wanted to talk about what was going on “inside my head, and doubts, and what I wanted to address.” Jessica explained when Dr. Jones wanted to focus solely on restricting food or losing weight, it gave her the wrong

impression: “She’s really only invested in my eating disorder and me following the cookie-cutter symptoms of recovery.”

Not giving second chances. Jessica explained she “left” Dr. Jones once to look for another therapist because she did not give her a “second chance.” To further explain this, Jessica illustrated a time when she was not doing well and Dr. Jones “threaten[ed] if I didn’t get my shit together in two days, she would immediately hospitalize me and call the place [the hospital] when I was sitting there.” She described even though it was serious, Dr. Jones did not let her explain what was going on; it angered and frustrated her as well as made her bitter. Jessica stated only one of the four times she hospitalized her was “truly necessary,” due to health concerns, and she wished Dr. Jones gave her more second chances. Although Jessica eventually went back to work with Dr. Jones and is still working with her, she described this was one of the primary reasons she left--Dr. Jones did not allow her space to explain her perspective or an opportunity to express her feelings about being hospitalized. When discussing why she returned to Dr. Jones, she stated, “After my last hospitalization...I realized how skilled my therapist [Dr. Jones] was and how much she really cared about me, so I went back to her.”

Unhelpful client factors.

Fear. Jessica described that at the beginning of therapy, she was scared to open up about her past trauma and did not want some things to be uncovered. She also did not want to give up her eating disorder because she thought, “Bad things would happen again,” meaning she did not want the trauma to occur again and used her eating disorder as a way “to disappear and...cope with the situation.” This fear made it difficult for her to fully open up to Dr. Jones and form a truthful and open relationship. Jessica also

avoided talking about things that were scary or difficult. One way she did this was when she over-focused on Dr. Jones and questioned if she had a history of an eating disorder. Although Dr. Jones never answered this question, Jessica hypothesized if she had, she might have easily focused on “Was she sicker than me? What was her lowest weight?”; it could have become a competition between her and Dr. Jones. Jessica also feared she might be too much for Dr. Jones to handle and worried she might “pass me off to someone else.”

Malnourishment and lack of self-worth. At the beginning of their work together, Jessica stated she was severely underweight, which affected her memory. She could not remember things from session to session and was not “thinking correctly.” Fortunately, Dr. Jones helped her remember and told her, “You said this.” However, being malnourished made it difficult to build a relationship with Dr. Jones early in treatment. Jessica also said many times throughout therapy, she did not feel worthy of life, happiness, or being healthy. This negatively impacted her ability to form a relationship with Dr. Jones and feel worthy of her time, attention, and care.

Lying about or admitting behaviors. Jessica struggled with the decision to tell Dr. Jones if she acted on eating disorder behaviors (e.g., restricting) or not. For example, if she lied about not completing a meal and Dr. Jones found out, it “would not do anything for our trust.” On the other hand, if she was honest and admitted to acting on behaviors, e.g., self-harming or not following her meal plan, she felt like there were negative “consequences in the relationship,” which she preferred to avoid. Due to this, she shared how either decision negatively impacted the relationship.

Snow

Background. Snow is a 45-year-old Caucasian female. She has had eating problems since she was in elementary school, which she did not describe in detail, and became aware she had an eating disorder at age 17. She received a formal diagnosis around age 19 when she first sought treatment. When Snow initially sought counseling, it was because her boyfriend forced her to go; however, she noted it did not work because it was not her choice and she was not ready. Snow's treatment history included attending a residential treatment program and working with several outpatient therapists prior to her current one. Currently, Snow seeks treatment on her own. She has worked with Susan for five years, seeing her once a week or once every other week for a total of over 200 sessions together. Snow is a vice president for a consulting company and has a master's degree. She and I met via phone to conduct our interview. After the interview, she did not respond when I asked for her feedback regarding the accuracy of her transcript, individual themes, or composite description.

Description of the alliance. The object Snow chose to symbolize the relationship with Susan was a small, gray rock. To Snow, a rock symbolized a touchstone--something one can rub to become more mindful and help deal with stress and worries. She described Susan as her touchstone and stated she helped bring reality and objectivity back to the situation. When she described the relationship, she stated there was a lot of trust between them; Susan helped her become "more self-actualized."

Helpful therapist factors.

Individualized treatment. One factor Snow highlighted was Susan individualized treatment specifically for her and her needs. Snow described one example of this:

I'm sure lots of anorexics do this where you just beat yourself up. You're convinced nothing's good enough and you're so trapped in those negative feelings and outlook and perceptions. And she [Susan] was really good at turning that around, and she would say, "What would you do if you're daughter said those things to you?" It was very difficult for me to get into the mindset of what I would say to myself as a child until I was able to make that connection with an actual child. And she's the first therapist who did that because she put it in context with me with my own daughter. And I said to her, "Well, of course I would say XYZ," and so then she would say to me, "Okay, well if that's what you would say to her, now imagine she is little you." And being a mother, it's so important to me, and so much a part of my identity, and she clearly understood that and was able to put things into context for me. Where for so long I have not been able to do that for myself; to be kind to myself and to be forgiving of myself. But she was able to put in a perspective where I almost could relate to it as though I was mothering that younger version of me.

Snow described this as being a "significant key" to her recovery; it also made her feel like Susan understood her and the relationships that were important to her. Other ways Susan individualized treatment included when she provided a hug (after asking permission) when Snow was upset and had a panic attack, as well as when they had a few sessions via phone when Snow was traveling.

Invested. Another factor that helped build their relationship was when Susan demonstrated she was genuinely invested in helping Snow and her recovery. One way Susan did this was checking in on Snow throughout the week via email or phone at the beginning of treatment. Although she stated she almost never responded; "just knowing she cared enough to check was very meaningful." Another way Susan was invested in her was when she remembered topics or information discussed in previous sessions. Additionally, Snow noted it helpful when Susan was available to talk on the phone during an emergency.

Genuineness and humor. Snow described Susan's genuineness and authenticity as helpful in alliance formation. She described Susan as "very honest, authentic, and

frank, and the kind of person whom I can work with.” For example, she stated Susan often “dropped the f-bomb” and she appreciated it because it was authentic. Susan also brought humor into their sessions and pointed out humor in situations. Many times Snow began the appointment and stated, “The world is ending!” and Susan replied, “That sounds like another AFGO: Another Fucking Growth Opportunity.” For Snow, this helped bring levity to the situation in a non-threatening way, and enabled her to view Susan as a real and humorous person.

Specialist in eating disorders. Snow described Susan as a specialist in eating disorders and stated it helped their relationship. Since Susan knew so much about eating disorders, she “heard all the lies...all the games, all the bullshit. You can’t fool her.” This helped Snow feel safe and she trusted Susan to hold her accountable. To illustrate, if Susan noticed Snow falling back into patterns or behaviors, she confronted her: “She doesn’t pull any punches.” Snow also explained nothing shocked or fazed her. For example, during session, Snow told Susan things to test what her reaction would be and Susan did not judge her or appear shocked or horrified. Lastly, Susan worked collaboratively with other eating disorder professionals. At one point, Snow needed a higher level of care—an intensive outpatient program. Snow described because of her family and work, she could not attend the entire outpatient program; therefore, Susan worked collaboratively with the program and “tag-teamed” Snow’s treatment so Snow could attend some of the intensive outpatient groups as well as continue individual treatment with Susan.

Confrontation. At the beginning of their work together, Snow skipped several appointments. Due to her absences, their schedule was “messed up” and Susan “called

her on it.” Snow remembered that Susan said, “I need to know if you’re serious about this, because if you don’t want to commit, that’s fine, but this isn’t going to work.”

When Susan did this, Snow described it as upsetting and it negatively impacted the relationship; however, when looking back on it, Snow noted it was exactly what she needed in that moment for her recovery. Therefore, even though she labeled it as unhelpful in the moment, looking at the big picture, it was helpful for their relationship.

Helpful client factors.

Verbalizing needs. Snow discussed verbalizing her needs and identified this as helpful to the relationship. A few years ago during a session, Snow asked Susan if she could have a hug; Susan said, “Absolutely,” and hugged her. Snow also brought to Susan’s attention that she needed a higher level of care such as an intensive outpatient program. She described how it was helpful to open up and share her needs, and stated it took their relationship to the next level.

Taking ownership of recovery. Another factor that positively impacted the relationship was when Snow took ownership of her recovery. One way she did this was when she bought a recovery workbook, completed the activities on her own, and brought them to session. She noted had Susan asked her to do it, she probably would not have; however, because it was her decision, it highlighted her investment in the process and in the relationship. She also explained that being honest about her eating disorder behaviors also conveyed her dedication to recovery and helped the alliance.

Unhelpful therapist factors.

Lack of focus on the eating disorder. Snow described her experience with a therapist prior to Susan; that therapist focused on everything but the eating disorder. For

example, her therapist focused on Snow's marriage problems and other life stressors; however, she did not work on her eating disorder or its underlying causes: "I was only dealing with the surface issues and not even remotely dealing with the underlying issues." Snow highlighted while she addressed the surface-level issues, she did not work on deeper issues, which affected her trust and belief in the therapist.

Unhelpful client factors.

Uncommitted and refusing recommendations. When she first began to work with Susan, Snow made it difficult because she was not committed to a regular schedule. At the time she thought, "What difference does it make as long as I'm coming?" However, she now recognized this made forming the relationship difficult; by not meeting regularly, "You almost have to start over again every time." Toward the beginning of therapy, she refused Susan's recommendations to work with a nutritionist and take medication. Currently, she does both, which she highlighted were influential in her recovery; however, at the beginning, she refused to trust Susan's judgment.

Avoiding talking about behaviors. Another unhelpful behavior in the relationship was when Snow avoided talking about her eating disorder behaviors. Because she had many underlying issues she needed to deal with, it was easy to avoid talking about the eating disorder symptoms and behaviors she was struggling with. She stated, "I avoided them [talking about behaviors] at all costs."

Cody

Background. Cody is a 53-year-old Caucasian male who was diagnosed with AN around the age of 50; however, he struggled with a negative body image and disordered eating since he was in middle school. He earned a bachelor's degree and

currently works in the banking industry. Prior to working with his current therapist, he had other individual therapists and attended an inpatient treatment program for eating disorders, which he referred to as “rehab.” He has worked with his current therapist, Sherri, for about a year and a half; they have had about 30 sessions. Cody also attends ‘Celebrate Recovery’ in conjunction with individual therapy. When he first sought treatment, he went at the encouragement of his family and a friend since he did not think he needed help or had a problem. Presently, he seeks treatment on his own and recognizes he has an eating disorder. Cody and I met via phone to conduct the interview. During the interview, he was willing to share his experiences and was open about his opinions and views. He provided feedback about his individual themes and agreed with the interpretations; however, he did give feedback regarding his transcript and the composite description.

Description of the alliance. Prior to our interview, I asked Cody to think about an object or objects he thought symbolized the relationship between him and Sherri. He chose a rock and an encyclopedia to symbolize their relationship. He said Sherri had helped him through several relapses and was a person whom he could depend on. Cody also chose an encyclopedia because “she has all the answers” and can “help me find the answers that I need.” At the beginning of his work with Sherri, he did not think he had a problem and did not want to be in therapy. He also did not trust therapists or thought they cared; however, after working with Sherri, he described their alliance as “a real and honest relationship” as well as “a team.”

Helpful therapist factors.

Dependable and straightforward. Cody highlighted that Sherri's dependability and availability were helpful. Sherri allowed Cody to email or call her if he had a problem and she called or emailed him back. Additionally, she was straightforward with him and he appreciated that. For example, when Sherri provided him information and feedback, he stated, "She's on my level...She doesn't use big words that no one understands. She just says this is the way it's going to be." He also commented several times that he appreciated when Sherri "argued" with him, expressed her opinion, and did not hide anything.

Balanced pushing and giving space. Cody discussed that Sherri was good at knowing when to "push his buttons" and when to give him space. He described an incident where he was "skirting around a topic" and Sherri confronted him. But when she realized he was not ready to discuss the topic, she told him they would address it another day. Cody also expressed that sometimes he told her nothing was wrong and she said, "I can tell something is wrong today. Spit it out." He stated having a therapist who was able to balance both pushing and giving him space was helpful in building the relationship.

Specialized in eating disorders. Another factor Cody identified as helpful was that Sherri specialized in treating eating disorders. He described his previous therapists provided recommendations without explaining why; however, Sherri showed him "proof" and explained where she found the information or described her experience with other clients with eating disorders. Other things she understood because she had experience included relapse and body dysmorphia. Oftentimes, Cody was discouraged because he

relapsed but Sherri normalized it and explained she expected relapse. She also helped him understand it could take 7 to 10 years to train the brain to eat normally, which helped him understand the disorder and the time it could take to recover. Cody also experienced it as helpful when Sherri challenged him with food. For example, during a session, she brought in ice cream sundaes, which Cody was “scared to death of.” They ate ice cream together during session as well as a candy bar the following week.

Collaboration with treatment team and family. Cody identified collaboration with external support as helpful. For example, Sherri communicated regularly with other members of his treatment team, which consisted of a nutritionist and a doctor. He stated it kept him honest about his progress and behaviors. Additionally, Sherri incorporated Cody’s family into a therapy session. She helped them understand the disorder and encouraged them to voice their concern for him. By collaborating with these other support systems, Cody felt supported and understood by Sherri, which strengthened their relationship.

Helpful client factors.

Engagement. Cody said as he became more comfortable with Sherri, he shared more information and engaged in the therapeutic process. For example, he explained as he opened up about his past, Sherri said, “I knew there was something else. And with you answering and telling me this, it answers a lot of my questions.” He also argued with and questioned Sherri; however, from Cody’s point of view, he believed she enjoyed this as it evidenced his engagement in their relationship.

Honest about behaviors. Another factor Cody highlighted as helpful was being open and honest with Sherri. At the beginning of treatment, he did not disclose acting on

eating disorder behaviors, especially when he gained weight and felt scared. However, more recently, he talked to Sherri about his fear before he acted on behaviors or if he engaged a behavior, he was honest with her.

Unhelpful therapist factors.

Pushing and challenging. At the beginning of their work together, Cody highlighted the difficulty whenever Sherri brought up the idea of him going back to “rehab” for his eating disorder. Cody used the word “rehab” instead of calling it “inpatient” or “residential treatment.” He described times when Sherri insisted he go to “rehab” and he became extremely angry: “I got mad and left. I told her she didn’t know what she was talking about and I didn’t need to go, and when she came to her senses I would be back.” Several times he told her, “I’m not coming back to you. I’m through with you.” However, Sherri let him “cool off,” called him within a few days, and said, “I expect you back in my office,” and he went back. Cody noted while Sherri’s insistence negatively impacted their relationship in the moment, he wondered if he had taken her advice, he might be further along in recovery.

Lack of knowledge and experience. Prior to seeing Sherri, Cody had another individual therapist. He stated this therapist diagnosed him with anxiety and depression and used these diagnoses to explain his 30-pound weight loss. Cody explained the therapist said, “You’re depressed. There’s nothing wrong with you except depression and anxiety.” Cody also noted Sherri once told him she thought the previous therapist knew he had an eating disorder but did not know how to handle it. Cody stated this lack of understanding and experience made it difficult to trust the previous therapist and, therefore, form a strong alliance.

Unhelpful client factors.

Dishonesty by omission. Several times during treatment, Cody dodged questions posed by Sherri, changed the subject, or tried to get out of the session “as fast as possible.” He stated by doing this, he did not exactly lie; rather, he did not provide an answer. Furthermore, if Sherri did not ask about eating disorder behaviors, he believed he did not need to tell her if he acted on them. Cody described one experience in which another person on his treatment team discovered he was trying to lose weight. Therefore, he admitted his behaviors to Sherri because she was going to find out “one way or another.” Although this experience injured the trust between Cody and Sherri, he acknowledged it helped him be honest and forthcoming in subsequent sessions.

Questioning the therapist. Another unhelpful factor was when Cody questioned Sherri’s knowledge and understanding, and asked if she had a history of an eating disorder. For example, one day when they did not have a good session, Cody asked, “How do you know all this stuff? What makes you think you have all the answers? Have you lived it?” He also said, “You’re full of bull,” got mad at her, and walked out. Cody recognized when he did this, it prevented him from talking about a difficult topic, which made it difficult for the relationship to grow.

Melissa

Background. Melissa is a 30-year-old Caucasian female who was diagnosed with AN at age 16 or 17. Her previous therapy included an intensive outpatient day program, individual therapy, group therapy, a support group, and seeing a psychiatrist for medication. Currently, Melissa’s individual therapist is Martha, whom she has worked with for 10 years. For many years, they met once per week; however, more recently, they

meet once every two or three weeks, totaling over 300 individual therapy sessions. Martha was initially her group therapist; as she became more comfortable with Martha, she asked her if she would be her individual therapist as well. Prior to seeing Martha, Melissa's mother forced her into treatment because she was a minor. Currently, she seeks treatment on her own, both group and individual therapy, and Martha is her therapist for both. Melissa's highest level of education is a master's in Social Work and she is employed as a social worker.

Interestingly, Melissa met the criteria to be included in this study as both a therapist participant and a client participant; however, she contacted me with the intent of sharing her experience as a client. Therefore, Melissa was included only as a client participant. Melissa did not provide feedback about the accuracy of her transcript or the composite description; however, she did state the individual themes I identified were accurate. Although, she added a few clarifying sentences to the themes, the additions did not change the meaning or interpretation.

Description of the alliance. The object Melissa chose to represent the relationship between she and Martha was Lego blocks. Melissa explained she was "the little bumps" on the block and Martha was the other block that covered her because she helped her out with things. Melissa also noted the bumps on the block looked like teeth, which reminded her, at the beginning of therapy, Martha had to "pull my teeth," meaning she asked many detailed questions because it was difficult for her to open up and share. Melissa said it took a long time to build the relationship and trust that Martha was not going to tell her mother what they discussed since she was a minor at the beginning of therapy. Currently, she described their relationship as trusting. She also knows they are

not “equals because she’s my therapist” but viewed their relationship as more of a mentorship because Melissa is a social worker.

Helpful therapist factors.

Acknowledging positive steps. A helpful therapist-facilitated factor Melissa depicted was when Martha acknowledged the positive steps she took:

It’s the little things. Acknowledgement is very important. If they [clients] did something good, acknowledge it, even if it’s the tiniest thing. Because somebody else in their life may not acknowledge it, and they may need it from their therapist.

For example, Melissa stated if she took an extra bite at lunch, or did not binge, or if she sat 20 minutes longer before purging, it helped when Martha acknowledged her progress. When Martha did this, Melissa felt understood as well as hopeful in making changes.

Earning trust. Due to Melissa being a minor at the beginning of therapy, Martha was legally able to disclose to her mother topics they discussed in therapy. This was scary for Melissa because she had difficulties with her mother and did not want her to know certain things. Martha asked her, “What if your mom calls me? What do you want me to tell her?” prior to her mother actually calling. She appreciated that Martha thought about this as it allowed her to have a voice in the decision-making process. She also stated, “That was really helpful and also proved to me that I could trust her.” On a few occasions, Martha told her mother about some things they discussed; however, she first told Melissa she was going to do it and explained her decision in a way that portrayed care rather than to “threaten” or “punish” her.

Previous contact. Another factor Melissa highlighted as helpful was she knew Martha prior to their individual work. When she discovered Martha saw some of the group members for individual therapy, she pursued individual therapy with her as well.

Melissa described that she was already comfortable with her because she knew how she communicated and led sessions, and she was knowledgeable about treating eating disorders. Previous contact with Martha appeared to help Melissa feel comfortable and trusted Martha was competent when working with clients with eating disorders.

Genuine care. Melissa said it was helpful when Martha showed her genuine care for Melissa as a person. One way she did this was when she talked to Melissa about attending an intensive outpatient program instead of seeing her in individual outpatient. Melissa recalled, “I didn’t feel like she was just throwing me off, like, ‘Alright, go there instead of coming to me.’ I remember feeling that she still wanted to see me...wanted to keep me as her client.” She also explained she knew Martha genuinely cared about her because of her tone--the emotion on her face changed when they talked about something hurtful.

Helpful client factors.

Choosing your own therapist. Prior to seeing Martha, Melissa worked with other therapists whom her mother chose for her. After attending group therapy sessions with Martha, she made the decision to change to Martha: “Because I picked her, I guess I always trusted her to begin with...now it’s my choice, my decision.” Melissa’s investment and autonomy in choosing her therapist was important to her and thus aided in building the trust and the working alliance.

Trusting the therapist’s advice. Another helpful factor was being able to trust Martha’s advice and judgment. Several times throughout treatment, Melissa had to make difficult decisions, e.g., whether or not to attend an intensive outpatient program or take

medication. She asked Martha for advice and found it helpful to hear her opinion and then follow through based on her feedback.

Attending appointments. Melissa stated simply attending her therapy sessions was helpful in building the relationship with Martha: “I think actually going to appointments when I really didn’t want to. I think that helped build the relationship because there were definitely times when I wasn’t so compliant with coming on a weekly basis...it was really hard.” She also highlighted the importance of not canceling appointments and attending them on time.

Honesty and respect. Melissa said repeatedly that it was important to be honest with Martha and not lie to her: “I will not lie to her. I can honestly say I will not lie to her. Because I feel like it could hurt our relationship and it could hurt me.” She also highlighted, along with being honest, the idea of being respectful: “I think the most important thing in the relationship is being honest and being respectful.”

Unhelpful therapist factors.

Naïve/gullible. One unhelpful therapist factor Melissa discussed was if the therapist was naïve or gullible. Although she never experienced this problem with Martha, she described having this problem with previous individual therapists. Melissa explained how she “BS’d” her previous therapist and told her everything was “totally fine, hunky dory.” The therapist believed her and did not question her. Due to this, she reported not caring for this therapist because she did not challenge her. She also highlighted that this therapist never made her “see anything” and did not provide insight into her problems or struggles.

Forcing change and judging. Melissa discussed the importance of pacing treatment. She described when her therapist forced change, it was unhelpful to the relationship. She instructed, “Don’t try and change them [the clients] if they are not ready.” She also explained her therapist’s judgment affected the relationship negatively.

Unhelpful client factors.

Feeling unworthy. One client-facilitated factor Melissa identified as a barrier was her sense of unworthiness. For example, Melissa stated, “I was always afraid that I wasn’t good enough.” She went on to explain, “One of the problems was thinking that the eating disorder wasn’t bad enough; that I wasn’t bad enough. Maybe I didn’t need her help, or that she should be dealing with somebody else that needs more help than me.” While Melissa recognized she needed help, she explained how lack of self-worth made her question whether she was “bad enough” to deserve treatment or Martha’s time. Melissa further explained that at times, she wondered if Martha wanted to treat her. She recalled thinking, “She [Martha] doesn’t really want to be here treating me. She’d rather be treating someone else. I’m not good enough in my eating disorder, so she should see somebody who needs her more.” Melissa clarified Martha never said or did anything that provided evidence of these beliefs; rather, it was due to Melissa’s insecurities.

Denial. Melissa acknowledged her denial about having an eating disorder negatively influenced the relationship. She explained prior to treatment with Martha, she was “forced” into therapy by her mother and did not believe she had a problem. She stated because she did not think she had a problem, she was not ready and willing to cooperate. Melissa remembered thinking, “My mom put me here. Why the hell would I talk to this lady?” Melissa also identified the lack of choosing her own therapist was an

unhelpful factor. Prior to Martha, her mother chose her individual therapists; however, after Melissa began group with Martha, she began trusting and chose to work with her.

Fear of therapist breaching confidentiality. Due to Melissa's unique experience of having Martha as both her individual and group therapist, she explained this brought up fear about boundaries and confidentiality. She shared that sometimes she did not discuss a topic in individual therapy for fear Martha might bring it up in group. Melissa remembered thinking, "If I bring something up in individual therapy, will she then say something in the group?" Fortunately, Martha never did this. Rather during their individual sessions, Martha questioned, "Can I bring this up in group?" and asked her permission first. Melissa explained that while it was helpful, it was "very nerve wracking because I wondered if they [the group members] are going to know that's me?"

Dishonesty. Melissa identified dishonesty as unhelpful to the therapy relationship. For example, in previous therapy relationships, she told her therapists she was "totally fine, hunky dory" when in reality she struggled with eating disorder behaviors and self-harm (i.e., cutting). Melissa also evaded questions or told her therapists, "I don't want to talk about it." She described she was dishonest with them because she feared repercussions, e.g., the therapist telling her mother or hospitalizing her.

Laura-Leigh

Background. Laura-Leigh is a 54-year-old Caucasian female. We met via phone to conduct the interview. She was excited to be a participant in the study as well as share her experiences in therapy. Laura-Leigh was diagnosed with AN at age 23; however, she

began a pattern of disordered eating when she was 17-years-old. Her treatment history included two hospitalizations and individual therapy with several different therapists.

Her current therapist is Dr. Moore whom she has seen for about 14 years, totaling over 500 sessions. Laura-Leigh stated Dr. Moore is a psychiatrist; however, she provided her medication and individual 50-minute therapy sessions. At the beginning of their work together, they met once a week; however, when Laura-Leigh's eating disorder behaviors lessened and her weight was stable, they met once every two weeks. Currently, they meet about once every two months. Laura-Leigh disclosed she sought treatment on her own and was not forced by anyone. Her highest level of education is an associate's degree; she currently works in the banking industry. Laura-Leigh provided feedback about her transcript and composite description. She also made minor grammar edits to her transcript and reported the composite description accurately depicted her experience. She did not provide feedback about her individual themes.

Description of the alliance. Prior to our interview, I asked Laura-Leigh to think about an object that symbolized the therapy relationship with Dr. Moore. During the interview, she described children's toys, e.g., stuffed animals and little puzzles. She chose these because Dr. Moore treats many children patients and because of this, her office is filled with toys. She also noted Dr. Moore moved offices several times; however, every time, she took the toys with her and put them in her office. Prior to seeing Dr. Moore, who is female, Laura-Leigh had only worked with male therapists and felt comfortable with them; however, she explained she was surprised when she started working with a female therapist and felt calm and relaxed. When describing their

relationship, she stated it was a formal doctor/patient relationship; however, Dr. Moore self-disclosed some information, which made it feel less formal.

Helpful therapist factors.

Relatability and warm presence. Laura-Leigh discussed helpful therapist-facilitated factors in building the alliance. One of these factors was the ability to relate to Dr. Moore. Several reasons she related to her was because they were close in age, both women, and they had had similar life experiences such as getting divorced. It appeared being the same gender helped Laura-Leigh feel connected and made her feel like Dr. Moore understood certain things because of this similarity. Laura-Leigh described this ability to relate when she said, “Of course it helps [for the therapist] to have had an eating disorder...it gives [the therapist] more of an understanding into what the patient is dealing with”; however, she did not say if Dr. Moore disclosed about her own history related to the disorder. To her, having a therapist who could truly understand and relate to her was helpful. Laura-Leigh also shared that her warm presence was helpful. For example, she described Dr. Moore as laid-back, relaxed, soft-spoken, gentle, and non-judging. She highlighted that these characteristics helped her feel safe and were vastly different from her mother, with whom she had a difficult relationship. Laura-Leigh also included a warm office environment as a helpful factor. She explained, “The office has always been comfortable. It’s never been a stark, cold office. It’s always been warm.”

Holding a neutral and non-challenging position. When discussing Dr. Moore’s approach to therapy, Laura-Leigh shared she held a “neutral position” and gave her a voice in treatment. To illustrate, Laura-Leigh described how she was, for the first time, able to verbalize her true feelings about her mother and not feel judged or criticized: “It

was the first time in my life that I ever talked with someone who I could share with, that I couldn't stand my mother, and she [Dr. Moore] had a totally neutral position.” She also shared it was helpful when she talked about her binge and/or purge episodes and Dr. Moore was neutral and did not judge her. Furthermore, Dr. Moore was not forceful or challenging with regard to attending group therapy or an inpatient program; she let her have a voice in her own treatment, which she described as helpful. However, directly after Laura-Leigh stated this during the interview, she said, “Maybe I could have done better [in recovery] if I had had someone who would have challenged me a little more. I don't know.”

Hopeful and strengths-based. Another factor Laura-Leigh highlighted as helpful was when Dr. Moore reassured her and gave her credit for the progress she made. She explained Dr. Moore had a “reassuring way” that helped her see things could get better, even though she struggled with several diagnoses (i.e., AN, depression). Laura-Leigh shared it was helpful when Dr. Moore pointed out the progress she made and highlighted the positives. Furthermore, she explained Dr. Moore never gave up on her, even when it felt like they were not “making headway.” She stated, “When you're a therapist, don't ever give up on the person if they have an eating disorder. Sometimes with what's going on with them, that [the therapy relationship] might be their only lifeline, if they come and have a safe place to talk.”

Helpful client factors.

Attendance and engagement. Laura-Leigh explained attending sessions and being engaged was helpful in establishing a therapeutic alliance: “I always showed up for my appointments. That's pretty basic...I'm very dependable.” She further described it

was helpful when she willingly engaged in the therapeutic process. To her, this included behaviors such as talking and listening during sessions.

Honesty. Honesty was another helpful client factor Laura-Leigh described. She explained she always tried to be honest in session, even when it was difficult. For example, during one session, Dr. Moore said something that upset her; Laura-Leigh confronted her about it and let her know it bothered her: “I told her what she had said and that I was offended by it, and we talked about it. I was satisfied with what she told me and I believed her.” It seemed impactful when Laura-Leigh was honest and verbalized her feelings and then allowed Dr. Moore to explain.

Giving up control. Although difficult for Laura-Leigh, she discussed giving up control was a helpful factor. She stated, “If someone is very, very underweight, to a certain extent they have to give up control to those who are taking care of them, because otherwise they probably won’t survive.” She also shared her own personal experience: “I was at the point where I was about 75 pounds and I couldn’t do anything. I couldn’t work, go to school, and I was bingeing and purging all the time. So I needed that [to give up control].”

Unhelpful therapist factors.

Scheduling sessions far apart and discussing termination. Laura-Leigh shared because she had “many, many sessions” with her therapist, she had the unique experience of seeing her therapist in different increments: once a week to once every two and a half months. While she recognized she might not need to meet with Dr. Moore every week, she shared, “When one sees a therapist every two and a half months, you don’t have the continuity that you do seeing someone every week or every two weeks.” Additionally,

Dr. Moore brought up the idea of ending therapy and proposed Laura-Leigh see someone else. She did not explain Dr. Moore's rationale for sharing this thought and she labeled it as unhelpful for the relationship.

Not focusing on eating disorder behaviors. One last unhelpful factor Laura-Leigh indicated was when Dr. Moore focused too much on the underlying issues and not enough on the eating disorder behaviors. For example, she stated, "In my situation...we've addressed more what's going on emotionally for me, but not talk about weight or food." She understood the emotional aspects influenced the eating disorder behaviors; however, Laura-Leigh admitted it was easy to avoid talking about the behaviors: "I think it's good to visit both aspects of it because you stay on top of everything. It's so easy to be secretive when you have an eating disorder." Specifically, she stated it would have been helpful if Dr. Moore asked, "What's really going on? How many episodes did you have this week?" She explained when a therapist does not do this, behaviors get "pushed aside or under the rug." She further explained why she thought some therapists did not discuss behaviors: "I think it's easy not to discuss it [behaviors] when the person in front of you looks okay."

Unhelpful client factors.

Resistant to change and therapy. One unhelpful factor Laura-Leigh highlighted was when "people are resistant to change." She explained, "I know, I could speak for myself." For example, she acknowledged she kept going over the same topics during sessions and guessed this made her therapist frustrated. To further explain, she stated, "If I binge, I can tell you exactly what's going on emotionally, but that doesn't keep me from doing it.... I can rationalize it...but going forward and making it happen is a whole

different thing.” She also shared being “resistant” to therapy was unhelpful. To illustrate, she shared she tended “to intellectualize more than talk about feelings when something is difficult.” Although Laura-Leigh acknowledged she did this and labeled it unhelpful, she recognized it kept her safe and helped her avoid uncomfortable topics. Another way she avoided focusing on herself during sessions was she tried to discover more about Dr. Moore’s personal life. For example, she stated, “I think I’ve been a little bit distracted by just thoughts like wanting to know more about her.”

Dishonesty. Laura-Leigh expressed how difficult and unhelpful it was when she was dishonest and kept secrets from Dr. Moore: “I’ve never broken the law, never done anything that’s bad, and yet I’ve been so secretive and so ashamed of the behaviors I’ve had with food over the years. It’s just so easy to hide.” She explained further, “I’ve been dishonest about food...and that creates distance even in the therapist/patient relationship. When you have that, it’s like you can only reach a certain extent...there’s going to be a wall there.”

Losing hope. One last unhelpful client factor Laura-Leigh shared was when she lost hope and became frustrated with herself. She explained she told herself, “You should be over this. You should be done. You’ve had all that money spent on therapy, and it’s time for you to do your thing. Get your shit together and move on.” Although Laura-Leigh did not explain how these thoughts influenced her behavior, she stated they were not helpful in building a relationship with her therapist.

Emily

Background. Emily is a 23-year-old Caucasian female with a bachelor’s degree in Mathematics and is pursuing a graduate degree. She was diagnosed with AN when she

was 22-years-old--about a year and a half ago. Prior to seeking treatment, a friend of hers saw her current therapist, Robin, due to eating disorder symptoms. Her friend noticed Emily also struggled with an eating disorder and encouraged her to seek treatment. Emily explained she has seen Robin for about a year and a half with the exception of a few months when she sought residential treatment. They have had approximately 100 sessions together. Emily and I completed the interview via Skype; she did not provide feedback about her transcript, individual themes, or the composite description.

Description of the alliance. The object Emily chose to symbolize the relationship she had with Robin was the Lion from the book, *The Chronicles of Narnia*. She explained the Lion represented “strength” and “wisdom,” and is always “pulling through for the characters.” She went on to explain how Robin did this for her: “She is going to be there and she doesn’t give up on anybody, and she’s always pulling through, even when you feel that you’re sinking; she’s not going to let you.” Emily highlighted it was important that her therapist was stable, dependable, and someone she could trust.

At the beginning of therapy, Emily shared she was initially uncomfortable opening up, did not know what to expect, and felt scared. As time went on, she shared how Robin’s demeanor helped her feel more comfortable. For example, she stated Robin was motherly: “She is very casual but at the same time very strict and she’ll discipline you when you need to be disciplined and call you out.” Emily also shared Robin called her out and talked to her directly, which she appreciated. Currently, Emily described their relationship as casual, relaxed, and comfortable. She explained, “You don’t feel like she is sitting there analyzing you or critiquing you. It’s more two people talking back and forth.”

Helpful therapist factors.

Balancing accountability and care. One factor Emily discussed that was helpful in building the alliance was Robin balanced holding her accountable and showing she cared. To further describe this, Emily shared, “She [Robin] is going to make sure you are serious. She says, ‘If you’re not here for recovery then I’m not going to treat somebody who doesn’t want it.’ She is serious and you have to be serious about it.” Emily also shared she never “got away” with leaving her meal plan blank or hiding behaviors such as restricting or purging. She stated, “Because of how strict she was and how serious she was about it, you knew you weren’t going to be able to stay in your eating disorder.”

Along with being “serious” and holding the client accountable, Emily also reported Robin was caring. She stated, “She is very loving and she cares a lot, and you can see that by just how serious she is...she cares so much about us [her clients] that she has to be serious about it.” Another way Robin showed she cared was she allowed Emily to contact her in between sessions. Emily explained, “Another thing that contributes to building the relationship is she gives you her phone number and tells you to text her if you need anything.” She shared that one time she was upset and called Robin. Robin stayed on the phone with her for about 20 minutes. Emily explained how much that meant to her: “It was really cool. Those are the things that shows she really cares; if she’s taking time out of her day, or her evening to sit and talk to me.” Robin was also available via phone when Emily was across the country at a residential treatment program. Emily explained how she was there five and a half months and stated, “She checked in weekly... and was there every step of the way.”

Expert in eating disorders. Emily acknowledged it was helpful that Robin was an expert in eating disorders. For example, Emily recalled that Robin stated at the beginning of their work together, “I have been doing this long enough to know that, at this point, I am fighting for your recovery more than you are, and I probably want it more than you do right now.” Although taken aback at first, Emily explained she began to understand this statement and the wisdom in it because of Robin’s experience treating eating disorders. Emily stated, “I have seen people who think, ‘I have a degree. I know everything’ kind of mentality” and went on to explain these mental health providers do not know how to treat this disorder. Emily also described Robin’s “expertness” as being attuned to Emily’s needs. For example, she implemented relaxation and breathing techniques when Emily was “fried.” She asked a lot of questions at the beginning when Emily was nervous to open up and talk and she self-disclosed over time.

Collaboration with others. Another helpful factor was Robin’s willingness to collaborate with Emily’s treatment team consisting of her doctor and dietician. Emily explained they were open with each other and the communication between them worked well. Emily also explained Robin collaborated with her parents and she described this as helpful: “We had a couple family sessions, which was probably the hardest thing for me, but also very beneficial because it forced me to talk to them which I never do.” She stated Robin also provided them with education about eating disorders and discussed ways they could be helpful to Emily in the recovery process.

Comfortable office environment. Another helpful factor Emily highlighted was that Robin had a warm and comfortable office environment. She shared Robin’s office

was in a house and was “very homey, comfortable, and a relaxed type of place.” She also shared there were couches and music--it did not look like a doctor’s office.

Helpful client factors.

Openness. Emily highlighted several of her own behaviors that helped build the relationship. She explained she “tried not to fight recovery” as well as the relationship with Robin. She observed younger clients in group who were forced to seek treatment and resisted forming a relationship with Robin; however, she attempted to “be more open” to forming the relationship.

Trusting the therapist. Emily shared that at first, it was difficult to trust Robin. She explained, “People with eating disorders have a hard time trusting people, so I just really tried to trust.” She explained her culture and family also played a role in her initial hesitation but chose to trust Robin: “My grandparents are very old, southern traditionalists. My grandpa was afraid that these people [therapists] were going to brainwash me. ‘Don’t get to thinking in their ways.’ But at the same time, just trying to trust.”

Unhelpful therapist factor—“Disciplining the client.” When Emily described the unhelpful aspects of the therapeutic relationship with Robin, she discussed how difficult it was when Robin challenged her: “She’s always challenging you. Even in group sessions, I have seen people get so frustrated with her. She can be very frustrating because she is being very honest with you.” Emily also “minimized” her eating disorder and Robin “disciplined” her and confronted her behaviors. Additionally, although Emily identified this as a challenge to the relationship, she noted, “In the moment it’s definitely frustrating. You’re like, ‘Stop. Leave me alone.’ But at the same time, I knew I was

going to continue going to treatment.” Therefore, even though this needed to be done, Emily recognized it as something that strained their relationship for a short time.

Unhelpful client factors.

Denial. Emily shared an unhelpful client factor was denial. For example, Emily shared she once told Robin, “I wasn’t sick until I started coming here.” She expressed although Robin and she laugh about it now, she explained, “That’s where your mind goes when you’re that sick. I didn’t realize how sick I was. You’re so oblivious.” Along with denial, Emily discussed ways in which she used different defenses to avoid or minimize talking about her eating disorder symptoms, which sometimes led to lying about what was really going on. For example, during one session, Robin asked about Emily’s “eating habits,” and Emily stated, “Oh, they are okay.” Emily explained she was “not necessarily lying about it, but definitely minimizing the severity of it [how poorly she was eating].” She explained when she did this, Robin asked, “So, you’ve decided to bring your eating disorder to session today?” followed by “Just to let you know, I’m not going to have that and you are never going to bring your eating disorder in session again.” Emily stated, “She gave me a good stern talking to.”

Cognitive challenges following malnutrition. Other unhelpful client factors Emily discussed included when she was malnourished and during the re-feeding process. Emily recalled the first few sessions: “I was always worn out and she could see from my face, my eyes, my body language when I was just exhausted. I wasn’t really getting anything she was saying; didn’t have the capacity to think straight.” She also described her re-feeding process and how difficult it was for her: “It’s funny how when you start feeding your body again, it’s not use to that...it just kind of goes crazy.”

Kelly

Background. Kelly is a 26-year-old Caucasian, female college student who works part-time at a hotel. She has aspirations to attend medical school in the future. Kelly was diagnosed with AN about nine years ago when she was 17-years-old. When first diagnosed, Kelly shared her family “forced” her to seek treatment. Her treatment history included several outpatient therapists, group therapy, “a few” residential treatment centers, and a doctor for medication. Kelly has worked with Dr. Puff, her current therapist, for about a year; they meet once or twice per week. They have had about 60 sessions together. She is currently in treatment and it is her choice. Kelly and I met via phone and she was willing and enthusiastic to share her experience. She reviewed her transcript and stated it was accurate; however, she did not provide feedback about her individual themes or the composite description.

Description of the alliance. The object Kelly chose to symbolize the relationship she had with Dr. Puff was a pillow. She explained a pillow is mobile and she can take it with her wherever she goes. Similarly, she shared Dr. Puff allowed her to call her whenever she needed, which was somewhat like being “mobile” as well. Kelly also described her pillow as “a very, very comfortable place” and “a good place to think and process.” She explained these descriptions of her pillow also described how she viewed her relationship with Dr. Puff. Prior to working with Dr. Puff, Kelly explained she did not want to seek treatment; however, because she was considered a minor, she attended treatment per her parents’ “force.” She also described she was not invested in staying with a therapist and working on the relationship: “I go through doctors and therapists like I go through a pack of gum; if I don’t like one single thing that they do, that’s it. I

usually don't go back because anorexia is fear-based, and if they provoke fear, I'm done." Furthermore, she described it took a "really long time" for her to open up to Dr. Puff; however, they eventually got to a "comfortable place." She described their current relationship as "professional...but also like talking to a friend. It's not that sterile, professional setting. We can just sit back and relax."

Helpful therapist factors.

Expertness and acknowledging limits. A therapist factor Kelly identified as helpful was Dr. Puff was an expert in eating disorders and attuned to her needs. For example, Kelly shared she chose Dr. Puff because she was experienced with eating disorders and trained in Eye Movement Desensitization Reprocessing (EMDR), and Kelly wanted someone who could provide this type of therapy. She also explained while Dr. Puff knew many traits and characteristics of clients with eating disorders, she also individualized treatment for her: "She's not a cookie-cutter doctor...she changes her treatment plan to cater to each individual, and that's huge." She further explained:

It's very important to know us as a whole as well as individually. Even though, yes, my community of anorexics are all struggling with the same thing, we all struggle from different things too. And there are very few people who can realize that.

By knowing eating disorders at large as well as individually, this helped Kelly view Dr. Puff as an expert and trustworthy. Kelly also shared although Dr. Puff was an expert, she did not pretend to understand all of her struggles: "She understands to an extent, but she realizes that her understanding is limited...she'll ask me if the thoughts she's having are accurate and check on it." She further illustrated the way Dr. Puff did this as well as how it impacted her trust:

They [the therapist] need to admit to me that they don't know everything. They've studied it and they know the information, book wise, but if they can convey to me that they're not trying to pretend that they know everything, then I feel a lot safer because they're not going to try and pull something over on me.

Personal comfort. Another helpful factor facilitated by Dr. Puff was her genuineness and slow, methodical approach. Kelly described in their first session, Dr. Puff sat back in her chair, put her feet up, and asked Kelly to call her by her first name. Kelly recalled, "I said, 'Yes ma'am,' and we laughed and went from there." She also shared Dr. Puff was "real" and opened up about some of her problems as well; however, she noted it "slowly, slowly, slowly developed" and Dr. Puff was "very careful with privacy and moral conduct."

Warm office environment. Dr. Puff had a comfortable and warm office environment, which Kelly noted was helpful. She described the office and what made it comfortable for her:

She took me into a room with one of those sound makers outside so it was very private. I sat down on this huge fluffy couch, which kind of swallowed me and was a pretty comforting thing for me. Her dog was in the room and came and cuddled with me a little bit...it was dimly lit. No fluorescents in her office. No colorless walls. No tile floors. It's carpeted and it's in an old house.... Nothing sterile about it.

Furthermore, she explained although she wants to become a doctor and work in a sterile environment, she did not want her therapy to occur in this type of environment: "I don't do the sterile environments. They scare me."

Balance and availability. Kelly shared another helpful factor: Dr. Puff balanced challenging her but not too much. She explained, "It's a very delicate situation. She can't push me too hard, but she needs to push me hard enough." Kelly also recognized the difficulty in this when she stated, "I don't envy her position." She also shared how

helpful it was when Dr. Puff gave Kelly her cell phone number to call in case of an emergency. Kelly stated, “That builds that extra layer of trust. She’s going to be there if I need her. She’s there if I don’t need her. She’s just there.”

Collaborative process. Kelly identified collaboration facilitated by Dr. Puff as a helpful factor. She stated, “It’s not just her treating me, it’s us getting better together...it needs to be a team.” One way in which Dr. Puff facilitated collaboration was at the beginning of therapy, Dr. Puff asked Kelly about her previous therapy experiences: “Who did you see before? What did you like? What did you not like? What do you need me to do? What would cross that line that you do not want me to do?” Kelly explained because Dr. Puff asked these questions, she felt she was invested and wanted Kelly’s input. She also described that Dr. Puff periodically assessed how she was doing as a therapist and if there was anything she could do better or “anything she needs to ask more regularly.” Additionally, Dr. Puff utilized collaboration when she was flexible in her treatment planning and allowed Kelly to change the topic. Kelly shared that a few weeks ago, she wanted to explore a topic they had not discussed in a while and she expected Dr. Puff to “be mad, and she wasn’t.” Kelly expressed she was surprised and it reaffirmed she did not have to be afraid. She stated, “[She is] not going to be mad. She doesn’t plan her sessions out. She has a rough draft, but if we don’t stick to it, it’s not a big deal.”

Helpful client factors.

Choosing treatment and a therapist. Kelly shared how helpful it was when she decided to seek treatment on her own as well as choose her own therapist. She explained, “It makes me feel empowered and like it’s my choice. Nobody is making me do it, and so I get out of it what I want to get out of it.” She also stated when she was a minor, her

parents chose her therapists for her and it was not helpful; what was beneficial was when she started setting the criteria and “experimenting” with choosing a therapist: “We need to be a part of our own treatment. If we aren’t a part of it, it’s not going to help.”

Engaged and open. Kelly described another aspect that helped build the relationship--her engagement and openness. She asked questions of Dr. Puff during therapy and researched topics outside of session, which portrayed engagement. She also expressed that once she realized Dr. Puff “wasn’t going to hurt me and that she wasn’t going to abandon me,” it was easier to be open and honest with her.

Assertive. Another client-factor was when Kelly shared her own thoughts and feelings and asserted herself with Dr. Puff. For example, Kelly explained, “I told her straight out why I left the other ones [previous therapists]. I told her what I did not like, what I would not put up with...but she was very receptive to it.” Kelly also gave an example where Dr. Puff encouraged her to tell her boyfriend about her relapse and she did not want to. She explained, “I was like, ‘Listen. I’m going to have to do this on my time. No, you can’t talk me into it.’” Kelly stated Dr. Puff was open to this feedback and it helped Dr. Puff know what she needed.

Unhelpful therapist factors.

Expert stance and “cookie-cutter approach.” While it was helpful that Dr. Puff did not take an expert stance, Kelly discussed her experiences with other therapists who “pretended to know everything.” She recalled these therapists said, “I know how you feel sweetheart,” when in reality, they did not. Another factor that created the illusion of an expert stance was if the therapeutic relationship was kept “super, super professional for too long.” She explained, fortunately, Dr. Puff began self-disclosing at exactly the right

time because if she had not, Kelly stated she might have left: “I had a bit of a hard time with it. I was being so vulnerable and I felt like she should at least be somewhat vulnerable...it just balances out in my head if I know a little bit about you as well.”

Kelly also described how unhelpful it was when previous therapists treated her “just like the next person” and did not individualize treatment.

Pushing too hard and moving too fast. Another unhelpful factor Kelly discussed was when her therapist “pushed” her in a direction she did not want or was not ready to go. She explained:

I realize that this is a very deadly disease. I realize that we are literally starving to death and that our lives are literally on the table, but if you move too fast, we just run harder and die faster. People don’t realize that if they run in, wanting to save our lives, they end up struggling because they move too quickly and scare us. It’s like a horse. You don’t go running up to a horse in a pasture; it spooks them.

Kelly went on to explain because AN is “fear-based” and “control-based,” she will “run every time” if she is pushed too hard in a direction she does not want to go, both physically and emotionally.

External factors. Other unhelpful factors Kelly identified were related to the external appearance of the therapist and the external office environment. She explained, “If a therapist is overweight and trying to tell me what to eat, that’s not going to be okay because obviously they don’t know.” She went on to discuss how in a previous therapy relationship, this therapist characteristic fueled her fear and uncertainty, thus making it difficult to fully trust and open up. Kelly also identified several unhelpful office characteristics: florescent lights, tile, and colorless walls. She explained these “sterile environments” scared her because they reminded her of a doctor’s office.

Unhelpful client factors.

Lack of choice. Kelly shared several unhelpful factors she facilitated, which included being “forced” into treatment and unable to choose her own therapist. She explained being forced into treatment negatively affected the relationship with her therapist: “If I’m not willing to get better, I’m not going to get better.” Along with not choosing treatment, she described the difficulty when she was unable to choose her own therapist. She stated, “We need to be part of our own treatment. If we aren’t a part of it, it’s not going to help.”

Fear. Fear was another unhelpful factor Kelly identified as getting in the way of building a strong working alliance, specifically fear of rejection/abandonment, fear of being imperfect, and fear of admitting relapse. Kelly explained when her fear of rejection and abandonment began: “My father ended up committing suicide a couple of years ago, and I’m terrified that everybody else will leave too. Because [of the] anorexia, we abandon the world, and when the world starts abandoning us, that’s scary.” Kelly also discussed her fear that if she was not perfect, people would “turn their back” on her since this happened in other relationships in her life. Additionally, she explained how her fear of admitting relapse prevented her from opening up to Dr. Puff and being honest about her progress: “It was hard for me to tell her that I was starting to relapse. I wanted her to be proud of me. I didn’t want her to realize I was human and prone to relapse like everybody else.”

Peacekeeping. Kelly described one of her tendencies was to be a peacekeeper and avoid conflict, which resulted in her lack of assertiveness. She described a situation with a previous therapist where she shared feedback about her treatment and the therapist

was defensive. Since then, Kelly described, “I stopped telling them [therapists] things because as anorexics, generally, we start out very much as peacekeepers. That’s just one of the qualities we have and so we have trouble ruffling feathers, so we just keep quiet.”

Jamie

Background. Jamie is a 63-year-old Caucasian female who is currently a substitute teacher and part-time nanny. She holds a bachelor’s degree and took several graduate-level courses. Jamie was diagnosed with AN 10 years ago at age 53. She took her adolescent son to see Henry, a therapist, about 10 years ago for counseling. During this process, Henry identified Jamie as struggling with an eating disorder and suggested she also complete individual therapy. Jamie explained Henry offered to be her individual therapist as well and she agreed. She shared she has worked with Henry for 10 years, once a week or once every two weeks, and totaling over 300 sessions. Jamie also noted Henry was and is her only individual outpatient therapist; however, throughout the 10 years working with him, she completed group therapy with him, an inpatient program, and a week-long therapy experience for eating disorders. Jamie and I met via phone to conduct the interview. She provided feedback about her transcript and the composite description and stated both were accurate; however, she did not provide feedback about her individual themes.

Description of the alliance. When asked to choose an object that symbolized the relationship with Henry, Jamie chose many pillows. She explained that Henry used the pillows to represent the “stuff” she hung onto, both in group and individual therapy. She stated, “It was stuff from my mother or from my husband... And getting rid of that instead of holding onto it was what we used the pillow for.” She shared the exercise

helped to build their relationship: “At first, it was difficult because I seem to hang onto everything, but as far as my relationship with him, it was good because I felt like he understood exactly how I felt with all this stuff.” Jamie explained she “felt very comfortable with him, and confident in him because he worked this miracle with my son.” When describing the relationship at the time of the interview, she described it as “very good,” “open,” and “very safe.”

Helpful therapist factors.

Identify feelings and lack of judgment. Jamie shared it was helpful for their relationship when Henry helped Jamie identify her feelings and did not blame or judge her for them. She shared:

He had this terrific knack for being able to help you identify your feelings, which I had trouble with in the beginning of even identifying my feelings, much less talking about them. But it helped me identify my feelings and give a voice to them.

Additionally, when she shook her foot, Henry asked, “If that foot could talk, what would it say?” and she recalled it helped her focus on what was causing her body to react.

Although Jamie shared it was “uncomfortable at first,” it helped her identify her anxiety and work through it so she could create a closer relationship with Henry. Also helpful in establishing their relationship was the fact Henry “didn’t put any blame on me for the situation I was in.” She explained this was quite different for her: “He’s very, very non-judgmental, and early on in my therapy, that was not something I was used to dealing with. Everything up to that point had been judgmental.”

Attentive and available. Another helpful factor was Henry’s presence during therapy, which Jamie described as “present,” “supportive,” and “attentive.” She further explained he took his time during therapy and listened to her. She also highlighted his

body language portrayed attentiveness: “He faces you and looks at you.” Also helpful was Henry invited Jamie to call him whenever she had an emergency or needed something as well as when she wanted to let him know what she was thinking. She explained he put the responsibility on her to let him know if he needed to call back or if she just wanted to share something that happened so they could discuss it in their next session. However, if she needed him to call back, she stated it was “always timely.”

Acknowledging limitations and collaboration. Jamie expressed how helpful it was when Henry was “very honest about the problems he can handle” and those he could not. For example, she explained Henry was not an expert in food, nutrition, or medicine; therefore, he referred her to “an excellent nutrition therapist” and a psychiatrist. Along with connecting Jamie to other professionals, Jamie noted he communicated and cooperated with these individuals:

Having my therapist being able to put me in touch with a good nutritionist and a good psychiatrist, and communicating with those people so we are all on the same page.... I think having everybody on the same page through his [Henry’s] coordination, that was a big thing for me.

One last way Henry collaborated with others was when he incorporated Jamie’s son into therapy: “He [Henry] and my son talked to me together and he helped my son express his feelings about what the eating disorder was doing to him, and how they wanted me to get help [at an inpatient program] for it.” Jamie described this as meaningful and acknowledged it portrayed Henry’s level of care and compassion to incorporate others into her treatment.

Good common bond. One way Henry helped to build the alliance with Jamie was through his self-disclosure. Jamie explained Henry shared his father was unable to say, “I love you” and “with him disclosing that, I knew he could truly understand how I

was feeling about my relationships.” She also explained Henry occasionally talked about his children and his relationship with them. By doing this, Jamie shared it created “a good common bond in being parents.”

Reassuring. Another helpful factor was Henry’s reassurance. For example, Jamie shared Henry “acknowledged that...I was trying to be present and giving my kids the affirmations that they need.” She also provided another example where she began to relapse by controlling her food and during a session, Henry was reassuring: “It’s been helpful to have somebody else remind me that I have been through this before and that controlling my food doesn’t solve my other problems.”

Building confidence. Another way Henry helped build the relationship was he aided in increasing Jamie’s self-confidence. She explained, “There’s got to be some confidence built up, or a person with anorexia can just completely shut down or say what they think you need to hear.” To do this, she explained Henry “did an excellent job of teaching, or re-teaching me to have some confidence in myself and in my decisions.”

Taking action. One last therapist-factor was Henry took action when he saw Jamie starting to relapse. She explained:

Even as recently as two weeks ago, I’ve been having some sort of relapse issues with my eating disorder as I’ve been going through some stress. And just being able to have him jump right on it and make some positive steps in the nutrition department, it’s easier for me to recognize when I’m relapsing and to bring that forward for some accountability.

By him taking action, it helped build trust between them as well as helped Jamie feel more comfortable speaking up if relapse occurs again.

Helpful client factor--Willingness to participate. The only helpful client factor Jamie identified was her willingness to be an active participant in therapy. She explained it was helpful when she “participate[d] in the therapy myself, instead of just being talked at.” She stated this was not easy at the beginning of therapy: “It was hard for me at the beginning to actually open up.” However, once she did, she noted it helped build their relationship and alliance.

Unhelpful therapist factor--Multiple roles. At the beginning of therapy, Henry took on multiple roles and it concerned her. She shared because Henry was her son’s therapist first and then her therapist second, she worried it would be difficult to set and keep boundaries between those relationships. She also explained because he was her son’s therapist, she did not want him judging or blaming her for some of the things her son shared in his own therapy. Although these were fears at the beginning, Jamie explained, “I couldn’t imagine opening up to anybody else.”

Unhelpful client factors.

Guilt and shame. An unhelpful factor Jamie highlighted she brought to the relationship was guilt and shame. She shared some of the guilt stemmed from the fact her son needed therapy and she needed therapy herself: “There was just a lot of personal guilt and shame...in my early years of therapy.” Another example of how guilt and shame entered the therapeutic relationship was when Jamie felt like she had not worked hard enough in therapy or if she “did something to irritate him [Henry] or let him down.” For example, there were several occasions when Henry asked her to do something, such as homework, and did not follow through. Because of this, she also shared her fear that

Henry would “cut me off” and say, “You’re not going to do it my way, so I’m not going to see you anymore.”

Malnourished. Jamie shared how it was difficult to create a helpful therapeutic relationship when she was malnourished. She shared: “I couldn’t do good therapy in a malnourished state of being. And that was another thing that made it important for me to eat better with my nutrition because I knew my therapy wasn’t going to be effective if I was starved.” She also shared how it was difficult for her to make decisions, both in therapy and in her own life when she was malnourished.

People pleasing and “shutting down.” One last unhelpful client factor Jamie highlighted was people pleasing. She explained that quite often a person with AN will “say what they think you need to hear.” She described that at times, she was not completely open and forthcoming with information. Also unhelpful was when she “shut down,” meaning she was not present and/or distracted in the therapy session.

Individual Therapist Participants

Stacey

Background. Stacey is a 63-year-old Caucasian female therapist who identifies as a Buddhist. Her highest level of education is a master’s degree in Women’s Studies and Counseling. She works as a full-time outpatient therapist in private practice. She is not licensed in the state in which she practices or any other state. Stacey has worked in the mental health field for 12 years; she has approximately 300 clients with AN. Stacey and I met via Skype to conduct the interview; after the interview, she approved the accuracy of her transcript and individual themes. She did not provide feedback about the composite description among the therapists.

Description of the alliance. Prior to our interview, I asked Stacey to think of an object that symbolized the relationship she has with her clients with AN. The object she chose was a teacup. She explained during therapy sessions she usually holds a teacup and drinks her tea. She stated, “It feels more like a conversation rather than something sterile and impersonal...it feels more friendly like you’re having a conversation with a friend over a cup of tea.” This description highlighted that Stacey tries to create a comfortable and warm environment with clients. I also asked Stacey to describe the process of building the therapeutic alliance with clients with AN. She explained, “Sometimes it feels kind of adversarial. And my experience is that anorexia is one of the most difficult eating disorders to treat.” She also described it as “frustrating” at times as well as a “battle” with the eating disorder.

Helpful therapist factors.

Collaboration with client. One therapist-factor Stacey highlighted that was helpful in forming the therapeutic relationship was collaborating with the client. Due to her Buddhist beliefs, she explained her approach was “less about me being an authority, as much as me being someone on the journey with them. It’s kind of like [me] going, ‘Look at that. What do you think of that?’” She explained that although it might not work with every client, she believed most of her clients found value in this approach. Stacey also described collaboration involved letting the client take ownership of his/her recovery and not taking over for them. She explained, “I have to be there to help them, but I also have to let them fly on their own.”

Instilling hope and new perspective. Another helpful factor was instilling hope for clients and encouraging them to see things in a new way. For example, she believed

having an eating disorder is not a “lifetime curse.” She stated, “I think it’s really important for anyone who’s coming into work on their recovery from an eating disorder, for them not to think of it as a lifetime sentence.” Another way Stacey helped form the relationship was to help clients see “gray.” She explained, “I don’t want to be as black and white as I know most of my clients come from. A lot of eating disorder thinking is very black and white, so I am more gray...there’s no absolute.”

Validating. Stacey expressed the helpfulness of validating her clients’ experience and not judging them. She explained that many times, she validated the client’s eating disorder by saying, “Obviously it [AN] was there for a reason... of course you needed [it]. There was something in your life that you felt was out of control or that you didn’t have any say in or that you didn’t know how to have a voice in.” By doing this, Stacey hoped to validate the client’s experience of the disorder and to reduce the judgment and blame clients might feel. Furthermore, she described she went a step further and not only validated the client’s experience but did not make the eating disorder the “enemy.” She instructed, “Don’t make the eating disorder the enemy. It’s not the enemy. It’s not something to get rid of. It’s not this thing to disintegrate, or demise, or figure out how to give up. Befriend it.” For Stacey, when she befriended the eating disorder, she portrayed an understanding that it served a purpose and provided a way to cope with difficult situations.

Moving slowly and redefining recovery. Stacey also established trust by moving slowly and not “trying to take away their eating disorder.” She explained this was one of the biggest learning curves for her when she first started working with this population. She described it was vital she recognized “how important it is for my clients with eating

disorders to not have somebody pull the rug out from under them.” She went on to say, “I don’t want to take somebody’s life preserver away, which is what an eating disorder can be seen as.” By moving slowly, she helped clients learn new ways of coping prior to taking away their only coping mechanism. Additionally, Stacey explained because she moved slowly with clients, sometimes she questioned her usefulness as well as the definition of recovery. She described one of her current clients whom she worked with for seven years:

I’m doing lots of work with this woman and she still has her eating disorder. She has changed a lot of her approach to life and how she feels about herself, and her eating disorder is like this little side activity...but there’s this other part of her that’s gotten stronger and more outspoken, and more willing to look at her relationships and be challenged. I don’t know what quote unquote recovery looks like. There are lots of variations.

For Stacey, it was important to maintain a flexible approach with clients, which included moving at their pace and identifying what recovery looked like for each client.

Helpful client factor--Willingness to change. Stacey described one of the most important client factors that aided in the formation of the therapeutic alliance was clients’ willingness to attend therapy and work. She explained when a client did this and was not “forced to come in,” they were determined and ready to change. She also highlighted individuals who portrayed a willingness to explore their eating disorder, their fears, and insecurities, and “are so ready, SO ready to be done with it [their eating disorder]” are usually easier to connect with and build a therapeutic relationship.

Unhelpful therapist factor--Over-focus on food/weight. Stacey described it unhelpful when she over-focused on food and weight or discussed how much weight the client lost or gained. Many times when she did this, it was easy to get stuck on the topic and avoid talking about the underlying issues and more difficult topics. While important

to discuss these at some point in therapy, she recognized the importance of balance. To aid with balance, Stacey stated, “I try to have them work with a nutritionist.”

Unhelpful client factors.

Malnourishment. Malnourishment was an unhelpful client factor Stacey highlighted. She described working with a woman who was malnourished; because of low weight, her brain activity was compromised and not “working properly.” She explained when she talked to the client and asked about behaviors, she had difficulty following the conversation and providing answers.

Pull it in and shrivel it up. Stacey described how another unhelpful factor was when clients restricted how much they spoke or “give you” during the session. She explained, “With anorexia, you almost suck and pull it in and shrivel it up, and with bulimia, you really want to get it out.” She further stated, “There’s more of a stinginess that goes with anorexia.” Because of this, it makes it difficult to connect and build a relationship compared to other clients who freely share and discuss.

Bridgett

Background. Bridgett is a 30-year-old Caucasian female and identifies with Buddhist beliefs and practices. She earned a master’s degree in counseling and is a licensed counselor in the state in which she practices. She currently works as an outpatient therapist in a private practice and primarily works with clients with eating and anxiety disorders. Bridgett has worked with clients with AN for five years and treated about 20 clients diagnosed with AN. Bridgett and I met in person in her office for our interview. Her office was located in an industrial building with large windows and natural lighting. In her office was a large couch with many pillows, many books on her

bookshelf, several pieces of Buddhist artwork, and small Buddhist figurines. Bridgett did not provide feedback regarding the accuracy of her transcript, individual themes, or the composite description.

Description of the alliance. The object Bridgett chose to symbolize the relationship with clients with AN was a small figurine of Quan Yin, the female Buddha. She explained Quan Yin represents compassion, love, positive energy, and wisdom, and she tries to represent that for her clients. She stated:

She [Quan Yin figurine] is hidden in a lot of places [in my office]. I'm attempting to offer that grounding support for all my clients that are working through an eating disorder, because a lot of times they feel so alone and isolated. I really try to [offer] open arms, and welcome, and try to create a safe place for them. And Quan Yin exudes that for me.

When she described the therapeutic relationship with clients with AN, Bridgett depicted this population as “sensitive.” She explained that oftentimes, they did not present with or want to work on the “real issue,” the eating disorder. She also explained these clients brought into the relationship what was going on in their lives. She stated that they “have something broken, and my job is to work with them and guide them on a journey to figure out what is broken, and try to recreate it, not fix it.” She also experienced clients testing her to make sure the relationship was safe and she could help them.

Helpful therapist factors.

Real and genuine. Bridgett shared being real and genuine was a therapist-facilitated factor that helped form the alliance. She explained she tried to be “lighthearted” with her clients because that was her personality in her everyday life. She stated, “Some people would say that I’m kind of a smart ass. I’m constantly smiling and trying to create that warmth. I laugh a lot with my clients and they laugh at me, which is

okay.” By using genuine humor and lightheartedness, she explained it helped with the power differential between her and her clients and made the relationship “more level.” She also shared admitting when she was wrong or made a mistake with a client was also part of being real and showed her humanness.

Empowering and reframing. Another helpful factor Bridgett highlighted was empowering clients, providing unconditional positive regard, and utilizing reframing. She explained how important it was to create an environment that empowered clients and did not judge or blame them. For example, she often told her clients, “Anorexia does not define who you are if you don’t want it to.” Bridgett also provided clients with total acceptance: “They [clients] need to feel that they’re in a safe and nonjudgmental place...to share and to go to those deep dark places. If I weren’t presenting that kind of compassion, I don’t think I’d get very far with them.” Another way she provided this acceptance and empowerment was by “reframing” things the client said or did. For example, Bridgett gave an example of a client with AN. The client told a story and mentioned she stood up to her friends at school. Bridgett stopped her and slowly stated, “Let me tell you what you just said.” The client had a difficult time asserting herself and using her voice, and did not recognize this success. Bridgett explained, “It’s my job to make sure that whatever insight they are demonstrating doesn’t go unnoticed.”

Competent in treating eating disorders and supervision. Bridgett discussed the importance and helpfulness for her clients to know she was comfortable and competent in treating eating disorders. She explained, “It goes back to them knowing that I’m competent and that I can assist them with a variety concerns, and that they’re not here to work on the anorexic issues for three sessions and they’re done.” A part of being

competent, Bridgett discussed, was letting the client know she was “stable and grounded.” She explained, “Being able to be here with open arms with whatever they throw at me; they’re not going to shake me. It’s not going to faze me. It’s okay.” She also described her role as “being able to catch them when they feel like falling...often times, [clients] feel like they’re walking a tight rope, so maybe I’m offering that balancing stick that they need.” Other ways Bridgett demonstrated competence was prioritizing treatment by deciding what to “tackle first,” meeting the client where they were, and focusing on the whole person, not just the eating disorder. Although she noted the competence factor as helpful, she acknowledged seeking supervision was just as helpful for her. She explained, “Make sure you have amazing supervision and make sure that you have someone...you’re working with that you can bounce ideas off of, because this population is so sensitive.”

Relating to the client. Another helpful factor in building the alliance was being able to relate to clients. For example, Bridgett explained all of her previous clients with AN were females in their teens and twenties. She believed that being female and slightly younger helped create a relationship with these clients more easily. Although relating to the client was helpful, Bridgett acknowledged how careful she was to not self-disclose too much. For example, for Bridgett explained, “Information they can find out online, heck yeah, I’ll disclose that. But other stuff that’s not [online], that’s just not appropriate.”

Helpful client factors.

Willingness and honesty. Bridgett shared that it was helpful when clients were ready and willing to begin treatment. Along with a willingness to attend treatment, it was

helpful when they were honest about their feelings and disclosed them. For example, Bridgett described working with a teen client. Prior to the client sharing, she asked Bridgett if she would have to tell her parents. She explained, “I know that we’re getting somewhere...when they ask me that. I feel as though the relationship has taken another step forward.” She also explained when clients challenged her and were honest about their nervousness, or if they said, “Do I really have to? Don’t make me do that!” it helped her know they were comfortable enough to push back versus going along with treatment.

Providing feedback. Also helpful was when clients provided feedback about her or the relationship. For example, she described one client told her, “You’re cool. I think I can talk to you.” She explained when she received this feedback, “It makes me feel like I’m in a little bit and that we’re on each other’s side, instead of across the room from each other.”

Unhelpful therapist factors.

Over focus on the eating disorder. Bridgett explained she had several clients with AN who shared with her they did not want their eating disorder to be the main focus of treatment. While important to discuss the eating disorder, she stated there were times when she spent too much time focusing on it. She explained these clients had “so many other co-occurring issues”; therefore, she tried to “help them with their entire world...rather than just focusing on that one little thing [the eating disorder].”

Improper self-disclosure. Another unhelpful factor Bridgett shared was improper use of self-disclosure. She explained that sometimes, she felt pulled to share more about herself with her clients and she “put myself in check” and stopped herself before she did:

“I’ve found that self-disclosure can be too much for people...I feel the therapist’s job is not to be someone’s friend, and self-disclosure is what you’d do with a friend, not a client.”

Making assumptions. Making assumptions about the client or what he or she might feel was another unhelpful therapist factor Bridgett addressed. She provided an example when she worked with a woman with AN and the woman’s mother died. Bridgett described she asked the client, “Some people in your situation wish they could still talk to the person...and maybe work through some of the hard emotions that you’re still carrying.” After Bridgett said this, she explained the client “BLEW up on me and just exploded.” The client stated, “She’s not here anymore and I can’t!” Bridgett explained she attempted to reframe and normalize and “it went really wrong.” Therefore, she highlighted it might have been better to ask and not assume.

Unhelpful client factors.

Avoidance. One unhelpful client factor Bridgett identified was when clients avoided talking about the “real” issues. For example, Bridgett stated she had many clients with AN say, “I don’t really feel like talking about that right now” or “You wouldn’t really understand.” For Bridgett, these statements disrupted the work they had done and made her feel like “Op! Now we’re kicking you across the river again.” Bridgett also noted some clients requested she self-disclose if she had a history of an eating disorder. She explained that sometimes she viewed this as clients trying “to create an alliance...feeling like they’re with people who have already worked through the issues.” However, she also shared these “can be games” and they might attempt “to trip

me up a little bit” and avoid talking about themselves; therefore, Bridgett does not answer this question.

Personality disorders. Another unhelpful client factor Bridgett discussed was clients who had a co-occurring personality disorders such as borderline personality disorder. She explained these types of clients often tested her and the relationship and played games to avoid talking about themselves. She also described many of these individuals were inconsistent; sometimes they were cautious about the information they provided and other times they over-shared.

Family dynamics. Some of Bridgett’s clients were minors and, therefore, had a parent or parents involved in treatment. She explained, “Sometimes, parents can become over involved and it disrupts the balance that we’re attempting to create within the therapeutic relationship.” For example, she described working with a 16-year-old whose mother and father said, “She’s crazy” and “You need to fix her!” She explained this was unhelpful and difficult when she tried to work with the client; she noted the importance of working with “the family dynamic and making it not work against what we’re trying to do.”

Jane

Background. Jane is a 59-year-old Caucasian female psychologist. She received her Ph.D. in Counseling Psychology and currently works as a clinic director for an eating disorders treatment facility. Jane has worked with clients with AN for 30 years and treated over 1,000 clients with AN. Jane and I conducted our interview over the phone and she was enthusiastic to help with this study. She did not provide feedback about her transcript, individual themes, or the composite description.

Description of the alliance. The object Jane chose to symbolize the relationship she had with clients with AN was a cluster of four, tiny, silver, antique dessert forks tied together with a blue ribbon. She explained a client, whom she worked with for a couple of years, gave them to her: “[She] gifted them to me at one point because she had turned the corner and was determined to recover, and so she felt like she needed to give up something that was very much a part of maintaining her eating disorder.” The client used these forks when she ate to limit the amount of calories she consumed. When this client gave Jane the forks, she explained, “[it] feels so very powerful because it indicates a level of trust and a level of collaborative effort that we were working together toward a common goal.” She also explained when the client gave her the forks, it symbolized the client made a commitment to recovery and the relationship.

When describing the therapeutic alliance with clients with AN, Jane explained, “Being in a relationship with someone who presents with anorexia...is arduous. It’s slow. You can’t force it or fake it.” She also described clients with anorexia as “master[s] at distant intimacy,” which made it “very hard to feel the connection.” She went on to say:

Unlike with other people who come in with eating disorders who don’t have that kind of anorexia personality, they come in and within 30 minutes of talking to them, they feel like you know them. Really know them. The anorexic, they’re not going to give you that experience. Even if they feel like you’re onto them and you do know them.

Jane further explained these clients did this because it was “scary to them”; to be “really known can be a pretty frightening thought, let alone experience.”

Helpful therapist factors.

Personalizing treatment. Jane explained how helpful it was when she tuned into clients and personalized treatment. For example, she read her clients' verbal and non-verbal messages and attempted to understand what they thought and felt. This also included finding ways to apply the training she learned that was of most use to each individual client. Furthermore, Jane described personalizing treatment involved being patient with all clients. She stated, "I think realizing up front that these are disorders that you can work with the individuals...over the course of years." She explained how there are clients she has worked with for 10 to 20 years of chronic relapse.

Client is the expert. Another helpful therapist-facilitated factor Jane described was inviting clients to teach her about them and asking them to share what would be most helpful. She told her clients, "You have the owner's manual. You've read it and I haven't. You're going to have to teach me who you are. If I make assumptions based on your behaviors...it would help if you would let me know as you're ready." She also explained she asked, "Does that fit for you?" and invited feedback. Another way Jane allowed the client to be the expert was to try and understand how their eating disorder worked for them (e.g., Motivational Interviewing).

Incorporating food in therapy. Jane relayed how helpful it was to incorporate food into the therapy session. She explained she did not think it was something many therapists do because "they're not trained to do [it] in graduate school"; however, in her experience, "It's deepened the trust in the relationship." Jane also highlighted that it was a tool to assess the level of trust in the therapeutic relationship: "What they do or don't do with food [is] symbolic about how they want to experience themselves in relationship to

others: the power they would like to have, the sense of control.” Jane expressed how meal therapy and working with food in session contributed to the power of the relationship.

Confidence and passion. Another helpful factor was the therapist’s confidence and passion. She explained how there were several approaches to treating eating disorders, but more important than what approach the therapist used was the therapist’s belief and discipline in sticking to a specific approach. She stated, “I think the patient is going to feel the therapist’s confidence in their approach and they’re going to benefit.” Jane also highlighted the importance of the therapist’s passion and how this kept her going when things were difficult with clients.

Limiting self-disclosure. Jane shared limiting self-disclosure was helpful in the relationship. She stated

I did not come of age with Oprah. I’m a late onset to reality T.V. and being in a tell-all culture. So, it does surprise me here over the last five to 10 years how willing people in the field of eating disorders are to disclose their own history of perhaps them having had an eating disorder, and then to share that with patients. My training and my temperament is such that I never felt comfortable disclosing much about myself.

To help with this, Jane explained how she “may use something that comes from my own experience, but I will give its ownership to someone else.” She explained her rationale for doing this was to create an empathic connection to the client and help them feel like they had a normal reaction. Jane also acknowledged the importance and helpfulness of being aware of her own reactions to the client and identifying how it might impact the alliance. To aid with this, she highlighted the importance of seeking supervision, especially with this population.

Helpful client factors.

Humor. Jane described clients' humor as something that positively impacted the therapeutic relationship. She explained, "I love it when they turn that corner because they are deadly serious; there's nothing funny about anorexia and there's no humor." She also described how she used this factor to assess the strength of the alliance.

Willingness to share and be challenged. Another helpful client-facilitated factor Jane described was clients' willingness to share about themselves. She discussed how easy it was to make assumptions about clients and, therefore, found it helpful when clients provided information about themselves so she did not have to guess or assume. Jane also identified the positive impact when clients were willing to be challenged, specifically with food. She stated if a client agreed to bring food into the therapy session, it was a good indicator the relationship was going well.

Unhelpful therapist factors.

Pushing own agenda. Jane described that it was unhelpful when she pushed her own agenda rather than working with the client to establish a direction for therapy. She explained clients picked up on this and it created resistance in the relationship: "If you try to drive an agenda...[client's] energy is going to go more into their defenses and into resisting." Furthermore, she explained that it "becomes something you want and need, and even if it's something they may want and need...there is going to be resistance to doing it for you."

Drawing strict boundaries early in treatment. Jane described drawing strict boundaries with clients early in treatment negatively impacted the alliance formation. For example, she explained she worked with patients who were "frighteningly low

weight, restrictive anorexics.” She told them, “If you lose any further weight, we are going to have to hospitalize you.” Although necessary for their survival, Jane explained, “If there’s not a relationship, that is going to be a therapy interfering behavior any way you cut it,” as clients have dropped out of therapy.

Infantilizing clients. Another unhelpful factor Jane witnessed was when therapists infantilized clients. To further describe this, Jane provided an example:

We have a very low-weight anorexic, and she’s 28-years-old, but she looks 12. When she comes into staffing she has her hair in a ponytail and looks a little bit like Strawberry Shortcake. She comes in and she talks in a little girl voice. And the therapist does the same thing: [talks] very, very gentle. Over the years I’ve said, “Use your grown-up voice. Talk with them as an adult.” These anorexics are tough as nails in terms of their character. So remember that, and to not get pulled into that place that you’re infantilizing them.

Unhelpful client factors.

Unwillingness. Jane identified a client’s unwillingness as an unhelpful factor to the therapeutic relationship. One example she described was when a client had not experienced negative consequences of the eating disorder (e.g., losing a relationship) because she was young and “protective of the eating disorder.” With this type of client, Jane noted the client was likely forced into treatment and did not attend on her own volition. Other ways clients portrayed unwillingness were when they did not talk or share. Jane explained, “They’ll give you nothing and sit in silence.”

Control and power. Jane described the difficulty of negotiating the distribution of control and power at the beginning of treatment. She explained this was often a struggle with clients with AN: “That idea of control. Who controls whom? Who has the power and what it means to have choice. They want power, but they are so afraid of power because of the responsibility and having to express power perfectly.” Jane also

described her interaction with a client: because of the client's fear of losing control and power, she screamed at Jane, "You will not make me fat!"

Kathy

Background. Kathy is a 32-year-old Caucasian female therapist. She has her master's degree in Clinical Psychology and is a licensed professional counselor (LPC) in an outpatient facility for eating disorders. She has worked in the mental health field with eating disorders for 10 years and provided individual therapy to approximately 150 clients with AN. Kathy and I conducted our interview over the phone. After the interview, she provided feedback about her individual themes and the composite description. She agreed with the themes and added a few clarifying statements to both documents. She did not comment on the accuracy of her transcript.

Description of the alliance. Prior to our interview, I asked Kathy to think about an object that symbolized the relationship she had with clients with AN. She explained she initially thought of a game of tug-o-war; however, after giving it more thought, she chose a game of chess. Kathy explained that with chess, "You have to be cautious with each move you make, or the impact you will have on the game, the other player, or yourself." She also highlighted the speed at which the game is played and how it parallels the alliance formation: "It's a very slow-moving, methodical process." Furthermore, Kathy described the alliance as a "collaborative relationship" and explained it is a process of "helping the client see why something is not working, or how to do things differently."

Helpful therapist factors.

Understanding the client's experience. Kathy shared how helpful it was when she tried to understand the client's experience. She explained, "I think it's really important to understand how their illness works for them, instead of assuming that it's not working and try to take it away." For Kathy, this exploration helped build rapport because it was less threatening as she did not try to change the client's eating disorder but rather understand it. Kathy also highlighted that the eating disorder was not a "bad thing" because it did something positive for the clients. By doing this, she explained, "For the first time, [the clients] feel understood, and not bad, wrong, or crazy." Kathy also tried to give clients permission to disagree with things she said and empower them to use their voice so she could further understand their experience.

Not everyone wants to get better. Another helpful factor Kathy described was for her to realize "not everyone wants to get better." She explained how difficult it was to want something for her clients they did not want for themselves. For Kathy, she had to "reconcile" this fact within herself; she realized getting better might look different from client to client as well as the rate at which this process occurred.

Authentic and setting boundaries. Kathy described how helpful it was to be authentic and genuine with her clients. She explained, "I'm a pretty 'as is' therapist; who I am as a person is similar to who I am as a therapist." For example, she described how she enjoyed intellectual battles with friends and she occasionally got into these with clients. She further described how this helped build trust in the relationship. While being authentic and genuine, Kathy also noted the importance of keeping boundaries.

I'm genuine. For me, it's not fair to be a blank slate. That being said, I also have boundaries. Obviously, I'm not sharing my life story. I'm not putting that stuff

out there. It's more just a genuine response. I'm not saying that I start crying and telling them about my childhood. It's more tears of empathy or laughing with them.

Kathy also highlighted awareness of each client's boundaries and explained with "certain clients...with looser boundaries...or have more borderline personality traits, I probably share less with, especially initially, just because they are seeking a lot more."

Awareness of self. One last helpful therapist factor Kathy identified was being aware of her own history and issues. She explained, "Knowing your own and being able to separate out what is yours and what is theirs [the client's] is huge." One way Kathy did this was to have a good support system and other professionals whom she consulted. She explained how helpful it was to "vent because it can be a very frustrating population." Additionally, it was helpful for Kathy to be cognizant of how she used language: "Language is one of the biggest pieces of effective therapy with this population. The way you say things and how you say things is so vital."

Helpful client factors.

Sharing life story and connecting. One helpful client-factor Kathy described was when clients shared their life story and how it related to their eating disorder. This knowledge allowed her to understand what life events the client held as "important and significant" and helped her "get touched by their story, and understand and empathize with it." While telling the story, Kathy also explained if clients connected to their experience and felt the emotions tied to the life events, it helped her feel more connected to them.

Trusting the therapist and the process. Kathy identified clients' trust in her and in the relationship as helpful. She explained, "I think the hardest part in the relationship

building is trust because you're asking the person to give up something they trust. In order to do that, they have to trust you." Kathy also described that it was helpful for clients to be patient and "trust the process in and of itself."

Unhelpful therapist factors.

Villainizing the eating disorder. Kathy explained how unhelpful it was when she criticized and judged the client's eating disorder. Kathy provided a metaphor for this process:

It's like if you're in a relationship and I don't think your boyfriend or significant other is that great of a person. If I villainize them and I tell you that they're a horrible person and that you should leave them...there's a greater likelihood that you're going to stay with them, because it's like I'm criticizing your judgment. "You're silly. You're stupid. You could get hurt." I start putting all of that on them.

Another way Kathy described criticizing the eating disorder was getting into a "logical battle." She gave an example where she found herself arguing with a male client about the logic of an eating disorder. She explained that she tried "to make sense of an illness that, for all intent and purposes, does not make any logical sense" and she got "stuck with that battle of feeling frustrated because I couldn't change his mind."

Different goals and negative reactions. Another unhelpful factor was when she had different goals than her client. Kathy explained that her definition of recovery at times did not match the client's definition of recovery. For example, "I may think recovery is not engaging in behaviors, being fully weight restored, [and] normalizing their eating; whereas their idea of recovery might be not being in the hospital anymore." She further noted when she and her client did not have the same goals, it created "a lot of resistance and frustration on the therapist's part because you feel like they don't want to do anything." Kathy also explained this difference in goals created negative reactions

toward the client. She asked herself, “Can I tolerate when they don’t want what I want them to want? And if I’m not cognizant that that’s my need and not theirs, it can create tension and frustration in the relationship.”

Personality-type does not “mesh.” Kathy explained how another unhelpful therapist-facilitated factor was when a client’s personality did not “mesh” or easily work with her personality. For example, Kathy had a difficult time working with clients who were very dependent or had a dependent personality disorder. She explained:

It’s just a personality that is harder for me to tolerate...I’m very much a therapist that challenges people to...ask for it and use your voice and not your body. And often times with more dependent [personality], there’s a lot of, “I’m going to show you what I need by curling up in the corner of your couch and being sad, but not saying it.” And that can get frustrating for me.

When Kathy worked with these types of clients, she noted the difficulty in building an alliance because she was often frustrated.

Unhelpful client factors.

Resistance. Kathy described resistance as a client behavior that was unhelpful for the relationship. To define resistance, she explained it as a client not wanting to get rid of his/her eating disorder. She noted that unlike clients with depression and anxiety who want to get rid of their disorder, clients with anorexia usually do not; they might want their “heart to beat normally or to feel energetic.” However, she expressed this did not necessarily mean they wanted to get rid of the illness. For Kathy, she identified this as the biggest hurdle in trying to figure out how to “move past resistance and try something [new].”

Trauma or personality disorders. Another factor Kathy highlighted that made the relationship difficult was if the client experienced a trauma or had a personality

disorder. She explained these can “impact the relationship and they [the clients] can have very rigid or very loose boundaries, and that makes the relationship difficult or a little bit more challenging.” Furthermore, she observed that it added another “piece to the puzzle” and was difficult to balance while working on other issues.

Tim

Background. Tim is a 38-year-old Caucasian male who is a licensed professional counselor. He has a master’s degree in Transpersonal Counseling and has taken several Ph.D.-level courses. Tim works at a residential treatment facility for adults with eating disorders; he works primarily as a family therapist. He has also had experience working with clients with AN in an outpatient setting. Tim has treated clients with eating disorders for approximately five years and provided therapy to approximately 200 clients with AN. Tim and I met in person at a public library to conduct the interview. He was willing to help with this study and expressed his appreciation that I was doing research on this topic and with this population. Tim was the only participant who provided feedback on all three documents: his transcript, individual themes, and composite description. The only changes he made to these documents were grammatical or clarifying in nature, and did not change the meaning of the themes.

Description of the alliance. The object Tim brought to our interview to describe the therapeutic relationship with clients with AN was a small stuffed animal giraffe. He explained that in therapy, he used a model called non-violent communication, which was a “basic conflict resolution model: when you...I feel...I need... and adds another piece to it where you share what you felt, but connect it to an unmet need.” In this model, the giraffe represents a non-violent approach and the main goal is to stay connected to the

client. Opposite of the giraffe is the jackal; the jackal's way of communicating is "I'm right and you're wrong." Tim highlighted how his role as a therapist, and as the giraffe, was to be accepting, empathic, compassionate, and patient. He also described the process of building the therapeutic relationship as "so much more an art than a science."

Helpful therapist factors.

Compassion, validation, and confidence. Tim highlighted several therapist characteristics that helped build the alliance including compassion and gentleness. He believed his compassion was communicated through his gentleness "If you say something more gently...it doesn't mean you shouldn't be firm, but there's no reason not to do it gently if you can... and with compassion." Tim expressed when he was gentle and compassionate, rapport was built quickly. Other helpful factors included being empathic, non-judgmental, and validating. He hoped by modeling this to clients, they could learn to be this way with themselves. Additionally, Tim expressed how important it was to have experience and confidence working with eating disorders. He stated, "They [clients] pick up on it. They are very savvy in the sense, just doing a lot of treatment for a long time. So they pick up very quickly if what you're doing is helping."

Collaboration with families. Another helpful factor Tim acknowledged was being able to work and collaborate with the client's family. He explained if he could help the client's parents and family understand the disorder and validate the client's experience, it was easier for the client to maintain recovery. Otherwise, if everyone was "checked out" and the client lived at home, "that's a huge set up [for failure]." One way Tim did this was by asking the families to identify ways they might avoid their own feelings such as watching too much television. He also tried to help the families

understand how the eating disorder functioned much like an addiction and tried to teach them to “really listen” to the client.

Relating to clients while maintaining boundaries. Tim described how helpful it was to be genuine and to relate to clients while maintaining boundaries. He explained being genuine helped build rapport: “People with eating disorders tend to be highly sensitive. So the more real and genuine you can be, the better.” He also related to clients with anorexia because he is a sensitive person; he stated, “I think my addiction would be work-o-holism.” He noted when he shared a little bit about himself, clients said, “Wow! That definitely makes you a little more human, and a little easier to relate to.” On the other hand, Tim also acknowledged being a straight male and working primarily with females could “bring up all sorts of things.” Therefore, he explained how he erred on the side of disclosing very little: “I’d rather be a little less human because I’m not there to be their friend.”

Attuned to clients’ needs. Another helpful factor Tim identified was being attuned to his clients’ needs and customizing therapy. One example he provided was working with clients who experienced trauma. He explained how it was vital to talk about “resourcing them first before doing really difficult emotional trauma work.” If he did not first assess their level of resources, he might have moved too quickly into trauma work, leaving the client with little to no resources to deal with what came up. Another way Tim was attuned to his clients’ needs was by paying attention to their non-verbals. For example, he used clients’ non-verbal behavior to identify when they were “checked out” and not engaged.

Being a secure base and self-care. One last helpful therapist-factor was being a stable, secure base for clients. Tim explained, “You are acting as a surrogate witness...until they are able to do that for themselves. And if you can’t bring that into the room, you don’t have much to offer them.” Because of this, he also highlighted the importance of self-care. He stated, “You can’t let yourself and your whole [being] go to shit.” For Tim, this meant he had to do his own work around staying balanced and learning self-care, which included taking vacations and days off.

Helpful client factors.

Trusting the therapist. A helpful client-facilitated factor Tim highlighted was when clients were able to trust him. He explained, “If there’s one thing I would ask patients, it’s to trust me.” He further described how trust is helpful: “The ones who are trusting, the work is so much more quick and so much more graceful.”

Honesty and providing feedback. Another helpful factor was when clients were honest with Tim and provided feedback about their needs and the relationship. He explained, “Any time they’re able to really be honest with me, but especially anything that I’m doing that’s quote, unquote wrong, there’s nothing more valuable than that.” For Tim, when a client was able to be honest about the relationship and what was going well and not so well, it provided him an opportunity to shift his work so he could meet the client’s needs. He also identified how difficult this was for clients, specifically those who experienced trauma and lost their ability to say no as well as clients who were “people pleasers.... It’s such a set-up for them not to tell me what they’re needing.”

Unhelpful therapist factors.

Arguing about body image. Tim shared how unhelpful it was to get into logical arguments with clients about their body image. He explained that he used to struggle with this: “They [clients] just think they’re fat, and you know they’re not. And it’s so easy to just slip into a power struggle and try to talk them out of it, but you can’t.” He noted it helpful when he understood it was their reality and treated it like a delusional disorder.

Lack of attunement. Another factor that negatively impacted the relationship was when Tim was not attuned to the client and her nonverbal behavior. Tim recalled an example where he became “too pushy and psycho-educational about something” and “lost them.” Looking back, he realized that had he kept it shorter and provided opportunities to see if what he said fit with her experience, “she would have had a chance to redirect me.”

Unhelpful client factors.

Hopeless and difficulty trusting. Tim described that when clients were hopeless and said, “Nothing works,” he found this unhelpful for the relationship. He explained that clients who had chronic relapse and in treatment many times, this was their experience: “dark and completely hopeless.” Tim also acknowledged clients who were hopeless had difficulty trusting that anything would help. He identified if he could help a client gain even a small amount of hope, “that’s really the key.”

Lack of readiness and unwilling to change. One last unhelpful factor was when clients were not ready or willing to change, specifically the way they viewed themselves. For example, Tim worked with the client’s inner child and explained how frustrating and

difficult it was when “they’re not willing to go there” and were negative with themselves. He described “wanting to call child protective services on their psyche, because their psyche is so nasty.” Tim further explained how unhelpful it was when clients were not able or not willing to change their “self-abuse.”

Sally

Background. Sally is a 28-year-old Caucasian female who has her Master of Social Work (MSW) and is a licensed social worker. Currently, she works as a social worker at an inpatient treatment facility for adults with eating disorders and provides individual therapy. She has worked with clients with eating disorders for two years and provided treatment to approximately 40 clients with AN. Sally and I conducted the interview in person; after the interview, she provided feedback about her individual themes, which she reported were accurate. She did not provide feedback regarding her transcript or the composite description.

Description of the alliance. When describing the therapeutic alliance with clients with AN, Sally chose a Chinese finger trap to symbolize this relationship. She described when playing with a finger trap, one puts a finger in each end of the tube; when one pulls one’s fingers apart in different directions, the trap gets tighter and will not come off. To get it off, one must push their fingers together and work with the resistance. Sally explained, “There is often a lot of resistance with patients with anorexia. Sort of this idea of pull at both ends and getting more and more stuck. And when you kind of ease with the resistance, you are able to work it off your finger.” Sally also stated she tried to build a relationship with a foundation of empathy, trust, and compassion.

Because many clients with AN have “trust trauma around connecting,” she explained that these therapist characteristics helped the client feel safe enough to start connecting.

Helpful therapist factors.

Using humor and being genuine. Sally highlighted the helpfulness in using humor. She used humor a lot with clients and found it helpful in creating a bond with them. She also described being genuine and authentic positively affected the relationship: “I think of all the populations I have ever worked with, the patients with anorexia are highly, highly sensitive people, and if you are not your authentic self, they will see through you in a second.”

Balance between compassion and boundaries. Another helpful factor Sally identified was striking a balance between compassion and setting boundaries. She explained eating disorders are “buried in lies and secrecy” and there is a lot of “shame, lying, and hiding”; therefore, she explained she had to confront these behaviors “pretty head on...and shine a light on those areas” while still meeting the client with pure compassion. She told clients, “This is really hard for you AND you need to do this.” Another way Sally portrayed empathy and compassion to clients was by using touch. She explained, “Depending on the patient and their trauma history, I do a lot of touch: hug them in therapy or touch their knee. I think there is some level of executing some empathy in doing that.”

Role-modeling. Being a good role model to clients was another helpful factor Sally identified. She explained:

I think such a pervasive theme for these patients is disempowerment, and a lot of my job is trying to role model being an empowered woman; this is what it is like for a woman who gets angry, and gets sad, and is able to form her own boundaries and relationships, and create a life she wants. I think that in itself is more

[helpful] than, “Here is some education about anorexia.” More like, “This is how I endure my life.” It is pretty powerful for them.

She also provided an example of how she role modeled being relaxed and comfortable, which sometimes helped clients relax sitting with her during a session. She stated, “They bring in so much anxious energy in their bodies.”

Letting go of outcome and redefining success. Sally identified being able to let go of her own definition of recovery and redefining success was helpful. She explained because this is a persistent and pervasive disease, it can take “a long, long time” for clients to get better: “You’re only going to be a very small part of a very big process.” For Sally, she found it helpful to “let go of getting them to weight restore, getting them to be more open in therapy, and looking for markers of success much smaller and more intangible.” For example, she described how a client might sit differently in his or her chair during a session or finally show some kind of emotion: “Sometimes getting screamed at by a patient is great. It means they are safe enough with you to be angry with you.” Whatever the change, Sally highlighted the utility of using these markers to identify success.

Collaborative approach and fostering hope. One last helpful factor Sally described was being collaborative with her clients and fostering hope. To create a collaborative environment, she invited feedback from clients and asked for their opinion about various topics including the therapeutic relationship. She also tried to foster hope and highlighted when the client was acting or reacting differently, especially in their relationship.

Helpful client factors.

Willingness and being present. One client behavior Sally noted as helpful was willingness. She explained this could look like a willingness to talk or share more, or a willingness to feel or try something uncomfortable. Sally also described the importance of a client being present in session: “Not just showing up to session, but actually being present in session. It is a big thing.”

Honesty and humor. Also helpful to the relationship was when clients were truthful and honest. Sally shared it was helpful when clients were transparent about their eating disorder behaviors and felt safe enough to discuss them during therapy. She also stated, “Anytime they [clients] are able to bring humor is helpful.”

Unhelpful therapist factors.

Stuck in the content rat wheel. Sally noted an unhelpful therapist factor was getting “stuck in the content and not the process.” She explained that many times, clients came in and wanted to talk about how much weight they gained or how their dietician tricked them because “she made me do this much avocado and I never do this much avocado.” Sally acknowledged, “There are days where they will suck you right into that, and twenty minutes later it’s like...I got right in that rat wheel with them. We’re both just spinning around now.” She explained that this was frustrating since she saw this as a way for clients to avoid connecting to her and themselves.

Invalidating the client’s experience. Another unhelpful factor was invalidating the client’s experience. Sally provided an example of a time when she unknowingly did this:

I think what happened with me and this patient was that I was such a champion of her recovery, and that was becoming really invalidating for her because she was

feeling pretty hopeless, pretty done, and pretty unsure. At first, I think we were really together, but at some point I think it shifted where I was kind of dragging her along and I wasn't aware of that because I cared about her and her recovery so much. I lost sight of that, and then there started some friction in our relationship.

Another way Sally described invalidating a client's experience was when she villainized the eating disorder and forgot it functioned for clients in a positive way. She stated it is a "very thin line between wanting to not put the eating disorder on a pedestal, and kind of disempowering it" without villainizing it.

Talking too much. Several times, Sally explained she talked too much in therapy sessions and acknowledged this was unhelpful to the relationship. She stated, "Sometimes, the sessions with these patients can be painful. They are just so rigid...and don't talk or share." Therefore, Sally tried to fill the silence by talking; at the end of the session, she realized, "Wow! Seventy percent of the session was me talking AT them." She also noted this was likely similar to other relationships in the client's life; she realized this was "probably exactly what they are getting from everybody else in their life and that is not therapeutic."

Making assumptions. Making assumptions was another unhelpful therapist factor. Sally explained because there are many pervasive traits from client to client and because many clients "tend to withhold so much [information], sometimes in an effort to get some trajectories in a session," she verbalized an assumption about eating disorders that did not "resonate with that person." What made this more difficult was that "these are not patients that typically get reactive and stand up for themselves. Sometimes, you get on this train with some idea about what they need or where they are, which is not true. And they won't stop you."

Unhelpful client factor--Avoidance and people pleasing. Sally highlighted avoidance as an unhelpful client factor. She explained many clients avoid feeling and experiencing emotion and connection. To do this, she stated, “They avoid in so many masterful ways,” such as accomplishing tasks. Another avoidant behavior included “people pleasing.” She stated, “People pleasing is ultimately really hurtful when the session becomes more about them just giving me what they think I want” versus sharing their personal thoughts and feelings.

Mary

Background. Mary is a 53-year-old Caucasian female who works as a psychologist in an outpatient private practice; she has a Ph.D. in Counseling Psychology. Mary has worked with clients with eating disorders for 25 years and has provided individual therapy to approximately 125 clients with AN. Mary and I met in person at her office to conduct the interview. Her office was dimly lit and had a large leather couch and chair. The walls of her office were decorated with various pieces of artwork; in the corner was a small bookcase with books about various disorders on the shelves. Mary was willing to share her experience. She was also active in reading over her transcript and individual themes and stated they were both accurate.

Description of the alliance. The object Mary chose to symbolize the relationship she had with clients with AN was a scene from the movie, *The Horse Whisperer*. She explained:

There’s a scene in the movie where the horse whisperer is working with the wild horse that won’t be ridden and they have a power struggle. The horse runs off. What the horse whisperer does is what feels like my experience working with anorexic clients...Because what he did, when the horse went out into the field, was to sit. They were a great distance apart and the horse whisperer sat and watched and just held the space while the horse was recovering doing what it

needed to do, [and] figuring out what was next. Gradually, he took a couple of steps closer and then stopped...The horse whisperer represents my approach to relationships to any client who is shut down, walled up, or hell bent on control.

Mary went on to describe this as a slow, methodical process of building a relationship and explained, “It’s on the horse’s terms. It’s never, ever on my terms.” She also explained that just like the horse, these clients have a reason for not trusting: “and the fact that the horse ever trusted the horse whisperer, or that my clients who have been so traumatized would ever trust me, that’s amazing.”

Mary further described the therapeutic relationship with clients with AN. She explained many of these clients withheld information “because the people in their lives have demanded, controlled, and criticized them, and that’s what they expect.” She then posed the question, “So why are they going to open up so I can be another person that’s just going to take out the knife and start hacking away?” By having this understanding as to why clients presented the way they did, she explained it made her job easier, which was to create a different relationship for them: one of care and respect versus control and perfection.

Helpful therapist factors.

Respect and recognizing resources. One helpful therapist behavior Mary highlighted was being respectful and recognizing the client’s resources. For Mary, when she thought of respect, she tried not to see an eating disorder, but rather a person. By doing this, she was able to see the person as “strong and having resources.” She explained, “When someone comes walking into my office and they weigh 85 pounds and they look like a skeleton, it’s very easy to see all of the problems that they have,” which she labeled as seeing the eating disorder. She went on to say, “What’s not always

apparent immediately is the real deal...the strength of will, the internal resources to somehow keep going.” Mary explained this strengths-based approach helped her connect to clients and build hope.

Balancing accountability and care. Another helpful therapist factor was being able to balance accountability and care. Mary explained an approach explained by Carolyn Costin: “She [Costin] talks about having an approach where she has one arm around the client while she’s kicking them in the butt with her foot.” According to Mary, this is what she tried to do. She noted she cannot “sit and wait in the field forever while the person starves themselves to death.” However, she tried to find a small piece of the client that wanted to feel better and highlighted this piece to them. She explained, “When I’m alert enough to catch those little moments, that’s how the relationship slowly begins to form.”

Attuned to client’s needs and therapist’s reactions. Mary discussed the importance and helpfulness of being attuned to the client’s needs as well as being attuned to her own biases and feelings. For example, Mary explained how some researchers found a correlation between anorexia and anxious-avoidant attachment style. She explained, “Their [clients] approach with relationships is not to approach, but to avoid. So, when I’m aware that the reason they’re sitting 10 feet away from me is that they’re trying not to need me. That gives me a framework that I can operate out of.” For Mary, this helped her respect the physical distance and not rush in because the client was resistant. Mary discussed further how helpful it was to notice the changes in clients’ bodies; how they were sitting or if something happened in their body, she helped them tune into it. She also noted that many times, a client came into her office tense and

uncomfortable, and she noticed herself becoming uncomfortable and tense. When this happened, she explained how she tried to make herself relax and use non-verbal modeling. One last way Mary tried to stay attuned to clients' needs was when she chose to self-disclose or not. She explained, "Self-disclosure has to be done in the right way at the right time, which usually means I don't do it." She went on to say that if she was attuned to the client and realized they were having a hard time trusting her, or they saw her as an authority figure, self-disclosure "can help break that barrier."

Acknowledging limitations. Mary explained one of the most difficult, but also one of the most helpful factors was acknowledging her limitations in creating change. She explained, "One of the most challenging aspects of this work, for me, is to know that I can't make anybody well, and sometimes therapy doesn't work." She went on to quote the statistics of recovery for clients with anorexia: "about 30% get better, 30% stay the same, and 30% get worse, with a 10% mortality rate." Although this can be difficult to accept, Mary alluded to how this helped alleviate the pressure she might feel to make her clients better.

Diplomacy and managing a team. One last helpful therapist factor Mary identified was being diplomatic when working with other professionals on the client's treatment team and managing the family. She explained that some of these professionals had different approaches and agendas when treating eating disorders and, sometimes, had a minimal understanding of the disorder. She also described that it was helpful to identify the roles of each professional: "I leave all of the medical complications to the medical professionals," e.g., assessing the client's risk and deciding if s/he needed hospitalization. Mary explained her role: "I try to set all of that aside when I'm in session

and try to go with the psyche.” She also noted that sometimes the client’s family might have their own agenda; therefore, it is important to “gather and manage a team.”

Helpful client factors.

Willingness. A client’s willingness was one helpful client factor Mary identified. She described willingness as “willingness to hurt, willingness to suffer, willingness to be vulnerable and feel like a mess.” She explained she cannot control if the client is “willing to face themselves or not.” Mary noted, “I build the safety. I provide the respect, but it’s really up to them...that is completely a client factor.”

Honesty. Another helpful client factor in building and measuring the therapeutic relationship was a client’s honesty. Mary explained when a client said, “I haven’t eaten for three days,” she knew things were moving in the right direction. She noted that although it might sound counterintuitive, when clients come in after the first session and say they did “really well,” she knew they were not being honest and truthful, which negatively impacted the relationship.

Unhelpful therapist factors.

Stuck talking about the eating disorder. An unhelpful factor Mary acknowledged was getting “stuck” talking about the details of the eating disorder. She explained that many times clients began the therapy session and wanted to talk about what they did or did not eat, the half-pound gained, or anything related to food and weight. She went on and described that these were more comfortable topics for the client. Because of this, it was easy to focus on rather than encourage clients to talk about the underlying issues such as “hating their mother or feeling incredibly alone or like a failure.”

Becoming the police system. Mary described another unhelpful factor was when she got into the “you have to eat and you have to get better mode.” She explained this included weight monitoring and becoming part of “the police and control system. That gets confusing and it’s not part of my horse whisperer approach.” She further hypothesized this was why about 50% of clients with anorexia develop bulimia:

My experience is a lot of times that happens because the family doctor, the parents, the schools says, “You have to eat. You have to gain weight.” That approach results in that the person will gain weight, but they’ll be throwing up everything they eat. Still needing that control.

Mary also fell into “the trap” of forcing, coercing, and controlling clients so they would eat and noted how unhelpful it was to the relationship.

Highlighting a client’s nonverbal communication. Mary explained there were times when she commented on a client’s nonverbal behavior, e.g., noting a shift in posture or when the client changed positions in the chair. Sometimes, these comments were welcomed and the client appeared to think, “Oh, she really is here with me. She’s really present.” However, other times when it was not welcomed, the client presented as “I’m not ready for that. Don’t talk to me about my body. Don’t go there.” When they were not ready for her comment, Mary explained, “That’s a clue that I missed it and need to back off.” Therefore, while this is not always unhelpful when it is done too soon, it can negatively impact the relationship.

Inappropriate self-disclosure. One last unhelpful factor Mary noted was the use of inappropriate self-disclosure. Whenever she shared with a client about her past or current relationship with food, “It seems like it just bogs things down.” She further explained why self-disclosure could also be unhelpful with this particular population:

Most of my eating disorder clients are very sensitive and have a caretaking pattern in their relationships. So, if I begin to talk about something it will often become a cue that they have to start taking care of me. And that's a burden in the therapeutic alliance that they don't need. That's what they have everywhere else in the world.

Unhelpful client factors.

Lack of an observing ego. An unhelpful client factor Mary observed was when clients lacked an observing ego, especially if they had schizophrenia or a personality disorder. She explained that this was unhelpful because they lacked a sense of self and, therefore, had difficulty being aware of their feelings and actions. She also noted these individuals had “internal instability,” which was also difficult to work with.

Avoidance. Another client factor Mary acknowledged as difficult was a client's avoidance. One way clients avoided in her office was talking about weight or food versus talking about their feelings and what was really going on to maintain the eating disorder such as hating their mother or feeling alone or like a failure. Mary understood clients used these defenses, consciously or unconsciously, to prevent them from making a connection with her. She explained, “Sometimes during the session, I feel like all we did was sit on opposite sides of the room and look at each other.” She explained they talked about school or who was in their family but there was no emotional content.

External systems. Mary shared that external systems in the client's life have also been unhelpful. Mary explained these systems could include doctors, physicians, school counselors, families, and managed care. Since she has been in the field for 20 years, she shared physicians have improved; however, several years ago, physicians did not know much about eating disorders and “would tell their clients they needed to go home and eat and gain weight.” The client's family has also posed a barrier when they had an agenda

for the client. For example, she explained when she worked with a teenager and her family was not willing to look at themselves and change some things, “the recovery process is very difficult and slow.” Additionally, she stated that managed care has been an unhelpful third party because they had limitations on what they would and would not pay. She explained that some insurance providers covered between three to five days for inpatient treatment, when 30 days was not even enough for the client. Mary noted while these external systems were not always unhelpful, many times they negatively impacted the relationship she had with her client.

Conclusion

In this chapter, I reviewed the participants’ background, experience in therapy and the eating disorder field, and object(s) they chose to represent the therapeutic working alliance. I also explored the participants’ individual themes and how they experienced the therapeutic working alliance in individual psychotherapy. Additionally, I identified the helpful and unhelpful client- and therapist-facilitated factors the participants highlighted. In the next chapter, I explore the participants’ overarching experience (composite experience), highlighting the similarities and differences among the clients’ and therapists’ experiences.

CHAPTER V

FINDINGS: COMPOSITE EXPERIENCE

The purpose of this phenomenological study was to understand how clients with Anorexia Nervosa (AN) and therapists who work with this population describe and experience the therapeutic working alliance in individual psychotherapy. In Chapter IV, I reviewed each participant's individual experience of the working alliance through a textural-structural description (Moustakas, 1994). In this chapter, I describe the composite description (i.e., shared meaning)--first for clients and then for therapists. I end the chapter by discussing the similarities and differences between the clients' and therapists' composite descriptions of the therapeutic working alliance.

Client Participants' Overarching Themes

In this section, I review the overarching themes among the eight client participants. First, I provide the grouped demographic information, followed by the similarities among the participant's description of the alliance including their artifact description, explanation of the alliance with their therapist, and how therapy goals influenced the alliance. I then report the overarching themes noted by a high number of the participants pertaining to the factors they believed were both helpful and unhelpful in building the therapeutic relationship.

Demographic Information

The eight participants ranged in age from 20 to 63-years-old, with an average age of 39.25 years and a median age of 52.5. Seven participants were female, one was male, and all were Caucasian/White. The number of sessions participants had with their current therapist ranged from 30 to over 500 sessions, the average number was 205, and the median number was 175. Additionally, the number of years the participants were diagnosed with AN ranged from one and a half years to 31 years, the average number was 12.75 years, and the median number was 9.5. Three participants earned an associate's degree, three had a bachelor's degree, one was finishing a master's degree, and one earned a master's degree. All participants were from the Midwest, Southeast, or Eastern part of the United States of America.

Description of the Alliance

Artifact description. Each client participant chose an artifact to describe the therapeutic working alliance with their individual therapist. The artifacts are reported in Table 3. Among the artifact descriptions, three themes emerged: touchstone and stability, knowledgeable and understanding, and warmth and support.

Table 3

Artifacts Reported by Client Participants

Name of Participant	Artifact
Jessica	Heart-shaped rock
Snow	Small gray rock
Cody	Rock and encyclopedia
Melissa	Building blocks/Lego blocks
Laura-Leigh	Children's toys: Stuff animals and little puzzles
Emily	Lion from the book, <i>The Chronicles of Narnia</i>
Kelly	Pillow
Jamie	A big pillow and many pillows

Touchstone and stability. A common theme among seven participants' artifact descriptions was that the relationship was like a touchstone, which Snow defined as something "stable...that brings objectivity to a situation." For example, Snow's artifact was a rock. She explained that both the rock and her therapist were a "touchstone"; when she rubbed it, she became less worried about a situation. Other participants described their artifact as stable and used it during times of difficulty. Emily chose the Lion in the book *The Chronicles of Narnia*: "he [pulled] through for the characters...even when you felt like you were sinking." The idea that therapists were available and stable during times of difficulty appeared helpful in building the relationship and establishing trust.

Knowledgeable and understanding. Another theme named by three participants was that therapists were knowledgeable and understanding. Emily described both the

Lion and her therapist as wise. Cody stated his therapist “knows all the answers” and was an “encyclopedia.” Along with being knowledgeable and wise, a similar theme of understanding emerged. Jamie explained that her therapist understood and knew how she felt in many different situations, which helped create trust and a bond.

Warmth and support. When describing their artifacts, four participants identified warmth and support as characteristics of both the artifact and the relationship. Kelly described her artifact, a pillow, as “a comfortable place”--one where nothing bad happened to her. Laura-Leigh used the words “warmth” and “comfort” when describing her artifact--children’s toys. Additionally, two participants said their therapist supported them by being objective and bringing “reality back to the situation.”

Relationship description at the beginning. After the participants discussed their artifacts, they described the working alliance with their therapist. Participants discussed the relationship at two different times: at the beginning of therapy and during the time this study took place. Three similar themes emerged when participants described the relationship at the beginning of therapy: slow and cautious, not ready for therapy, and therapist’s role: building trust.

Slow and cautious. Four participants approached the therapy relationship in a slow and cautious fashion. Several did so because they were nervous and scared about what would happen if they opened up or disclosed personal information. Melissa stated it took a long time to build trust because she was nervous her therapist would tell her mother everything discussed during the session as she was a minor at the beginning of treatment. Furthermore, Emily described she was initially “horrificed” and scared as she did not know what to expect in her first therapy session.

Not ready for therapy. Three participants were unwilling to seek therapy at the beginning of treatment. Jessica described she was “resistant to therapy and to health in general;” thus, she did not readily open up or discuss her past trauma until two or three years into therapy. Additionally, all eight participants began treatment because a family member or friend “forced” or strongly encouraged them to go. Cody explained he was in “denial” and did not think he needed therapy because there was nothing wrong with him.

Therapist’s role: Building trust. Three participants viewed building trust and the therapeutic relationship as the therapist’s responsibility early in treatment. For example, Melissa said her therapist “pull[ed] my teeth” and asked many questions to help her feel comfortable to open up and talk. She also explained that her therapist proved to be a trustworthy person by not telling her mother information discussed during therapy.

Current relationship description. All participants reported their current relationship with their therapist was “good” or “great.” Although many described the beginning as difficult, slow, and more of the therapist’s responsibility, their descriptions of the current relationship were more positive and collaborative in nature. Themes that emerged from descriptions of the current relationship included comfortable and safe, dependable, and professional friendship/mentorship.

Comfortable and safe. A common theme among four participants’ descriptions of the relationship was comfortable and safe. Emily described the relationship as “relaxed, casual, and comfortable,” and explained that it was two people talking back and forth. Kelly also acknowledged her relationship was professional but similar to talking to a friend--nothing that felt “sterile.” Additionally, several participants conveyed the relationship was a non-judgmental space where they felt open and safe. Jamie stated she

was able to express her feelings and did not fear being put down for them. Emily did not experience being analyzed or critiqued when she spoke during sessions.

Dependable. Four participants described their therapist and the therapeutic alliance as dependable. Snow explained that she depended on her therapist when working through difficult topics. Cody's therapist supported him through several relapses. He stated, "She's my rock. That's what I call her." Knowing the participants could rely on their therapist, specifically during times of distress, helped create a strong relationship.

Professional friendship/mentorship. Four participants described the current relationship as similar to a friendship or mentorship, yet still acknowledged there were boundaries. For example, Jessica described her relationship as a friendship, "although she's the therapist and I'm the client." Similarly, Melissa highlighted that due to her profession as a social worker, she saw her therapist as a mentor. However, she stated, "We are not equals because she's my therapist." Cody also explained that his relationship with his therapist was like a team, as they collaborated.

Therapy Goals

I asked participants to describe therapy goals and how they impacted the alliance. Five participants created specific therapy goals with their therapist and three did not. Those goals had focused on weight restoration/stabilization, changing eating disorder behaviors, and/or reducing post-traumatic stress disorder symptoms (e.g., nightmares, flashbacks, concentration problems). Themes regarding therapy goals emerged from the descriptions and included benefits of having concrete goals, therapist took the lead, created collaboratively, and goals can be unhelpful.

Benefits of having concrete goals. Four participants described having concrete goals as helpful for their treatment and alliance. For Jessica, goals provided motivation and helped her focus on the future. Snow highlighted that they were helpful because she was “task- and goal-oriented.” Jamie and Snow’s therapists had them identify tasks to work on between sessions (e.g., journaling about their food intake and/or feelings) or left them with something to think about before their next session. Snow emphasized this helped her think about her therapist and the relationship during the week, and was like a “touch point.” Laura-Leigh was a client participant who did not establish goals with her therapist; however, when discussing this, she admitted, “I might have benefited more if I had [goals]; if my therapist had had more aptitude for that.”

Therapist took the lead. At the beginning of treatment, three participants’ therapists took the lead in identifying goals and a plan for treatment. For example, Emily’s therapist established goals for her treatment: the first month included getting to know each other and building the relationship, then “digging into the past,” and then working on “CBT, coping skills, and cognitive distortions.” Kelly admitted she was unsure at the beginning and did not know what to expect; therefore, it was helpful when her therapist was active in identifying goals and a direction for therapy. Additionally, Melissa acknowledged that once she could not think of a goal, so her therapist provided her with some ideas.

Created collaboratively. Five participants noted collaboration was helpful in the creation of goals. Several admitted they set their standards too high; they were not realistic or achievable. Therefore, their therapist helped make them more realistic. Jessica explained that her therapist was a “sounding board” to help identify if her goals

were “irrational.” Cody also stated he wanted to be “better quicker”; however, his therapist was helpful, explaining it could take many years to “retrain your brain.” Furthermore, Jessica’s therapist collaborated with her and was “on my team and on my side, and she wanted me to succeed. She wanted me to have what was in my best interest.”

In addition to collaboration, three participants identified flexibility as helpful when working toward goals. Emily and Kelly stated their therapists were flexible in changing the goals or the time frame in which they wanted to reach them. For example, Emily noted her therapist had an outline of the session and identified goals but did not get “bogged down on plans or a schedule” and changed the direction of therapy if needed. Kelly explained that she feared her therapist would react and “get mad” when she asked to change the focus of treatment; however, her therapist was flexible and listened to what she needed. Two participants acknowledged that their therapists did not put time restraints on goals. For example, Kelly explained when she was forced to move too fast, she felt scared. She also noted it was helpful when her therapist revised the goals when needed.

Goals can be unhelpful. Four participants described instances when therapy goals were unhelpful. For example, both Jessica and Melissa acknowledged when they did not meet their goals, they felt “depressed,” “worthless,” “disappointed,” “not good enough,” or “like giving up.” Jessica stated, “Goals should be done with extreme caution because a lot of people with anorexia are really perfectionistic.” Furthermore, Snow and Laura-Leigh rebelled against them. To illustrate, Snow explained that she did not work on every goal because she “tested the boundaries” to see how much she could get away

with. Laura-Leigh also described she was “sort of a rebel” and did not like being challenged or told what to do; therefore, occasionally, she did not follow-through.

Helpful Therapist Factors

Seven themes emerged regarding what participants’ therapists did or said that was helpful in building the therapeutic working alliance: contact outside of session, appropriate self-disclosure, collaborating with external systems, strong basic counseling skills, competent and experienced in treating eating disorders, attuned to client’s needs, and warm office environment. These themes are reflected in Table 4. Following the table is a description of each theme.

Table 4

Helpful Therapist Factors Reported by Client Participants

Helpful Therapist Factors	Description
Contact outside of session	Therapists were available for contact in between sessions and during inpatient treatment
Appropriate self-disclosure	Appropriate self-disclosure: (a) occurred slowly, (b) highlighted similarities, (c) created a bond, and (d) balanced “that line” to maintain boundaries
Collaborating with external systems	Therapists collaborated with (a) treatment team (e.g., physician, psychiatrist, dietician), (b) inpatient/hospital personnel, and (c) family
Strong basic counseling skills	Therapists portrayed strong basic counseling skills by (a) validating, (b) lacking judgment, (c) investing in the client, (d) being genuine/authentic, (e) collaborating, and (f) focusing on strengths
Competent and experienced in treating eating disorders	Therapists were competent and experienced when they (a) set boundaries with care, (b) were consistent and reliable, (c) helped clients identify and feel emotions, and (d) were honest about limitations
Attuned to client’s needs	therapists were attuned when they (a) were aware of non-verbal behavior, (b) used touch appropriately, (c) met clients where they were, (d) used caution and care when discussing more intensive treatment, (e) individualized treatment, and (f) provided corrective emotional experiences
Warm office environment	A warm office environment was “homey,” relaxing, safe, and may have carpet, dim lights, and soft music in the waiting room

Contact outside of session. Six participants stated it was helpful when their therapists were available to call, text, or email in between sessions. A few acknowledged they contacted their therapist only if it was an “emergency”; however, others explained

that their therapist encouraged them to call or text if they were struggling or about to “act on” an eating disorder behavior, e.g., restricting or over exercising. Jamie and her therapist developed an agreement whereby Jamie could call and leave a message about anything she wanted, but it was her responsibility to state if she needed her therapist to respond. Kelly noted that even if she chose not to contact her therapist, the option added “an extra layer of trust” because she knew “she’s just there; somebody is there to help me.”

Additionally, Emily and Jamie described it helpful to have their therapist “there every step of the way” when they went to inpatient treatment. For example, Emily’s therapist checked on her weekly and she was able to call her therapist whenever she needed something. For Snow, it meant a lot that her therapist reached out during the week via email (after getting permission) to make sure she was doing okay. She stated although she never responded to the emails, it was meaningful to know her therapist was concerned for and thinking about her.

Appropriate self-disclosure and boundaries. The experiences the participants shared about their therapists’ self-disclosure ranged from self-disclosing about very personal topics (e.g., pregnancy, children, marriage) to limiting self-disclosure to only their professional self (e.g., their degrees earned, their experience in the eating disorder field). Of those whose therapists shared more personal topics, several commonalities emerged. One included the therapists disclosed slowly and cautiously. For example, Melissa stated her therapist self-disclosed “slowly” and “over-time.” Kelly’s therapist “shared things slowly” and was “very, very, very careful with privacy and moral

conduct.” Furthermore, Emily’s therapist was more open about her personal self the farther Emily got in her recovery.

Although self-disclosure occurred slowly, five participants believed their therapist’s rationale was to highlight similarities, provide a connection, and/or be more “human.” To illustrate, Melissa’s therapist self-disclosed about getting married and her pregnancy when Melissa discussed planning her wedding and raising her son. Snow and Laura-Leigh agreed it was helpful to have a therapist who related to things they were going through, e.g., being in the same age range, being a woman who works full-time, raising a family, and being divorced. Jamie stated self-disclosure helped to create “a good common bond.”

While participants appreciated self-disclosure, they also appreciated their therapist’s tentative approach and keeping boundaries. Even though Snow’s therapist shared about herself, she balanced “that line of friend and professional” and was “a therapist first and friend second.” For many participants, it was important for their therapist to frequently acknowledge boundaries, maintain objectivity, and honor the professional relationship.

Collaborating with external systems. Four participants noted the benefits of their therapist collaborating with external systems. One external system included the participants’ treatment team, usually consisting of a medical professional--a physician or psychiatrist and someone trained in nutrition--a nutritionist or dietician. Jamie’s therapist referred her to a nutritionist and psychiatrist and managed the communication between her treatment providers to make sure they were “all on the same page.” Emily explained that her treatment team communicated well and were open with each other. Several

participants' therapists also encouraged them to be involved in additional treatments such as group therapy, 12-step programs, and/or 'Celebrate Recovery.'

Two participants identified it was helpful when their therapist collaborated with their inpatient/residential treatment or intensive outpatient staff. For example, Snow's schedule and lifestyle were not conducive to attending an inpatient treatment program; therefore, her therapist "tag-teamed" and collaborated with an intensive outpatient program so she could receive the treatment she needed. Additionally, three participants' therapists worked with their families, which they identified as useful. Both Cody's and Emily's therapist had a session with their families to educate them about eating disorders and discuss ways they could promote recovery. When therapists worked with external systems, participants shared it positively influenced the alliance and portrayed care and investment.

Strong basic counseling skills. All participants identified that their therapist portrayed at least one basic counseling skill. These skills included validation, lack of judgment, investment, authenticity and genuineness, collaboration, and using a strengths-based approach. When discussing validation, whenever Snow stated she felt "crazy," her therapist said, even if it feels "crazy, it's okay." Cody's therapist explained that she did not expect him to be perfect at recovery and validated it was "okay" if he made a mistake. Additionally, four participants discussed the importance of their therapist having a non-judgmental attitude. Laura-Leigh described it as "a neutral position" and "non-critical," whereas Emily defined it as "not analyzing or critiquing." This approach helped participants feel comfortable in sharing and created a non-blaming environment.

Other helpful therapist skills included the portrayal of care and investment. When Jessica's therapist hospitalized Jessica, she explained her decision in a way that portrayed care and investment and not in a way that made Jessica believe her therapist saw her as "a liability issue." Six participants also described their therapist as authentic and genuine. Ways therapists conveyed this included using humor in session, showing empathy (e.g., crying in session, changing voice to a softer tone, being attentive and facing the client), and being blunt, honest, and straightforward.

Collaboration and a strengths-based approach were also helpful therapist factors described by five participants. Kelly described collaboration: "It's not just her treating me; it's us getting better together." When discussing a strengths-based approach, five participants noted it helpful when their therapist acknowledged their progress. For Melissa, this meant her therapist acknowledged and praised her for eating all of her lunch or having an "extra bite today, or not throw[ing] up for those 20 minutes." Furthermore, Kelly stated simply attending therapy was a "huge step" for her and appreciated her therapist acknowledging this.

Competent and experienced in treating eating disorders. All participants identified their therapists' competence and experience treating eating disorders as helpful. Melissa explained that because her therapist had training in eating disorders, she understood what Melissa was talking about, provided insight, and helped "open my eyes" to alternative coping strategies. Also, because Snow's therapist was experienced, she knew "all the games, lies, and bullshit" and could not be fooled.

While being "knowledgeable" included having knowledge and experience treating eating disorders, it also meant the therapist set boundaries and was consistent and

reliable. For example, Snow said her therapist “doesn’t pull any punches” and if she saw an eating disorder behavior, she would “call it out.” Emily’s therapist held her accountable and she was not able to get away with not following her meal plan. When setting boundaries, it was important therapists were reliable and followed through. Jessica’s therapist told her if she lost any more weight, she would hospitalize her; Jessica knew she would follow through on this boundary. Although several participants described this as frustrating, they also acknowledged boundaries created trust and safety in the relationship. Jessica stated it helped her trust her therapist “would not let me fall too far.”

Another way therapists portrayed they were knowledgeable about eating disorders was by helping participants identify and feel their emotions. Three participants discussed their eating disorders helped avoid feeling emotions; therefore, it was helpful when their therapists helped them connect to and express emotion. Melissa explained that her therapist “gave me space to cry [and] that was helpful because I can be really scared to cry.” In addition, Jamie’s therapist helped her be aware of her feelings; Jamie knew she could “express my feelings and not be put down for them.”

While helpful for therapists to be knowledgeable, two participants stated it was as important that their therapists acknowledged their limitations and recognized their lack of competence. Kelly’s therapist recognized she did not know everything and did not pretend to know what Kelly was going through. Furthermore, her therapist asked her if her interpretations were accurate. Similarly, Jamie’s therapist was honest about not having training in nutrition and medication and, therefore, encouraged her to work with a nutritionist and a psychiatrist. When the therapists were honest about the limitations of

their expertise, it helped build trust. Kelly stated, “It made me feel safer, like the therapist is not going to try to pull something over on me.”

Attuned to client’s needs. All participants labeled it helpful when their therapists were attuned to their needs. One way therapists did this was they paid attention to participants’ non-verbal behaviors. Snow provided an example of a time when she had a panic attack during session; even though she did not ask her therapist to do this, her therapist sat next to her, slowly put her hand on Snow’s back, and helped her slow down her breathing. Two participants also stated it was helpful when their therapist questioned or acknowledged their change in eye contact, voice tone, or look on their face.

Another way therapists portrayed attunement was they accepted clients’ stage of change and did not force movement if participants were not ready. Melissa instructed, “Don’t try to change them [the clients] if they’re not ready.” Laura-Leigh said her therapist was patient and did not give up on her even though her therapist was likely frustrated. Kelly acknowledged the difficulty for therapists because they have to balance pushing and not pushing too much. She described this as a “delicate situation” and stated, “I don’t envy my therapist’s position.”

Four participants highlighted the caution and care their therapists used when discussing a higher level of care, e.g., intensive outpatient, residential, or hospitalization. These conversations were different among the participants. For example, Jamie’s therapist incorporated her son into this conversation and asked him to express his feelings and concern about her illness. Melissa’s therapist discussed this topic in a way in which Melissa “didn’t feel that she was throwing me out. She wanted to keep me as her client.” Laura-Leigh explained that her therapist brought up this topic in a non-forceful way and

let her agree or disagree with attending a more intensive treatment; however, because her therapist was less forceful, Laura-Leigh chose not to go. She admitted although this was helpful for their relationship, it might not have been the most helpful approach for her recovery.

Two other ways therapists portrayed their attunement to participants' needs included individualizing treatment and providing corrective emotional experiences. Ways participants' therapists individualized treatment included using metaphors specific to the participant, doing sessions via phone when the participant was out of town, incorporating relaxation techniques when a participant was "fried," and incorporating "bio-neural feedback." Furthermore, seven participants' therapists individualized treatment when they provided a corrective emotional experience. For Jessica, this meant her therapist showed her what a healthy relationship looked like and helped her learn to create and set boundaries. In addition, Laura-Leigh's therapist was "laid back, relaxed, soft-spoken, gentle, and provided TLC," which contrasted significantly from how her mother treated her when she was younger.

Warm office environment. Three participants identified the therapist's office environment as helpful in building the relationship. For example, Laura-Leigh described her therapist's office as warm and not something "stark or cold." Her therapist also had stuffed animals and things for children that helped create a safe, inviting atmosphere. Laura-Leigh stated, "I'm very sensitive to my environment. I really think a lot of folks that have eating disorders are highly sensitive." Emily and Kelly also stated comfortable couches in the office helped it feel "homey" and relaxing, as well as carpet floors, dim lights, and soft music in the waiting room.

Helpful Client Factors

Participants described common themes when identifying their contributions to the therapeutic relationship: readiness and investment, active participation and honesty, asserting self and advocating for needs, and trusting the therapist. These themes are reflected in Table 5 and described below.

Table 5

Helpful Client Factors Reported by Client Participants

Helpful Client Factors	Description
Readiness and investment	Clients portrayed readiness and investment by (a) choosing to seek therapy, (b) choosing own therapist, (c) attending therapy sessions regularly, and (d) working outside of sessions
Active participation and honesty	Active participation and honesty included (a) engaging during sessions, (b) being vocal and opening up, and (c) being truthful
Asserting self and advocating for needs	Clients asserted and advocated for themselves when they (a) asked the therapist for what they needed and (b) confronted the therapist when they were offended or “pushed too hard”
Trusting the therapist	Clients trusted their therapist when they (a) gave up control, (b) listened to and followed-through on the therapist’s recommendations, and (c) were confident in their therapist’s effectiveness

Readiness and investment. Five participants identified readiness and investment as helpful client factors. Both Kelly and Jessica explained that it was helpful when they

were willing to seek therapy on their own versus a family member forcing them.

Similarly, once Kelly chose to seek treatment, she felt “empowered; like it’s my choice.”

Cody portrayed readiness when he acknowledged he had an eating disorder and was no longer in “denial.” Additionally, both Cody and Laura-Leigh noted simply attending therapy appointments was helpful even when they did not want to go. One last example that highlighted Snow’s investment was she bought an eating disorders workbook on her own and worked through it between sessions. She noted this represented her readiness to do the work necessary for recovery.

Active participation and honesty. All participants acknowledged active participation was helpful. Ways participants actively participated included being engaged and vocal during therapy. For several participants, this meant talking more during the therapy sessions and sharing what they thought and felt. Jamie explained that her engagement represented “a willingness and an ability to actually participate in the therapy, instead of being talked at.” Additionally, Kelly and Cody asked their therapist questions and argued with them, which they viewed as being engaged. Along with being engaged and vocal, many participants labeled being honest as helpful. For instance, Snow and her therapist agreed, at the beginning of every session, to discuss her eating disorder behaviors so she could be honest about them. Cody also acknowledged it was helpful when he was honest about his fear of gaining weight and taking part in eating disorder behaviors, both with his therapist and treatment team.

Asserting self and advocating for needs. Three participants noted the relationship with their therapist developed when they asserted and advocated for their needs. To illustrate, Snow described an experience where she wanted a hug from her

therapist and asked for one. She explained that her therapist said, “Absolutely” and hugged her. Laura-Leigh and Kelly also provided examples of times when they were frustrated and offended when their therapist said something they did not agree with; therefore, they confronted their therapist. Both identified this as helpful as they were able to discuss their concerns and reach a resolution.

Trusting the therapist. Five participants explained how helpful it was when they trusted their therapist. For Laura-Leigh, this included “giving up control,” especially when she was extremely underweight. She explained it was very difficult to put her trust in her therapist during this time and gain weight. Other participants’ therapists provided recommendations, e.g., seeing a psychiatrist for medication or a dietician for nutrition therapy. The participants noted it was helpful when they trusted their therapists’ advice and followed-through with the recommendations. Furthermore, at the beginning of Emily’s treatment, her family did not believe in therapists. It was difficult for her to get “over the negative connotation related to mental health professionals.” However, she said it was helpful when she did not try to fight the therapy relationship and trust her therapist. One last way Jamie trusted her therapist was she believed in his effectiveness. Due to her therapist working with her son first, she had confidence and trusted his ability--if he could “work miracles” with her son, she believed he could do the same for her.

Unhelpful Therapist Factors

Participants shared four unhelpful therapist factors when building alliance. Common themes included boundaries were too rigid or too flexible, content imbalance,

lack of attunement, and lack of competence or confidence. These themes are reflected in Table 6 along with a description of each theme.

Table 6

Unhelpful Therapist Factors Reported by Client Participants

Unhelpful Therapist Factors	Description
Boundaries were too rigid or too flexible	Therapists were (a) too rigid with boundaries (e.g., immediately hospitalizing clients), or (b) too flexible (e.g., being gullible, not holding the client accountable)
Content imbalance	Therapists focused too much on (a) the eating disorder (e.g., following meal plan, talking about food/weight), or (b) underlying issues (e.g., emotions, family)
Lack of attunement	Therapists lacked attunement when they (a) did not individualize treatment, (b) judged the clients, (c) did not engage or physically respond, (d) confronted clients at the wrong time, and (e) forced change and took away control
Lack of competence or confidence	Therapists lacked competence and confidence when they (a) did not understand or know how to treat eating disorders, (b) did not provide insight, and (c) terminated treatment if the client's symptoms changed or worsened

Boundaries were too rigid or too flexible. Three participants' therapists were too rigid or too flexible with boundaries. When describing being too strict with boundaries, Jessica provided an example when her therapist did not give her "second chances." She explained her therapist threatened to hospitalize her if she did not get her

“shit together in two days” and a few times, immediately hospitalized her. According to Jessica, only one of the four hospitalizations was necessary; therefore, this frustrated her and negatively impacted their relationship.

A few participants described when their therapists were too flexible with boundaries. To illustrate, one of Melissa’s therapists was gullible and easily fooled. Melissa told her she was “fine” and “hunky dory,” and her therapist did not challenge her. Jessica also explained that she told her previous therapist she ate even though she clearly lost weight. Although participants acknowledged, at times, they preferred flexible boundaries so they could get away with behaviors, they questioned their therapist’s ability to keep them safe and challenge them, which negatively impacted the relationship.

Content imbalance. Four participants explained that it was unhelpful when their therapist spent too much time focusing on the eating disorder or underlying issues. To illustrate, Emily said her previous therapist talked about food too much and did not listen to what she wanted to focus on. Jessica’s therapist focused on her meal plan and her physical appearance rather than what was going on “inside my head and doubts.” On the other end of the spectrum, Laura-Leigh explained that her therapist overly focused on emotions and not enough on food and weight. She stated because a client might physically “look okay,” the therapist might assume they are not engaging in eating disorder behaviors; therefore, discussing the behaviors might get “pushed aside or under the rug.” Through the descriptions, the majority of participants preferred to have a balance between focusing on the eating disorder and the underlying issues.

Lack of attunement. Every participant identified lack of attunement to clients as an unhelpful therapist factor. One example included when their therapists did not

individualize treatment. For example, Kelly explained that it was unhelpful when her therapist used a “cookie-cutter” approach and rigidly followed a treatment plan. Snow said her therapist did not remember topics previously discussed in session. Another way therapists portrayed a lack of attunement was when they judged clients, were disengaged, or did not physically respond. Three participants identified a therapist’s judgment as unhelpful. Laura-Leigh encouraged, “If at all possible, never convey that you judge them [clients].” Cody explained that he worked with several therapists who wrote on a notepad throughout the session and did not provide eye contact, which made him feel disconnected. Additionally, Jessica’s therapist did not provide her a hug when she was crying during a session; the lack of physical responsiveness made Jessica question her therapist’s care and wonder if she was “cold.”

Two other ways therapists lacked attunement was if they confronted the participant or forced change and took away control. Both Snow and Emily described examples when their therapist confronted and “disciplined” them. For Snow, she explained that her therapist “called me out” about attendance because she was consistently missing and rescheduling appointments; it felt punitive and unhelpful at the time. Similarly, Emily’s therapist confronted her dishonesty about eating behaviors; Emily explained that it was very frustrating in the moment.

One last way participants’ therapists lacked attunement was when they forced change, moved too fast, or tried to take away control. Melissa stated, “Don’t try to change them [clients] if they’re not ready... and try not to rush them.” One example Kelly shared was when her therapist strongly encouraged her to tell her boyfriend about her relapse but she was not ready. Cody stated his therapist pushed him to attend a higher

level of care but he did not want to go. Kelly stated, “Anorexia is control-based and fear-based. Pushing a client in a direction they don’t want to go...the client will run every time.”

Lack of competence or confidence. Four participants stated it was unhelpful when their therapist was not competent and confident in diagnosing and treating eating disorders. Snow explained that she was frustrated with a previous therapist who believed the underlying cause of anorexia was solely due to body image concerns, which did not fit with her experience. Similarly, Cody acknowledged he was angry when a previous therapist believed his 30 pound weight loss was due to depression and did not consider he had an eating disorder. Another way Melissa’s therapist portrayed a lack of knowledge was she did not help Melissa “see” anything or provide insight into the reasons for her eating disorder. She explained that her current therapist, who specialized in eating disorders, was able to do this because she understood the disorder.

Lack of confidence was also a factor the participants acknowledged as unhelpful. For example, Snow provided an illustration when she had a panic attack during a session. Because her therapist was not comfortable or confident to help, Snow became panicked and worried, which increased her panic and anxiety. Kelly also described she was “dropped” by a previous therapist because she developed bulimia and her therapist was comfortable and competent only treating anorexia.

Unhelpful Client Factors

Participants shared six themes when they described their negative contributions to the alliance: avoidance, medical issues, negative self-beliefs, lying about eating disorder

behaviors, fear, and over-focus on the therapist. These themes are reflected in Table 7 along with a description of each theme.

Table 7

Unhelpful Client Factors Reported by Client Participants

Unhelpful Client Factor	Description
Avoidance	Clients lacked readiness and avoided treatment when they (a) were in denial and forced to attend treatment, (b) minimized problems and were people-pleasers, and (c) did not trust and intellectualized feelings
Medical issues	Medical issues, including malnourishment and the re-feeding process, affected the client's (a) thinking process, (b) memory, (c) energy level, and (d) decision-making
Negative self-beliefs	Negative self-beliefs included (a) feeling unworthy or "too much to handle," (b) believing they should be further along in recovery, and (c) feeling guilt or shame for not working hard enough
Lying about eating disorder behaviors	Lying about eating disorder behaviors included (a) being dishonest, (b) not telling the whole truth, (c) dodging questions and omitting information, and (d) over-focusing on underlying issues
Fear	Clients feared (a) getting close to the therapist; (b) being rejected, abandoned, and judged; and (c) being imperfect and relapsing
Over-focus on the therapist	Clients over-focused on the therapist when they were preoccupied (a) with wondering if the therapist had a history of an eating disorder, or (b) with the therapist's external appearance

Lack of readiness and avoidance. All participants acknowledged lacking readiness and avoidance negatively impacted the therapeutic relationship. Several ways participants portrayed a lack of readiness was when they did not open up, were in denial about having an eating disorder, were forced or strongly encouraged to attend treatment, and/or if their therapy attendance was inconsistent. Along with being forced into

treatment, several participants acknowledged they were minors when they began therapy and were unable to choose their own therapist. In addition, three participants used avoidance to keep from getting close to the therapist and opening up. Emily stated she “sugarcoat[ed]” and minimized the severity of her eating disorder, and tried to make her therapist believe she was “okay” so she would be discharged. Jamie and Kelly also admitted their tendency to be “peace-keepers” and people-pleasers. Kelly stated, “Anorexics, generally, start out very much as peacekeepers... we have trouble ruffling feathers, so we just keep quiet.”

One last way participants described avoiding treatment was not trusting their therapist and intellectualizing their feelings. For example, Snow explained that she did not follow through and trust her therapist’s initial recommendations about working with a nutritionist and taking medication; she was resistant to anything the therapist recommended. Additionally, Kelly was “very skeptical” about trusting her therapist. Laura-Leigh said she intellectualized her feelings to avoid feeling them, which kept her from connecting and feeling close to her therapist.

Medical issues. Three participants highlighted medical issues, specifically malnourishment and the re-feeding process, as impacting their thinking and functioning. Jessica was severely underweight at the beginning of her treatment; she could not think correctly or remember things from previous sessions. Even during the interview, she had difficulty remembering and describing the first few therapy sessions. Jamie also stated, “I couldn’t do good therapy in a malnourished state of being” and explained that she could not make decisions when she was extremely underweight. Additionally, Emily explained that she did not have “the capacity to think straight” and felt “worn out” and

“exhausted.” Due to these difficulties, she remembered not understanding much of what her therapist said. She also acknowledged during the re-feeding process, “your body goes crazy,” which made it difficult to focus on anything else in therapy.

Negative self-beliefs. Four participants noted negative self-beliefs were unhelpful in the relationship. One of these beliefs was feeling unworthy or too much to handle. Both Jessica and Melissa experienced times when they felt unworthy of their therapist’s time and thought they should help someone else. Because of this, Jessica feared her therapist wanted to get rid of her or pass her off to another therapist because she was “too much to handle.” Jessica vacillated between thinking she was “too much to handle” and as if she was not “bad” enough to take up her therapist’s time. Additionally, Laura-Leigh stated she was disappointed with herself because she should be further along in recovery and felt embarrassed for struggling with her eating disorder for so long. Some of her negative thoughts included “You should be over this. You should be done. You’ve had all that money spent on therapy. Get your shit together and move on. Why can’t you just get it going?” Jamie also expressed feeling guilty and shameful for not working hard enough in therapy and not following through on her therapist’s recommendations. The lack of follow-through made her fear she let her therapist down or irritated him.

Lying about eating disorder behaviors. Five participants reported lying about their eating disorder behaviors (e.g., restricting, over-exercising, taking laxatives) and labeled it unhelpful to the relationship. One way participants did this was simply being dishonest. For example, Melissa told her therapist she was fine and “hunky dory,” even when she was not. Jessica acknowledged part of the truth but did not share “the whole

truth.” Both Cody and Laura-Leigh stated they dodged questions and omitted information when answering questions. Several participants stated dodging questions was not exactly lying but “omitting” information. Furthermore, Snow avoided talking about eating disorder behaviors by over-focusing on underlying issues such as her negative relationship with her mother. This helped Snow believe she was not lying, just not admitting relapse.

Although not a common theme, Jessica expressed feeling trapped when she acted on an eating disorder behavior (e.g., restricted, purged): either she lied to her therapist and felt guilty, or admitted it, which negatively impacted the trust in the relationship. She stated, “If I do the symptoms [and admit them], there will be consequences in the relationship because of me doing the symptoms.” Although other participants did not acknowledge this experience, Jessica indicated either choice (admitting to or lying about behaviors) negatively impacted the relationship.

Fear. Seven participants reported their fear negatively impacted the relationship. Several were cautious when getting close to their therapist for fear their therapist would reject, abandon, or judge them. For example, Jamie feared her therapist “would cut me off and not see me anymore.” Melissa stated, “I feel like she’s judging me, even though I know she’s not. That’s just my insecurity.” Jessica acknowledged in her other relationships with family and friends, she had difficulty getting close, navigating their boundaries, and setting her own. The relationship with her therapist was the same; she initially feared opening up and setting boundaries. Kelly stated, “We [clients with AN] abandon the world, and when the world starts abandoning us, that’s scary... Anorexia is fear-based, and if they [therapists] provoke fear, I’m done.” A few participants also

feared being imperfect and admitting relapse. Kelly noted she feared admitting that she struggled because she wanted her therapist to be proud of her. Furthermore, Melissa expressed she feared if she admitted to relapse, she would have to go back to the hospital day-program.

Over-focus on the therapist. Half of the participants admitted over-focusing on their therapist, which they identified as unhelpful. Jessica, Laura-Leigh, and Cody admitted they wondered or asked their therapist about their history of an eating disorder. Laura-Leigh never asked but acknowledged the curiosity distracted her thoughts. Both Cody and Jessica asked their therapist and acknowledged this was in an effort to take the focus off of them. Kelly also acknowledged she over-focused on her therapist's body size and shape. She explained that when her therapist was overweight, it provoked fear, which made it difficult for her to trust and open up.

Summary of Client Themes

In summary, descriptions of the working alliance at the beginning of therapy included participants taking a slow and cautious approach, not being ready for therapy, and the therapist's role as building trust. At the time of the interview, participants described the relationship as comfortable and safe, dependable, and a professional friendship/mentorship. When discussing therapy goals, participants identified the benefits of concrete goals, their therapists' role in goal development, and the need for collaboration and flexibility when creating goals. Participants also discussed when goals were unhelpful.

Additionally, I discussed participants' common views of factors that influenced alliance formation. Therapist factors that positively influenced alliance formation

included contact outside of session, appropriate self-disclosure, collaborating with external systems, strong basic counseling skills, competent and experienced in treating eating disorders, attuned to client's needs, and warm office environment. Positive client factors included readiness and investment, active and honest participation, asserting self and advocating for needs, and trusting the therapist. Therapist factors that negatively influenced alliance included boundaries were too rigid/flexible, content imbalance, lack of attunement, and lack of competence or confidence. Negative client factors included avoidance, medical issues, negative self-beliefs, lying about eating disorder behaviors, fear, and over-focus on the therapist. In the next section, I review common themes among the therapist participants.

Therapist Participants' Overarching Themes

In this section, I discuss the overarching themes among the seven therapist participants. First, I provide the demographic information, followed by a discussion of the commonalities among the participant's description of the alliance including their artifact description, explanation of the alliance with clients with AN, and how therapy goals influenced the alliance. I then report the overarching themes noted by a majority of the participants pertaining to the factors they believed were both helpful and unhelpful in building the therapeutic relationship.

Demographic Information

Six therapist participants were female, one was male, and all were Caucasian. Their ages ranged from 28 to 63 years with an average age of 43.28 and a median age of 38. Three participants had a master's degree, one had a master's degree and several doctoral-level courses, and two had earned doctoral degrees. The average number of

years participants had worked with clients with AN was 12.57, ranging from 2 to 30 years, and a median of nine years. Additionally, participants worked with an average number of 258 clients with AN, ranging from approximately 20 to “well over 1,000,” with a median of 150 clients. At the time of data collection, three therapists worked at a private practice, one worked at an outpatient treatment facility for eating disorders, and three worked at an inpatient treatment facility for eating disorders. All participants practiced in a Rocky Mountain state in the United States of America. All acknowledged they had worked with clients with AN in an outpatient setting at one time or another.

Description of the Alliance

Artifact description. Participants each chose an artifact to describe the therapeutic alliance with clients with AN. The artifacts are reported in Table 8. Among the artifact descriptions, three themes emerged: compassion, connection, and safety, moving slowly and building trust, and working with resistance.

Table 8

Artifacts Reported by Therapist Participants

Name of Participant	Artifact
Stacey	Teacup
Bridgett	Small figurine of Quan Yin (female Buddha)
Tim	Stuffed animal giraffe
Sally	Chinese finger trap
Mary	Scene from the movie, <i>The Horse Whisperer</i>
Jane	Antique dessert forks (cluster of tiny, silver forks)
Kathy	Game of chess

Compassion, connection, and safety. When describing the artifacts, five participants identified the importance of offering compassion, connection, and safety in the therapeutic relationship. For example, Bridgett and Tim explained that their artifact represented compassion and a safe place. Mary, Stacey, and Jane also discussed their artifact symbolized the importance of connecting to their clients as well as creating a comfortable environment that was more personal and “less sterile.”

Moving slowly and building trust. Three participants explained that their artifacts captured the process of forming the relationship. Kathy discussed forming the relationship was a “slow moving, methodical process”; she was cautious with each move. Jane explained that the process involved trust and working toward a common goal. When Mary described the scene from the movie, *The Horse Whisperer*, she explained

that clients with AN, just like the horse, had a reason for not trusting; the rate at which the relationship formed was determined by the client, not the therapist.

Working with resistance. Two artifact descriptions also captured the difficult nature of building the relationship and how it required the therapist to “work with resistance.” For example, Sally’s artifact was the Chinese finger trap. She explained that to get it off one’s fingers, one has to ease with the resistance; otherwise, if one tries to pull at both ends, it gets stuck. Mary also depicted the power struggle she encountered with her clients when she described the process between the horse and horse whisperer.

Relationship description. After participants discussed their artifacts, they described the alliance with clients with AN. Common themes included collaboration and patience, and corrective emotional experience.

Collaboration and patience. Five participants described the process of building a relationship with clients with AN as frustrating, challenging, some sort of a battle, adversarial, resistant, and/or sensitive. Although the descriptions were more critical in nature, several participants acknowledged the experience could be positive if the therapist and client collaborated. For example, Jane said if she drove the agenda, then the client’s energy went into their defenses of resisting the relationship even if they wanted it. Therefore, she and Kathy acknowledged the importance of the relationship being collaborative in nature. Furthermore, Kathy and Jane explained that even if the relationship was collaborative in nature, it could still be a slow process, hence the need to be patient.

Corrective emotional experience. Four participants identified their role as providing a corrective emotional experience for the clients. Bridgett’s clients brought

into the relationship what was going on in their lives, which oftentimes was not a healthy way of being and interacting; therefore, Bridgett believed her role was to react in a healthy way. Sally did this by helping clients connect to themselves and her because many of her clients with AN have “trust trauma.” Jane also acknowledged many of her clients had “distant intimacy” and did not let her in for fear of being known; therefore, she described the process of building the relationship as a “constant renegotiating of space.”

Therapy Goals

I asked participants to describe the creation of therapy goals and how goals impacted the alliance. All seven participants stated they created therapy goals with their clients with AN. During the discussion, four themes emerged from participants’ descriptions: agreement and identified early, provided structure for client and therapist, need to be flexible and realistic, and caution needed with this population.

Agreement and identified early. Five participants noted the importance for the therapist and client to agree on goals. Mary explained that the client needed to be the one to define their goals. Both Kathy and Jane acknowledged if the goals were not agreed upon, it made for “a very bumpy therapeutic process.” Additionally, Tim and Mary stated that every client had a goal even if it was to feel better. Four participants also discussed the importance of discussing and agreeing upon goals early in treatment. For example, after the third session, Bridgett developed goals and a treatment plan with her clients to guide therapy and form the relationship.

Provided structure for client and therapist. Three participants explained that goals provided structure for both the client and therapist. Mary stated, “Goals are crucial

because eating disorders are complicated and messy, and left to their own accord, we could swim around in them for ever and ever.” Jane also noted goals helped provide structure: “clients with anorexia typically like structure; helps them know what needs to be achieved and know where we are going.” Similarly, Sally agreed and said goals pushed clients and held them accountable.

Need to be flexible and realistic. Five participants agreed goals needed to be flexible and realistic. According to Tim, he attempted to keep therapy goals flexible. Sally noted she evaluated and reformed goals when necessary. Kathy, Jane, and Mary all expressed the need for goals to be realistic because if they were not, it could set clients up for frustration and failure.

Caution needed with this population. Two participants noted goals should be created with caution, particularly with this population. Sally stated, “They [clients with AN] are typically overachievers, perfectionistic, and achievement-oriented, so goals can become about an assignment they just have to complete.” She also acknowledged goals could be a form of avoiding emotional experiences. Similarly, Bridgett explained that sometimes her treatment-plan “makes more trouble than good.” She said, “Sometimes it brings up more shame or more guilt that they can’t or don’t want to get better.”

Helpful Therapist Factors

Participants conveyed seven themes when discussing helpful therapist factors: strong basic counseling skills, collaborative approach, empowering clients, genuineness, instilling hope, competence in treating eating disorders, and doing your own work and seeking supervision. These themes are reflected in Table 9 followed by a description of each theme.

Table 9

Helpful Therapist Factors Reported by Therapist Participants

Helpful Therapist Factors	Description
Strong basic counseling skills	Strong basic counseling skills included (a) empathy and unconditional positive regard, (b) trust and safety, (c) nonjudgmental, and (d) validation and rapport
Collaborative approach	Collaborative approach included (a) collaborating with the client and letting them be the expert about themselves, and (b) collaborating with third parties (e.g., families and other professionals)
Empowering clients	Therapists empowered clients by (a) balancing accountability and care, and (b) pushing client out of comfort zone
Genuineness	Therapists were genuine and related to clients by (a) being authentic, humorous, and passionate; (b) normalizing what clients were going through by relating to their struggles; and (c) self-disclosing while keeping boundaries
Instilling hope	Therapists fostered and instilled hope by (a) reframing and focusing on strengths, (b) highlighting change, (c) redefining success, and (d) being patient
Competence in treating eating disorders	Therapists were competent in treating eating disorders when they (a) had confidence and an effective approach, (b) were attuned to clients and personalized treatment, and (c) focused on the whole person
Doing own work and seeking supervision	When therapists did their own work and sought supervision, they were (a) aware of their personal reactions, (b) able to be a secure base for clients, and (c) modeled wanted behavior

Strong basic counseling skills. All seven participants identified at least one basic counseling skill that was helpful in building the alliance. One commonly mentioned characteristic was empathizing with clients. Tim conveyed empathy when he was gentle and compassionate when talking with clients. Sally explained that she used touch (when

appropriate) to portray empathy, e.g., giving a hug or putting her hand on the clients back or leg. Additionally, Mary stated she tried to make her relationship about care and Jamie attempted to provide “unconditional positive regard.”

Three participants also acknowledged the helpfulness of creating safety and trust, as well as being nonjudgmental. Stacey instructed, “Don’t judge them for having an eating disorder.” Jane and Sally explained that they tried to understand how clients’ eating disorders worked for them and validated their experience. Sally observed the eating disorder functioned for them in a positive way; she viewed it important not to “villainize it” or put “it on a pedestal.” Furthermore, Kathy described that by exploring how the eating disorder worked for them, it helped build rapport.

Collaborative approach. All participants relayed collaborating with either the client or third parties, e.g., family or other professionals, was helpful in building the relationship. Both Stacey and Bridgett acknowledged the importance of collaborating with the client and not implementing an authoritarian approach. One way Sally collaborated with clients was by processing the relationship often and to “check things out with the client.” Furthermore, Jane and Kathy noted the importance of letting the client be the expert about himself or herself, inviting feedback, and giving the client permission to disagree with something they said. In addition, Tim and Mary collaborated and communicated with external third parties. For example, Tim he tried to help the clients’ families understand how the eating disorder functioned and what it was really about. Mary also attempted to be “diplomatic and professional” when working with the clients’ families and other professionals on the treatment team (e.g., physicians, psychiatrists, nutritionists/dieticians).

Empowering clients. Seven participants described the importance and helpfulness of empowering clients. Stacey described this as “being there, but letting them fly on their own.” Mary depicted it as “having one arm around the client while kicking them in the butt with your foot.” Some ways participants empowered clients included allowing them to make choices about their recovery, helping them diffuse their “inner critic,” and encouraging them to use their voice versus speaking through behaviors. Kathy and Jane also identified a way they empowered clients--they incorporated food into therapy. When Jane ate with clients, it empowered them to try new, possibly scary, foods they normally did not eat. She also said depending on what they did or did not do with food provided useful information about where the therapeutic relationship was.

Genuineness. All participants identified genuineness and relating to clients as helpful in the process of forming the alliance. Several ways they were genuine included being authentic, passionate, and using humor. Both Tim and Sally explained that if they were not genuine and authentic, clients could “pick up on that” and “see right through it.” According to Bridgett, one way she tried to do this was by being humorous with clients, creating warmth, and laughing with them; humor helped her be “more level.” Sally said humor was bonding.

Participants also identified normalizing the client’s experience as helpful. For example, both Bridgett and Tim identified ways they related and normalized clients’ struggles. Bridgett explained that because she is female, she tried to normalize body image concerns, whereas Tim stated he related to clients’ sensitivity, pain, and work-oholism. While most participants labeled self-disclosing as helpful, all were clear about

maintaining boundaries and not self-disclosing too much. For Stacey, she reported it was “important to relate to them [the clients], but not to the disorder. That is what group therapy is for.” Mary also stated, “Self-disclosure has to be done in the right way, at the right time, which usually means I don’t do it.”

Instilling hope. All participants discussed the helpfulness of fostering and instilling hope. One way participants did this was by reframing and focusing on strengths. Stacey explained that she worked to open the clients’ “narrow view of the world,” which helped them see “more gray, and not so black and white.” Similarly, Tim noted many clients had a “close-up view” and his job was to help them have a “big picture view.” Other ways participants reported focusing on strengths included identifying clients’ internal resources: their strength of will, acknowledging how far they had come and changes made, and redefining success.

Five participants described how they redefined success. For Sally, she “let go of outcome” and “look[ed] for markers of success that are smaller and more intangible,” e.g., evoking emotion during a session. Similarly, Kathy realized “not everyone wants to get better or will get better”; success might look different among clients. Being patient was a final way participants instilled hope. Jane expressed, “Recovery can take years” and “therapists must be patient.” Additionally, Kathy stated, “Both parties [therapists and clients] have to be patient for what change looks like.”

Competence in treating eating disorders. All seven participants acknowledged being competent in treating eating disorders benefited the alliance formation. Bridgett attempted to convey she was competent in treating eating disorders and that she could assist them. Similarly, Tim stated, “Clients are savvy. Many have been in treatment for a

long time and pick up if what you're doing is helping.” Jane also stated empirically-based treatments exist; however, therapists need confidence in the treatment because “clients can sense if the therapist is confident and believes in what he or she is doing.”

All participants described a competent therapist as someone who is attuned to the client's needs, meet the client where s/he is, and/or provides personalized treatment. Mary stated, “Different clients need different things.” Bridgett highlighted the importance of “meeting clients where they are” and prioritizing clients' problems. Tim shared an example of this when he provided resources and coping strategies to clients prior to working on their trauma and eating disorder. Other ways participants tuned into clients was by reading their non-verbal body language and being aware of what was happening in the relationship. Additionally, four participants acknowledged the importance of focusing on the whole person and not just the eating disorder. For example, Mary stated, “It's very easy to see some of these clients as fragile,” especially if they were extremely underweight; however, “what's not always apparent is their strength of will and their internal resources.” Bridgett also reported she tried to focus on all of the client's troubles, e.g., co-occurring issues or past trauma, not just the eating disorder.

Doing your own work and seeking supervision. All seven participants noted the helpfulness of dealing with their own struggles and/or seeking supervision. For example, Tim acknowledged he tried to stay balanced in his life and incorporated self-care strategies such as taking vacation time. Kathy also relayed she had a good support system, a person to consult with regularly, and a “place to vent.” The participants described the importance of being healthy and balanced because it impacted their personal reactions towards clients, which then impacted the alliance.

Additionally, three participants described the therapist's role as being a secure base for clients and, therefore, the therapist needed to be "strong," "stable," and "grounded." Bridgett wanted her clients to know "they are not going to shake me or faze me. Everything is okay." Over half of the participants modeled wanted behavior in the relationship and acknowledged the importance of modeling healthy ways of being. For example, Sally explained that she modeled being "an empowered woman." Kathy and Bridgett described modeling making mistakes, admitting they are wrong, and being "okay" when they are imperfect.

Helpful Client Factors

Two common themes emerged among participants' descriptions of helpful client factors: willingness and honesty. These themes are explained in Table 10 followed by a description of each theme.

Table 10

Helpful Client Factors Reported by Therapist Participants

Helpful Client Factors	Description
Willingness	Willing clients were ready to (a) change and get rid of their eating disorder; (b) hurt, suffer, "feel like a mess," and explore fears; (c) open up and share; and (d) connect to the therapist
Honesty	Clients portrayed honesty when they (a) disclosed their feelings, (b) admitted to not eating, and (c) provided genuine feedback to the therapist

Willingness. Six participants described that alliance formation was easier when clients were ready and willing to seek treatment. One of the descriptions of readiness

included the client's readiness to change and get rid of their eating disorder. Stacey explained that she experienced "success" in the relationship when a client was "ready to be done with the eating disorder; not because someone forced them to come in." Other participants described it helpful when clients were willing and ready to hurt, suffer, "feel like a mess," and explore their fears. Jane noted that all of these required clients to take risks, be challenged, and go out of their "comfort zone." Sally said she found it helpful when a client brought "some sense of willingness to talk and share more." When clients talked and shared, Kathy acknowledged it helped her connect to them and their experience, and led to a stronger bond.

Honesty. Four participants described a client's honesty as helpful in building the alliance. Bridgett provided an example of a client who was honest and disclosed she was nervous about increasing her food intake. For Bridgett, this disclosure showed her that the client was being genuine and "the relationship has taken a step forward." Similarly, Mary knew things were moving in the right direction when a client reported she had not eaten for three days. She acknowledged this statement appeared counterintuitive--that a client not eating would help the relationship. However, Mary noted it provided evidence the client trusted her. Bridgett and Tim also noted the helpfulness when clients provided feedback about the relationship. Most of Tim's clients with AN did not provide feedback unless prompted; however, he noted it was helpful when they did. Similarly, when Bridgett's client gave her feedback, it appeared as though they were "on each other's side, and not across the room."

Unhelpful Therapist Factors

Participants identified three unhelpful therapist-factors. Common themes included lack of attunement to client's needs, judgmental, and lack of objective distance. These themes are noted in Table 11 along with a description of each theme.

Table 11

Unhelpful Therapist Factors Reported by Therapist Participants

Unhelpful Therapist Factors	Description
Lack of attunement to client's needs	therapists lacked attunement when they (a) pushed their own goals and agenda, (b) focused only on the eating disorder behaviors, and (c) were too "pushy" or tentative
Judgmental	Therapists judged and invalidated clients when they (a) criticized, blamed, and evaluated; and (b) "villainized" the eating disorder
Lack of objective distance	Therapists lacked objective distance when they (a) portrayed countertransference, (b) modeled maladaptive relationships in clients' lives, (c) lost hope, and (d) used self-disclosure improperly

Lack of attunement to client's needs. All participants identified the lack of attunement to client's needs as unhelpful. Five participants described themselves as lacking attunement when they pushed their own goals onto the clients. For example, Sally described a time when she wanted her client to recover more than the client. She became "a champion of her recovery" and it "was invalidating for her because she was feeling pretty hopeless." Therefore, Sally had to let go of the goal of getting rid of the eating disorder. Kathy also acknowledged having different goals than clients made them appear "like they don't want to do anything."

Additionally, five participants noted it unhelpful and lacking attunement when they focused solely on the eating disorder behaviors and not the underlying issues. Tim remembered arguing with a client about her body image and described it as "slipping into

that power struggle.” Sally described it as “getting in that rat wheel with them.” Mary encouraged therapists to “try to connect to the person and not get stuck in the details of their eating disorder.”

Also unhelpful was when participants were “too pushy” or too tentative. Some ways participants described being “pushy” included forcing change and telling the client “you have to eat” or becoming part of the “police and control system.” On the other hand, Jane relayed some of the therapists she worked with were “too tentative” with clients and treated them like they were fragile children. Likewise, Kathy described being too tentative when she allowed clients to “speak through their behaviors” rather than using their words and helping them find their voice.

Judgmental. Four participants identified therapists’ judgment and invalidation as unhelpful. Both Tim and Bridgett stated judging a client, even inadvertently, was unhelpful; Tim described it as “violent” communication. Kathy and Sally explained that “villainizing” the eating disorder invalidated the client’s experience and allowed them to forget it served a purpose. Kathy identified when she criticized clients for having an eating disorder, she “criticize[d] their judgment.”

Lack of objective distance. All participants acknowledged a lack of objective distance as an unhelpful therapist factor. Jane and Kathy identified countertransference as a lack of objective distance. For example, Kathy explained she did not “mesh” with clients who had dependent personality styles, which at times negatively impacted the relationship. Sally observed herself lacking objective distance when she modeled maladaptive relationships in the client’s life. With one client, she found herself talking more than half the session because the client was quiet. Then she realized this is what

people in the client's life often did--talk "at" her and not leave space for her to share.

Tim noted that when he lost hope because he lacked objective distance, he and his client were "both dead in the water." Additionally, both Bridget and Mary identified improper use of self-disclosure as unhelpful. Mary stated, "Self-disclosure can bog things down; it can become a burden to the client because many take on the caretaking role."

Unhelpful Client Factors

Three common themes emerged from the participants' descriptions of unhelpful client factors: fear, lack of trust in the therapist, and lack of self: difficulty with differentiation. These themes are reflected in Table 12 along with a description of each theme.

Table 12

Unhelpful Client Factors Reported by Therapist Participants

Unhelpful Client Factors	Description
Fear	Clients feared (a) talking or opening up, (b) feeling and making a connection with the therapist, and (c) committing to recovery and giving up their eating disorder
Lack of trust in the therapist	Clients were unable to trust or had "a difficult time surrendering"
Lack of self: Difficulty with differentiation	Clients had difficulty with differentiation when they (a) lacked a sense of self or observing ego, (b) were "people pleasers" and strove for perfection, and (c) had boundaries that were too rigid or loose

Fear. All participants acknowledged clients' fears and/or resistance as unhelpful to alliance formation. A specific fear five participants highlighted was the fear of talking or opening up. Stacey stated, "With anorexia, you almost suck and pull it in and shrivel up." She used the lack of sharing "as a diagnostic tool between anorexia and bulimia." Bridgett also recalled several clients saying, "I don't feel like talking right now" and it seemed as if they were "kicking me across the river" because they were scared to share. Mary framed clients non-disclosures as part of their defense to "prevent them from making a connection" to her.

Additionally, several participants identified the client's fear of committing to recovery and getting rid of their eating disorder as unhelpful. Kathy explained that some of her clients were not willing to give up something they viewed as working. Similarly, Jane stated some clients, usually those who were younger, were not ready to change because they had not experienced any "negative consequences" of the disorder such as ruptures in relationships.

Lack of trust in the therapist. Four participants identified a client's lack of trust as unhelpful. Tim referred to this as the "inability to trust" and Sally identified it as "having a difficult time surrendering." Although Mary agreed lacking trust was unhelpful, she acknowledged clients had a reason for not trusting. She explained, "People in their lives have demanded, controlled, and criticized them, and that's what they expect [from me]. So why are they going to open up so I can be another person that's just going to take out the knife and start hacking away?" She further said, to think her clients who were traumatized ever trusted her, "that's amazing."

Lack of self: Difficulty with differentiation. Five participants described it unhelpful when clients had difficulty with differentiation and lacked a sense of self. Mary referred to the lack of observing ego as “internal instability.” Bridgett noted this was often observed with personality disorders. Both Sally and Jane described clients who had difficulties with differentiation and observed they struggled with “people pleasing” and control. Jane stated clients often “want the power, but [are] afraid of power. They are afraid of making the wrong choice...and having to express power perfectly.” Similarly, Kathy reported clients who had these difficulties usually struggled to set appropriate boundaries--they were either too loose or too rigid. She stated many times these clients have a trauma history, which made it difficult for them to know what healthy boundaries looked like.

Summary of Therapist Themes

I reviewed the seven therapist participants’ descriptions of the working alliance and therapy goals. Participants described the importance of providing compassion, connection, safety, and patience when forming the alliance as well as the need to provide a corrective emotional experience. Other ways participants described the alliance included the slow rate at which it formed and the need to work with resistance. When discussing therapy goals, participants shared goals needed to be agreed upon, identified early, flexible, and realistic. They also identified goals provided structure and needed to be created with caution due to “people-pleasing” and perfectionistic tendencies often encountered with this population.

Additionally, I discussed participants’ common views of factors that influenced alliance formation. Therapist factors that positively influenced alliance included strong

basic counseling skills, collaborative approach, empowering clients, genuineness, instilling hope, competence in treating eating disorders, doing your own work, and seeking supervision. Positive client factors included willingness and honesty. Furthermore, therapist factors that negatively influenced alliance included lack of attunement to client's needs, judgmental, and lack of objective distance. Negative client factors included fear, lack of trust in the therapist, and lack of self: difficulty with differentiation. In the next section, I compare the client and therapist participants' overarching themes.

Comparison of Clients' and Therapists' Overarching Themes

In the previous section, I reviewed common themes from the therapist and client participants. In this section, I compare and contrast the common themes and identify what findings were similar and different.

Similarities

I first describe the similarities between the clients' and therapists' descriptions (see Table 13).

Table 13

Similarities Between Clients' and Therapists' Descriptions

Common Theme	Similar Descriptions
Description of alliance	• Safe and stable • Slow process • Therapist's role: Building trust
Helpful therapist factors	• Strong basic counseling skills: validation, nonjudgmental attitude, unconditional positive regard, genuineness, authenticity, and collaboration • Strengths-based approach • Collaborated with external systems: treatment team and family • Therapist self-disclosure • Expertness and experience treating eating disorders ▪ Subtheme: Balance between setting boundaries and portraying compassion • Individualized treatment
Helpful client factors	• Honesty • Engagement and participation during therapy ▪ Sub-theme: Asserting self and advocating for needs • Trusting and connecting to the therapist
Unhelpful therapist factors	• Lacking attunement to clients' needs ▪ Sub-theme: Being too pushy or tentative ▪ Sub-theme: Focusing too much on the eating disorder behaviors • Judgmental/invalidating attitude
Unhelpful client factors	• Forced into treatment and unwilling to commit • Perfectionism and "people-pleasing" • Fear connecting to the therapist • Boundaries were too rigid or too flexible

Description of the alliance. When therapists and clients described the alliance, there were many similarities in their descriptions--both in the artifact and relationship descriptions. One similarity was the theme of safety and stability. Many participants stated safety played a key role in the formation and maintenance of the alliance. For several clients, their therapists created safety by being dependable, safe, and like a “touchstone.” For therapists, they described trying to create an open and safe environment in which clients did not feel judged and could freely share. Warmth, support, and compassion were also common descriptions. Several participants chose artifacts that symbolized warmth and support, e.g., stuffed animals, pillows, Quan Yin, and a teacup.

Another common description included the slow pace at which the alliance formed. At the beginning of treatment, many clients acknowledged they were very cautious and slow to open up. Some explained that it took years to establish an alliance in which they felt comfortable enough to share about their past. The therapists also observed this slow process and noted the importance of being patient versus rushing in and forcing them to open up and connect. One reason this slow process took place was because most clients acknowledged they were not ready; they were “forced” or strongly encouraged to seek treatment. Due to the fact that most clients entered treatment either in denial or with ambivalence, the therapists “work[ed] with resistance.”

Many clients viewed the therapist’s role as building trust. While they acknowledged they played a part in opening up, sharing, and being active in the alliance, it appeared they saw the therapist as holding most of the responsibility for alliance formation. Similarly, most therapists agreed they were responsible for creating an

environment in which clients could trust them. A few therapists described their role in alliance formation as providing a new and healthy relationship for clients.

One last description highlighted by both therapists and clients was the collaborative nature of the relationship. The therapists described wanting an equal relationship described as building rapport while setting boundaries. Similarly, clients used terms such as “mentorship” and “professional friendship” to express this concept of collaboration and hoped for a more balanced relationship.

Helpful therapist factors. Several similarities emerged between the client and therapists’ descriptions of helpful therapist factors. One similarity included the use of strong basic counseling skills, specifically validation, nonjudgmental attitude, unconditional positive regard, genuineness, authenticity, and collaboration. Almost all participants noted it helpful when the therapist validated the client’s experience and did not judge them for having an eating disorder or expressing emotion during the session. Similarly, participants agreed it was helpful when the therapist was genuine and collaborative. These skills seemed to help create a warm, safe environment and trusting relationship.

Another helpful therapist factor was using a strengths-based approach. Clients described examples of their therapists celebrating their “small” victories or acknowledging the positive steps made in therapy or between sessions. In a similar fashion, several therapists discussed their search for “internal resources,” such as the client’s will, and pointed out when a client made progress such as saying “no” or showing emotion during the session.

A large majority of the participants highlighted helpfulness when the therapist communicated and collaborated with external systems such as treatment team providers and families. Several clients noted this helped all providers be on “the same page” and the client received a similar message from everyone. Additionally, one client explained that watching her therapist communicate with her treatment team providers modeled “healthy” communication. The therapists also acknowledged the helpfulness of working with the client’s treatment team and family, as well as establishing boundaries with these systems. For example, one therapist discussed by working with a team, she was able to focus on the “psyche” and left the medical and nutritional components to other providers.

The majority of participants acknowledged therapist self-disclosure as helpful. When describing self-disclosure, most participants described the disclosures as minimally to moderately personal. For example, this included disclosures about how the therapist was feeling in the room with the client and things such as getting married or having a baby; however, the disclosures did not include sharing about the therapist’s personal history of an eating disorder. Both therapists and clients acknowledged the usefulness of the therapist maintaining boundaries, sharing just enough to show they are “human” while still keeping a “professional relationship.”

Another common theme included the therapist being an expert and having experience treating eating disorders. Several clients expressed the helpfulness of working with a therapist who specialized in eating disorders because they were experienced and comfortable with this population. Similarly, therapists used the term “confident” when treating eating disorders and highlighted the importance of the therapist believing in his or her treatment approach. Almost all participants noted therapists who were

knowledgeable and experienced were also effective, which included having a balance between setting boundaries and portraying compassion. Clients explained that working with an experienced therapist helped them feel safe, as if they would not “fall too far.”

Many participants labeled it helpful when a therapist individualized treatment and accepted the client’s level of readiness and stage of change. Several clients believed their therapist understood them as an individual and as part of a larger group. Likewise, several therapists acknowledged they tried to individualize treatment by meeting clients where they were and not pushing their own agenda during sessions.

Helpful client factors. Both clients and therapists highlighted similar client factors that were influential in creating the alliance. One client factor included being honest about their feelings and admitting when they acted on an eating disorder behavior. Several clients explained that although difficult to admit, it strengthened the relationship with their therapist when they vocalized their struggles. The therapists also acknowledged they felt more connected to their clients when they admitted relapse.

Participants also agreed a client’s engagement and participation in therapy was helpful. Several clients acknowledged the difference between “being talked at” versus actually engaging with the therapist and collaborating. The therapists also stated it was helpful when clients shared their feelings and emotions, which deepened the relationship. A sub-theme of this theme included clients asserting themselves and advocating for their needs. For example, a client participant reported she asked for a hug from her therapist and another confronted her therapist when she offended her and “pushed too hard.” A few therapists acknowledged when clients “push[ed] back,” said no, and had a voice, they viewed this as helpful and a sign the alliance was getting stronger.

One last helpful factor included when clients were able to trust and connect to the therapist. Clients described this as “trusting the therapist’s advice,” “giving up control,” “trying not to fight the relationship,” and “realizing she [the therapist] wasn’t going to hurt or abandon me.” Similarly, therapists identified trust as a helpful component in building the alliance.

Unhelpful therapist factors. The therapists and clients shared several similarities when discussing therapist factors that were unhelpful to the alliance. One of these included when the therapist lacked attunement to clients’ needs. One way therapists did this was by pushing their own agenda. For example, a few therapists described being a champion of their client’s recovery more than the client, which invalidated the client’s experience. Likewise, a few clients described times when their therapist challenged and confronted them, which they labeled as unhelpful to the alliance. Although confrontation was necessary, several clients noted the way their therapists did it made it difficult to hear and accept.

A sub-theme of lacking attunement included creating boundaries that were too rigid or flexible. When discussing boundaries that were too rigid, descriptions included therapists hospitalizing clients too quickly, forcing change, or taking away control. Boundaries that were too flexible included threatening to hospitalize the client and not following through, as well as talking to the client in a tentative, child-like voice.

Another sub-theme included focusing too much on the eating disorder. Several clients expressed frustration when their therapist focused on meal planning, food, or weight when they had other stressors they wanted to discuss. Similarly, several therapists

described getting “stuck in the rat wheel” with clients--spending too much time on the eating disorder and not enough time on underlying issues.

Similar to lacking attunement, many participants acknowledged judgment as unhelpful. Therapists used words such as blaming, criticizing, evaluating, and “villainizing” the eating disorder when describing judgment. Additionally, most clients reported if they felt judged, they did not feel safe in the relationship.

Unhelpful client factors. Common themes emerged from the client and therapists’ descriptions of unhelpful client factors. One of these included the client being forced to attend treatment and unwilling to commit to recovery. A few clients explained that when they first sought treatment, they did not think they had a problem. Likewise, several therapists described working with clients who did not want to get rid of their eating disorder and did not want treatment. Due to this, they stated it was difficult because they usually had different goals than their clients, which negatively impacted the alliance.

Another common theme reported by participants included clients’ tendencies to strive for perfection and fear of imperfection. The majority of clients shared they struggled with perfectionism and had difficulty making mistakes. They had a tendency to portray a very “put-together” outward appearance so others would think they were doing very well when, in reality, this was not true. Several therapists also identified times when clients strove for perfection regarding schoolwork, outward appearance, and recovery, and explained that it was difficult for the relationship. Similar to perfectionism, clients and therapists also acknowledged “people-pleasing” as a client factor that was unhelpful to the relationship. One client described this as “minimizing” her problems, whereas

another described it as not wanting to cause conflict in the therapeutic relationship.

Therapists reported their frustration with this as they were unsure if the client was being genuine or if they were saying what they thought the therapist wanted to hear.

Another unhelpful client factor was the client's fear of getting close or making a connection with the therapist. For example, a few clients noted they had negative experiences with therapists in the past and, therefore, found it difficult to open up with their current therapist. A few clients feared if they fully opened up and connected with the therapist, he or she would "abandon" them like others in their lives. Several therapists were also aware of this fear of connection. While able to intellectually understand this fear, it still made it hard to create an alliance when the client was guarded.

One last similarity among the participants' descriptions of unhelpful client factors included when their boundaries were too rigid or too flexible. Several therapists explained that some of their clients had too loose of boundaries and asked invasive questions, e.g., if they ever had an eating disorder. While therapists noted not all clients who asked this question had inappropriate boundaries, several observed it was an attempt to take the focus off of them. Several clients also admitted asking this question of their therapist and invading their personal life in an effort to avoid a sensitive topic. Additionally, one client provided an example where she focused too much on her therapist's weight, which made opening up and connecting difficult.

Description Differences

Differences between the clients' and therapists' descriptions are reflected in Table 14.

Table 14

Differences Between Clients' and Therapists' Descriptions

Clients' Descriptions	Therapists' Descriptions
Description of alliance • Therapist is responsible to form the alliance	Description of alliance • Alliance formation is a collaborative process
Helpful therapist factors • Willingness to be contacted outside of session • Warm and safe office environment	Helpful therapist factors • Aware of personal reactions toward clients • Sought supervision
Helpful client factors • Readiness: independently seeking treatment, attending sessions, admitting they had an eating disorder	Helpful client factors • Readiness: active and engaged, willing to hurt, ready to get rid of their eating disorder
Unhelpful therapist factors • Lack of individualizing treatment • Lack of competence and confidence	Unhelpful therapist factors • Lack of objective distance
Unhelpful client factors • Medical issues due to malnourishment • Negative self-beliefs • Lying	

Description of the alliance. In this section, I review the differences between the therapists' and clients' descriptions of alliance. When describing alliance formation, many clients agreed it was the therapist's responsibility to build trust and form the alliance. Several clients believed it was a "huge step" simply walking into the therapy office and, therefore, it was the role of the therapist to form the relationship. Therapists,

on the other hand, described alliance formation as a collaborative process where both the clients and therapists work to form the relationship.

Helpful therapist factors. When describing helpful therapist factors, several differences existed between the clients' and therapists' descriptions. One difference included the clients having contact with their therapist outside of session (via phone, text, or email) and labeled it as helpful. Most clients observed this as something that enhanced the trust in the relationship; however, none of the therapists discussed this factor or noted it helpful or unhelpful.

Another difference included several clients who described their therapists' office environment as aiding in alliance formation. For example, several clients discussed that having couches, carpet, and music created a "warm" and "safe" environment, yet none of the therapists acknowledged this as an influential factor. Two therapists noted the importance of the therapist being "warm" and "safe," but not the office environment. The therapists noted two helpful therapist factors that the clients did not. One of these included the therapist working on his/her personal struggles outside of the relationship and being aware of personal reactions toward clients. It is possible because these were internal and private processes on the therapist's part, the client did not observe if or how they impacted the relationship. The other factor therapists noted was seeking supervision. Many reported that because this could be a difficult population to work with, supervision was helpful in having a place to "vent" and process their relationship with clients.

Helpful client factors. One main difference between the clients' and therapists' responses was regarding helpful client factors. Although many participants used words

such as “ready,” “willing,” and “invested,” it appeared these words took on slightly different meanings. For client participants, they viewed “readiness” as seeking treatment on their own, choosing their therapist, and attending therapy sessions regularly. The therapists, however, used the word “readiness” to represent more active involvement--the client’s willingness to hurt, suffer, explore fears, open up, share, connect, and get rid of their eating disorder. It appeared clients saw readiness as taking the first steps to walk in the office door, whereas therapists used this word to represent the client’s commitment to doing the hard work of recovery.

Unhelpful therapist factors. Differences emerged between clients’ and therapists’ descriptions of unhelpful therapist factors. One difference included the client’s experience when his/her therapist did not individualize treatment. One client shared her therapist forgot many things she said from session to session, which made her believe she was treating her similar to other clients. Another theme clients identified was when therapists lacked competence and/or confidence. Although both therapists and clients agreed competence and confidence were helpful therapist characteristics, therapists did not identify the lack of this as unhelpful.

The only theme therapists identified that the clients did not include when therapists lacked objective distance. This included engaging in countertransference, modeling maladaptive relationships, and losing hope. Although one client encouraged therapists to not give up or lose hope, it was not a common theme among the clients.

Unhelpful client factors. Several differences existed between the clients’ and therapists’ descriptions of unhelpful client factors. One unhelpful factor reported by clients was client’s medical issues. Several clients explained that being malnourished

impacted their cognitive functioning and, therefore, hindered alliance formation.

Additionally, two therapists acknowledged this was unhelpful; however, it was not a common theme.

Additionally, clients acknowledged their negative self-beliefs were unhelpful. These included believing they were unworthy of recovery or their therapist's time, as well as feeling guilt and shame. Clients also noted lying as unhelpful to the relationship and described their attempts to avoid telling the "whole truth" and "dodging questions." No common unhelpful factors were noted by therapists that clients did not address.

Conclusion

In this chapter, I reviewed the composite descriptions among participants, which highlighted the essence of this phenomenon. I discussed the commonalities among the clients' and therapists' descriptions of the alliance as well as factors they viewed as influencing alliance formation. Additionally, I examined the similarities and differences between the clients' and therapists' experiences. In the next chapter, I provide a discussion of the findings, review the implications and limitations, and suggest directions for future research.

CHAPTER VI

DISCUSSION

The purpose of this study was to explore perceptions and experiences of clients diagnosed with Anorexia Nervosa (AN) and therapists who work with AN regarding how the working alliance was formed and challenged in the process of individual psychotherapy. This chapter contains a summary of the study, discussion of the findings, and applies working alliance theory to those findings. This chapter also highlights the implications and limitations of the study as well as directions for future research.

Summary of the Study

Researchers have investigated the process and outcome of individual psychotherapy for several decades. Through these investigations, they identified several elements common to all types of therapy, also known as common factors (Lambert & Ogles, 2004). The most frequently mentioned common factor in psychotherapy literature is the working alliance, or therapeutic relationship, between the client and therapist (Wampold, 2001). The most commonly accepted conceptualization of the working alliance was defined by Bordin (1979), wherein he described the alliance composed of three components: agreement on the goals of therapy, agreement on the tasks of therapy, and the relational bond between the client and therapist. One reason it is the most commonly utilized conceptualization is because it is pantheoretical in nature and common to all forms of therapy. Researchers also found that the working alliance is one

of the most robust predictors of therapy outcome (Horvath et al., 2011; Safran et al., 2002).

Several researchers (Horvath & Bedi, 2002; Horvath et al., 2011; Horvath & Symonds, 1991) discovered therapist and client ratings on working alliance measures often differed, particularly early in therapy, and clients' ratings were better predictors of outcome compared to therapists' (Hersoug et al., 2001; Horvath & Luborsky, 1993; Horvath & Symonds, 1991). Due to these differences in ratings, Bedi et al. (2005) and Bedi (2006) asserted the need to research clients' subjective understanding of the working alliance, specifically in different mental health populations. One population that has received little attention regarding the working alliance is clients diagnosed with AN.

Therapeutic progress is often slow and prognosis poor with clients diagnosed with AN (Franko & Rolfe, 1996). Furthermore, forming a working alliance can be difficult with this population because they frequently have difficulty trusting their therapist (Warren et al., 2009) and often portray insecure attachment styles (Wechselblatt et al., 2000). Previous research (Bedi, 2006; Bedi et al., 2005) examined clients with various diagnoses and their subjective understanding of the working alliance using a qualitative paradigm. Other studies (Gallop et al., 1994; Loeb et al., 2005; Pereira et al., 2006; Toman, 2002; Zeeck & Hartmann, 2005) also measured the working alliance with clients with eating disorders using a quantitative approach. However, prior to the current study, researchers have not investigated the subjective understanding of the working alliance with clients with AN and therapists who work with this population.

This study explored the following questions:

- Q1   How do clients diagnosed with Anorexia Nervosa experience the working alliance in individual psychotherapy?

- Q2   How do therapists who work with clients diagnosed with Anorexia Nervosa experience the working alliance in individual psychotherapy?
- Q3   What factors influence the working alliance between therapists and clients diagnosed with Anorexia Nervosa?

Fifteen individuals participated in this study. Eight participants were clients currently diagnosed with AN and actively pursuing individual psychotherapy. Seven of the clients were female, one was male, and they ranged in age from 20 to 63 years old. All clients were Caucasian and lived in the United States of America. One client was from the Midwest, three were from the East Coast, and four were from the Southeast. The remaining seven participants were therapists who provided individual psychotherapy to clients diagnosed with AN; however, they were not providing psychotherapy to the client participants. One therapist was male, six were females, and all were Caucasian. The therapists' ages ranged from 28 to 63 years old and all practiced in a Rocky Mountain state. Three therapists had a master's degree, one had a master's degree and several doctoral-level courses, and two had earned a doctorate.

To recruit participants, I identified therapists who worked with clients with AN and their email addresses from two professional national association websites: the National Eating Disorders Association and the National Association of Anorexia Nervosa and Associated Disorders. I emailed therapists regarding the study, asking if they would participate or be willing to provide a recruitment letter to their clients with AN who met the appropriate criteria. Interested clients contacted me privately; their therapists were not made aware of their participation.

Data were collected through semi-structured interviews via in-person, phone, or Skype. I conducted in-person interviews with four therapists, phone interviews with two

therapists and six clients, and Skype interviews with one therapist and two clients. The in-person interviews were completed in the therapists' office or at a public library. Interviews were recorded on a digital audio recorder and transcribed. To analyze the data, I utilized Moustakas' (1994) phenomenological method of data analysis. This included highlighting significant statements or quotes that captured each participant's experience of the working alliance and factors that were influential in forming or challenging the relationship. I then grouped and labeled the statements and quotes and created a textural-structural description for each participant, which were reviewed in Chapter IV. Next, I used the participants' individual themes to create the invariant structure, or the composite experience, between clients with AN and therapists. The composite experience was detailed in Chapter V.

To enhance the trustworthiness and rigor of this study, I employed several methods: saturation, triangulation, member checks, peer/expert checks, researcher reflexivity, thick descriptions, and an audit trail (Guba & Lincoln, 1989; Lincoln & Guba, 1985; Merriam, 2009; Morrow, 2005). I utilized triangulation by interviewing multiple participants, both clients and therapists, and used multiple researchers. Another doctoral student, trained in qualitative methodology, served as my co-researcher. We independently analyzed each transcript, identifying the textural-structural description (individual themes) and the composite description (overarching themes). We then compared our independent findings, identified the similarities and differences, and discussed the differences until an agreement was made to incorporate the theme or not. Additionally, my research advisor read all the transcripts, textural-structural description, and composite description to aid in peer/expert check.

Furthermore, I employed member checks by emailing the participants their transcripts, individual textural-structural descriptions, and the composite description; I asked them to review all of the documents and add, re-categorize, or delete data they deemed necessary. Three therapists and four clients responded regarding their transcript, four therapists and two clients replied about their individual textural-structural description, and two therapists and two clients provided feedback about the composite description. The participants' feedback did not change the original themes or the meaning of the themes; rather, it provided clarification and further details. Throughout the study, I maintained an audit trail, documenting contact with participants, their feedback, and how the textural-structural and composite descriptions were created. I also kept a reflexive journal and reviewed it with my co-researcher during data analysis to aid in bridling (Dahlberg, 2006).

Discussion of the Findings

In Chapter IV, I provided a detailed account of each participant's textural-structural description. I then used common themes to create the composite experience of the working alliance between clients and therapists in Chapter V. In this section, I provide a discussion of the research findings, focusing on the description of the working alliance and factors that influenced its formation.

Working Alliance Description

Clients' experience. All eight client participants acknowledged when they first entered psychotherapy, it was not because they sought treatment on their own or wanted to get rid of their eating disorder; rather, many admitted they began therapy to appease a friend, family member, or partner. Similar to this finding, Franko and Rolfe (1996)

observed most clients with AN do not perceive themselves to be sick or ill and often seek treatment due to another person's request. Several participants were adolescents when they first began treatment and reported their parents "made" them attend therapy. Due to therapy not being their choice, several acknowledged they entered the therapeutic relationship with ambivalence and even resistance. Forsberg et al. (2012) also highlighted that challenges to the alliance can be greater with adolescents as they are often brought to therapy by their parents and deny that they have a problem. Additionally, many clients "do not complain about their condition; on the contrary, they glory in it" (Bruch, 1988, p. 7). One explanation for this phenomenon is likely due to the ego-syntonic nature of AN (Vitousek, Watson, & Wilson, 1998), which inhibits clients from seeing themselves as sick and needing treatment. Westwood and Kendal (2012) furthered this concept and explained treatment likely poses a threat to the client's sense of self, which could lead to negative or ambivalent views of therapy and avoiding treatment.

When describing their experience of the working alliance early in therapy, many clients acknowledged a "slow" and "cautious" approach to building a relationship with their therapist. Several stated they feared opening up and connecting to another person. Warren et al. (2009) stated clients with eating disorders often experience difficulty trusting their therapist and sharing power and control early in therapy, which paralleled the participants' experiences. Another way to interpret the clients' cautious approach is through an attachment lens. Researchers observed clients with AN often portray insecure attachment styles, described as anxious or avoidant, which can negatively impact the client's ability to form an attachment with the therapist (Wechselblatt et al., 2000). Although clients' attachment styles were not measured in this study, it appeared several

might have had a type of anxious attachment as they described fear of their therapist abandoning them or getting hurt, thus explaining why the clients would approach the relationship slowly and cautiously

Due to difficulty trusting the therapist, clients noted it was the responsibility of the therapist to build trust, the alliance, and prove him/herself to the client. Many believed it was a “huge step” simply walking into the therapy office and, therefore, the majority of the responsibility was on the therapist to form the relationship. This finding did not fit with previous conceptualizations of alliance in that many researchers believe collaboration between the therapist and client is a necessary building block in alliance formation (Bordin, 1979; Gelso & Hayes, 1998). Horvath (2000) described Bordin’s (1979) conceptualization of alliance as a “collaboration between the therapist and the client; thus, ...a ‘true’ bidirectional relationship” (p. 167). This description of alliance did not appear to fit the clients’ experiences, at least at the beginning of therapy.

Although many clients acknowledged difficulty building the alliance in the beginning, all clients described a “very good” or “great” working alliance at the time of the interview. Several expressed it felt comfortable and safe due to the therapist being dependable and reliable throughout treatment. Theorists and researchers also referenced the importance of the therapist being a “secure base” to aid clients during times of distress and difficult emotional exploration (Moore & Gelso, 2011). Gulliksen et al. (2012) interviewed clients with AN and discovered they felt secure when their therapists were giving, affectionate, caring, kind, understanding, confident, and authoritative. Four clients also defined their current relationship with their therapist as a “friendship,” “mentorship,” or “team.” These adjectives highlight the clients’ comfort level with their

therapists and portray growth of the alliance over time. The descriptions also imply a more collaborative relationship; therefore, clients appeared to view alliance creation as more the therapist's responsibility and the maintenance of alliance as more collaborative in nature.

Therapists' experience. Many therapists described the difficulty in building an alliance with clients with AN and used words and phrases such as “resistance,” “adversarial,” “some sort of battle,” “challenging,” “frustrating,” “slow,” and “arduous.” Due to this, therapists voiced the need to be patient and collaborative with clients. Similarly, Odom (1997) interviewed therapists regarding their work with clients with eating disorders; many described it as frustrating, challenging, and requiring patience. It is likely clients' difficulty trusting and forming attachments, as well as the ego-syntonic nature of the disorder, might increase the therapists' frustration when attempting to build a relationship, as it might take more time compared to other diagnosed populations.

Horvath and Greenberg (1994) noted, “The building of a viable working alliance is a slow and delicate process with individuals who have weak capacities for forming real relationships and strong transference propensities” (p. 17). Furthermore, Satir et al. (2011) explained the difficulty in building an alliance with this population is likely due to a client's goals being dissimilar from the therapist's, which likely creates interpersonal difficulties. The participants in this study experienced a difference in therapy goals, discussed later in this chapter, which they described as negatively impacting alliance. Therefore, as the therapist participants communicated, it is important to be patient and collaborative during alliance formation. If a therapist is not patient and does not expect

or normalize clients' resistance, therapists may become defensive and feel rejected by clients (Satir et al., 2011; Snyder & Anderson, 2009).

Four therapists described the difficulty "connecting" to clients with AN and several observed this is similar to what clients do with others in their lives. They also highlighted the importance of providing a corrective emotional experience. For example, one therapist acknowledged many people in her clients' lives had "demanded, controlled, and criticized them"; she believed her role was to be different and provide "care and respect." Another therapist called this "distant intimacy" and explained how she was constantly "renegotiating space in the relationship" and assessing if it was too close or not close enough. The concept of providing a corrective emotional experience in therapy has been researched and shown to be effective in changing the client's internal working models of self and others and aids in alliance formation (Moore & Gelso, 2011).

Comparison of descriptions. Both client and therapist participants described the working alliance formation as difficult at the beginning of therapy. While most therapists understood why clients approached the relationship with hesitancy (e.g., due to attachment style, past trauma, lack of motivation for treatment, wanting to maintain their disorder), many were straightforward about their negative reactions and how it required much patience on their part. The therapists also highlighted the need for collaboration with clients during this time, not "drive the agenda," but rather set goals with the client.

Although therapists and previous researchers (Bordin, 1979; Gelso & Hayes, 1998) agreed collaboration is necessary at the beginning of treatment, most clients identified the therapist as primarily responsible for building the alliance. To do this, clients suggested therapists be stable, reliable, supportive, and hopeful, and ask questions

to help the client open up. Furthermore, several researchers (Bachelor, 1995; Bedi, 2006; Bedi et al., 2005) discovered a similar discrepancy between therapists' and clients' views--clients do not see collaboration as important at the beginning of therapy and assign the majority of responsibility of alliance formation to their therapist. Due to this discrepancy, therapists might feel more frustrated as they are expecting clients to collaborate, whereas clients do not see this as their role or responsibility at the beginning of the relationship. In the next section, I discuss helpful and unhelpful therapist and client factors participants discussed as influencing alliance formation.

Influential Factors in Alliance Formation

Helpful therapist factors.

Similarities. Both client and therapist participants acknowledged strong basic counseling skills as helpful therapist factors in alliance formation. These skills included validation, nonjudgmental attitude, unconditional positive regard, genuineness, authenticity, and collaboration. Some ways therapist participants conveyed these characteristics included showing a genuine interest in understanding how the eating disorder functioned for clients in a positive way (i.e., "Don't make the eating disorder the enemy"), creating a different relationship (e.g., corrective emotional experience), and using touch, when appropriate, to convey empathy. Clients described similar counseling skills--normalizing and validating the disorder and relapse, letting clients have a voice and choosing the session topic, remembering things the client said in previous sessions, using humor, and showing genuine emotion (e.g., crying) and attentive body language.

Bedi (2006) discovered similar results and stated, "Many key factors that clients understand to be important for alliance formation may be deceptively simple and reflect

counselor skills such as nonverbal gestures and empathic listening” (p. 32). Gelso and Hayes (1998) asserted that using Rogers’ (1951) therapist-offered conditions, such as empathy, unconditional positive regard, and congruence assisted in building the working alliance early in therapy. Additional factors that have been researched as helpful in alliance formation include genuineness, respect, trustworthiness, warmth, and compassion (Ackerman & Hilsenroth, 2001; Bedi & Richards, 2011; Gelso & Carter, 1985; Gelso & Hayes, 1998; Horvath, 2000; Horvath & Luborsky, 1993; Lambert & Barley, 2002). Specific to clients with eating disorders, Garner, Vitousek, and Pike (1997) stated warmth, genuineness, engagement, and positive regard aided in alliance formation. It is likely that the basic counseling skills reflected the therapist’s willingness to move slowly and collaborate on the therapeutic goals, which clients noted as important in the early stages of therapy. Unconditional positive regard and genuineness might have also aided in building trust as clients learned their therapists cared about them and would be honest and genuine in their communication.

Client and therapist participants referenced the effectiveness of a therapist who used a strengths-based approach. Several clients provided examples of their therapist providing verbal reinforcement for their positive steps, e.g., highlighting the courage it took to enter therapy or praising them if they were able to sit an extra 20 minutes before purging. Therapist participants illustrated similar examples and suggested using reframing and recognizing the client’s internal resources. Additionally, the majority of therapists relayed the importance of redefining success and outcome when working with clients with eating disorders because “recovery” might look different from client to client

and might take years; therefore, one therapist suggested looking for smaller, more intangible markers of success (e.g., evoking emotion) and making it known to the client.

Gulliksen et al. (2012) discovered clients with AN preferred therapists who focused on their resources, strengths, and abilities. Similarly, Redko, Rapp, Elms, Snyder, and Carlson (2007) found similar results when interviewing clients who abused substances about the helpful characteristics of their case managers. They discovered clients appreciated when their case managers helped them recognize their personal strengths/skills as it increased their sense of self-worth. In this study, when the therapists highlighted clients' strengths and internal resources, it appeared to do two things. First, it helped clients develop hope and confidence that they could fight the disorder. Since many clients enter treatment ambivalent about getting rid of their disorder, this might help clients see they have what it takes to battle the disease. Additionally, it helped the therapist maintain a hopeful and optimistic view about their clients' recovery. As previously discussed, many of the therapists in this study described alliance formation as frustrating and difficult. When focusing on the client's internal resources as well as highlighting small successes, it helped the therapists maintain a positive outlook and modeled adaptive thinking for clients.

In contrast, Sexton and Whiston (1994) discovered therapists who were more challenging, thematically focused, and here-and-now oriented had stronger alliance ratings than therapists who attempted to clarify/obtain information, explore feelings, or offer support and encouragement. The authors hypothesized that because the alliance is collaborative in nature and support and encouragement put the client in a passive role, this might explain the findings; however, in this study, the client participants preferred

having a more passive role at the beginning of therapy and appreciated their therapist obtaining information, exploring feelings, offering encouragement, and highlighting strengths. One reason this could be explained was due to client factors present at the beginning of treatment, e.g., ambivalence about treatment, insecure attachment style, and ego-syntonic nature of the disorder. Therefore, having a more active therapist could allow clients time to trust, learn to be collaborative, and develop motivation to battle their disorder.

Another helpful therapist characteristic four clients and three therapists highlighted included the therapist communicating and collaborating with external systems--people such as the client's family members, treatment team (e.g., physician, psychiatrist, dietician), and personnel at a more intensive treatment facility (e.g., intensive outpatient). Several clients found it helpful when their therapist consulted with the treatment team so everyone was "on the same page." Another client appreciated when her therapist referred her to a dietician and physician. Similarly, three clients expressed how helpful it was for their therapist to collaborate with their family members to help them understand the disorder and use them to encourage the client to continue in recovery. A few therapists also described collaborating with families, helping them understand the disorder, and using "diplomacy and professionalism" when working with the treatment team and the family system.

While research (Lyon, Silber, & Atkins, 2005; Rienecke Hoste, Celio Doyle, & Le Grange, 2012) specifically focusing on eating disorders supported collaborating with the treatment team to promote better outcome, no research has explored how a therapist's collaboration with the treatment team impacts working alliance formation. Godkin

(2010) utilized a case study approach to investigate how the use of a treatment team composed of eight different psychotherapists impacted a client's addiction to substances. Although the Working Alliance Inventory (Horvath & Greenberg, 1989) was used to measure client's alliance to therapists and high scores were noted, it was not investigated if the treatment team impacted the alliance.

Similarly, previous research has not identified if incorporating a client's family into individual therapy positively influenced alliance. In a study investigating two types of treatments for adolescents with AN, researchers discovered higher observer ratings of alliance in a family-based treatment versus the adolescent-focused treatment (i.e., individual therapy; Forsberg et al., 2013). While this study supported the use of family therapy when treating adolescents with AN, it did not note if this was useful in adults as well as how incorporating family into individual treatment impacted alliance. Additionally, this finding-- incorporating others into treatment influences alliance-- contrasted many of the working alliance definitions such as Bordin's (1979) focus on goals, tasks, and bond. Bordin's theory posited the alliance forms in the dyad between the client and the therapist and did not suggest external parties, e.g., a client's family or other treatment providers, influenced this relationship.

The finding of incorporating treatment team providers and family into therapy was helpful in alliance formation was a unique finding of the current study. While previous literature supported collaboration with a treatment team and family as helpful in treatment and outcome, no research has investigated its influence on alliance formation. One reason collaborating with external systems was helpful for participants might be due to the fact that it helped therapists focus on building the alliance. When working with

clients diagnosed with AN, many variables need to be focused on in treatment including the client's physical health and nutritional intake (Rumney, 2009). By incorporating members of a treatment team, such as a physician and nutritionist/dietician, it enabled the therapist to spend more time and energy building the alliance versus worrying if the client was medically stable or reviewing a client's food journals to ensure he/she was getting adequate nutrition. Additionally, incorporating a client's family into treatment could help them better understand the disorder and ways they could be supportive to the client between therapy sessions. Having a support system that echoed messages the therapist communicated in session might help enhance the alliance with the therapist as the client is reminded of therapy and the therapist between sessions.

Many participants identified self-disclosure by the therapist as helpful in alliance formation. Theorists and researchers distinguished between two types of self-disclosure: "self-involving statements" that disclose the therapist's immediate reactions to clients and "self-disclosing statements" that disclose something about the therapist or his/her past (Watkins, 1990). While most clients focused on self-disclosing statements in their discussion, several therapists commented on both self-disclosing and self-involving statements, often favoring self-involving statements. Therapists described helpful self-disclosure as relating to the clients, but not the disorder, normalizing body image issues, relating to their sensitivity, and being genuine while maintaining boundaries. Clients shared self-disclosure was useful when their therapist used it to connect, happened slowly and over-time, and did not focus too much on the therapist.

Three therapists and one client noted they or their therapist kept strict boundaries and limited self-disclosure to their "professional self"--defined as information one could

find on the internet or in the therapist's office (e.g., where they attended graduate school as listed on their diploma, expertise in eating disorders), or they did not disclose at all. Researchers (Hill & Knox, 2002) suggested therapists use self-disclosure sparingly, making up an estimated 3.5% of all therapists' interventions. When discussing the helpfulness of therapist self-disclosure, the majority of therapist and client participants highlighted that it normalized clients' reactions and struggles, developed a stronger bond and connection with the therapist, and helped clients feel safer to open up and share about themselves.

Two clients acknowledged asking their therapist to self-disclose about her history of an eating disorder. While one client stated she was genuinely interested, another admitted to using this as a distraction from focusing on himself. Although previous research (Hayes & Gelso, 2001; Hill & Knox, 2002) found judicious use of therapist self-disclosure as helpful in alliance formation, there were mixed results as to whether it had a positive, negative, or neutral impact on client outcome (Kelly & Rodriguez, 2007).

According to the results of this study, self-disclosure was helpful when used slowly and with the intention of connecting and normalizing the client's experience. It appeared the client participants appreciated their therapist balancing self-disclosure, i.e., they shared some things about their personal lives such as a vacation they took or something about their children, but also recognized the value of their therapist not disclosing very personal information such as if he or she had a history of an eating disorder. The clients also appreciated self-disclosure happening over time--with their therapist not sharing as much in the beginning but more throughout the course of therapy. Therefore, it is important for therapists to be thoughtful when they self-disclose and

consider the purpose of the disclosure, the timing, the amount of information to disclose, and if it fits with the therapist's theoretical orientation and personality. It would also be useful to consider limitations of self-disclosing and how it might negatively impact alliance, which is discussed later in this chapter.

All 15 participants described the therapist's expertness or experience treating eating disorders as a helpful factor in alliance formation. Therapists described expertness as having much experience working with this population, confidence, and utilizing effective treatment approaches. Clients defined expertness as having experience and knowledge; however, several noted the importance of the therapist not taking an "expert stance" and being able to admit when s/he did not know something. One client admitted she felt safer when her therapist told her she did not know something so she knew "my therapist is not going to try to pull something over on me."

Clients also highlighted other factors that portrayed their therapist's expertness: teaching them how to identify and feel feelings, knowledgeable about medications and treating co-occurring issues, maintaining confidentiality, and providing structure during sessions. Researchers identified similar therapist characteristics such as experience levels (Horvath & Greenberg, 1994), credibility (Wei & Heppner, 2005), honesty (Bedi, 2006; Garner et al., 1997), and confidence (Ackerman & Hilsenroth, 2003) as positively influencing the working alliance.

In a review of adolescent clients' views toward the treatment of AN, Westwood and Kendal (2012) discovered clients' alliance scores were positively affected if they perceived their therapist as knowledgeable and competent; they found it less helpful if clients viewed them as inexperienced as they felt more able to deceive their providers.

Similarly, Gulliksen et al. (2012) interviewed adults with AN regarding preferred therapist characteristics and found that participants preferred a therapist who was knowledgeable about and experienced with eating disorders, confident in their abilities, and authoritative in sessions.

The finding that a therapist's expertness positively influenced alliance was not a new discovery; however, the finding that a therapist's honesty about his/her limitations and lack of knowledge positively influenced alliance was a unique finding in the present study. Having a therapist who was experienced treating eating disorders helped the clients feel safe and comfortable in the relationship; however, equally important was a therapist who was able to identify what knowledge he or she lacked. Some examples included knowledge about nutrition, medical concerns, and medication. Additionally, it appeared important for therapists to be an expert but not "act" like an expert. Ways therapists did this were by asking the client about him or herself and understanding that each client is unique and different.

A sub-theme of expertness included therapists being able to balance setting boundaries, challenging the client, and showing compassion. One therapist participant described this as "having one arm around the client while kicking them in the butt with your foot." Over half of the client participants explained by having their therapist be direct, not "pull any punches," and having a "no fooling around" attitude toward their eating disorder, their feelings of trust and safety increased. Many admitted how in-the-moment, these challenges were difficult; however, looking back, several acknowledged how it made them trust that their therapist would keep them safe.

Researchers identified similar findings of setting boundaries and showing compassion. Gulliksen et al. (2012) interviewed adult clients with AN and discovered that therapists who were both challenging and understanding were preferred characteristics of a therapist. Westwood and Kendal (2012) relayed while clients with AN initially disliked having their control taken away, e.g., being forced to eat and gain weight, many identified this to be a “life-saving part of their treatment” (p. 502). Additionally, in a study examining treatment providers’ experiences of treating eating disorders, the authors (Warren et al., 2009) discovered a theme of “stern guide,” highlighting the importance of balancing encouragement and assertiveness by setting clear boundaries. Therefore, therapists who are able to find a balance of encouraging the client and setting boundaries/challenging will likely be more successful at building alliances with clients with AN.

The last helpful therapist factor clients and therapists agreed upon included the therapist individualizing treatment. One client encouraged therapists to not be a “cookie-cutter doctor” and treat all clients the same. She went on to say, “It’s very important to know us [clients with AN] as a whole as well as individually.” Similarly, Westwood and Kendal (2012) found alliance was positively influenced when clients were treated as an individual rather than “merely an anorexic” (p. 506). Gulliksen et al. (2012) also discovered clients with AN preferred therapists who took the client’s perspective, listened to them, and viewed them as unique individuals.

Several clients provided examples of how their therapist individualized treatment: using metaphors specific to the client’s family, conducting a session via telephone when the client was traveling, pausing therapy to use a relaxation technique when the client

was “fried,” and knowing when to push a client or when to give him/her space. All seven therapist participants acknowledged the importance of individualizing treatment by moving slowly, respecting physical distance, being attuned to client’s nonverbal communication, collaborating and prioritizing treatment goals, and assessing client’s resources prior to starting trauma therapy. Other therapist behaviors suggested by participants and researchers that positively influenced the alliance and portrayed individualized treatment included flexibility (Ackerman & Hilsenroth, 2003; Garner et al., 1997), providing corrective emotional experiences (Horvath & Greenberg, 1994), using touch (e.g., hug) when appropriate and initiated by clients (Horton, Clance, Sterk-Elifson, & Emshoff, 1995), and utilizing caution and care when bringing up the need for more intensive treatment.

Differences. When discussing helpful therapist factors to alliance formation, three major themes differed between the therapist and the client participants. The first theme named by six of the eight client participants consisted of being able to contact their therapist outside of the therapy sessions. Some clients contacted their therapist via phone or text, while others utilized email. Many explained they discussed the boundaries around communication with their therapist (i.e., when and why they would contact their therapist) prior to contacting them. Several clients acknowledged they had not contacted their therapist; however, knowing they could if needed seemed reassuring.

Researchers discovered similar findings when interviewing clients with various diagnoses (Bedi & Richards, 2011) and those diagnosed with substance abuse (Redko et al., 2007); they found clients appreciated being able to call or email their therapist or case worker between sessions as it aided in alliance formation. In an article exploring e-mail

as an adjunctive therapeutic tool in outpatient treatment with four clients with AN, Yager (2001) put forth that email was helpful with this population. To illustrate, email increased the frequency and contact of the relationship, allowed clients to email when they felt most “inspired” and emotionally driven, made clients more aware of their behaviors and being in therapy, allowed more time in-session to discuss topics other than calorie counts or behavior logs as those were documented in the email, and might have increased client’s honesty.

One possible reason clients viewed the ability to contact their therapist as helpful to alliance formation was because it might have shaped their view of the therapist as a reliable, dependable secure-base and assisted in creating a corrective emotional experience with the therapist. Clients with AN often have insecure attachment styles (Wechselblatt et al., 2000); therefore, being able to experience a secure attachment with someone between therapy sessions might foster trust and safety in the relationship. Furthermore, Gelso and Hayes (1998) stated,

It is critical that the therapist provide the client with a secure base.... In doing so, the therapist strengthens the working alliance. In turn, a strong working alliance allows for the secure base the client must have if she or he is to explore difficult, threatening affects and experiences in the session, as well as behaviors outside the session. (p. 30)

Although client participants in this study deemed this a helpful factor, it does not necessarily mean every therapist should provide their personal contact information to every client with AN. Bhuvaneswar and Gutheil (2008) highlighted several potential risks when using email to communicate with clients: boundary violations, loss of nuances in communication, loss of empathy, and hurting the client’s feelings if a response was not sent promptly or at all. Furthermore, if the client has safety concerns, they acknowledged

the risk by stating, “E-mail may not give quite enough evidence for legal action to protect the patient or target of the patient’s harmful thoughts; yet, it may be used after an incident has occurred to hold the receiving clinician responsible” (Bhuvaneswar & Gutheil, 2008, p. 246). In place of email, the authors proposed alternative solutions: providing the client with information regarding online message boards, online support groups, and/or chatrooms.

Although previous research has investigated the use of email between sessions as it related to treatment and outcome, previous research has not identified if and how email, text, or phone calls with therapists influenced alliance formation, thus making this a distinctive finding of this study. According to the clients in this study, even if they did not contact their therapist, simply knowing they could helped them feel as if they were not “alone” between sessions and seemed to create a trusting, secure relationship. However, due to ethical concerns, as well as client characteristics (e.g., those with loose boundaries, safety concerns) and therapist characteristics (e.g., unable to be on-call, theoretical orientation), it is important this factor be implemented with caution.

The second helpful therapist factor three clients identified included the therapist’s office environment. One client participant stated, “I’m very sensitive to my environment...I really think a lot of folks that have eating disorders are highly sensitive.” Some of the specifics clients noted as promoting a warm office environment included decorations and furniture that were “homey” and “comfortable,” playing soft music in the waiting room, having a white noise machine for privacy, carpet versus tile floors, dim lighting, and stuffed animals. Another client recalled that her therapist had a therapy dog and allowed her to pet and cuddle her during therapy, which helped the client feel safer.

It is noteworthy two therapist participants commented on their office environment: one stated she tried to create a warm office environment and another acknowledged she did not have photos of her family or husband in her office due to her psychoanalytic approach and limiting self-disclosure. However, neither participant suggested that their choice of office décor influenced alliance formation

Although Bordin's alliance (1979) definition and theory did not take into account the external office environment, recent researchers (Bedi, 2006; Bedi et al., 2005; Bedi & Richards, 2011; Benton & Overtree, 2012) investigating client's conceptualizations of alliance found similar results: office environment was a significant factor in clients' understandings of alliance formation. For example, in previous studies, client participants noted office size, lighting, decorations (e.g., plants and flowers), color scheme, and types of books in the therapist's office were all influential in alliance formation (Bedi, 2006; Bedi et al., 2005). Additionally, office furnishings (e.g., couch, chair, desk) were found to impact perceived credibility, trustworthiness, and expertness of the therapist (Nasar & Devlin, 2011), which was previously discussed as influential in alliance formation.

Benton and Overtree (2012) highlighted the importance of creating a multicultural sensitive office environment that included office décor (e.g., furniture, artwork, magazines in the waiting room), printed materials and the website, clinical paperwork, statements regarding fairness, and accessibility. Although their article was theoretical in nature, they proposed the office environment, specifically its multicultural sensitivity, impacted the therapeutic alliance. Unfortunately, there was little to no research that identified what specific types of office lighting, décor, furnishings, and color schemes,

just to name a few, were more or less helpful; however, according to the participants in this study, objects that encouraged comfort and privacy were helpful, e.g., soft music in the waiting room, a white noise machine, carpet, dim lighting, and a comfortable couch.

The last themes that differed between therapists' and clients' descriptions of helpful therapist factors consisted of "doing your own work as a therapist" and seeking supervision, which were identified by a majority of therapist participants. One therapist described the need to "have your own well-being solid," "stay balanced," and "learn self-care." By working on their own personal struggles, the therapists explained they were cognizant of their own reactions toward clients, were able to be "strong" and "grounded" when the client was not, and modeled wanted adaptive behavior.

Researchers found similar results, noting a therapist's reactions could influence the alliance. For example, Gelso and Carter (1994) acknowledged the importance of the therapist being aware and monitoring his/her reactions so they did not negatively impact alliance. Countertransference, or the negative personal reactions therapists have toward clients, can negatively impact alliance, specifically in the treatment of eating disorders (Bloomgarden, 2009). Bloomgarden (2009) acknowledged that therapists who attempt to be compassionate, genuine, and promote positive regard, may find themselves having negative reactions toward their clients with eating disorders. Additionally, researchers discovered client and clinician factors that predicted negative clinician reactions toward adolescent clients with eating disorders: clinician's gender, group differences between psychiatrists and psychologists, patient personality, pretreatment level of functioning, length of time in treatment, and improvement in treatment (Satir, Thompson-Brenner, Boisseau, & Crisafulli, 2009).

Several therapist participants also relayed the importance and helpfulness of seeking supervision, which aided in self-reflection and monitoring their reactions. Gelso and Carter (1994) stated, “The working alliance is fostered by therapists’ careful monitoring of their own countertransference reactions to the client” (p. 299). The client participants did not identify this as a helpful therapist factor, possibly because they did not observe their therapist implementing “self-care” or seeking supervision. However, it is possible that the clients experienced the lack of these and labeled them as the therapist’s “judgment” and “criticism,” which they reported as unhelpful and discussed later in this chapter.

Helpful client factors.

Similarities. The majority of client and therapist participants acknowledged client honesty as a facilitative factor in developing a therapeutic alliance. For example, one therapist stated, “I know things are moving in the right direction when they [clients] say, *I haven’t eaten for three days.*” Similarly, several clients shared it was helpful when they were honest and told their therapist they acted on eating disorder behaviors (e.g., used laxatives, restricted). Although most participants discussed being honest about behaviors, one client and one therapist specified being honest about feelings, specifically fear or nervousness. Due to the medical concerns and risk with AN, it is likely that a client’s disclosure and honesty might help the therapist trust the client and, therefore, develop a better bond in the relationship. Previous research has not specified if and how clients’ honesty impacted alliance; however, through the participants’ descriptions, honesty appeared to be a form of clients’ engagement, which is discussed next.

Another helpful client factor put forth by clients and therapists included clients' engagement and participation during the session such as talking about their eating disorder and feelings. One client stated it as "a willingness and an ability to actually participate in the therapy, instead of being talked at." Participants also described engagement as being open, teaching the therapist about him/herself, and sharing his/her life story. Researchers (Bordin, 1994; Horvath, 2000; Patterson et al., 2008) also identified client engagement and participation as a helpful contributor to the alliance as it created a more collaborative partnership. Henry and Strupp (1994) stated, "The patient's willingness and ability to become actively involved in the treatment process seemed to be a crucial factor in alliance" (p. 57).

A sub-theme under client engagement included the client asserting him/herself and advocating for his/her needs. While this was an example of client engagement, it appeared to be a deeper level of disclosure and vulnerability. For example, one client reported asking her therapist for a hug when she needed it and another confronted her therapist when she said something that offended her. Two therapists also acknowledged this as helpful. One stated, "It [client feedback] makes me feel like I'm 'in' a little bit and that we're on each other's side, instead of across the room from each other."

Previous research has not investigated if and how clients' assertive behaviors impacted alliance. One reason clients' assertiveness aids in alliance formation might be because it provides the therapist with evidence that the client feels safer to open up and share. As many participants described, clients with AN often have a difficult time talking and opening up at the beginning of therapy; therefore, a client's assertiveness might provide feedback to the therapist that the relationship is becoming stronger. Additionally,

a client's assertiveness might help the therapist know what the client views as helpful and unhelpful. By knowing this, the therapist can then shift his or her behavior, if appropriate, to reinforce the client's assertive behavior and create trust in the relationship.

The last helpful client factor highlighted by three therapists and five clients was the client's ability to trust and connect to the therapist. Clients described this as "trusting the therapist's advice," "giving up control," "trying not to fight the relationship," and "realizing she [the therapist] wasn't going to hurt or abandon me." One therapist stated, "The ones who are trusting... the work is more quick and graceful." Warren et al. (2009) stated clients with eating disorders often experience difficulty trusting their therapist and sharing power and control early in therapy.

One possible explanation as to why many clients with AN have difficulty trusting and connecting to their therapists might be due to an insecure attachment style often found in this population (Wechselblatt et al., 2000). Researchers (Gelso & Carter, 1985; Gelso & Hayes, 1998; Wei & Heppner, 2005) determined that clients with less secure attachments often have more trouble forming and maintaining a positive alliance. Due to this difficulty, the bond component of the alliance is likely to form at a slower rate. When a client is able to trust the therapist and give up control, it likely helps the relationship feel more collaborative, which also might decrease any feelings of frustration the therapist might have felt.

Difference. There was one main difference between what clients and therapists deemed as helpful client factors. Although five clients and six therapists highlighted "readiness" and "willingness" as helpful client factors, how each group described these terms differed. Many clients defined "readiness" as willing to seek treatment on their

own, choose their therapist, acknowledge they had an eating disorder (i.e., no longer in denial), attend appointments regularly, and work toward changing behaviors outside of session. Therapists, however, described “readiness” as willing to give up their eating disorder, explore their fears and insecurities, be vulnerable and “feel like a mess,” be challenged with food, and go out of their “comfort zone.” Therefore, it appeared the client participants viewed readiness as taking the first step to seek treatment (e.g., choosing a therapist, attending appointments), whereas therapists seemed to conceptualize readiness as a more active and engaged approach.

This finding was similar to the description of alliance described above; at the beginning of therapy, therapists saw alliance as more collaborative, whereas clients saw it as more the therapist’s responsibility. Bedi (2006) found comparable results and stated, “Clients do not characteristically affirm the importance of collaborative efforts in alliance formation. Instead they more often choose to assign the majority of the responsibility to the counselor” (p. 32). Likewise, in a qualitative study (Bedi et al., 2005) with 40 participants with various diagnoses, only 33% mentioned their own contributions to alliance formation and viewed the therapist as mostly responsible for its creation.

Luborsky’s (1976) conceptualization of the alliance might help explain the difference in readiness descriptions between clients and therapists. He discussed that alliance is dynamic and changes with the different stages of therapy. He described two types of alliance: Type I and Type II. Type I alliance is described as the client viewing and experiencing the therapist as supportive and warm, which provides a foundation in which the work of therapy can proceed. Type II alliance involves an investment from the client and therapist for a commitment to the process as well as a shared responsibility and

working together toward common goals. From the descriptions, it appears clients viewed readiness from a Type I perspective, whereas therapists described it from the lens of Type II. These differences might also explain why the therapist participants described alliance formation as “frustrating,” “arduous,” and “challenging,” because they expected clients to collaborate and be invested, whereas clients wanted to confirm their therapist was supportive and warm prior to investing in the relationship.

Another way to view this finding is through the Transtheoretical Stages of Change Model (Prochaska & DiClemente, 1983, 1984). According to this model, clients enter treatment with differing levels of motivation to change and defined by five categories: precontemplation, contemplation, preparation, action, and maintenance. Prochaska and DiClemente (1984) stated that clients in precontemplation and contemplation stages are not often willing to engage in a collaborative relationship with the therapist. Similarly, clients in advanced stages of change reported stronger working alliances compared to those in lower stages (Rochlen, Rude, & Barón, 2005). Alliance scores are often higher for clients who progress to the action stage of change versus those who remain in the contemplation stage (Emmerling & Whelton, 2009). Therefore, the clients in this study appeared to define readiness from a contemplation or preparation stage, whereas therapists viewed it more from an action stage. This could also explain the therapists’ frustration and difficulty they felt when forming an alliance with clients with AN.

Unhelpful therapist factors.

Similarities. There were two common themes among the therapists’ and clients’ descriptions of unhelpful therapist factors. The first theme included a lack of attunement to the clients. One way both clients and therapists described lacking attunement included

being too “pushy” or “tentative.” Several therapists provided examples of ways they were too pushy--working toward a goal that was not shared with the client, setting their own agenda for the session, and not being flexible. Previous research (Hersoug et al., 2009) supported the finding and stated that therapists’ rigidity and over-structuring therapy sessions were negative contributors to alliance formation. Similarly, clients shared stories of when their therapist tried to force behavior change, e.g., strongly encouraged a client to tell her partner about her relapse and “pushed” a client to attend an inpatient program for eating disorders. Although participants identified the act of challenging clients as a helpful therapist factor, the timing of the challenge and if it was balanced with care appeared to differentiate the times it was helpful versus those labeled as “pushy” and unhelpful.

On the opposite end of the spectrum, both clients and therapists detailed being too “tentative” as unhelpful. Two clients recalled a previous therapist being gullible--taking what the client said about her emotional state and eating disorder at face value (e.g., “I’m fine”) and not inquiring further. One therapist labeled it unhelpful when she observed another therapist treating her client like a “fragile child,” which she described as talking to them in a child-like voice and not challenging them. Additionally, another therapist remembered a time when she enabled her client to speak through her behaviors when her client curled up on her couch and was quiet; she did not challenge her client to use her voice and share what she was really feeling and needing. Previous research (Safran et al., 1994) indicated that a lack of empathic attunement leads to ruptures in the alliance. Although being challenging and compassionate have their place in the therapy

relationship, a better alliance likely will form when therapists are attuned to clients and able to balance challenging the client and providing compassion.

Another way five therapists and four clients depicted lacking attunement included a content imbalance during the session, specifically over-focusing on eating disorder symptoms and behaviors. During one session, one client stated her therapist wanted to focus the whole session on her meal plan, whereas she preferred to focus on “inside my head, and doubts, and what I wanted to address.” Therapists described over-focusing on eating disorder behaviors as a “power struggle” and “getting in that rat wheel.”

Westwood and Kendal (2012) discovered that clients with AN found it unhelpful when their therapist focused exclusively on physical aspects of the disorder; however, they also noted treatment might need to focus on physical elements first to stabilize weight prior to focusing on psychological concerns.

Although therapists did not acknowledge the opposite of this, one client explained how an over-focus on underlying issues was unhelpful. She explained focusing too much on emotions or the causes of the eating disorder enabled her to avoid talking about her eating disorder behaviors. She went on to suggest that a therapist might not focus on or inquire about behaviors if the client does not appear too thin. De la Rie et al. (2008) investigated eating disordered clients’ and therapists’ views of important components in the therapy process, structure, and outcome. They found that therapists often stressed the focus on eating disorder symptoms and changing these behaviors, whereas clients often focused on the importance of the therapeutic relationship and addressing the underlying problems of their eating disorder. Due to the participants’ descriptions and previous research, it appeared while important to focus on eating disorder behaviors and

stabilizing the client's weight, it was also important to spend time focusing on underlying issues and other problems the client might be experiencing in his or her life (de la Rie et al., 2006).

The last unhelpful characteristic highlighted by several participants was a therapist with a judgmental and invalidating attitude. Two therapists specified criticizing the client for having an eating disorder and "villainizing" it, whereas one client discussed being "put down" for expressing her feelings. Gulliksen et al. (2012) discovered adult clients with AN do not prefer therapists who do not pay attention to clients' feelings and opinions, display a lack of care and compassion, and blame the client for their condition. Researchers also identified therapist criticalness as negatively impacting the alliance (Ackerman & Hilsenroth, 2001).

While this finding appears intuitive—invalidation and judgment are unhelpful therapist factors, several clients acknowledged they experienced this with their individual therapist. One way therapists did this was when they talked about the eating disorder as something that was "all bad," "negative," and "a villain." Since many clients with AN enter therapy with ambivalence about getting rid of their disorder, a therapist's criticalness is not a helpful way to join with the client and inhibits the therapist from seeing the disorder from the client's perspective. Although therapists might not want to put the disorder "on a pedestal," as one therapist described it, it would be useful to discuss with clients ways the eating disorder was helpful and practical, as well as unhelpful, as it showed clients their therapist wanted to understand them and how they viewed their disorder.

Differences. Two themes clients endorsed as unhelpful therapist characteristics included the therapist not individualizing treatment and a lack of competence or confidence when treating eating disorders. While both clients and therapists agreed individualizing treatment and being competent were helpful therapist factors (see discussion above), only clients noted the lack of these as unhelpful. Similarly, Ackerman and Hilsenroth (2001) discovered both rigidity and uncertainty as therapist factors that negatively influenced the alliance.

Another unhelpful therapist factor all seven therapists highlighted and clients did not was lacking objective distance. Ways therapists described how one might observe this in session included the therapist not being aware of his/her reactions, e.g., reacting to a client in a maladaptive way, losing hope, therapist not working on his/her personal struggles, and improper use of self-disclosure. In a study investigating therapist's reactions toward clients with different diagnoses, Franko and Rolfe (1996) discovered less experienced therapists reported feeling more frustrated and angry with clients diagnosed with AN and a therapist's years of experience and size of case load affected their reactions. Inappropriate self-disclosure was also found to correlate negatively with alliance (Ackerman & Hilsenroth, 2001).

In a study investigating self-disclosure from clients' perspectives, Hanson (2005) described "unhelpful disclosures" as those that decreased trust and safety and put clients in a position to manage the relationship. Hanson also inquired about "unhelpful non-disclosures" (i.e., when a therapist did not self-disclose and it would have been beneficial if they had) and explained the greatest detriment of non-disclosure was to the alliance, experienced as a lack of connection and decreased trust. Additionally, Pope and Keith-

Spiegel (2008) stated, “The idea that self-disclosure is always appropriate, always therapeutic, always wanted by the client, always free of risks or unintended consequences, or always the best option is the source of countless boundary mistakes” (p. 647). As noted in participants’ discussions and previous research, it is important for therapists to be aware of their own reactions toward clients as well as carefully consider the option of using or not using self-disclosure; these both appeared to influence alliance formation.

Unhelpful client factors.

Similarities. An unhelpful client factor according to three therapists and six clients was being “forced” or strongly recommended to attend treatment and unwilling to give up their eating disorder. A few therapists used the term “resistant” to describe these clients and highlighted how this created a difference in goals between client and therapist. Clients further detailed this theme when describing themselves as “in denial,” attending sessions inconsistently, and not wanting to give up control. Previous research (Westwood & Kendal, 2012) also indicated many clients with AN viewed their disorder as an achievement, which could enhance resistance.

In a review of literature, Snyder and Anderson (2009) noted that mandated clients who entered treatment with greater resistance were generally less motivated to change than voluntary clients. Clients who are reluctant or ambivalent to change often have a difficult time forming an alliance (Bachelor & Horvath, 1999). Additionally, many adolescents with AN have little motivation to change and do not acknowledge their problems, which impacts the alliance negatively (Bourion-Bedes et al., 2013). Although it might take longer to develop an alliance with resistant or mandated clients, Snyder and

Anderson (2009) proposed it is possible to do so; how the therapist responds to resistance and or reluctance determines the outcome.

Another important client factor described by several therapists and clients included clients' perfectionism and people-pleasing tendencies. Three clients described their fear of not being perfect at recovery and needing to reenter inpatient treatment. One participant discussed her people-pleasing tendencies: "Anorexics [are] generally very much peacekeepers. That's just one of the qualities we have. We have trouble ruffling feathers, so we just keep quiet."

Researchers (APA, 2000; Kracke, 1999) previously identified perfectionism as a trait many clients with AN possess and also suggested approximately 25% of clients with AN-restricting subtype met criteria for obsessive-compulsive personality disorder (Satir et al., 2011). This relates to alliance formation as clients with higher degrees of rigidity often have weaker working alliances than those rated with lower rigidity (Sexton & Whiston, 1994). Additionally, clients with perfectionistic attitudes frequently experience difficulty building a positive alliance with therapists (Hewitt, Habke, Lee-Baggley, Sherry, & Flett, 2008). Therefore, because perfectionism, rigidity, and people-pleasing tendencies are characteristics often present with clients with AN, therapists need to anticipate how best to respond to these characteristics to enhance alliance formation. Additionally, when a client presents in a new way, such as being more relaxed or asserting him/herself in the relationship, it would likely be helpful for the therapist to highlight the client's new behavior, be receptive and open to it, and reinforce it.

The majority of participants identified the client's difficulty and fear connecting to the therapist as unhelpful in alliance formation. Most therapist participants described

this as a “lack of trust,” whereas clients discussed this as fear, specifically fear of rejection, abandonment, or getting “cut-off.” One client stated, “We [clients with AN] abandon the world, and when the world starts abandoning us, that’s scary... anorexia is fear-based and if they [therapists] provoke fear, I’m done.” Previous research (Kaplan & Garfinkel, 1999) supported that clients with eating disorders often have difficulty trusting their therapist, possibly due to previous family dynamics and/or the therapist’s lack of experience.

Many clients with AN have a type of insecure attachment style, which can promote difficulties trusting and work against alliance formation (Moore & Gelso, 2011; Wechselblatt et al., 2000). Furthermore, many clients with AN also have a diagnosable personality disorder such as borderline, dependent, avoidant, or obsessive-compulsive (Satir et al., 2011). Bordin (1994) stated, “There is a group so severely deprived in their object relations capacities... for whom the development of the capacity to enter into an elementary working alliance is critical, extended, and a painful process” (p. 27). Similarly, Carter, Bewell, Blackmore, and Woodside (2006) found a significant proportion of clients with eating disorders reported a history of childhood sexual abuse, which could create interpersonal struggles and difficulties forming a strong alliance (Keller, Zoellner, & Feeny, 2010). Due to many clients’ experiences, personalities, and difficulty trusting others, this often creates a difficult environment for the alliance to develop and grow.

One last common theme among clients and therapists was a client’s difficulty differentiating themselves from others and having boundaries that were too rigid or too loose. Several therapists highlighted this when discussing clients who had a history of

trauma or a personality disorder, whereas clients described this as being preoccupied or overly-focused on their therapist (e.g., “Did my therapist have an eating disorder?” “Was s/he sicker than me?”). A few clients shared they asked their therapist about her history of an eating disorder; one therapist told her client no, whereas the other chose not to disclose this information and explained why. Only one client acknowledged being hyper-aware of her therapist’s weight; she stated if her therapist was overweight, she refused to work with him/her because it provoked fear. Golan et al. (2009) proposed clients with AN might see their therapist as another competitor in the battle for thinness and explained how this competitive approach likely interfered with forming a positive alliance.

Due to the likelihood clients with AN will present with too rigid or too loose boundaries, therapists should be prepared as to how they will react to these clients. For clients with too rigid boundaries, such as those who hesitate to trust and open up, it might be helpful for the therapist to model self-disclosure, possibly through self-involving statements. This could aid in the client trusting the therapist and in alliance formation. As for clients who present with too loose boundaries, it might be helpful for the therapist to portray the opposite behavior, i.e., the therapist might self-disclose minimally to model boundary setting.

Differences. Several differences emerged between clients’ and therapists’ descriptions of unhelpful client factors. One factor several clients referenced included medical issues such as being severely underweight. Clients explained how this impacted their cognitive processing including their memory, ability to think, make decisions, and have enough energy to do the work needed in and out of therapy. One client also acknowledged how the re-feeding process made therapy difficult as “your body goes

crazy.” Only one therapist noted when clients are malnourished, their brains do not work properly; however, this was not a common theme among therapists.

It has been known for several decades that nutritional restitution is needed before therapy can be possible and meaningful (Bruch, 1988). Tchanturia and Hambrook (2010) acknowledged the limited efficacy of interventions for individuals with AN might be due to factors such as high dropout rates, ego-syntonic nature of the disorder, and difficulties with cognitive processing due to low body weight and malnourishment.

While clients’ body weight and malnourishment were factors considered in treatment and outcome literature, previous research has not acknowledged that a clients’ state of malnourishment negatively impacted the alliance; therefore, this was a unique finding of this study. The clients’ descriptions highlighted the need for cognitive functioning in alliance formation. As previously discussed, it is helpful when clients are willing to talk and open up, work toward recovery, and trust the therapist. When clients are malnourished, their cognitive abilities are diminished, thus making it difficult to be active and collaborative in the therapeutic relationship. Additionally, therapists might view clients who are malnourished and have low energy as “resistant” or “unwilling to work”; however, they lack the ability to do so until they are able to restore weight and become medically stable. Therefore, it is likely as clients become more nourished, they are more capable of engaging in the relationship and being more collaborative.

Another factor half of the client participants highlighted as unhelpful included clients’ negative self-beliefs. Clients described their negative self-beliefs as feeling “too much to handle”; not feeling worthy of life, happiness, health, or the therapist’s time; feeling not “bad enough” and thinking the therapist should help someone “worse-off”;

losing hope because they “should” be further along in recovery; and feeling embarrassed, guilty, and shameful. It was not surprising therapists did not identify these as unhelpful client factors as these were internal processes therapists were unaware of unless verbalized by the client.

Negative self-beliefs, or core beliefs, are common in clients with eating disorders (Cooper & Cowen, 2009). Cooper and Cowen (2009) investigated clients with eating disorders and categorized their negative self-beliefs into six categories: isolated, repelled by self, self-dislike lacking warmth, childlike, and highly organized. These self-beliefs also highlight how personality types (e.g., obsessive-compulsive personality disorder; Satir et al., 2011) and attachment styles (e.g., anxious-avoidant; Wechselblatt et al., 2000) might influence one’s beliefs about him/herself and how s/he relates to others.

Although research has identified that clients with AN often have negative self-beliefs, there is a paucity of research examining if and how they impact alliance formation. It is possible that clients with AN who hold more negative self-beliefs have less motivation to engage in the alliance and form a relationship as they do not believe they are “worthy” or “good enough” for the therapist’s time and attention. Additionally, because they view themselves in a negative light, they might expect others to reject or abandon them; therefore, they might enter the relationship with more ambivalence and fear, thus making it more difficult to form a relationship with them.

Client participants also identified lying about eating disorder behaviors as an unhelpful factor to alliance formation. Although therapists acknowledged a client’s lack of sharing and opening up as unhelpful, the clients provided specific examples with regard to not opening up or being honest. Some clients believed they did not lie; rather,

they did not tell the whole truth or omitted important information. One client explained she would tell her therapist, “Everything is fine; hunky dory,” whereas another admitted to “dodging” questions or not answering them entirely. Although it negatively impacted trust in the relationship, several clients explained they lied due to fear of being hospitalized, feeling like they would let their therapist down, or feeling embarrassment, shame, or guilt for relapsing. Kelly and Yuan (2009) found a similar connection between omitting information and the therapeutic alliance; they discovered client secret-keeping was negatively correlated with a strong working alliance.

Through the clients’ descriptions, it appeared they felt trapped as to whether they should tell their therapist about their relapse or attempt to hide it as they believed either would negatively impact the alliance. When therapists did not ask clients about their eating disorder behaviors, several clients found it easier to withhold this information as it was not “lying,” rather “omitting information.” It also appeared the clients felt guilty with either outcome because if they told their therapist, they felt guilty for relapsing and letting their therapist down, whereas if they kept it a secret, they felt guilty for withholding the information. To aid in this dilemma, it might be helpful for therapists to normalize relapse for clients. As one client’s therapist told him, “You’re not perfect. You’re going to have a relapse. It’s expected. I don’t want them all the time, but it’s expected. You’ve had this [disorder] for twenty-years. You’re not going to get better overnight.”

Theoretical Application: Working Alliance Theory

Throughout history, several terms and definitions have been used to describe the therapeutic working alliance: *ego alliance* (Sterba, 1934), *rational transference*

(Fenichel, 1945), *therapeutic alliance* (Zetzel, 1956), *mature transference* (Stone, 1961), and *working alliance* (Greenson, 1965). Since these terms were conceptualized from a psychoanalytic perspective, researchers and theorists from other theories (e.g., learning theories, humanistic theories) sought a term more pantheoretical in nature. Bordin (1979) used the term *working alliance*, which was first identified by Greenson (1965); however, Bordin proposed a broader definition and argued the working alliance occurred in all types of therapy and applicable to all theories. When describing the working alliance, he proposed it was made up of three components: agreement on the goals of therapy, agreement on the tasks of therapy, and a bond between the therapist and client. Hersoug et al. (2010) stated Bordin's definition of the working alliance is the conceptualization most researchers utilize because of its applicability across different therapies and techniques. Below, I explore the participants' experiences through Bordin's working alliance theory and discuss similarities and differences.

Goals

Previous research and literature has highlighted the difficulty between therapists and clients with AN agreeing on the goals of therapy. For example, clients with AN often want to maintain their disorder or parts of it (Wright, 2010); they may see their symptoms as achievements (Westwood & Kendal, 2012). Westwood and Kendal (2012) explained this as the "ego-syntonic nature" of AN and suggested treatment goals pose a threat to the client's sense of self and accomplishments. In this study, several therapists and clients acknowledged this phenomenon, specifically when discussing clients' denial about having an eating disorder or unwillingness to make healthy behavioral changes. Due to clients' presentation style, the participants highlighted the importance of the

therapist being flexible, collaborative, and realistic when identifying therapy goals. Wei and Heppner (2005) reviewed several studies and concluded therapist flexibility was associated with the strength of the alliance.

Several clients and therapists also discussed the helpfulness of setting goals early in therapy and making them specific, concrete, and attainable. A few clients shared specific goals they focused on: weight restoration, changing thoughts and behaviors, and decreasing posttraumatic stress disorder (PTSD) symptoms. Three clients noted their therapist did not discuss therapy goals and took it “week-by-week.” Although two clients did not state this was helpful or not, one wondered if she and her therapist “wasted more time without them.”

Another reason participants acknowledged goals as helpful was they provided structure for both clients and therapists. A therapist participant stated, “I think goals are crucial because eating disorders are complicated and messy, and left to their own, we could swim around in them forever and ever.” Furthermore, because clients with AN often present as rigid (Sexton & Whiston, 1994) and perfectionistic (Hewitt et al., 2008), structure might help clients feel more comfortable and know what direction therapy is going.

Two therapists and four clients noted how goals could be unhelpful, specifically with this population. For example, one therapist described her experience implementing a treatment plan and it bringing up shame and guilt for the client when she could not meet the expectations. Another client reported, “Goals sometimes made me feel really depressed; like a worthless person if I didn’t meet the goals in the time I wanted to.” Another description of goals as unhelpful was when clients reached goals due to their

people-pleasing and/or perfectionistic tendencies and not for themselves. One client stated, “Goals should be done with extreme caution because a lot of people with anorexia are really perfectionistic.” Additionally, a therapist explained how focusing on goals might help clients avoid their emotional experience. The last reason goals might be detrimental is if clients use them to “test the boundaries” or “rebel.” Two clients discussed how they purposefully did not reach goals to (a) see what their therapist would do (i.e., follow through with consequences), or (b) seek autonomy and “be a rebel.”

Overall, the participants generally agreed with Bordin’s (1979) theory--agreement on therapy goals is useful in alliance formation and disagreement can negatively influence alliance. However, the lack of goals did not necessarily weaken alliance but rather, it appeared to slow recovery. It is possible that the clients who took longer to recover might have had difficulty building an alliance as alliance is a robust predictor of outcome (Safran et al., 2002). Also of interest, Bordin’s theory did not discuss if and when goals might be unhelpful, which several clients and therapists acknowledged; therefore, this was a unique contribution of this study.

One reason a lack of therapy goals did not weaken alliance might have been because the therapy goal was to develop an alliance. One client explained her therapist walked her through the phases of therapy, the first one being “getting to know each other.” It is possible that because many therapists know clients with AN enter therapy with ambivalence and difficulty trusting, the goal of therapy might be to develop an alliance first before goals focused on the eating disorder are created. Therefore, although the clients might not have identified therapy goals with their therapist, the implicit goal might have been to develop the alliance. Additionally, identifying how goals are

unhelpful is a needed area of investigation. While goals provided structure and a road map for participants, they also created guilt and shame for clients when they did not reach them, which could increase their negative self-beliefs as previously discussed. Clients might also reach goals to appease their therapist or family. When this is done, the therapist might believe the client is motivated and in agreement on the therapy goals; however, they might be doing it for others, which might or might not influence alliance formation.

Tasks

Agreement on the tasks of therapy was the second component of Bordin's (1979) conceptualization of alliance. Tasks refer to the "specific activities that the partnership will engage in to instigate or facilitate change" (Bordin, 1994, p. 16). Examples of tasks include, but are not limited to, topics discussed in therapy (e.g., family dynamics, eating disorder behaviors, cognitive distortions), food journals and meal plans, techniques such as role-plays or empty chair, bibliotherapy, art therapy, and incorporating others into therapy (e.g., a spouse, child, parents, or treatment team members). The tasks address how various activities will contribute to the resolution of the client's problems (Horvath, 2000), need to be agreed upon, and might take place in-session or out-of-session (Gelso & Hayes, 1998). Additionally, they will likely differ depending on the therapist's theoretical orientation and empirically supported treatment(s) for the client's diagnosis. For example, if a therapist ascribes to a cognitive-behavioral therapeutic approach, he or she might implement tasks such as focusing on automatic thoughts, cognitive distortions, and core beliefs; utilize Socratic dialogue; and implement exposure therapy, behavioral rehearsal, and homework. Whereas a therapist using an interpersonal theoretical

orientation might focus on the client's view of self and others, family dynamics, attachments to others, and implement self-involving statements and experiential techniques. Furthermore, Horvath et al. (2011) noted that at the beginning of treatment, adapting the tasks of therapy to suit clients' needs and expectations is important in building an alliance.

In this study, the participants described only a few examples of therapy tasks. One client described a task when she bought an eating disorder workbook and completed the activities between sessions. However, she used this as an example to describe her motivation and readiness; she did it independently of her therapist and told her after she filled it out. Furthermore, several clients discussed their therapist collaborating with external systems such as their treatment team providers and family members. Although the clients did not discuss how this task was established or agreed upon, they noted it was helpful to alliance formation.

Another task client participants reported included contacting their therapist between sessions via e-mail or phone. Several participants noted that they discussed this with their therapist during session and agreed upon the boundaries that would be in place to enable this communication. Additionally, several participants highlighted the unhelpfulness when therapists did not balance the content of the session and focused too much on the eating disorder behaviors or underlying issues.

The participants in this study provided very few examples of what tasks were utilized in therapy as well as how they did or did not influence alliance formation. In their discussions, many of their examples described how the therapist and client factors influenced therapy goals or the bond between the client and therapist, rather than the

tasks. Previous research found the Task subscale of the Working Alliance Inventory portrayed a stronger association with outcome than the Goal or Bond subscales (Strunk, Brotman, & DeRubeis, 2010). Although this study did not address outcome, rather factors influential in alliance formation, it is interesting to note that participants in this study did not view the task component as influential in alliance formation compared to the goal and bond components, which was a unique finding of this study.

One explanation as to why the participants in this study did not emphasize the task component of the alliance might have been because during the interviews, the term *alliance* was replaced with the term *therapy relationship* as alliance might have been “unfamiliar or confusing to participants” (Bedi et al., 2005, p. 313). Due to this term being used, it is possible the participants associated therapy relationship with the bond component of the alliance more than the task component. Another plausible explanation is that the questions in the interview guide inquired about the bond and goal components of the working alliance but not the task component. If the participants were asked specifically about the tasks of therapy, they might have identified more tasks that positively or negatively influenced alliance formation.

One last explanation could be clients with AN do not view the task component as important as agreement on goals or the bond. Since clients with AN often enter treatment with characteristics that make forming a bond difficult and frequently disagree on the goals of therapy, it is possible these two components of alliance require more time and attention than the task component; once the goals are agreed upon and the client feels safe and trusts the therapist, then the tasks can be established. Additionally, client participants preferred that their therapist took the lead at the beginning of therapy and

assigned the majority of the responsibility to build the alliance to their therapist, which has also been found in other diagnosed populations (Bachelor, 1995; Bedi, 2006; Bedi et al., 2005). Due to this finding, the client participants might have believed their therapist would choose the tasks of therapy versus it being a collaborative process.

Bond

The last component of Bordin's (1979) definition of the working alliance was the bond between client and therapist. The bond is described as an "attachment that reflects most fundamentally the participants' trust and belief in each other as members of a working team" (Gelso & Hayes, 1998, p. 24). Bordin (1994) stated, "The bonding of the persons in a therapeutic alliance grows out of their experience of association in a shared activity... this is likely expressed and felt in terms of liking, trusting, respect for each other, and a sense of common commitment and shared understanding in the activity" (p. 16). Many clients in this study appeared to feel a bond with their therapist as evidenced by their descriptions of the relationship as a "team," "mentorship," and "friendship." The therapists did not describe the bond they felt with clients; rather, many described the difficulty forming a bond with this population due to client characteristics (e.g., fear, insecure attachment style, difficulty connecting to emotions). Previous researchers discovered similar findings--therapists reported difficulty forming a bond with clients with AN (Franko & Rolfe, 1996; Odom, 1997).

When reviewing the common themes participants acknowledged as influencing alliance formation, many factors appeared to either improve or worsen the bond component of alliance. Those that appeared to improve the bond consisted of the therapist implementing strong basic counseling skills such as unconditional positive

regard, validation, authenticity (e.g., Bedi, 2006; Garner et al., 1997; Gelso & Hayes, 1998), using a strengths-based approach (Gulliksen et al., 2012; Redko et al., 2007), individualizing treatment (Ackerman & Hilsenroth, 2003; Garner et al., 1997; Gulliksen et al., 2012; Westwood & Kendal, 2012), and appropriately self-disclosing (Hayes & Gelso, 2001; Hill & Knox, 2002). Client factors that positively contributed to the bond included opening up and sharing (Bordin, 1994; Henry & Strupp, 1994; Horvath, 2000; Patterson et al., 2008), being honest (Kelly & Yuan, 2009), giving up control, and trusting the therapist (Gelso & Hayes, 1998). Factors that negatively influenced the bond included the therapist's lack of attunement (Hersoug et al., 2009; Safran et al., 1994) and invalidating and criticizing the client (Ackerman & Hilsenroth, 2001; Gulliksen et al., 2012). Additionally, negative client factors included a fear of connecting and trusting (Kaplan & Garfinkel, 1999), boundaries that were too rigid or too loose, negative self-beliefs, and lying (Kelly & Yuan, 2009).

Overall, participants in this study acknowledged the bond between the client and therapist as a major part of the working alliance formation. The client participants placed the majority of the responsibility of creating the bond on the therapist; whereas most of the therapists saw the creation of the bond as more collaborative in nature. This could explain some of the therapists' frustration and, at times, exasperation when their clients would not actively participate and open up during sessions. Researchers have discovered clients' ratings of the alliance are often more favorable than therapists' ratings (Hersoug et al., 2001; Hersoug, Monsen, Havik, & Høglend, 2002; Horvath & Luborsky, 1993; Horvath & Symonds, 1991). The finding related to clients assigning a majority of responsibility to therapists to form the alliance could, in part, explain why clients rated

alliance as more favorable; therapists might experience frustration due to clients' passivity and rate collaboration and agreement on goals and tasks less than the clients.

Additionally, several therapists appeared to understand why clients with AN had a difficult time collaborating and trusting, which they attributed to their negative past relationships, personality styles, trauma history, and insecure attachment styles. The therapists who understood these client characteristics appeared less frustrated and able to be patient while clients learned to trust them and develop a bond in the relationship. Using Luborsky's (1976) conceptualization of alliance might provide therapists with a framework that normalizes clients' passivity. In Type I alliance, therapists are expected to portray a warm and caring demeanor to enhance the client's trust, whereas Type II is more collaborative and endorses a shared responsibility between the client and therapist. By viewing alliance formation through the Type I lens, therapists expect clients to be more passive and view their role as gaining trust.

Discussion of Theory

In sum, many participants' descriptions of the alliance and factors influencing alliance formation fit with Bordin's (1979) theory; however, several differences existed. First, participants acknowledged how goals, even if agreed upon openly, could be unhelpful to the alliance. This finding might be unique to the participants in this study, the population diagnosed with AN or eating disorders, or might be a shared phenomenon with many types of clients. It appeared client characteristics including people-pleasing tendencies and perfectionism played a role in situations when goals were unhelpful. Second, participants did not provide many descriptions of the tasks of therapy; rather, they focused on goals and factors that influenced the bonding component. Therefore, the

tasks of therapy might not be as influential in alliance formation compared to the goals and bond components in the early stages of therapy.

Several themes did not easily fit into one of the three categories: goals, task, and bond. One of these included the therapist's office environment. Several clients noted their therapist's warm and safe office environment aided in alliance formation, specifically soft music in the waiting room, a white noise machine, carpet, dim lighting, and a comfortable couch. Recent research has identified a therapist's office environment as influential in alliance formation (Bedi, 2006; Bedi et al., 2005; Bedi & Richards, 2011; Benton & Overtree, 2012); however, it was not represented in Bordin's (1979) theory of alliance.

Another theme client participants identified as negatively influencing alliance formation was clients' low body weight and malnourishment, which is not described in the current alliance theory. Although AN is a disorder that directly impacts one's physical health and ability to cognitively process information (Tchanturia & Hambrook, 2010), other disorders such as major depressive disorder and generalized anxiety disorder (American Psychiatric Association, 2000) might also influence a client's capability to form an alliance as these disorders impact the client's ability to concentrate and actively engage in session. Researchers discovered that different diagnostic variables do not predict the quality of the working alliance; rather, the quality of current and past relationships are better predictors of alliance (Hersoug et al., 2002). Due to this finding, it is possible a client's cognitive and physical abilities might impact the capacity he or she has to form relationships with others or stay engaged in treatment, thereby influencing the client's ability to form an alliance with his/her therapist.

Two additional factors identified by participants that were not taken into account in the alliance theory were clients' negative self-beliefs and the therapist's lack of competence and confidence. Clients with eating disorders often enter treatment with negative self-beliefs (Cooper & Cowen, 2009), yet limited research exists on if and how these self-beliefs impact alliance formation. The clients in this study feared not being "good enough" or "worthy" of their therapist's time and energy. These beliefs appeared to create ambivalence and hesitancy for clients and impacted their ability to engage in alliance formation. Additionally, a therapist's competence and confidence in treating eating disorders was an influential factor in clients feeling safe and comfortable trusting their therapist. Previous literature supported this finding (Gulliksen et al., 2012) and highlighted the importance of clients perceiving their therapist as experienced and credible.

Due to these findings, it is possible that Bordin's (1979) definition of alliance might be too narrow and ignores the clients' subjective understanding of this phenomenon. The four factors discussed above--therapist's office environment, client's low body weight/malnourishment, client's negative self-beliefs, and therapist's expertise treating eating disorders--were all identified by the client participants and failed to be captured in Bordin's current alliance theory. Several of these factors might be specific to clients diagnosed with AN, such as a client's malnourishment and the therapist's expertise treating eating disorders; however, it is possible they are prevalent in other diagnosed populations as well. Further research in this area is necessary to make this conclusion.

Additionally, many of the measures and assessments used to quantify the alliance utilized Bordin's (1979) conceptualization and, thus, might neglect the clients' subjective experience. For example, the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) is considered "the gold standard" (Forsberg et al., 2013, p. 37) when measuring the alliance and is based on Bordin's conceptualization of the working alliance as it has three subscales: goal, task, and bond. Bedi (2006) stated,

Present measures of the alliance may not tap a number of the areas of the alliance that are important to clients. The omission or underrepresentation in these scales of constructs subjectively deemed important by the participants may result in test scores that inadequately reflect the strength of the alliance as experienced by the client...consequently if investigators wish to claim to measure a client's subjective experience of the alliance, then constructs that reflect the client's perspective need to be included into future measures. (p. 33)

For the participants in this study, inquiring about the therapist's office environment, client's medical stability, and cognitive processing, the client's negative self-beliefs and the therapist's level of competence or perceived competence might aid in better measuring this phenomenon with clients with AN. Due to this, there is a need for researchers and theorists to look at the construct of alliance, broaden its definition, and create measures that incorporate the client's experience.

Limitations

There were several limitations in this study. First, I used criterion sampling (Creswell, 2007) rather than maximum variation sampling (Merriam, 2009). While criterion sampling was appropriate for the methodology used in this study, maximum variation sampling would have allowed participants to represent the widest possible range of characteristics and thus allow the results to be more generalizable. To illustrate, the participants in this study were mostly female (2 of 15 participants were male), all were

Caucasian/White, and they lived and sought/provided therapy in the United States of America. Incorporating participants of diverse race, ethnicity, gender, and geographic location could have possibly provided a broader depiction of this phenomenon and potentially allowed the results to be more generalizable.

Due to exclusionary criteria identified at the beginning of the study, client participants were currently diagnosed with AN, attended individual outpatient psychotherapy, and did not have a diagnosable Axis II disorder as determined by the therapist who referred them for the study. Although exclusionary criteria required clients to have a minimum of five therapy sessions with the same therapist, the lowest number of sessions a client had was 30 and the highest was well over 500.

The therapist participants all resided and practiced in a Rocky Mountain state and considered themselves experienced with and knowledgeable about eating disorders. Due to the homogeneity of participants, experience level of the therapists, and high number of therapy sessions of clients, the results might be less fitting and generalizable for clients and therapists with different characteristics--different ethnicities, clients in an inpatient setting, clients with few sessions, and/or inexperienced therapists. As Merriam (2009) noted, it is the responsibility of the reader to decide whether or not the results are applicable to his/her specific situation.

One of the foundational assumptions of this study was participants were able to retrospectively recall and verbalize important factors in alliance formation. Although researchers propose retrospective reports of the client-therapist relationship portray theoretical associations that seem to have significant construct validity (Howard, 1979), there is a risk participants might forget important information or nuances of experiences

as well as experience retrospective bias (Nisbett & Wilson, 1977). Furthermore, during the interviews, several clients noted difficulty remembering the beginning of therapy, either because it was so long ago or because they were extremely underweight and their cognitive functioning was impaired (i.e., they were not storing memories properly). Therefore, participants' reports might have lacked information or details not remembered and/or they may have recalled and deemed information as important due to their own biases.

Another limitation of this study was not including a question in the interview guide pertaining to the task component of the working alliance. When interviewing participants, I asked questions regarding the therapeutic goals and therapeutic relationship, which could have been interpreted as the bond component; however, I did not ask specific questions about tasks. This was a limitation as it made it difficult to identify if the participants' lack of discussion around influential tasks was due to not being directly asked or if tasks were not as influential in alliance formation as the goals and bond components.

Additionally, only views of participants who consented to participate were reflected, which failed to highlight views of participants who did not participate such as clients who prematurely terminated therapy. Therefore, views of the alliance might display a more positive view than non-participants. Similarly, it is possible client participants felt an obligation to portray their therapists in a favorable light, possibly due to loyalty, their people-pleasing, or the conflict-avoidant personality styles often present in this population (Joos, Cabrillac, Hartmann, Wirsching, & Zeeck, 2009). Although clients were made aware of confidentiality and notified that their therapist would not be

informed of their participation, they might have been hesitant to describe difficult interactions and highlight unhelpful therapist factors.

The last limitation included the comparison of clients' and therapists' experiences of the therapeutic alliance. To protect confidentiality and increase the likelihood client participants would disclose fully, I did not interview the client participants' therapists; rather, I interviewed therapists who worked with the AN population. Therefore, a comparison of therapists and clients in the same working alliance relationship might have provided greater depth of information for comparison.

Implications

Due to the exploratory nature of this study, caution is warranted when applying the results to individual psychotherapy. It is the responsibility of the reader to decide whether or not the results are applicable to their specific situation (Merriam, 2009). Furthermore, as Bedi (2006) concluded, "Counselors should not unconditionally provide clients with whatever types of alliance they desire. There are clinical (e.g., transference) and ethical considerations" (p. 33). While prudence is encouraged, many of the experiences and factors detailed in this study had previous research to substantiate the application of these in individual psychotherapy with clients with AN.

For Therapists

It is likely most therapists who work with clients with AN will encounter clients' ambivalence (Bourion-Bedes et al., 2012), fear, and ego-syntonic nature of the diagnosis (Vitousek et al., 1998) at the beginning of therapy, which might induce therapists' frustration and irritation. While this emotional reaction was common among therapists in this study and other investigations (Franko & Rolfe, 1996; Odom, 1997), it is important

for therapists to be patient with clients, aware of their personal reactions toward clients (Gelso & Carter, 1994), and seek consultation or supervision to work through those reactions.

Due to a client's ambivalence and the ego-syntonic nature of the disorder (Vitousek et al., 1998), therapists might need to be more directive and active at the beginning of therapy to help the client feel safe and establish trust (Bachelor, 1995; Bedi, 2006; Bedi et al., 2005), which aligns with Luborsky's (1976) theory of alliance. While this goes against Bordin's (1979) theory of alliance formation, which posits collaboration is necessary, client participants in this study reported a better experience when their therapist was more active in setting goals and guiding therapy during the initial stages of therapy. However, after trust was established, clients appeared more apt to collaborate with the therapist and engage in the relationship.

It is important for therapists to use caution when creating therapy goals with clients with AN. While most participants agreed goals were helpful in providing structure and direction in therapy, some clients stated that goals created frustration, guilt, and shame when they did not meet them in the time frame they set for themselves or relapsed and began acting on behaviors again such as restricting. Due to this, it might be useful to educate clients about the pervasiveness of this disorder, normalize relapse, and help them create realistic and attainable goals. Additionally, participants encouraged therapists to collaborate with other treatment providers (e.g., psychiatrist, physician, nutritionist, dietician) and, if appropriate, incorporate family into therapy sessions. Although this finding was supported in the literature related to treatment outcome (Rienecke Hoste et al., 2012), it has yet to be investigated in alliance formation.

Other ways therapists might positively contribute to alliance formation with clients with AN include implementing basic counseling skills (e.g., unconditional positive regard, validation, authenticity; Gelso & Hayes, 1998; Lambert & Barley, 2002), using a strengths-based approach (Gulliksen et al., 2012), utilizing appropriate self-disclosure (Hayes & Gelso, 2001; Hill & Knox, 2002), and having experience and expertise working with clients with eating disorders (Horvath & Greenberg, 1994; Wei & Heppner, 2005; Westwood & Kendal, 2012). Additionally, balancing care and setting boundaries (Gulliksen et al., 2012; Warren et al., 2009), being flexible (Ackerman & Hilsenroth, 2003), and individualizing treatment might encourage alliance formation.

Another finding for therapists to consider includes creating a warm office environment. While some therapists utilize an office they cannot change, it might be beneficial to consider incorporating furniture and/or décor that portray warmth, e.g., pillows and soft lighting, as well as multicultural sensitive décor and printed material (Benton & Overtree, 2012). One finding that should be applied with caution includes allowing the client to contact the therapist outside of therapy sessions. While previous researchers discovered similar findings that contact outside of session could enhance the alliance (Bedi & Richards, 2011; Redko et al., 2007), this might not be ethical or helpful due to clients' difficulties with boundaries (Bhuvaneswar & Gutheil, 2008); however, the majority of client participants noted this helped build trust with their therapist and aided in alliance formation.

Other considerations include what therapists should *not* do. It appeared alliance formation was difficult when therapists lacked attunement to clients (Safran et al., 1994). Examples of this included being too forceful or tentative, portraying rigidity (Hersoug et

al., 2009), or focusing too much on the eating disorder behaviors versus the underlying issues (Westwood & Kendal, 2012). Furthermore, it appeared unhelpful when therapists were judgmental and invalidating toward clients (Ackerman & Hilsenroth, 2001) such as blaming the client for having an eating disorder or “villainizing” the disorder. As previously discussed, supervision and/or consultation might enable therapists to explore their own biases and frustrations, which might reduce the therapist’s portrayal of these attitudes in therapy.

Several implications are specific to counseling psychologists. Gelso and Fretz (2001) identified five themes that differentiated counseling psychology from related fields. One of these themes included “...the focus on people’s assets and strengths, and on positive mental health, regardless of the degree of disturbance” (Gelso & Fretz, 2001, p. 6). This theme--focusing on health rather than psychopathology--was a common theme discussed by the participants. Counseling psychologists could implement this with clients diagnosed with AN by maintaining hope, identifying the client’s internal strengths (e.g., strong willpower), looking for intangible markers of success (e.g., a client showing emotion or asserting him/herself), and highlighting the positive steps clients take throughout treatment.

Another theme that distinguishes counseling psychologists from other related fields includes “an emphasis on person-environment interactions, rather than an exclusive focus on either the person or the environment” (Gelso & Fretz, 2001, p. 8). Participants also highlighted this as a helpful factor that encouraged alliance formation. Counseling psychologists could do this with clients diagnosed with AN by incorporating a client’s family/partner/children into treatment, collaborating with the client’s treatment team

(e.g., physician, dietician), and creating a warm and safe office environment in which therapy takes place.

For Clients

Through participants' descriptions of alliance formation in this study and others, many clients were unsure or unaware of what to do early in therapy and, therefore, saw the therapist as owning the majority of responsibility in forming the relationship (Bachelor, 1995; Bedi, 2006; Bedi et al., 2005). Due to this finding, it might be helpful for therapists to speak with clients about ways they can positively influence the relationship. This might include clients being honest and admitting when they acted on eating disorder behaviors (e.g., restricted, purged), engaging with the therapist and sharing/talking (Bordin, 1994; Horvath, 2000; Patterson et al., 2008), asserting their needs and setting boundaries within the therapeutic relationship, trusting the therapist despite fear of rejection/abandonment, and willingness to attend sessions and admit they have a problem.

Similarly, it might be helpful for therapists to share with clients ways they can negatively impact the alliance: maintaining rigidity (Sexton & Whiston, 1994) and perfectionism (Hewitt et al., 2008), attempting to please the therapist, fear of rejection or abandonment, and fear of opening up and connecting, possibly due to a maladaptive attachment style or past trauma (Keller et al., 2010). Additionally, maintaining a low weight (as it impacts cognitive functioning) and not discussing their negative self-beliefs (e.g., "I don't deserve recovery") would likely be unhelpful in alliance formation. By discussing the client's contributions early and throughout therapy, clients might feel more

comfortable when they know what is expected of them and can discuss when they are unable to fulfill the agreed upon role.

Future Research Directions

Through this study, I investigated experiences of seven therapists and eight clients in individual psychotherapy and how the working alliance was formed and challenged in the process. Due to the smaller sample size ($N = 15$) and homogeneity among participants (e.g., ethnicity, gender, AN diagnosis), conducting similar studies utilizing a larger, more diverse sample would help distinguish between findings that are generalizable and those that were more specific to the participants in this study. It would also be useful to replicate this study in different settings (e.g., inpatient, residential, intensive outpatient) and different diagnosed populations (e.g., bulimia nervosa, binge-eating disorder, personality disorders, trauma survivors) to gain a better understanding of how different types of diagnosed populations conceptualize alliance formation similarly and differently.

This study provided several unique findings previous researchers had not identified as influential in alliance formation. The first finding included the therapist collaborating with clients' treatment team providers and/or family. While previous research (Lyon et al., 2005; Rienecke Hoste et al., 2012) identified this as useful in the treatment and outcome of eating disorders, it has not been researched to influence alliance; therefore, this is a therapist factor researchers could continue to investigate.

Another finding not previously researched included the therapist disclosing about his or her lack of knowledge and expertise about specific topics (e.g., the client, nutrition, medication) and how this helped build trust within the alliance. Studies have found that

the therapist's knowledge, competence (Westwood & Kendal, 2012), and honesty positively influenced alliance (Bedi, 2006; Garner et al., 1997); however, previous research has not specified admitting to a lack of expertise as helpful in alliance formation. Future research could investigate this finding to see if it was unique to the participants in this study or a shared experience among clients in general.

Two client factors previously not identified as influential in alliance formation included the client's medical issues (which affect cognitive functioning) and clients' negative self-beliefs. Both factors have been researched in the context of treatment and outcome: client's medical issues (Bruch, 1988; Tchanturia & Hambrook, 2010) and negative self-beliefs (Cooper & Cowen, 2009); however, there is a paucity of research on if and how these two factors influence alliance formation. This would be a useful area of continued investigation.

Additionally, many assessments that measure the working alliance (e.g., Working Alliance Inventory; Horvath & Greenberg, 1989) use Bordin's (1979) conceptualization of goals, task, and bond; however, this study and several others (Bachelor, 1995; Bedi, 2006; Bedi et al., 2005; Bedi & Richards, 2011) have highlighted that clients understand alliance formation differently. For example, client participants in this study believed that at the beginning of therapy, it was more the therapist's responsibility to form the alliance. Furthermore, participants identified additional constructs that impacted the strength of the alliance including the therapists' office environment, client's medical stability and cognitive processing, the client's negative self-beliefs, and the therapist's level of competence. Upon the accumulation of studies that have investigated the client's and therapist's perspectives on alliance formation, researchers could develop a new alliance

measure that assesses *both* the therapists' and clients' subjective understanding of the working alliance, which might predict better therapy outcomes.

Conclusion

The therapeutic working alliance is an important construct to all forms of therapy, especially within the population diagnosed with AN. While much research has focused on the quantitative measurement of this construct, more research is needed on the clients' subjective understanding as it is a collaborative phenomenon involving two groups: clients and therapists. Specifically within the population diagnosed with AN, it is imperative that therapists work to form a strong working alliance with their clients; treatment is often slow and difficult with this population and dropout and relapse rates are high. To do this, therapists need to be patient and understanding. Mary, a therapist participant, summarized,

There's a scene in the movie [*The Horse Whisperer*] where the horse whisperer is working with the wild horse that won't be ridden and they have a power struggle. The horse runs off. What the horse whisperer does feels like my experience working with anorexic clients...the horse went out into the field and they were a great distance apart. The horse whisperer sat and watched and just held the space while the horse was recovering, doing what it needed to do. Figuring out what was next. Gradually, he took a couple of steps closer and then stopped... it's on the horse's terms. It's never on my terms. I always want to know more and to be more connected to my anorexic clients, but just like the horse, they have a reason for not trusting. And the fact that that horse ever trusted the horse whisperer, or that my clients, who have been so traumatized, would ever trust me...that's amazing. That's amazing.

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APPENDIX A

INSTITUTIONAL REVIEW BOARD APPROVAL

UNIVERSITY of
NORTHERN COLORADO
Institutional Review Board (IRB)

December 20, 2011

TO: Silvia Correa-Torres
Nursing

FROM: Maria Lahman, Co-Chair 
UNC Institutional Review Board

RE: Expedited Review of Proposal, *Understanding the Working Alliance between Clients with Anorexia Nervosa and Therapists in Individual Psychotherapy*, submitted by Laura Oyer (Research Advisor: Mary Sean O'Halloran)

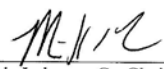
First Consultant: The above proposal is being submitted to you for an expedited review. Please review the proposal in light of the Committee's charge and direct requests for changes directly to the researcher or researcher's advisor. If you have any unresolved concerns, please contact Maria Lahman, Applied Statistics and Research Methods, Campus Box 124, (x1603). When you are ready to recommend approval, sign this form and return to me.

I recommend approval as is.


Signature of First Consultant

1-18-12
Date

The above referenced prospectus has been reviewed for compliance with HHS guidelines for ethical principles in human subjects research. The decision of the Institutional Review Board is that the project is approved as proposed for a period of one year: 1-19-12 to 1-19-13.


Maria Lahman, Co-Chair

1-19-12
Date

Comments:

APPENDIX B

EMAILS TO THERAPISTS

Emails to Therapists

1)

Hello, My name is Laura Oyer and I'm a doctoral student in the Counseling Psychology PhD program at the University of Northern Colorado. I'm currently looking for participants for my qualitative dissertation and was wondering if you could help me out. My study is investigating the working alliance (therapeutic relationship) in individual therapy with clients diagnosed with Anorexia Nervosa. There are two possible ways you could assist me.

First, if you are currently seeing one or more clients diagnosed with Anorexia Nervosa, I would greatly appreciate if you could give them a letter about my study and they could contact me privately to conduct an interview about their experience in therapy. I would like the client(s) to have had at least 5 individual therapy sessions with you (their therapist), be at least 18 years of age or older, and not have an Axis II diagnosis.

If you do not currently have any clients you are working with diagnosed with AN, or would not be interested in giving these clients a letter, there's another way you could help!

The second way would be for me to interview you about your experience working with clients with AN. The only criteria would be that you have had at least 5 individual therapy sessions (currently or in the past) with a client diagnosed with AN.

Just to be clear, I will not be interviewing dyads (both you and your client/client(s)); I will interview either you OR your client(s). If you are interested in participating, either as the therapist to be interviewed, or giving your client(s) a letter, or you would like more information about my study, please respond to this email or call me at (765) 914-1761. Thank you so much for your consideration and I look forward to hearing from you!

Best,
Laura Oyer

2)

My name is Laura Oyer and I'm a doctoral student in the Counseling Psychology PhD program at the University of Northern Colorado. I am currently collecting data for my dissertation in which I am investigating the therapeutic relationship in individual therapy with clients diagnosed with Anorexia Nervosa. To collect data, I need to interview about seven clients who meet the following criteria:

- 1) Are at least 18 years of age or older
- 2) Have been diagnosed with Anorexia Nervosa in the past or present – OR – have met or meet almost all of the criteria for this disorder
- 3) Are currently in individual, outpatient psychotherapy and have had at least 5 sessions

The questions I will ask the clients are simply about their experience in individual therapy, and what things have been helpful and not so helpful in building the therapeutic

relationship with their therapist. The interview will last about 60 minutes and can be in-person, phone, or Skype. One last piece of information that you could tell your clients is that I will be doing a raffle and 2 out of the 7 participants will get a \$50 Visa gift card as a thank you.

If you are working with any clients who meet these criteria and you would be willing to help, I would GREATLY appreciate it! I have attached a recruitment letter in which you could give/forward these clients with my contact information on it. They could contact me privately so that you are not breaking confidentiality. Furthermore, I am not going to ask clients who their therapist is, and therefore, I will not know what clients are yours. If it would be easier, I would be happy to print the recruitment letters and send them to you in the mail, or you are more than welcome to print them on your own and give them to your clients. If you have any questions at all, please let me know and I would be happy to answer them. My phone number is (765) 914-1761 and my email is oyer2483@gmail.com. Last, if you know of any colleagues or other therapists who work with this population, please forward this email to them.

Warmly,
Laura Oyer

APPENDIX C

LETTER TO CLIENT PARTICIPANT



Dear Interested Participant,

My name is Laura Oyer and I am a doctoral student at the University of Northern Colorado (UNC), and currently working on my dissertation. I am researching the relationship between clients diagnosed (or previously diagnosed) with Anorexia Nervosa and their individual therapists. To gather information, I would like to interview you to discuss your experience with your therapist and your relationship with him or her. Your therapist will **NOT** know whether you do or do not participate in this study, and your responses will be confidential. The interview will last approximately 60-90 minutes and will be conducted in a quiet, confidential location of your choice, such as your office, a private room in a public library, or in a confidential space on the University of Northern Colorado campus. Interviews can also be conducted via Skype or phone in the event you live far away.

As a thank you, you will be entered into a raffle to win a **\$50.00 Visa gift card**. I will be interviewing about 7 clients, and I am giving away 2 \$50.00 gift cards. If you are interested in participating in this study, or if you would like to learn more, please contact me by phone (765) 914-1761 or email laura.oyer@unco.edu . Thank you for your consideration!

Sincerely,

Laura Oyer, M.A.

APPENDIX D

CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH: THERAPIST IN PERSON



CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH: THERAPIST IN PERSON

Project Title: *Understanding the Working Alliance between Clients Diagnosed with Anorexia Nervosa and Therapists in Individual Psychotherapy: A Phenomenological Approach*

Researcher: Laura M. Oyer, M. A., Department of Counseling Psychology
(765) 914-1761 oyer2483@bears.unco.edu

Research Advisor: M.S. O'Halloran, Ph.D., Department of Counseling Psychology
(970) 351-1640 mary.ohalloran@unco.edu

I am researching the therapy relationship between clients diagnosed with Anorexia Nervosa (AN) and therapists who work with clients diagnosed with AN. If you agree to participate in this study, I will interview you in a quiet location of your choice (e.g., your office, a private office on campus, a private room in a public library). The interview will last approximately 60 – 90 minutes and I will ask you questions that focus on your experience in therapy. For client participants, I will ask questions regarding your experience in therapy and factors that influenced the relationship with your therapist. For therapist participants, I will ask questions regarding your experiences working with clients diagnosed with AN and factors that influenced the relationship. After the interview, I will contact you via email or by phone to provide you an opportunity to review your transcribed interview for accuracy, and to discuss the emerging findings of the study and see if they fit your experience(s).

The purpose of the research study is to identify factors that influence the formation of the therapy relationship between clients diagnosed with AN and therapists who work with this population. I am also investigating similarities and differences between clients' and therapists' experiences and views of the relationship. I will report my findings as part of my doctoral dissertation and may present the results at a professional conference and/or in the form of a manuscript for professional publication. You are welcome to request a copy of the final paper to review before I submit it for presentation or publication.

Your confidentiality will be protected to the best of my ability. Your signed informed consent form (this document) will be stored in a locked filing cabinet and kept for three years. I will audio-record the interview on a password protected audio-recording device, which will later be transcribed. Prior to recording the interview, I will ask you to choose a pseudonym that I will refer to you as during the interview. After the interview, myself or a member of my research team will transcribe the interviews. The members of the research team will be Masters or Doctoral students in Counseling or Psychology and will be trained in confidentiality and ethics. Because you will only be referred to as your pseudonym on the audio recording, the research team members will only know you as your pseudonym, and not your real name. Only you and I will know your identity and it will not be shared with anyone. Furthermore, if you reveal

information during the interview that could identify you, I will remove the information on the transcript. Once the interviews are transcribed, the audio-recordings will be deleted. Your pseudonym will also be used in the final report. Additionally, demographic information (e.g. age, gender, ethnicity) will be grouped in the final report and linked to your quotes; however, if any information could easily identify you, I will not include it in the final report.

Please note that as a mandated reporter in the State of Colorado, I am required to break confidentiality for the following reasons:

- Suspected or reported child abuse
- Suspected or reported suicidal thoughts, plan, or intent
- Suspected or reported homicidal thoughts, plan, or intent

While I will do my best to inform you if I need to break confidentially because of one of these reasons, I am not required to do so.

I foresee minimal to no risks to participants in this study. The minimal foreseeable risks may include participant discomfort in discussing personal experiences regarding the therapy relationship, specifically if the therapy relationship is/was negative. If, during the interview, you experience discomfort or uncomfortable emotions, you may end the interview at any time, and all participants will be provided with a referral list of mental health providers. Foreseeable benefits of this study include time to reflect on your own personal experiences of the therapy relationship, as well as reflect on how the relationship was formed and challenged, which may lead to new personal insights regarding the process of therapy. Also, this study may benefit therapists and other mental health providers by helping them to better understand the therapy relationship from the perspective of clients diagnosed with AN, and potentially lead to better therapy outcome.

Participation is voluntary. You may decide not to participate in this study and if you begin participation you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled. Having read the above and having had an opportunity to ask any questions, please sign below if you would like to participate in this research. A copy of this form will be given to you to retain for future reference. If you have any concerns about your selection or treatment as a research participant, please contact the Office of Sponsored Programs, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-2161.

If you have any questions or concerns, please do not hesitate to ask me in person or contact me via email or phone.

Thank you for participating.

_____
Participant's Printed Name

_____
Date

_____
Participant's Signature

_____
Date

_____
Researcher's Signature

_____
Date

APPENDIX E

CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH: THERAPIST SKYPE/PHONE



CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH: THERAPIST SKYPE/PHONE

Project Title: *Understanding the Working Alliance between Clients Diagnosed with Anorexia Nervosa and Therapists in Individual Psychotherapy: A Phenomenological Approach*

Researcher: Laura M. Oyer, M. A., Department of Counseling Psychology
(765) 914-1761 oyer2483@bears.unco.edu

Research Advisor: M.S. O'Halloran, Ph.D., Department of Counseling Psychology
(970) 351-1640 mary.ohalloran@unco.edu

I am researching the therapy relationship between clients diagnosed with Anorexia Nervosa (AN) and therapists who work with clients diagnosed with AN. If you agree to participate in this study, I will interview you via Skype (or a similar computer program) or phone. The interview will last approximately 60 – 90 minutes and I will ask you questions that focus on your experience in therapy. For client participants, I will ask questions regarding your experience in therapy and factors that influenced the relationship with your therapist. For therapist participants, I will ask questions regarding your experiences working with clients diagnosed with AN and factors that influenced the relationship. After the interview, I will contact you via email or by phone to provide you an opportunity to review your transcribed interview for accuracy, and to discuss the emerging findings of the study and see if they fit your experience(s).

The purpose of the research study is to identify factors that influence the formation of the therapy relationship between clients diagnosed with AN and therapists who work with this population. I am also investigating similarities and differences between clients' and therapists' experiences and views of the relationship. I will report my findings as part of my doctoral dissertation and may present the results at a professional conference and/or in the form of a manuscript for professional publication. You are welcome to request a copy of the final paper to review before I submit it for presentation or publication.

Your confidentiality will be protected to the best of my ability; however, there are inherent limitations to confidentiality using the internet to transmit information. Your electronically signed informed consent form (this document) will be stored in a locked filing cabinet and kept for three years. I will audio-record the interview on a password protected audio-recording device, which will later be transcribed. Prior to recording the interview, I will ask you to choose a pseudonym that I will refer to you as during the interview. After the interview, myself or a member of my research team will transcribe the interviews. The members of the research team will be Masters or Doctoral students in Counseling or Psychology and will be trained in confidentiality and ethics. Because you will only be referred to as your pseudonym on the audio recording, the research team members will only know you as your pseudonym, and not your real name. Only you and I will know your identity and it will not be shared with anyone. Furthermore, if you reveal information during the interview that could identify you, I will remove the information on the transcript. Once the interviews are transcribed, the audio-recordings will be deleted. Your

pseudonym will also be used in the final report. Additionally, demographic information (e.g. age, gender, ethnicity) will be grouped in the final report and linked to your quotes; however, if any information could easily identify you, I will not include it in the final report.

Please note that as a mandated reporter in the State of Colorado, I am required to break confidentiality for the following reasons:

- Suspected or reported child abuse
- Suspected or reported suicidal thoughts, plan, or intent
- Suspected or reported homicidal thoughts, plan, or intent

While I will do my best to inform you if I need to break confidentially because of one of these reasons, I am not required to do so.

I foresee minimal to no risks to participants in this study. The minimal foreseeable risks may include participant discomfort in discussing personal experiences regarding the therapy relationship, specifically if the therapy relationship is/was negative. If, during the interview, you experience discomfort or uncomfortable emotions, you may end the interview at any time, and all participants will be provided with a referral list of mental health providers. Foreseeable benefits of this study include time to reflect on your own personal experiences of the therapy relationship, as well as reflect on how the relationship was formed and challenged, which may lead to new personal insights regarding the process of therapy. Also, this study may benefit therapists and other mental health providers by helping them to better understand the therapy relationship from the perspective of clients diagnosed with AN, and potentially lead to better therapy outcome.

Participation is voluntary. You may decide not to participate in this study and if you begin participation you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled. Having read the above and having had an opportunity to ask any questions, please sign below if you would like to participate in this research. A copy of this form will be given to you to retain for future reference. If you have any concerns about your selection or treatment as a research participant, please contact the Office of Sponsored Programs, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-2161.

If you have any questions or concerns, please do not hesitate to ask me in person or contact me via email or phone. Thank you for participating.

_____
Participant's Printed Name

_____
Date

_____
Participant's Signature

_____
Date

_____
Researcher's Signature

_____
Date

APPENDIX F

CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH: CLIENT SKYPE/PHONE



**CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH:
CLIENT SKYPE/PHONE**

Project Title: *Understanding the Working Alliance between Clients Diagnosed with Anorexia Nervosa and Therapists in Individual Psychotherapy: A Phenomenological Approach*

Researcher: Laura M. Oyer, M. A., Department of Counseling Psychology
(765) 914-1761 oyer2483@bears.unco.edu

Research Advisor: M.S. O'Halloran, Ph.D., Department of Counseling Psychology
(970) 351-1640 mary.ohalloran@unco.edu

I am researching the therapy relationship between clients diagnosed with Anorexia Nervosa (AN) and therapists who work with clients diagnosed with AN. If you agree to participate in this study, I will interview you via Skype (or a similar computer program) or phone. The interview will last approximately 60 – 90 minutes and I will ask you questions that focus on your experience in therapy. For client participants, I will ask questions regarding your experience in therapy and factors that influenced the relationship with your therapist. For therapist participants, I will ask questions regarding your experiences working with clients diagnosed with AN and factors that influenced the relationship. After the interview, I will contact you via email or by phone to provide you an opportunity to review your transcribed interview for accuracy, and to discuss the emerging findings of the study and see if they fit your experience(s).

The purpose of the research study is to identify factors that influence the formation of the therapy relationship between clients diagnosed with AN and therapists who work with this population. I am also investigating similarities and differences between clients' and therapists' experiences and views of the relationship. I will report my findings as part of my doctoral dissertation and may present the results at a professional conference and/or in the form of a manuscript for professional publication. You are welcome to request a copy of the final paper to review before I submit it for presentation or publication.

Your confidentiality will be protected to the best of my ability; however, there are inherent limitations to confidentiality using the internet to transmit information. Your electronically signed informed consent form (this document) will be stored in a locked filing cabinet and kept for three years. I will audio-record the interview on a password protected audio-recording device, which will later be transcribed. Prior to recording the interview, I will ask you to choose a pseudonym that I will refer to you as during the interview. After the interview, myself or a member of my research team will transcribe the interviews. The members of the research team will be Masters or Doctoral students in Counseling or Psychology and will be trained in confidentiality and ethics. Because you will only be referred to as your pseudonym on the audio recording, the research team members will only know you as your pseudonym, and not your real name. Only you and I will know your identity and it will not be shared with anyone. Furthermore, if you reveal information during the interview that could identify you, I will remove the information on the transcript. Once the interviews are transcribed, the audio-recordings will be deleted. Your pseudonym will also be used in the final report. Additionally, demographic information (e.g. age,

gender, ethnicity) will be grouped in the final report and linked to your quotes; however, if any information could easily identify you, I will not include it in the final report.

Please note that as a mandated reporter in the State of Colorado, I am required to break confidentiality for the following reasons:

- Suspected or reported child abuse
- Suspected or reported suicidal thoughts, plan, or intent
- Suspected or reported homicidal thoughts, plan, or intent

While I will do my best to inform you if I need to break confidentially because of one of these reasons, I am not required to do so.

I foresee minimal to no risks to participants in this study. The minimal foreseeable risks may include participant discomfort in discussing personal experiences regarding the therapy relationship, specifically if the therapy relationship is/was negative. If, during the interview, you experience discomfort or uncomfortable emotions, you may end the interview at any time, and all participants will be provided with a referral list of mental health providers. Foreseeable benefits of this study include the opportunity to win one of two \$50.00 Visa gift cards, as well as time to reflect on your own personal experiences of the therapy relationship, as well as reflect on how the relationship was formed and challenged, which may lead to new personal insights regarding the process of therapy. Also, this study may benefit therapists and other mental health providers by helping them to better understand the therapy relationship from the perspective of clients diagnosed with AN, and potentially lead to better therapy outcome.

Participation is voluntary. You may decide not to participate in this study and if you begin participation you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled. Having read the above and having had an opportunity to ask any questions, please sign below if you would like to participate in this research. A copy of this form will be given to you to retain for future reference. If you have any concerns about your selection or treatment as a research participant, please contact the Office of Sponsored Programs, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-2161.

If you have any questions or concerns, please do not hesitate to ask me in person or contact me via email or phone. Thank you for participating.

_____
Participant's Typed Name

_____
Date

_____
Participant's Electronic Signature

_____
Date

_____
Researcher's Signature

_____
Date

APPENDIX G

**CLIENT AND THERAPIST DEMOGRAPHIC
INFORMATION SHEETS**

Client Demographic Information Sheet

1. Pseudonym: _____
2. Age: _____
3. Gender: Male _____ Female _____ Transgender _____
4. Highest level of education completed: _____
5. Ethnicity/Race: _____
6. Occupation: _____
7. When were you diagnosed with Anorexia Nervosa?
_____
8. How many sessions have you had with your current individual therapist?
_____
9. Have you been in treatment prior to your current treatment?
_____
  - a. If yes, what type of treatment (e.g., inpatient, residential, individual therapy)?
_____
10. May I contact you after the interview to gather more information or verify research findings? Yes _____ No _____
  - a. If yes, please fill in. Phone _____
Email _____
11. Please check the statement that best represents why you sought treatment for your eating disorder:
  - ____ I sought treatment on my own
  - ____ I sought treatment because a friend or family member strongly encouraged me to
  - ____ I was mandated to seek treatment by my college/university, employer, etc.
  - ____ Other: Please explain
 _____
12. Please include any other demographic information that you believe would be important for us to know about you for the purposes of this study:
_____
_____
_____

Therapist Demographic Information Sheet

1. Pseudonym: _____
2. Age: _____
3. Gender: Male _____ Female _____ Transgender _____
4. Highest level of education completed: _____
5. Ethnicity/Race: _____
6. Occupation/Licensure: _____
7. How long have you been in the mental health field and working with clients diagnosed with Anorexia Nervosa (AN)? _____
8. Approximately, how many clients diagnosed with AN have you provided individual therapy to? _____
9. May I contact you after the interview to gather more information or verify research findings? Yes _____ No _____
  - a. If yes, please fill in. Phone _____
Email _____
10. Please include any other demographic information that you believe would be important for us to know about you for the purposes of this study:
_____
_____
_____

APPENDIX H

MENTAL HEALTH REFERRALS AND RESOURCES

MENTAL HEALTH REFERRALS AND RESOURCES

Eating Disorder Treatment

ACUTE Center for Eating Disorders at Denver Health	1-877ACUTE4U
Eating Disorder Center of Denver	866 771-0861
Eating Recovery Center, Denver	303 825-8584
La Luna Center, Boulder	720 470-0010
La Luna Center, Fort Collins	970 282-8282
http://www.edreferral.com/states/co.html	

Emergency for non-Denver County Residents:

Call Crisis Lines for Community Mental Health Centers

Adams County Mental Health Center	303 853-3500
Arapahoe Mental Health Center	303 730-3303
Aurora Community Mental Health Center (North office)	303 617-2400
Jefferson Center for Mental Health	303 425-0300
Note: This line rolls over to Inpatient Pavilion for University of Colorado Health Sciences Center at night (12605 E. 16 th Ave – Colfax & Ursula)	
	720 848-5197

Emergency for Denver County Residents (psychiatric, drug/alcohol):

Denver Health Medical Center (formerly Denver General)	
777 Bannock St.	303 602-7221
	303 602-7236
United Way Information and Referral Search	211

Suicide Hotline

COMITIS Helpline	303 343-9890
National Suicide Prevention Lifeline	1-800-273-TALK (8255) 1-888-628-9454 (Spanish)

Greeley Community Resources

Addiction Recovery Center	970 352-6537
Family Recovery Center	970 352-1056
Greeley Police Department	970 350-9605
North Colorado Medical Center Emergency Room	970 350-6366
North Colorado Behavioral Health(Formerly PsychCare)	970 352-1056
North Range Behavioral Health	970 347-2120
North Range Outpatient	970 347-2314
United Way: Resource Referral Directory	211
University of Northern Colorado Psych Services Clinic	970 351-2731
Weld County Department of Social Services	970 352-1551
Weld County Health Department	970 304-6420
Weld County Legal Assistance	970 351-7300
Weld County Sheriff's Department	970 356-4015

APPENDIX I
INTERVIEW GUIDE

Interview Guide

Therapist Questions

Artifact description

- Describe the objects you brought that characterize the therapy relationship between you and your clients diagnosed with AN.
- How do these objects represent or characterize your experience of the therapy relationship between you and your clients diagnosed with AN?

General Alliance questions

- How would you describe the therapy relationship between you and your clients diagnosed with AN?
- What factors do you believe were influential in forming the therapy relationship with your clients diagnosed with AN?
- What factors do you believe were influential in challenging the therapy relationship with your clients diagnosed with AN? (i.e., What made it difficult to build a relationship with your clients?)

Client-focused factors

- In your experience of therapy with clients diagnosed with AN, what are some things these clients have done, said, etc. to facilitate building the relationship between you two?
- What are some things that the clients have said, done, etc. that have made building the relationship between you two difficult?

Therapist-focused factors

- What are some things that have been helpful in building a relationship with your clients diagnosed with AN that you have facilitated?
  - What types of things did you say?
  - What types of things did you do (nonverbally)?
- What are some things that you did or said that made forming the relationship difficult?
- How does your theoretical orientation affect/influence the relationship between you and your clients diagnosed with AN?
- How does self-disclosure impact/affect/influence the relationship between you and your clients diagnosed with AN?

General

- How did or did not talking about therapy goals impact the relationship with your clients diagnosed with AN?
- How closely do you and your clients' with AN world-view align? How does this impact the relationship?
- Did you ever experience a “tear” in the relationship between you and a client with AN? What created this “tear”? How was the “tear” repaired? How did the “tear” influence your overall therapy relationship?
- How has the relationship between you and your clients diagnosed with AN impacted their initial problems, symptoms, or reasons for coming into therapy?
- Is there anything else you would like to add?

Client Questions

Artifact description

- Describe the objects you brought that characterize the therapy relationship between you and your therapist
- How do these objects represent or characterize your experience of the therapy relationship between you and your therapist?

General Alliance questions

- How would you describe the therapy relationship between you and your therapist?
- What factors do you believe were influential in forming the therapy relationship with your therapist?
- What factors do you believe were influential in challenging the therapy relationship with your therapist?

Therapist-focused factors

- In your experience of therapy thus far, what are some things, facilitated by the therapist, that have been helpful in building the therapy relationship?
  - What types of things did the therapist say?
  - What types of things did they do (nonverbally)?
- In your experience of therapy thus far, what are some things, facilitated by the therapist, that have made building a relationship with him or her difficult?
- How has your therapist's self-disclosure, so things like telling you about them in general or how they are thinking or feeling during the session impacted/affected/influenced your relationship with them?

Client-focused factors

- In your experience of therapy thus far, what are some things that have been helpful in building a relationship with your therapist that you have facilitated?
  - What types of things did you say?
  - What types of things did you do (nonverbally)?
- What are some things that you did or said that made forming the relationship difficult?
- Have you been in individual therapy before? (If yes, go on to the next question. If no, skip the next one and continue).
  - How has your past experience(s) with individual therapy influenced your relationship with your current therapist?
- How do you feel your past and current personal relationships with others have impacted your relationship with your therapist?

General

- How did or did not talking about therapy goals impact the relationship with your therapist?
- How closely did you and your therapist's world-view align? How did this impact the relationship?
- Did you ever experience a "tear" in the relationship between you and your therapist? What created this "tear"? How was the "tear" repaired? How did the "tear" influence your overall therapy relationship?
- How has the relationship between you and your therapist impacted your initial problems, symptoms, or reasons for coming into therapy?
- Is there anything else you would like to add?

APPENDIX J

MANUSCRIPT DRAFT

Abstract

The therapeutic working alliance is a vital ingredient to psychotherapy, specifically clients diagnosed with Anorexia Nervosa (AN), as progress is often slow and treatment difficult. This phenomenological study investigated the experiences of eight clients with AN and seven therapists who worked with this population regarding what therapist factors aided in and challenged the working alliance formation in individual psychotherapy. Phenomenology was the methodology used to guide this study and data were gathered through semi-structured interviews. Findings revealed the following helpful therapist factors in alliance formation: strong basic counseling skills, strengths-based approach, collaboration with external systems, appropriate self-disclosure, expertise and experience treating eating disorders, individualizing treatment, willingness to be contacted outside of session, warm and safe office environment, awareness of personal reactions toward the client, and seeking supervision. Unhelpful therapist factors included lack of attunement to clients' needs, judgmental/invalidating attitude, failure to individualize treatment, lack of confidence and competence, and lack of objectivity.

THERAPIST FACTORS INFLUENCING THE WORKING ALLIANCE IN INDIVIDUAL PSYCHOTHERAPY WITH ANOREXIA NERVOSA

Introduction

I realize that this is a very deadly disease. I realize that we are literally starving to death and that our lives are literally on the table, but if you move too fast, we just run harder and die faster. People don't realize that if they run in, wanting to save our lives, they end up struggling because they move too quickly and scare us. It's like a horse. You don't go running up to a horse in a pasture; it spooks them.
Kelly (client participant)

Anorexia Nervosa (AN) is a serious psychiatric disorder with a lifetime prevalence rate of approximately .5% and an estimated long-term mortality rate of over 10% (American Psychiatric Association [APA], 2000). Females with AN have a 58 times greater suicide rate than do healthy females; 3 to 20% of those with AN attempt suicide (Warren, Crowley, Olivardia, & Schoen, 2009). Additionally, because AN involves a reduced intake of food, semi-starvation characteristics can affect these individuals, e.g., problems with the individual's major organ systems, anemia, dehydration, osteoporosis, cardiovascular and gastrointestinal abnormalities, and even death (APA, 2000; Wright, 2010). Due to the increased rate of physical problems, suicide, and death, it is clear AN is a serious disorder.

Treating clients diagnosed with AN can be difficult as progress is often slow and prognosis usually poor (Franko & Rolfe, 1996). In a meta-analysis of outcome studies, Steinhausen (2002) discovered approximately 46.9% of clients with AN fully recovered, 33.5% improved, and 20.8% developed a chronic course of the disorder. There are several reasons treatment could be difficult with this population including, but not limited to, high dropout rates, difficulties with cognitive processing due to low body weight and malnourishment (Tchanturia & Hambrook, 2010), the ego-syntonic nature of the disorder

that inhibits the client from seeing themselves as sick (Vitousek, Watson, & Wilson, 1998), and comorbidity with other disorders such as obsessive-compulsive personality disorder (Satir et al., 2011), anxiety disorders, and substance abuse disorders (Steinhausen, 2002). Furthermore, forming a working alliance with this population is often complicated due to clients' difficulties trusting the therapist (Warren et al., 2009) and high prevalence of insecure attachment styles often found in this population (Wechselblatt, Gurnick, & Simon, 2000).

Working Alliance

Several terms have been used to refer to the relationship between the client and therapist: *therapeutic alliance*, *working alliance*, *helping alliance*, and *therapeutic relationship* (Horvath & Luborsky, 1993). The most commonly used conceptualization of the working alliance was defined by Bordin (1979). He described it as a collaborative relationship between the client and therapist comprised of three different components: agreement on the goals of therapy, agreement on the tasks of therapy, and the relational bond between client and therapist.

Since Bordin (1979) offered this pantheoretical definition, researchers have investigated how the alliance affects therapeutic outcome and have used a variety of measures to evaluate these constructs. For example, in a recent meta-analysis on alliance and outcome, Horvath, Del Re, Flückiger, and Symonds (2011) analyzed 201 outcome studies using over 30 different types of alliance measures. Additionally, when measuring outcome, researchers have used a variety of constructs, e.g., global ratings of satisfaction and improvement, target complaints and symptom checklists, pre-and post-counseling changes, and session evaluations (Horvath & Luborsky, 1993; Kivlighan, 2007).

Although there is much variability among the assessments used to measure alliance and outcome, researchers found alliance to correlate moderately with outcome--it is one of the most robust predictors of outcome (Safran, Muran, Samstag, & Stevens, 2002).

Helpful Therapist Factors on Alliance Formation

Research demonstrates that several therapist factors have been helpful in alliance formation. The therapist-offered conditions of empathy, genuineness, respect, and unconditional positive regard have been associated with developing and maintaining a positive working alliance (Gelso & Carter, 1985; Lambert & Barley, 2002). Therapists who were compassionate and portrayed a willingness to help their client face his or her problems also contributed to better therapeutic relationships (Gelso & Carter, 1985). Wei and Heppner (2005) reviewed several studies and concluded therapist flexibility and credibility were associated with the strength of the alliance. Additionally, therapists who were more challenging, thematically focused, and here-and-now oriented had stronger alliance ratings than did therapists who attempted to clarify or obtain information, explored feelings, or offered support and encouragement (Sexton & Whiston, 1994). Other therapist characteristics that contributed a strong working alliance included trustworthiness, warmth, honesty, integrity, confidence, and openness (Hersoug, Høglend, Havik, von der Lippe, & Monsen, 2009). Hersoug, Høglend, Monsen, and Havik (2001) and Hersoug et al. (2009) found that therapists who had more perceived social support and a higher degree of comfort in close interpersonal relationships also had higher-rated working alliances.

Unhelpful Therapist Factors on Alliance Formation

Therapist factors can, unfortunately, have a negative impact on the working alliance. Safran, Muran, and Samstag (1994) discovered that lapses in the therapist's empathic attunement produced ruptures in the alliance. Ackerman and Hilsenroth (2001) reviewed studies in which the researchers investigated therapists' characteristics and techniques that negatively impacted the working alliance. They found therapist characteristics--being rigid, uncertain, critical, distant, tense, and distracted--negatively impacted the therapeutic relationship. Additionally, they discovered specific therapeutic techniques--over-structuring the therapy session, inappropriate self-disclosure, excessive use of transference interpretation, and inappropriate silence--also negatively influenced the working alliance.

Hersoug et al. (2001, 2009) asserted that therapists' cold/detached behaviors, as rated by both clients and therapists, had the most consistent and strongest negative impact on the working alliance. Another finding from Hersoug et al. (2009) suggested that clients whose therapists had more professional training (i.e., years of formal postgraduate training in psychotherapy and supervision) rated the working alliance as poorer than therapists with less professional training. The authors hypothesized that therapists with more interpersonal problems might stay in training longer or seek more training. However, Sexton and Whiston (1994) reviewed several studies that discovered as a therapist's experience increased, so did the strength of the working alliance.

Researchers also found mixed findings regarding how a therapist's self-disclosure impacted alliance. Sexton and Whiston (1994) reviewed a number of studies that examined therapist self-disclosure and self-involving statements. Some researchers

found that participants rated disclosing therapists better than non-disclosing therapists and the disclosures strengthened client involvement, whereas others found that self-disclosure did not have a positive or negative effect (Sexton & Whiston, 1994).

Purpose

Previous research has identified general therapist factors that influenced the working alliance formation; however, there is a dearth of research on the working alliance in the population diagnosed with AN. This is necessary because dropout rates are high and treatment outcome is usually poor with this population--poor outcomes can ultimately lead to death (Franko & Rolfe, 1996). By illuminating therapist factors that both therapists and clients diagnosed with AN view as beneficial and problematic in forming the working alliance, therapists can be better informed on how to form an alliance with this specific population, which could lead to lower dropout rates and improve therapeutic outcome. Therefore, the purpose of this phenomenological study was to explore perceptions and experiences of clients diagnosed with AN and therapists who work with this population regarding how the working alliance was formed and challenged in the process of individual psychotherapy. The goal of this study was to identify therapist factors that influenced alliance formation. The research question that guided this study was: What therapist factors influence the working alliance between therapists and clients diagnosed with Anorexia Nervosa?

Methodology

Phenomenology

The methodology used in this study was phenomenology, which explores “how human beings make sense of experience and transform experience into consciousness,

both individually and as shared meaning” (Patton, 2002, p. 104). As a method of analysis, Patton (2002) stated that phenomenology seeks to identify and illuminate the meaning, structure, and essence of a phenomenon for a person or group of people. To do this, the researcher must capture how individuals experience a phenomenon: “how they perceive it, judge it, remember it, make sense of it, and talk about it with others” (Patton, 2002, p. 104).

Participants

In this study, 15 participants were interviewed, all of whom had experienced the working alliance in individual psychotherapy. The first set of participants included eight clients who met the following criteria at the time of the study: 18 years of age or older, diagnosed with AN by a physician or mental health provider, not diagnosed with a DSM-IV-TR (APA, 2000) Axis II diagnosis (e.g., Borderline Personality Disorder), and attending individual psychotherapy to treat AN at the time of the study. The eight clients ranged in age from 20 to 63-years-old. Seven clients were female, one was male, and all were Caucasian/White. The number of sessions the clients had with their therapist ranged from 30 to over 500 sessions; the average number was 205. The number of years the clients had been diagnosed with AN ranged from one and a half years to 31 years. The clients were from the Midwest, Southeast, and Eastern parts of the United States of America. Table 1 portrays the demographic information for the client participants.

Table 1

Demographics of Client Participants

Participant Pseudonym	Age	Gender	Race	Highest level of education	Occupation	Years diagnosed with AN	Sessions with current therapist	Previous treatment
Jessica	20	Female	White/Caucasian	Completed 2 years of Bachelor's degree	Student; part-time at jewelry store	7	150	Hospitalization and outpatient therapy
Snow	45	Female	White/Caucasian	Bachelor's degree; few courses short of Master's degree	Vice president of a consulting firm	28	200	Inpatient, 4 week residential program, intensive outpatient
Cody	53	Male	White/Caucasian	Bachelor's degree	Banking consultant	1.5	30	Inpatient, group therapy, and 'Celebrate Recovery'
Melissa	30	Female	White/Caucasian	Bachelor's and Master's degree	Social Worker	14	300	Intensive outpatient/day program and group therapy
Laura-Leigh	54	Female	White/Caucasian	Associate's degree	Bank teller	31	500	Two hospitalizations
Emily	23	Female	White/Caucasian	Bachelor's degree	Graduate student	1.5	100	Residential
Kelly	26	Female	White/Caucasian	Associate's degree	Student; part-time at hotel	9	60	Inpatient and group therapy
Jamie	63	Female	White/Caucasian	Bachelor's degree and several graduate courses	Substitute teacher and part-time nanny	10	300	Inpatient and group therapy

The second set of participants included seven therapists who worked with clients diagnosed with AN at the time of the study. The therapists did not provide individual psychotherapy to the client participants. Six of the therapists were female, one was male, and all were Caucasian. Their ages ranged from 28 to 63 years. Three participants had a master's degree, one had a master's degree and several doctoral-level courses, and two had earned doctoral degrees. The average number of years the therapists had worked with clients with AN ranged from 2 to 30 years. Additionally, participants worked with

an average number of 258 clients with AN, ranging from approximately 20 to “well over 1,000.” At the time of data collection, three therapists worked in private practice, one worked at an outpatient treatment facility for eating disorders, and three worked at an inpatient treatment facility for eating disorders. All participants were from a Rocky Mountain state in the United States of America and all had experience working with clients with AN in an outpatient setting. Table 2 portrays the demographic information for the therapist participants.

Table 2

Demographics of Therapist Participants

Participant Pseudonym	Age	Gender	Race	Highest level of education	Occupation	Years working with clients with AN	Approximate number of clients with AN provided treatment to
Stacey	63	Female	White/Caucasian	Master's degree	Outpatient therapist; unlicensed	12	300
Bridgett	30	Female	White/Caucasian	Master's degree	Therapist at a private practice	5	20
Tim	38	Male	White/Caucasian	Master's degree and several PhD courses	Therapist at a treatment facility for eating disorders	5	200
Sally	28	Female	White/Caucasian	Master's degree	Social Worker at a treatment facility for eating disorders	2	40
Mary	53	Female	White/Caucasian	Doctoral degree	Psychologist at a private practice	25	125
Jane	59	Female	White/Caucasian	Doctoral degree	Psychologist and Clinical Director at a treatment facility for eating disorders	30	1,000
Kathy	32	Female	White/Caucasian	Master's degree	Therapist at a treatment facility for eating disorders	9	150

Data Collection

The primary method of data collection was semi-structured interviews directed by an interview guide. Examples of questions on the interview guide for therapists included the following: (a) What are some things that have been helpful in building a relationship with your clients diagnosed with AN that you have facilitated? (b) What types of things did you say/do (non-verbally)? and (c) What are some things you did or said that made forming the relationship difficult? Examples of questions for clients included the following: (a) In your experience of therapy thus far, what are some things facilitated by your therapist that have been helpful in building the alliance? (b) What types of things did your therapist say/do (non-verbally)? and (c) What are some things facilitated by your therapist that made building a relationship with him or her difficult? All interviews were digitally recorded and transcribed verbatim. To maintain confidentiality, participants were referred to as their pseudonym, versus their real name, on the audio recording, transcripts, and manuscript.

Procedures

Participants were recruited through two national organizations: the National Eating Disorders Association (NEDA) and National Association of Anorexia Nervosa and Associated Disorders (ANAD). Both organizations' websites provided a referral list of treatment providers and their contact information. I contacted therapists via email and asked if they were interested in participating in the study. To recruit client participants, I utilized similar methods to identify therapists who worked with this population and sent them an email explaining the study. I asked that they give their clients who met the criteria a recruitment letter explaining the study and asking the client to contact me

privately via email or phone. Interviews were conducted in three formats: Skype, phone, and in person. Two clients and one therapist completed their interviews via Skype, six clients and two therapists utilized the phone, and four therapists' interviews were in person. Skype and phone were utilized as a means of interviewing participants who lived far away or were unable to meet in person due to scheduling conflicts. The four interviews completed in person were held in the therapist's office or a public library.

Analyses

After the interviews were transcribed, I analyzed the data using Moustakas' (1994) method of analysis, which includes seven steps. First, I examined each participant's transcript and highlighted significant statements to better understand how the participants experienced the phenomenon known as horizontalization. Next, I developed clusters of meaning from the significant statements from which themes were developed. These themes were then used to write a textural description or what the participants experienced. Next, a structural description, sometimes called the imaginative variation, was created to describe the context or the setting in which the participants experienced the phenomenon or how they experienced it (Creswell, 2007). Finally, I combined the textural and structural descriptions and constructed the essence or invariant structure for all participants.

To enhance the trustworthiness, credibility, dependability, and confirmability, I utilized several techniques. One technique included member checking (Guba & Lincoln, 1989), which included sending participants their transcript, individual themes (textural-structural description), and overarching themes (invariant structure) to confirm the plausibility of the findings. Additionally, I employed prolonged engagement/saturation,

triangulation, audit trail, thick descriptions (Guba & Lincoln, 1989), and bridling/researcher reflexivity (Dahlberg, 2006; Morrow, 2005). A second coder, trained in qualitative methodology, and I independently analyzed each transcript and identified the textural-structural description (individual themes) and the invariant structure (overarching themes). We then compared our independent findings, identified the similarities and differences, and discussed the differences until an agreement was made to incorporate the theme or not. Furthermore, an outside expert in the field of eating disorders read all the transcripts, textural-structural description, and invariant structure to aid in peer/expert check.

Findings

Similarities between Participants' Descriptions

Table 3 identifies the helpful and unhelpful therapist factors a majority of the client and therapist participants agreed upon, followed by a discussion of each theme.

Table 3

Similar Helpful and Unhelpful Therapist Factors

Factors	Similar Themes
Helpful therapist factors	• Strong basic counseling skills: validation, nonjudgmental attitude, unconditional positive regard, genuineness, authenticity, and collaboration • Strengths-based approach • Collaboration with external systems: treatment team and family • Therapist self-disclosure • Expertise and experience treating eating disorders ▪ Subtheme: Balance between setting boundaries and portraying compassion • Individualized treatment
Unhelpful therapist factors	• Lack of attunement to clients' needs ▪ Sub-theme: Being too pushy or tentative ▪ Sub-theme: Focusing too much on the eating disorder behaviors • Judgmental/invalidating attitude

Helpful therapist factors.

Strong basic counseling skills. Several similarities emerged between the client and therapists' descriptions of helpful therapist factors. One similarity named by all participants included the use of at least one basic counseling skill, specifically validation, nonjudgmental attitude, unconditional positive regard, genuineness, authenticity, and collaboration. Some ways therapist participants conveyed these characteristics included showing a genuine interest in understanding how the eating disorder functioned for clients in a positive way ("Don't make the eating disorder the enemy" – Stacey), creating a different relationship (e.g., corrective emotional experience), and using touch, when

appropriate, to convey empathy. Clients described similar therapist characteristics--normalizing and validating the disorder and relapse, encouraging clients to use their voice and choosing the session topic, remembering things the client said in previous sessions, using humor, and showing genuine emotion (e.g., crying), and attentive body language.

Strengths-based approach. Another helpful therapist factor was using a strengths-based approach. Five clients provided examples of their therapist providing verbal reinforcement for their positive steps. Melissa stated:

It's the little things. Acknowledgement is very important. If they [clients] did something good, acknowledge it, even if it's the tiniest thing. Because somebody else in their life may not acknowledge it, and they may need it from their therapist.

Therapist participants illustrated similar examples and suggested using reframing and recognizing the client's internal resources. Mary explained, "What's not always apparent immediately is the real deal...the strength of will, the internal resources to somehow keep going." Additionally, five therapists relayed the importance of redefining success and outcome when working with clients with eating disorders because "recovery" might look different from client to client and might take years; therefore, one therapist suggested looking for smaller, more intangible markers of success (e.g., evoking emotion) and making them known to the client.

Collaboration with external systems. Four clients and three therapists noted it helpful when the therapist communicated and collaborated with external systems--people such as the client's family members, treatment team (e.g., physician, psychiatrist, dietician), and personnel at a more intensive treatment facility (e.g., intensive outpatient).

Several clients, including Jamie, found it helpful when their therapist consulted with the treatment team so everyone was “on the same page,” whereas Laura-Leigh appreciated when her therapist referred her to a dietician and physician. Similarly, three clients expressed how helpful it was for their therapist to collaborate with their family members to help them understand the disorder and use them to encourage the client to continue in recovery. A few therapists also described collaborating with families, helping them understand the disorder, and Mary identified using “diplomacy and professionalism” when working with the treatment team and the family system.

Therapist self-disclosure. Seven clients and six therapists acknowledged appropriate therapist self-disclosure as helpful. When describing self-disclosure, most participants described the disclosures as minimally to moderately personal. For example, this included disclosures about how the therapist was feeling in the room with the client and things such as getting married or having a baby; however, the disclosures did not include sharing about the therapist’s personal history of an eating disorder. Both therapists and clients acknowledged the usefulness of the therapist maintaining boundaries. Snow shared that her therapist balanced “that line of friend and professional” and was “a therapist first and friend second.”

Expertise and experience treating eating disorders. Another common theme described by all participants included the therapist having expertise and experience treating eating disorders. Therapists described expertise as having much experience working with this population, confidence, and utilizing effective treatment approaches. Clients defined expertness as having experience and knowledge; however, several noted the importance of the therapist not taking an “expert stance” and being able to admit

when s/he did not know something. Kelly admitted she felt safer when her therapist told her she did not know something so she knew “my therapist is not going to try to pull something over on me.” Clients also highlighted other factors that portrayed their therapist’s expertness: teaching them how to identify and feel feelings, knowledgeable about medications and treating co-occurring issues, maintaining confidentiality, and providing structure during sessions.

A sub-theme of expertness included having a balance between setting boundaries and portraying compassion. Mary, a therapist participant, described this as “having one arm around the client while kicking them in the butt with your foot.” Over half of the client participants explained by having their therapist be direct, not “pull any punches,” and having a “no fooling around” attitude toward their eating disorder, their feelings of trust and safety increased. Many admitted how in-the-moment, these challenges were difficult; however, looking back, several acknowledged it made them trust their therapist would keep them safe.

Individualized treatment. All participants labeled it helpful when therapists individualized treatment and accepted the client’s level of readiness and stage of change. Kelly encouraged therapists to not be a “cookie-cutter doctor” and treat all clients the same. She went on to say, “It’s very important to know us [clients with AN] as a whole as well as individually.” Several clients provided examples of how their therapist individualized treatment: using metaphors specific to the client’s family, conducting a session via telephone when the client was traveling, pausing therapy to use a relaxation technique when the client was “fried,” and knowing when to push a client and when to give him/her space. All seven therapist participants acknowledged the importance of

individualizing treatment by moving slowly, respecting physical distance, being attuned to client's nonverbal communication, collaborating and prioritizing treatment goals, and assessing client's resources prior to starting trauma therapy.

Unhelpful therapist factors.

Lack of attunement to clients' needs. The therapists and clients shared several similarities when discussing therapist factors that were unhelpful to the alliance. One of these included a therapist's lack of attunement to clients' needs and was described by all participants. Several therapists provided examples of ways they were too pushy-- working toward a goal that was not shared with the client, setting their own agenda for the session, and not being flexible. Sally recalled an experience with a previous client and stated, "I think what happened with me and this patient was that I was such a champion of her recovery, and that was becoming really invalidating for her because she was feeling pretty hopeless, pretty done, and pretty unsure." Similarly, clients shared stories of when their therapist tried to force behavior change, e.g., strongly encouraged a client to tell her partner about her relapse and "pushed" a client to attend an inpatient program for eating disorders.

A sub-theme of lack of attunement included creating boundaries that were too rigid or flexible. When discussing boundaries that were too rigid, descriptions included therapists hospitalizing clients too quickly, forcing change, or taking away control. Kelly explained that because AN is "fear-based" and "control-based," she will "run every time" if she is pushed too hard in a direction she does not want to go, both physically and emotionally. Boundaries that were too flexible included threatening to hospitalize the client, not following through, and talking to the client in a tentative, child-like voice.

Two clients recalled a previous therapist being gullible--taking what they said about their emotional state and eating disorder at face value (e.g., “I’m fine”) and not inquiring further. Additionally, two therapists labeled it unhelpful when therapists treat their clients like “fragile children” or enable them to speak through their behaviors.

An additional sub-theme of lack of attunement included focusing too much on the eating disorder. Three clients expressed frustration when their therapist focused on meal planning, food, or weight when they had other stressors they wanted to discuss. During one session, Jessica stated her therapist wanted to focus the whole session on her meal plan, whereas she preferred to focus on “inside my head, and doubts, and what I wanted to address.” Similarly, five therapists described over-focusing on eating disorder behaviors as unhelpful; Sally described it as a “power struggle” and “getting in that rat wheel.”

Laura-Leigh, a client participant, explained how an over-focus on underlying issues was unhelpful; however, the therapists did not identify this as unhelpful. She explained focusing too much on emotions or the causes of the eating disorder enabled her to avoid talking about her eating disorder behaviors. She went on to suggest that a therapist might not focus on or inquire about behaviors if the client did not appear too thin: “I think it’s easy not to discuss it [eating disorder behaviors] when the person in front of you looks okay.”

Judgmental/invalidating attitude. Similar to lack of attunement, three clients and four therapists acknowledged judgment and an invalidating attitude as unhelpful. Therapists used words such as blaming, criticizing, evaluating, and “villainizing” the eating disorder when describing judgment. Additionally, several clients reported if they

felt judged, they did not feel safe in the relationship. Laura-Leigh encouraged, “If at all possible, never convey that you judge them [clients].”

Differences between Participants’ Descriptions

Table 4 identifies the differences between the client and therapist participants’ descriptions of helpful and unhelpful therapist factors, followed by a discussion of each theme.

Table 4

Different Helpful and Unhelpful Therapist Factors

Clients’ Descriptions	Therapists’ Descriptions
Helpful therapist factors • Willingness to be contacted outside of session • Warm and safe office environment	Helpful therapist factors • Aware of personal reactions toward clients • Seeking supervision
Unhelpful therapist factors • Failure to individualize treatment • Lack of competence and confidence	Unhelpful therapist factors • Lack of objectivity

Helpful therapist factors.

Willingness to be contacted outside of session. When describing helpful therapist factors, several differences existed between the clients’ and therapists’ descriptions. Six clients labeled a therapist’s willingness to be contacted outside of session as helpful. Some clients contacted their therapist via phone or text, while others utilized email. Many explained they discussed the boundaries around communication with their therapist (i.e., when and why they would contact their therapist) prior to

contacting them. Kelly noted that even if she chose not to contact her therapist, the option added “an extra layer of trust” because she knew “she’s just there; somebody is there to help me.” Although most of the clients observed this as something that enhanced the alliance, none of the therapists discussed this factor or noted it helpful or unhelpful.

Warm and safe office environment. Another difference included three clients who described their therapists’ office environment as aiding in alliance formation; however, none of the therapists acknowledged this as an influential factor. Laura-Leigh stated, “I’m very sensitive to my environment...I really think a lot of folks that have eating disorders are highly sensitive.” Some of the specifics clients noted as promoting a warm office environment included decorations and furniture that were “homey” and “comfortable,” playing soft music in the waiting room, having a white noise machine for privacy, carpet versus tile floors, dim lighting, and stuffed animals. Kelly recalled her therapist had a therapy dog and allowed her to pet and cuddle her during therapy, which helped her feel safer.

Aware of personal reactions toward clients. The therapists noted two helpful therapist factors that the clients did not. One factor described by all the therapist participants included the therapist working on his/her personal struggles outside of the relationship and being aware of personal reactions toward clients. Tim, a therapist participant, described the need to “have your own well-being solid,” “stay balanced,” and “learn self-care.” By working on their own personal struggles, the therapists explained they were cognizant of their own reactions toward clients, were able to be “strong” and “grounded” when the client was not, and modeled wanted adaptive behavior.

Seeking supervision. The other factor three therapists noted was seeking supervision. Many reported that because this could be a difficult population to work with, supervision was helpful in having a place to “vent” and process their relationship with clients. Bridgett stated, “Make sure you have amazing supervision...a go-to person that you can bounce ideas off of.”

Unhelpful therapist factors.

Failure to individualize treatment. Differences emerged between clients’ and therapists’ descriptions of unhelpful therapist factors. One difference included three clients’ experience when their therapist failed to individualize treatment. Snow stated her therapist forgot many things she said from session to session, which made her believe she was treating her similar to other clients. Similarly, Kelly stated:

It’s very important to know us as a whole as well as individually. Even though, yes, my community of anorexics are all struggling with the same thing, we all struggle from different things too. And there are very few people who can realize that.

Lack of competence and confidence. Another theme four clients identified was when therapists lacked competence and/or confidence. Snow discussed an experience with a previous therapist: “I had a panic attack in front of her...it was almost as though that therapist clearly was worried when I was having a panic attack, and that was not good for me...for my therapist to be panicking.” Although both therapists and clients agreed competence and confidence were helpful therapist characteristics, therapists did not identify the lack of this as unhelpful.

Lack of objectivity. The only theme all therapist participants identified that the clients did not include a therapist's lack of objectivity. One way therapists described how one might observe this in session included the therapist not being aware of his/her reactions. Sally recalled a session where she did this:

At the end of the session, I reflected and realized that, wow, 70% of the session was me talking AT them [the client]. I am a model of other relationships, and if I am doing that, that's exactly what they are getting from everybody else in their life, and that is not therapeutic.

Other examples included losing hope, therapist not working on his/her personal struggles, and improper use of self-disclosure. Mary stated, "Self-disclosure can bog things down; it can become a burden to the client because many take on the caretaking role." Although one client encouraged therapists to not give up or lose hope, it was not a common theme among the clients.

Discussion

Helpful Therapist Factors

Similarities. Both client and therapist participants acknowledged strong basic counseling skills as helpful therapist factors in alliance formation. These skills included validation, nonjudgmental attitude, unconditional positive regard, genuineness, authenticity, and collaboration. Bedi (2006) discovered similar results and stated, "Many key factors that clients understand to be important for alliance formation may be deceptively simple and reflect counselor microskills such as nonverbal gestures and empathic listening" (p. 32). Gelso and Hayes (1998) asserted that using Rogers' (1951) therapist-offered conditions such as empathy, unconditional positive regard, and

congruence assisted in building the working alliance early in therapy. Specific to clients with eating disorders, Garner, Vitousek, and Pike (1997) stated warmth, genuineness, engagement, and positive regard aided in alliance formation. It is likely that the basic counseling skills reflected the therapist's willingness to move slowly and collaborate on the therapeutic goals, which clients noted as important in the early stages of therapy. Unconditional positive regard and genuineness might have also aided in building trust as clients learned their therapists cared about them and would be honest and genuine in their communication.

Client and therapist participants referenced the effectiveness of a therapist who used a strengths-based approach. Gulliksen et al. (2012) discovered clients with AN preferred therapists who focused on their resources, strengths, and abilities. Similarly, Redko, Rapp, Elms, Snyder, and Carlson (2007) found similar results when interviewing clients who abused substances about the helpful characteristics of their case managers. They discovered clients appreciated when their case managers helped them recognize their personal strengths/skills as it increased their sense of self-worth. In this study, when the therapists highlighted clients' strengths and internal resources, it appeared to do two things. First, it helped clients develop hope and confidence that they could fight the disorder. Since many clients enter treatment ambivalent about getting rid of their disorder, this might help clients see they have what it takes to battle the disease. Additionally, it helped the therapist maintain a hopeful and optimistic view about their clients' recovery. As previously discussed, many of the therapists in this study described alliance formation as frustrating and difficult; when focusing on the client's internal

resources as well as highlighting small successes, it helped therapists maintain a positive outlook and modeled adaptive thinking for clients.

In contrast, Sexton and Whiston (1994) discovered therapists who were more challenging, thematically focused, and here-and-now oriented had stronger alliance ratings than did therapists who attempted to clarify/obtain information, explore feelings, or offer support and encouragement. The authors hypothesized that because the alliance is collaborative in nature and support and encouragement put the client in a passive role, this might explain the findings; however, in this study, the client participants preferred having a more passive role at the beginning of therapy and appreciated their therapist obtaining information, exploring feelings, offering encouragement, and highlighting strengths. One reason this could be explained is due to client factors present at the beginning of treatment such as ambivalence about treatment, insecure attachment style, and ego-syntonic nature of the disorder (Vitousek et al., 1998); therefore, having a more active therapist could allow clients time to trust, learn to be collaborative, and develop motivation to battle their disorder.

Another helpful therapist characteristic included the therapist communicating and collaborating with external systems. While research (Lyon, Silber, & Atkins, 2005; Rienecke Hoste, Celio Doyle, & Le Grange, 2012) specifically focusing on eating disorders supports collaborating with the treatment team to promote better outcome, no research has explored how a therapist's collaboration with the treatment team impacts alliance formation. Godkin (2010) utilized a case study approach to investigate how the use of a treatment team composed of eight different psychotherapists impacted a client's

addiction to substances; however, it was not investigated if the treatment team impacted the alliance.

Similarly, previous research has not identified if incorporating a client's family into individual therapy positively influenced alliance. In a study investigating two types of treatments for adolescents with AN, researchers discovered higher observer ratings of alliance in a family-based treatment versus the adolescent-focused treatment (i.e., individual therapy; Forsberg et al., 2013). While this study supported the use of family therapy when treating adolescents with AN, it did not note if this was useful in adults and how incorporating family into individual treatment impacted alliance. Additionally, this finding-- incorporating others into treatment influences alliance--contrasted with many working alliance definitions such as Bordin's (1979) focus on goals, tasks, and bond. Bordin's theory posited the alliance forms in the dyad between the client and the therapist and did not suggest external parties, e.g., a client's family or other treatment providers, influenced this relationship.

The finding that incorporating treatment team providers and family into therapy is helpful in alliance formation was a unique finding of the current study. While previous literature supported collaboration with a treatment team and family as helpful in treatment and outcome, no research has investigated its influence on alliance formation. One reason collaborating with external systems was helpful for participants might be due to the fact that it helped therapists focus on building the alliance. When working with clients diagnosed with AN, many variables need to be focused on in treatment including the client's physical health and nutritional intake (Rumney, 2009). By incorporating members of a treatment team, e.g., a physician and nutritionist/dietician, it enabled the

therapist to spend more time and energy building the alliance versus worrying if the client was medically stable or reviewing a client's food journals to ensure they were getting adequate nutrition. Additionally, incorporating a client's family into treatment could help them better understand the disorder and ways they could be supportive to the client between therapy sessions. Having a support system that echoes messages the therapist communicates in session might help enhance the alliance with the therapist since the client is reminded of therapy and the therapist between sessions.

Many participants identified self-disclosure by the therapist as helpful in alliance formation. Theorists and researchers distinguished between two types of self-disclosure: "self-involving statements" that disclose the therapist's immediate reactions to clients and "self-disclosing statements" that disclose something about the therapist or his/her past (Watkins, 1990). While most clients focused on self-disclosing statements in their discussion, several therapists commented on both self-disclosing and self-involving statements often favoring self-involving statements. Therapists described helpful self-disclosure as relating to the clients but not the disorder, normalizing body image issues, relating to their sensitivity, and being genuine while maintaining boundaries. Clients shared that self-disclosure was useful when their therapist used it to connect, it happened slowly and over-time, and it did not focus too much on the therapist.

Three therapists and one client noted they or their therapist kept strict boundaries and limited self-disclosure to their "professional self"--defined as information one could find on the internet or in the therapist's office (e.g., where they attended graduate school as listed on their diploma, expertise in eating disorders), or they did not disclose at all. Researchers (Hill & Knox, 2002) suggested therapists use self-disclosure sparingly,

making up an estimated 3.5% of all therapists' interventions. When discussing the helpfulness of therapist self-disclosure, the majority of participants highlighted that it normalized clients' reactions and struggles, developed a stronger bond and connection with the therapist, and helped clients feel safer to open up and share about themselves.

Two clients acknowledged asking their therapist to self-disclose about her history of an eating disorder. While one client stated she was genuinely interested, another admitted to using this as a distraction from focusing on himself. Although previous research (Hayes & Gelso, 2001; Hill & Knox, 2002) found judicious use of therapist self-disclosure as helpful in alliance formation, there were mixed results as to whether it had a positive, negative, or neutral impact on client outcome (Kelly & Rodriguez, 2007).

According to the results of this study, self-disclosure was helpful when used slowly and with the intention of connecting and normalizing the client's experience. It appeared the client participants appreciated their therapist balancing self-disclosure, meaning they shared some things about their personal lives, such as a vacation they took or something about their children, but also recognized the value of their therapist not disclosing very personal information, such as if he or she had a history of an eating disorder. The clients also appreciated self-disclosure happening over time, with their therapist not sharing as much in the beginning, but more throughout the course of therapy. Therefore, it is important for therapists to be thoughtful when they self-disclose and consider the purpose of the disclosure, the timing, the amount of information to disclose, and if it fits with the therapist's theoretical orientation and personality. It would also be useful to consider limitations of self-disclosing and how it might negatively impact alliance.

All participants described the therapist's expertise and experience treating eating disorders as a helpful factor in alliance formation. Researchers identified similar therapist characteristics such as experience levels (Horvath & Greenberg, 1994), credibility (Wei & Heppner, 2005), honesty (Bedi, 2006; Garner et al., 1997), and confidence (Ackerman & Hilsenroth, 2003) as positively influencing the working alliance. Similarly, in a review of adolescent clients' views toward the treatment of AN, Westwood and Kendal (2012) discovered clients' alliance scores were positively affected if they perceived their therapist as knowledgeable and competent; they found it less helpful if clients viewed them as inexperienced as they felt more able to deceive their providers. Similarly, Gulliksen et al. (2012) interviewed adults with AN regarding preferred therapist characteristics and found that participants preferred a therapist who was knowledgeable about and experienced with eating disorders, confident in their abilities, and authoritative in sessions.

The finding that a therapist's expertise positively influenced alliance was not a new discovery; however, the finding that a therapist's honesty about his/her limitations and lack of knowledge positively influenced alliance was a unique finding in the present study. Having a therapist who was experienced treating eating disorders helped the clients feel safe and comfortable in the relationship; however, equally important was a therapist who was able to identify what knowledge he or she lacked. Some examples included knowledge about nutrition, medical concerns, and medication. Additionally, it appeared important for therapists to be an expert but not 'act' like an expert. Ways therapists did this were by asking the client about him or herself and understanding that each client is unique and different.

A sub-theme of expertness included therapists being able to balance setting boundaries, challenging the client, and showing compassion. Researchers identified similar findings of setting boundaries and showing compassion. Gulliksen et al. (2012) interviewed adult clients with AN and discovered that therapists who were both challenging and understanding were preferred characteristics of a therapist. Westwood and Kendal (2012) relayed while clients with AN initially disliked having their control taken away, e.g., being forced to eat and gain weight, many identified this to be a “life-saving part of their treatment” (p. 502). Additionally, in a study examining treatment providers’ experiences of treating eating disorders, the authors (Warren et al., 2009) discovered a theme of “stern guide,” highlighting the importance of balancing encouragement and assertiveness by setting clear boundaries. Therefore, therapists who are able to find a balance of encouraging the client and setting boundaries/challenging will likely be more successful in building an alliance with clients with AN.

The last helpful therapist factor clients and therapists agreed upon included the therapist individualizing treatment. Westwood and Kendal (2012) found alliance was positively influenced when clients were treated as an individual rather than “merely an anorexic” (p. 506). Gulliksen et al. (2012) also discovered clients with AN preferred therapists who took the client’s perspective, listened to them, and viewed them as unique individuals. Other therapist behaviors suggested by participants and researchers that positively influenced the alliance and portrayed individualized treatment included flexibility (Ackerman & Hilsenroth, 2003; Garner et al., 1997), providing corrective emotional experiences (Horvath & Greenberg, 1994), using touch (e.g., hug) when

appropriate and initiated by clients (Horton, Clance, Sterk-Elifson, & Emshoff, 1995), and utilizing caution and care when bringing up the need for more intensive treatment.

Differences. When discussing helpful therapists' factors to alliance formation, three major themes differed between the therapist and the client participants. The first theme named by a majority of client participants was a therapist's willingness to be contacted outside of the therapy session. Researchers discovered similar findings when interviewing clients with various diagnoses (Bedi & Richards, 2011) and those diagnosed with substance abuse (Redko, Rapp, Elms, Snyder & Carlson, 2007); they found clients appreciated being able to call or email their therapist between sessions as it aided in alliance formation. In an article exploring e-mail as an adjunctive therapeutic tool in outpatient treatment with four clients with AN, Yager (2001) put forth that email was helpful with this population. To illustrate, email increased the frequency and contact of the relationship, allowed clients to email when they felt most "inspired" and emotionally driven, made clients more aware of their behaviors and being in therapy, allowed more time in-session to discuss topics other than calorie counts or behavior logs as those were documented in the email, and might have increased client's honesty.

One possible reason clients viewed the ability to contact their therapist as helpful to alliance formation was because it might have shaped their view of the therapist as a reliable, dependable secure-base and assisted in creating a corrective emotional experience with the therapist. Clients with AN often have insecure attachment styles (Wechselblatt et al., 2000); therefore, being able to experience a secure attachment with someone between therapy sessions might foster trust and safety in the relationship.

Although client participants in this study deemed this a helpful factor, it does not necessarily mean every therapist should provide their personal contact information to every client with AN. Bhuvaneswar and Gutheil (2008) highlighted several potential risks when using email to communicate with clients: boundary violations, loss of nuances in communication, loss of empathy, and hurting the client's feelings if a response was not sent promptly or at all. Furthermore, if the client has safety concerns, they acknowledged the risk by stating, "E-mail may not give quite enough evidence for legal action to protect the patient or target of the patient's harmful thoughts; yet, it may be used after an incident has occurred to hold the receiving clinician responsible" (Bhuvaneswar & Gutheil, 2008, p. 246). In place of email, the authors proposed alternative solutions: providing the client with information regarding online message boards, online support groups, and/or chat rooms.

Although previous research has investigated the use of email between sessions as it relates to treatment and outcome, previous research has not identified if and how email, text, or phone calls with therapists influence alliance formation, making this a distinctive finding of this study. According to the clients in this study, even if they did not contact their therapist, simply knowing they could helped them feel as if they were not 'alone' between sessions and seemed to create a trusting, secure relationship. However, due to ethical concerns, as well as client characteristics (e.g., those with loose boundaries, safety concerns) and therapist characteristics (e.g., unable to be on-call, theoretical orientation), it is important this factor be implemented with caution.

The second helpful therapist factor clients identified included the therapist's office environment. Although Bordin's alliance (1979) definition and theory did not take

into account the external office environment, recent researchers (Bedi, 2006; Bedi, Davis, & Williams, 2005; Bedi & Richards, 2011; Benton & Overtree, 2012) investigating client's conceptualizations of alliance found similar results: office environment was a significant factor in clients' understandings of alliance formation. For example, in previous studies, client participants noted office size, lighting, decorations (e.g., plants and flowers), color scheme, and types of books in the therapist's office were all influential in alliance formation (Bedi, 2006; Bedi et al., 2005). Additionally, office furnishings (e.g., couch, chair, desk) were found to impact perceived credibility, trustworthiness, and expertness of the therapist (Nasar & Devlin, 2011), which was previously discussed as influential in alliance formation.

Benton and Overtree (2012) highlighted the importance of creating a multiculturally sensitive office environment that included office décor (e.g., furniture, artwork, magazines in the waiting room), printed materials and the website, clinical paperwork, statements regarding fairness, and accessibility. Although their article was theoretical in nature, they proposed the office environment, specifically its multicultural sensitivity, impacted the therapeutic alliance. Unfortunately, little to no research identified what specific types of office lighting, décor, furnishings, and color schemes were more or less helpful; however, according to the participants in this study, objects that encouraged comfort and privacy were helpful, e.g., soft music in the waiting room, a white noise machine, carpet, dim lighting, and a comfortable couch.

The last themes that differed between therapists' and clients' descriptions of helpful therapist factors consisted of "doing your own work as a therapist" and seeking supervision, which were identified by a majority of therapist participants.

Researchers found similar results, noting a therapist's reactions could influence the alliance. For example, Gelso and Carter (1994) acknowledged the importance of the therapist being aware and monitoring his/her reactions so they did not negatively impact alliance. Countertransference, or the negative personal reactions therapists have toward clients, could negatively impact alliance, specifically in the treatment of eating disorders (Bloomgarden, 2009). Bloomgarden (2009) acknowledged that therapists who attempt to be compassionate, genuine, and promote positive regard, might find themselves having negative reactions toward their clients with eating disorders. Additionally, researchers discovered client and clinician factors that predicted negative clinician reactions toward adolescent clients with eating disorders: clinician's gender, group differences between psychiatrists and psychologists, patient personality, pretreatment level of functioning, length of time in treatment, and improvement in treatment (Satir, Thompson-Brenner, Boisseau, & Crisafulli, 2009).

Several therapist participants also relayed the importance and helpfulness of seeking supervision, which aided in self-reflection and monitoring their reactions. Gelso and Carter (1994) stated, "...the working alliance is fostered by therapists' careful monitoring of their own countertransference reactions to the client" (p. 299). The client participants did not identify this as a helpful therapist factor possibly because they did not observe their therapist implementing "self-care" or seeking supervision. However, it is possible the clients experienced the lack of these and labeled them as the therapist's "judgment" and "criticism," which they reported as unhelpful.

Unhelpful Therapist Factors

Similarities. There were two common themes among the therapists' and clients' descriptions of unhelpful therapist factors. The first theme included a lack of attunement to the clients; a sub-theme of this included creating boundaries that were too rigid or flexible. Previous research (Hersoug et al., 2009) supported the finding and stated that therapists' rigidity and over-structuring therapy sessions were negative contributors to alliance formation. On the opposite end of the spectrum, both clients and therapists detailed being too "tentative" as unhelpful. Previous research (Safran et al., 1994) indicated that a lack of empathic attunement leads to ruptures in the alliance. Although participants identified the act of challenging clients as a helpful therapist factor, the timing of the challenge and if it was balanced with care appeared to differentiate the times it was helpful versus those labeled as "pushy" and unhelpful; therefore, a better alliance likely will form when therapists are attuned to clients and able to balance challenging the client and providing compassion.

Another way participants depicted lacking attunement included a content imbalance during the session, specifically over-focusing on eating disorder symptoms and behaviors. Westwood and Kendal (2012) discovered that clients with AN found it unhelpful when their therapist focused exclusively on physical aspects of the disorder; however, they also noted treatment might need to focus on physical elements first to stabilize weight prior to focusing on psychological concerns.

Laura-Leigh, a client participant, explained how an over-focus on underlying issues was unhelpful. De la Rie, Noordenbos, Donker, and van Furth (2008) investigated eating disordered clients' and therapists' views of important components in the therapy

process, structure, and outcome. They found that therapists often stressed the focus on eating disorder symptoms and changing those behaviors, whereas clients often focused on the importance of the therapeutic relationship and addressing the underlying problems of their eating disorder. Due to the participants' descriptions and previous research, it appeared while important to focus on eating disorder behaviors and stabilizing the client's weight, it was also important to spend time focusing on underlying issues and other problems the client might be experiencing in his or her life (de la Rie, Noordenbos, Donker, & van Furth, 2006).

The last unhelpful characteristic highlighted by several participants was a therapist with a judgmental and invalidating attitude. Two therapists specified criticizing the client for having an eating disorder and "villainizing" it, whereas one client discussed being "put down" for expressing her feelings. Gulliksen et al. (2012) discovered adult clients with AN do not prefer therapists who do not pay attention to clients' feelings and opinions, display a lack of care and compassion, and blame the client for their condition. Researchers also identified therapist criticalness as negatively impacting the alliance (Ackerman & Hilsenroth, 2001).

While this finding appears intuitive--invalidation and judgment are unhelpful therapist factors--several clients acknowledged they experienced this with their individual therapist. One way therapists did this was when they talked about the eating disorder as something that was "all bad," "negative," and "a villain." Since many clients with AN enter therapy with ambivalence about getting rid of their disorder, a therapist's criticalness is not a helpful way to join with the client and inhibits the therapist from seeing the disorder from the client's perspective. Although therapists might not want to

put the disorder “on a pedestal,” as one therapist described it, it would be useful to discuss with clients what ways the eating disorder is helpful and practical, as well as unhelpful, as it shows clients their therapist wants to understand them and how they view their disorder.

Differences. Two themes clients endorsed as unhelpful therapist characteristics included the therapist’s failure to individualize treatment and a lack of competence or confidence when treating eating disorders. While both clients and therapists agreed individualizing treatment and being competent were helpful therapist factors (see discussion above), only clients noted the lack of these as unhelpful. Similarly, Ackerman and Hilsenroth (2001) discovered both rigidity and uncertainty as therapist factors that negatively influenced the alliance.

Another unhelpful therapist factor all therapists highlighted and clients did not was a lack of objectivity. In a study investigating therapists’ reactions toward clients with different diagnoses, Franko and Rolfe (1996) discovered less experienced therapists reported feeling more frustrated and angry with clients diagnosed with AN and a therapist’s years of experience and size of case load affected their reactions. Inappropriate self-disclosure was also found to correlate negatively with alliance (Ackerman & Hilsenroth, 2001).

In a study investigating self-disclosure from clients’ perspectives, Hanson (2005) described “unhelpful disclosures” as those that decreased trust and safety and put clients in a position to manage the relationship. Hanson also inquired about “unhelpful non-disclosures” (i.e., when a therapist did not self-disclose and it would have been beneficial if they had) and explained the greatest detriment of non-disclosure was to the alliance,

experienced as a lack of connection and decreased trust. Additionally, Pope and Keith-Spiegel (2008) stated, “The idea that self-disclosure is always appropriate, always therapeutic, always wanted by the client, always free of risks or unintended consequences, or always the best option is the source of countless boundary mistakes” (p. 647). As noted in participants’ discussions and previous research, it is important for therapists to be aware of their own reactions toward clients as well as carefully consider the option of using or not using self-disclosure; these both appeared to influence alliance formation.

Implications

Due to the exploratory nature of this study, caution is warranted when applying the results to individual psychotherapy. It is the responsibility of the reader to decide whether or not the results are applicable to their specific situation (Merriam, 2009). Furthermore, as Bedi (2006) concluded, “Counselors should not unconditionally provide clients with whatever types of alliance they desire. There are clinical (e.g., transference) and ethical considerations” (p. 33). While prudence is encouraged, many of the experiences and factors detailed in this study had previous research to substantiate the application of these in individual psychotherapy with clients with AN.

Ways therapists might positively contribute to alliance formation with clients with AN include utilizing basic counseling skills (e.g., unconditional positive regard, validation, authenticity; Gelso & Hayes, 1998; Lambert & Barley, 2002), using a strengths-based approach (Gulliksen et al., 2012), utilizing appropriate self-disclosure (Hayes & Gelso, 2001; Hill & Knox, 2002), and having experience and expertise working with clients with eating disorders (Horvath & Greenberg, 1994; Wei & Heppner, 2005;

Westwood & Kendal, 2012). Additionally, balancing care, setting boundaries (Gulliksen et al., 2012; Warren et al., 2009), being flexible (Ackerman & Hilsenroth, 2003), and individualizing treatment might encourage alliance formation. Another finding for therapists to consider included creating a warm office environment. While some therapists utilize an office they cannot change, it might be beneficial to consider incorporating furniture and/or décor that portray warmth, e.g., pillows and soft lighting, as well as multiculturally sensitive décor and printed material (Benton & Overtree, 2012).

One finding that should be applied with caution includes allowing the client to contact the therapist outside of therapy sessions. While previous researchers discovered similar findings that contact outside of session could enhance the alliance (Bedi & Richards, 2011; Redko et al., 2007), this might not be ethical or helpful due to clients' difficulties with boundaries (Bhuvaneswar & Gutheil, 2008). However, the majority of client participants noted this helped build trust with their therapist and aided in alliance formation.

Other considerations include what therapists should *not* do. It appeared alliance formation was difficult when therapists portrayed a lack of attunement to clients (Safran et al., 1994). Examples of this included being too forceful or tentative, portraying rigidity (Hersoug et al., 2009), or focusing too much on the eating disorder behaviors versus the underlying issues (Westwood & Kendal, 2012). Furthermore, it appeared unhelpful when therapists were judgmental and invalidating toward clients (Ackerman & Hilsenroth, 2001), e.g., blaming the client for having an eating disorder or “villainizing” the disorder. As previously discussed, supervision and/or consultation might enable therapists to

explore their own biases and frustrations, which might reduce the therapist's portrayal of these attitudes in therapy.

Several implications are specific to counseling psychologists. Gelso and Fretz (2001) identified five themes that differentiate counseling psychology from related fields. One of these themes included "...the focus on people's assets and strengths, and on positive mental health, *regardless* of the degree of disturbance" (Gelso & Fretz, 2001, p. 6). This theme--focusing on health rather than psychopathology--was a common theme discussed by participants. Counseling psychologists can implement this with clients diagnosed with AN by maintaining hope, identifying the client's internal strengths (e.g., strong willpower), looking for intangible markers of success (e.g., a client showing emotion or asserting him/herself), and highlighting the positive steps client take throughout treatment.

Another theme that distinguishes counseling psychologists from other related fields includes "an emphasis on person-environment interactions, rather than an exclusive focus on either the person or the environment" (Gelso & Fretz, 2001, p. 8). Participants also highlighted this as a helpful factor that encouraged alliance formation. Counseling psychologists can do this with clients diagnosed with AN by incorporating a client's family/partner/children into treatment, collaborating with the client's treatment team (e.g., physician, dietician), and creating a warm and safe office environment in which therapy takes place.

Future Research Directions

Through this study, I investigated experiences of seven therapists and eight clients in individual psychotherapy and how the working alliance was formed and challenged in

the process. Due to the smaller sample size ($N = 15$) and homogeneity among participants (e.g., ethnicity, gender, AN diagnosis), conducting similar studies utilizing a larger, more diverse sample would help distinguish between findings that are generalizable and those that were more specific to the participants in this study. It would also be useful to replicate this study in different settings (e.g., inpatient, residential, intensive outpatient) and different diagnosed populations (e.g., bulimia nervosa, binge-eating disorder, personality disorders, trauma survivors) to gain a better understanding of how different types of diagnosed populations conceptualize therapist factors that influence alliance formation.

This study provided several unique findings previous researchers had not identified as influential in alliance formation. The first finding included the therapist collaborating with clients' treatment team providers and/or family. While previous research (Lyon et al., 2005; Rienecke Hoste et al., 2012) identified this as useful in the treatment and outcome of eating disorders, it has not been researched to influence alliance; therefore, this is a therapist factor researchers could continue to investigate.

Another finding not previously researched included the therapist disclosing about his or her lack of knowledge and expertise about specific topics (e.g., the client, nutrition, medication) and how this helped build trust within the alliance. Studies have found that the therapist's knowledge, competence (Westwood & Kendal, 2012), and honesty positively influenced alliance (Bedi, 2006; Garner et al., 1997); however, previous research has not specified admitting to a lack of expertise as helpful in alliance formation. Future research could investigate this finding to see if it was unique to the participants in this study or a shared experience among clients in general.

Limitations

There were several limitations in this study. One of the foundational assumptions of this study was participants were able to retrospectively recall and verbalize important factors in alliance formation. Although researchers proposed that retrospective reports of the client-therapist relationship portrayed theoretical associations that seemed to have significant construct validity (Howard, 1979), there is a risk that participants might forget important information or nuances of experiences as well as experience retrospective bias (Nisbett & Wilson, 1977). Furthermore, during the interviews, several clients noted difficulty remembering the beginning of therapy, either because it was so long ago or because they were extremely underweight and their cognitive functioning was impaired (i.e., they were not storing memories properly). Therefore, participants' reports might have lacked information or details not remembered and/or they might have recalled and deemed information as important due to their own biases.

Additionally, only views of participants who consented to participate were reflected, which failed to highlight views of participants who did not participate such as clients who prematurely terminated therapy. Therefore, participants' views of the alliance might display a more positive view than non-participants. Similarly, it is possible client participants felt an obligation to portray their therapists in a favorable light, possibly due to loyalty, people-pleasing, or the conflict-avoidant personality styles often present in this population (Joos, Cabrillac, Hartmann, Wirsching, & Zeeck, 2009). Although clients were made aware of confidentiality and notified that their therapist would not be informed of their participation, they might have been hesitant to describe difficult interactions and highlight unhelpful therapist factors.

The last limitation included the comparison of clients' and therapists' experiences of the therapeutic alliance. To protect confidentiality and increase the likelihood client participants would disclose fully, I did not interview the client participants' therapists; rather, I interviewed therapists who worked with the AN population. Therefore, a comparison of therapists and clients in the same working alliance relationship might have provided greater depth of information for comparison.

Conclusion

The therapeutic working alliance is an important construct to all forms of therapy, especially within the population diagnosed with AN. While much research has focused on the quantitative measurement of this construct, more research is needed on the clients' subjective understanding as it is a collaborative phenomenon involving two groups: clients and therapists. Specifically within the population diagnosed with AN, it is imperative that therapists work to form a strong working alliance with their clients; treatment is often slow and difficult with this population and dropout and relapse rates are high. To do this, therapists need to be patient and understanding. Mary, a therapist participant, summarized,

There's a scene in the movie [*The Horse Whisperer*] where the horse whisperer is working with the wild horse that won't be ridden and they have a power struggle. The horse runs off. What the horse whisperer does feels like my experience working with anorexic clients...the horse went out into the field and they were a great distance apart. The horse whisperer sat and watched and just held the space while the horse was recovering, doing what it needed to do. Figuring out what was next. Gradually, he took a couple of steps closer and then stopped... it's on

the horse's terms. It's never on my terms. I always want to know more and to be more connected to my anorexic clients, but just like the horse, they have a reason for not trusting. And the fact that that horse ever trusted the horse whisperer, or that my clients, who have been so traumatized, would ever trust me...that's amazing. That's amazing.

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