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“I wish that I hadn't compared...my body to...theirs”:

Exploring Female Clients' Experience of Their Female Therapist's Body During Anorexia
Nervosa Treatment

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Abstract

Anorexia nervosa (AN) is a type of mental distress with particularly high rates of treatment attrition. Given AN's high mortality rate, identifying factors that influence treatment engagement is critical. Clients with AN are known to observe and assess body-related stimuli, paying significant attention to their own appearance as well as the bodies of those around them (Daly, 2016; Fairburn, 2008; Kaplan & Garfinkel, 1999; Lowell & Meader, 2005; Rance et al., 2014). As the therapist is a salient figure in treatment, their body is likely to be a significant part of the client's experience. Despite this, there is little research on how clients with eating disorders experience their therapist's body. However, existing studies suggest that clients form assumptions and judgments about their therapist's body, which can impact their engagement in treatment. This research aims to build on this underexplored area by investigating how female clients with AN experience and make sense of their female-identifying therapist's body during treatment. Using an interpretative phenomenological approach, semi-structured interviews were conducted with three female participants who identified as recovered and had received AN treatment in New Zealand with a female therapist. Findings revealed that the therapist's body played a key role in the client's treatment experience. Most notably, participants compared their bodies to their therapist's, which created a sense of similarity or difference. This comparison, in combination with their stage of recovery, led to assumptions and judgments about their therapist that influenced their willingness to engage in treatment. Specifically, at the early stages of recovery, when their anorexia nervosa was most severe, participants interpreted body comparisons through the lens of their distress, making assumptions and judgments that reduced their willingness to engage in treatment. In contrast, participants at later stages of recovery, who were motivated to recover, formed different assumptions and judgements, fostering a greater willingness to engage. The therapeutic alliance underpinned the participants' treatment

engagement, meaning that the participants' sense of trust and feeling understood were also crucial to treatment engagement. Participants strongly recommended that therapists acknowledge and discuss their bodies with clients and adopt a transparent approach. These findings provide preliminary evidence that the therapist's body influences the client's experience and engagement in treatment. Therefore, therapists should consider and address these reactions to support client engagement effectively.

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CHAPTER ONE: Introduction

1.1 Introduction

"When a body meets a body, no formal introductions are made...As therapists, we focus on words, but our bodies also speak...Yet most accounts of therapeutic processes mention very little of what the bodies mean to each other" (Petrucci, 2008, p. 237).

Bodies convey meaning without words. As humans, we form judgments and assumptions about others based on physical appearance within milliseconds of meeting each other (Howlett et al., 2013; Johnson et al., 2002; Rumsey & Harcourt, 2005). We also have an innate drive to understand how and where we fit into the world, meaning that social comparison plays a pervasive role in our interactions (Festinger, 1954).

Women with anorexia nervosa (AN) are known to observe and assess body-related stimuli, paying attention to their own appearance and the bodies around them (Daly, 2016; Fairburn, 2008; Kaplan & Garfinkel, 1999; Lowell & Meader, 2005; Rance et al., 2014). Therefore, it is surprising that the client's experience of their therapist's body during AN treatment has largely been overlooked across the literature. To the best of my knowledge, the only other qualitative study that has investigated this topic was undertaken by Rance et al. (2014) in the United Kingdom. The lack of research is problematic given that Rance et al.'s (2014) findings highlighted that the perceptions, assumptions, and judgments of clients with AN and Bulimia Nervosa (BN) of their therapist's body influence their willingness to engage in treatment. This is concerning, given the significant treatment attrition and mortality rates for AN (DeJong et al., 2012; Arcelus et al., 2011).

My interest in this topic stemmed from my experience in the forensic setting, where clients sometimes doubted my skills and experience based on how "young" I looked. This, combined with my interest in the ED space, prompted the thought that if my appearance influences my clients' assumptions about my competence to provide support, and their willingness to engage in treatment, how would a therapist's body impact those with AN, where their body is likely to hold even more significance? The neglect of this seemingly important topic may be due to concerns about suggesting there is an ideal body type for therapists. This study does not intend to make any claims around an ideal body shape. Instead, the goal is to explore how clients with AN experience their therapist's body, with the hope that this will inspire further research to inform therapeutic practices that help foster treatment engagement. Therefore, the research question guiding this thesis is:

- How do female-identifying clients in New Zealand (NZ) experience and make sense of their female-identifying therapist's body during anorexia nervosa treatment?

1.2 Background

The following section will provide background information important for understanding AN and its treatment, as well as providing a rationale for the research topic. The diagnostic criteria, epidemiology, treatment and outcomes of AN in NZ will be outlined. This will be followed by the lived experience of AN and its treatment to provide a holistic understanding of AN that aligns with the lived experience focus of this research.

1.2.1 Diagnosis

Anorexia Nervosa (AN) is a complex, multifaceted eating disorder (ED), meaning that its diagnosis is often criticised for being oversimplified through its focus on BMI and a check-list of

symptoms in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) (American Psychiatric Association, 2022; Christian, 2024). Despite this criticism, the DSM-5-TR criteria have been presented here as it is the most recent version of the DSM-5 which is the leading scheme for classifying and diagnosing EDs in NZ (Brown et al., 2023).

According to the DSM-5-TR (American Psychiatric Association, 2022, p. 381–382), a diagnosis of AN can be made when an individual meets the following criteria:

- A) “Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of the age, sex, developmental trajectory, and physical health (less than minimally normal/expected)
- B) Intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain, even though at a significantly low weight
- C) Disturbed by one’s body weight or shape, self-worth influenced by body weight or shape, or persistent lack of recognition of the seriousness of low body weight.”

The DSM-5-TR shows there are two AN subtypes which need to be specified during diagnosis (American Psychiatric Association, 2022). This included the restricting subtype and the binge-eating/purging subtype. The restricting type is specified if, during the last three months, the individual has not engaged in recurrent episodes of binge eating or purging behaviour – e.g., self-induced vomiting, misuse of laxatives, diuretics, or enemas (American Psychiatric Association, 2022). The binge-eating/purging type is specified when the individual has, during the last three months, engaged in regular episodes of binge eating or purging behaviour.

Furthermore, the DSM-5-TR specifies whether the client's AN is in partial or full remission (American Psychiatric Association, 2022). Partial remission means that at one point in time, the full criteria were met, however, at the time of assessment, the criteria of low body weight has not been met for a sustained period, and at least one of the following two criteria have still been met: 1) Intense fear of gaining weight/becoming obese or 2) Behaviour that interferes with weight gain or disturbed by weight and shape. Full remission is specified when none of the criteria have been met for a sustained period of time (American Psychiatric Association, 2022).

BMI (body mass index; $BMI = \frac{\text{Weight (kg)}}{(\text{Height (m)})^2}$) is also used as the basis for specifying the level of severity of AN in adults. This is derived from the World Health Organisation's (2000) categories for thinness in adults. The criteria in the DSM-5 TR are Mild: $BMI \geq 17 \text{ kg/m}^2$; Moderate: $BMI 16-16.99 \text{ kg/m}^2$; Severe: $BMI 15-15.99 \text{ kg/m}^2$; Extreme: $BMI < 15 \text{ kg/m}^2$ (American Psychiatric Association, 2022).

There is often overlap between AN and other types of EDs, such as BN and binge eating disorder (BED). This is common, especially because AN frequently evolves into other EDs, such as BN and vice versa (Christian, 2024; Fairburn, 2008). Although these are all EDs, it is important to note that the major difference lies within the relative balance of undereating and overeating and its effect on body weight. In BN, the person's undereating and overeating tend to cancel each other out, meaning that their body weight is usually stable. In BED, bingeing tends to predominate, with the absence of compensatory behaviours, often leading to increased body weight. In AN, undereating predominates, with the possibility of no bingeing, resulting in significantly low body weight (Fairburn, 2008). AN is also highly comorbid with other mental distress. A comprehensive review by Treasure et al. (2020) found that over 50% of those with

AN meet the criteria for at least one additional DSM-5 disorder (commonly mood, anxiety, and impulse control disorders).

1.2.2 Epidemiology

Although outdated, NZs most recent mental health epidemiological survey (done in 2006) found that around 1% of people aged 16 and over have experienced either AN or BN in a 12-month period. This included a lifetime prevalence of 1.7% for the whole population and 3.1% for Māori (Oakley Browne et al., 2006). AN is also around three times more likely in women than men (National Eating Disorders Association, 2022; Sharan & Sundar, 2015). Although these numbers appear relatively low at first glance, they are likely an underestimate. This is because individuals under 16 years of age were not surveyed, which is often the age group where EDs emerge (commonly between 16 and 18) (Ministry of Health, 2024), and those with AN often only take part in treatment when those close to them seek help on their behalf (Kirby et al., 2016). These two factors mean that the true extent of the prevalence of AN is likely much higher than statistics suggest. This is further supported by the fact that international epidemiological data suggests that the global lifetime prevalence of EDs has increased by 25% over the last 10 years, which is likely to be comparable to New Zealand data (Ministry of Health, 2024). The increase in the prevalence of AN may be attributable to multiple factors, including the rise of social media, which perpetuates ‘thinness’ ideals (Cohen et al., 2017; Saiphoo & Vahedi, 2019), as well as the general increase in psychological distress due to factors such as the COVID-19 pandemic (Sideli et al., 2021).

With the exception of the opioid epidemic in the United States of America, AN has the highest mortality rate of any psychiatric disorder, with a 5% mortality rate (NIMH, 2016; American Psychiatric Association, 2022). The high mortality rate of AN is due to malnutrition,

complications from comorbid substance abuse, and/or suicide (American Psychiatric Association, 2022). Other non-lethal health impacts also include but are not limited to, hypokalaemia, hypomagnesaemia, osteoporosis, infertility, dysfunction in the endocrine system, cardiovascular abnormalities, oesophageal strictures and rupture, pancreatitis, perimyolysis, anaemia, leukopenia and ulcers (American Psychiatric Association, 2022). This highlights the severity of AN due to its high mortality rate and life-altering non-lethal impacts.

1.2.3 Treatment of Anorexia Nervosa

New Zealand (NZ) uses a hub and spoke model to deliver services to treat EDs. There are three specialist regional ED services based in Auckland, Wellington and Christchurch (the hubs), that the government funds to provide services, as well as training, supervision and support to local services in nearby district health board areas (the spokes) (Lawson & Dunnachie, 2017). New Zealand uses key treatment guidelines from the Royal Australian and NZ College of Psychiatrists (RANZCP) (Hay et al., 2014). These recommend a multidisciplinary approach which involves medical, psychological, and nutritional interventions. However, treatment is tailored to the individual's needs and may therefore differ from person to person. The multidisciplinary nature of AN treatment means many different practitioners are involved in a client's treatment journey (Hay et al., 2014). These practitioners may include but are not limited to doctors, psychiatrists, nurses, dieticians, psychotherapists, counsellors, group facilitators, and psychologists.

Initially, weight gain is the goal of treatment. This ensures medical stabilisation of the client and reduces the cognitive impairments that result from starvation, which may limit the effectiveness of psychological intervention (Hay et al., 2014). If the individual's weight is determined to be critically low, putting them at medical risk, or there is a lack of responsiveness

to outpatient treatment, this may take place in hospital (Hay et al., 2014; National Institute for Health and Care Excellence, 2017). However, outpatient/day treatment is recommended where possible, as it is the least restrictive environment.

Once medically stable, National Institute for Health and Care Excellence (2017) guidelines for adults recommend either eating disorder-focused cognitive behavioural therapy (CBT-E), Maudsley Anorexia Nervosa Treatment for Adults (MANTRA), or specialist supportive clinical management (SSCM). The American Psychiatric Association (2022) also recommends CBT-E, interpersonal psychotherapy (IPT) or psychodynamic therapy.

1.2.4 The Therapeutic Alliance

The therapeutic alliance is a measure of the mutual engagement between clients and therapists, meaning it is a critical component of treatment success regardless of the type of treatment chosen (Horvath & Symonds, 1991). There is some debate about the definition of the therapeutic alliance. However, Bordin's (1979) model is commonly used. This model proposes that the therapeutic alliance has three elements: (1) the client-therapist bond, which includes trust, rapport, and emotional connection; (2) goals, having the shared understanding of therapy objectives; and (3) tasks which include the agreed-upon methods and interventions used to achieve these goals (Bordin, 1979).

The therapeutic alliance is one of the strongest predictors of treatment success (Stargell, 2017; Werz et al., 2022). Notably, a meta-analysis found that the association between therapeutic alliance and treatment outcomes was weaker in adults with EDs compared to clients with other diagnoses (Flückiger et al., 2018). This was cited as being due to the ambivalence towards recovery experienced by those with EDs. However, this finding was challenged by Werz et al.

(2022) study, which found that the therapeutic alliance was an even stronger predictor of treatment outcomes for those with AN in comparison to other diagnoses. This makes sense, as a strong therapeutic alliance is needed to combat the ambivalence clients may experience. The qualitative literature supports Werz et al. (2022) findings, particularly those that centre on the client's perspective. Watterson's (2020) qualitative study (N=18) in NZ found that participants emphasised the need to feel safe to be open and honest without fear of judgment or rejection during ED treatment. Many clients also expressed concern about the emotional impact of their disclosures on their therapist. The participants also shared that, at times, this led to withholding details about their distress to avoid a negative impact on their therapist (Watterson, 2020).

1.2.5 Treatment outcomes

The following section aims to indicate the general treatment outcomes that can be expected at present. This section does not present a comprehensive picture of recovery, nor does it cover all the complexities around recovery from all stakeholders. Determining outcome rates for AN treatment is difficult because there is no clear definition of recovery (Bardone-Cone et al., 2018; Murray, 2020). Previous studies have determined ED recovery to include weight restoration, no longer binge eating and purging, changes in preoccupation with food and reductions in negative body image but the clients' views on recovery are often missing from these definitions (Murray, 2020). Clients with EDs consider recovery to be ongoing, meaning that they see themselves as being in the 'process' of recovery (Federici & Kaplan, 2008) rather than ever being considered 'fully recovered' (Darcy et al., 2010).

Regardless of whether recovery is ongoing or something that can be achieved, treatment outcomes for AN are widely regarded as unsatisfactory, and there remains uncertainty about the most effective course of treatment (Abbate-Daga et al., 2016; Treasure et al., 2020). A recent 30-

year outcome study found that less than two-thirds of participants had been symptom-free for at least six months at follow-up (Dobrescu et al., 2020). Although this may not present a comprehensive picture of recovery after treatment, and no data is available for the NZ context specifically, it does indicate the general treatment outcomes that can be expected.

Different treatment modalities have varying degrees of efficacy. Cognitive Behavioural Therapy-Enhanced (CBT-E) and Interpersonal Psychotherapy (IPT) are among the most supported approaches for adults with AN, with recovery rates estimated to be approximately 30% which, while relatively low, surpass those of other psychological interventions (Miniati et al., 2018). On the other hand, family-based interventions demonstrate the highest efficacy for adolescents with AN (Waller, 2016). One of the issues that likely contributes to poor treatment outcomes is the high rate of clients who drop out of treatment prematurely. It has been estimated that between 20 to 40% of outpatients with AN drop out from treatment, depending on the type of treatment (DeJong et al., 2012). These high dropout rates are likely influenced by clients' ambivalence toward recovery associated with the fear of weight gain (Rance et al., 2014; Williams & Reid, 2010).

1.2.6 Lived Experience of Anorexia Nervosa and Treatment

This thesis is focused on the client's perspective on treatment in relation to how they made sense of the therapist's body. Therefore, to align with this approach, it was deemed important to briefly outline the day-to-day experience of AN and its treatment from the client's perspective. This additional context also gives the reader a more holistic understanding of AN, extending beyond the symptoms presented in the DSM-5-TR. Rance et al. (2017) conducted a thematic analysis study, looking at the day-to-day experience of AN and Treatment in the United Kingdom with 12 women aged 18-50. The participants were asked about the history of their ED,

their understanding of its causes, and their experiences of seeking help and treatment. The findings highlighted that the participants' lives were shaped by a relentless cycle of isolation, shame, and occasional feelings of salvation. The women described a sense of loneliness due to the belief that they were fundamentally different from others and that others in society did not understand them. This isolation was further exacerbated by the 'secrets, lies, and manipulation' they used to sustain their AN. Shame was another powerful emotion that the participants experienced. They felt overwhelming self-hatred and inadequacy due to their struggle with eating.

Rance et al. (2017) noted that the participants' experience of AN was not solely characterised by suffering. Their experience included moments of 'salvation' or positive emotions, creating a cycle providing insight into the strong ambivalence towards engaging in treatment. For example, the participants described a 'high' associated with the attention they received from others for achieving the thinness ideal or for being hospitalised. The women also spoke about moving 'in' and 'out' of their disorder. When 'in' their AN, their thoughts and actions were dictated by it; however, there were moments when they were 'out', during which they could recognise how distorted their thoughts had become and could step outside the disorder to reflect upon it (Rance et al., 2017).

This research into the client's experience of AN and treatment provides insight into the strong sense of ambivalence to recovery that appears inherent to this distress. This ambivalence provides justification for investigating any factors that impact treatment engagement, including the therapist's body, which is the purpose of the current research. This is important as during these windows of engagement; it is important to provide a treatment environment that encourages this engagement and reduces any factors that reduce this, given that it already

appears inconsistent. This insight also demonstrates the importance of qualitative research, which provides insight into the real-life sense-making of clients during treatment.

1.2.7 Chapter Summary and Rationale

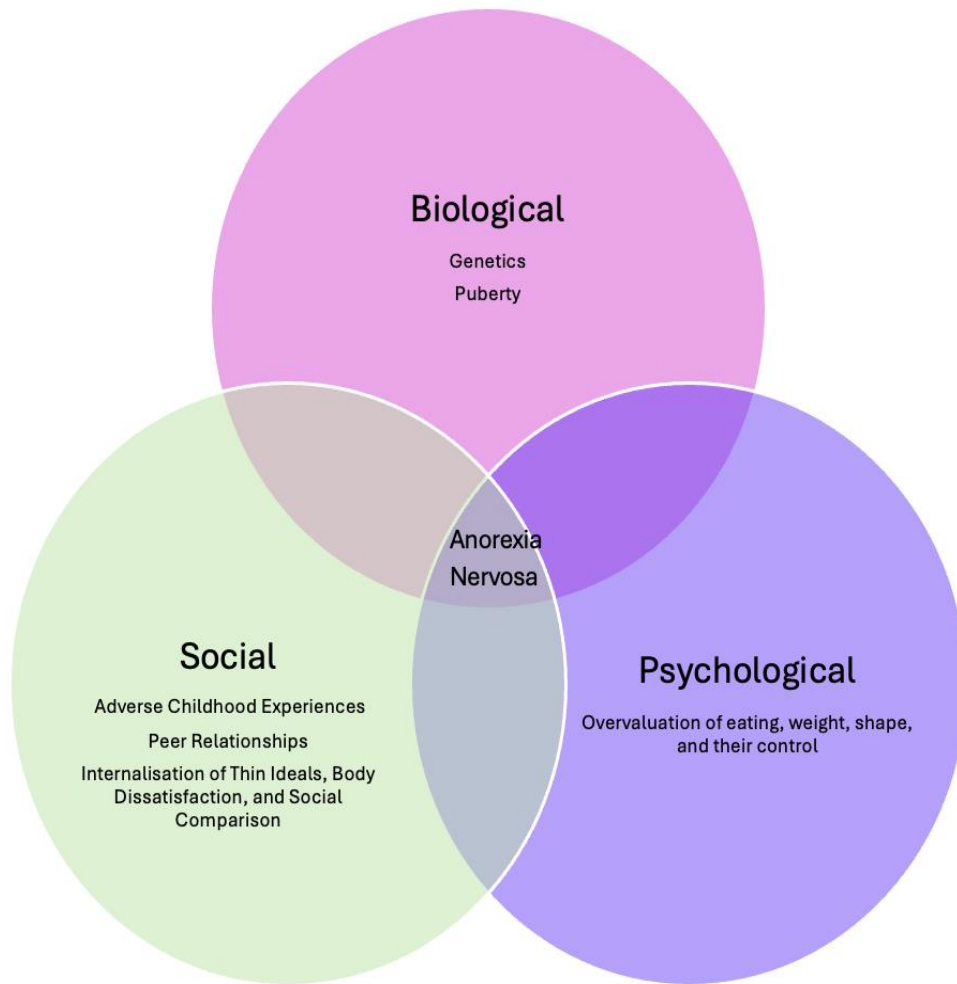
Anorexia nervosa is a complex and potentially fatal eating disorder that has significant health consequences. Although its lifetime prevalence in NZ is relatively low, it disproportionately impacts Māori and the true extent of the disorder is likely underestimated, making it an important topic to be investigated in NZ. Furthermore, the prevalence of AN appears to be rising, making it an increasingly relevant area of distress to study, particularly among women, who are most commonly affected by this disorder. Current treatment outcomes for AN remain unsatisfactory, with high rates of treatment dropout, partially due to the ambivalence to recovery that becomes clear from accounts of their lived experience. Given the lethal nature of this distress, it is crucial to investigate the factors that may influence treatment engagement for women with AN, which may include the client's experience of their therapist's body. There is a surprising lack of research focused specifically on this aspect of the treatment experience. This may be because concerns with body weight and shape are so taken for granted that researchers have not thought to ask about this specifically. The rationale for this research stems from gaps in the research and a desire to give people with AN the chance to tell their story.

CHAPTER TWO: Aetiology and Maintenance of Anorexia Nervosa

Recent consensus suggests that the biopsychosocial model provides the most comprehensive framework for understanding the aetiology and maintenance of AN, with a focus on adult women, who are the participants in the current study (Figure 1). This model highlights the complex interplay between genetic, environmental, and psychological factors (Le Grange, 2016). It is, therefore, important to note that while this chapter is organised into the three domains, they are not discrete but interdependent and interactive in nature. This thesis proposes that elements of AN aetiology and maintenance may be important to consider in terms of the client's perceptions of, and responses to, their therapist's body. Fairburn's (2008) Transdiagnostic Model and social comparison will be explored in the most detail due to their potential relevance to the client's experience of their therapist's body. Other aetiological factors are introduced in this chapter for completeness but are kept brief to acknowledge their importance and intersections, but they are not as relevant to this research.

Figure 1

Biopsychosocial Model of Anorexia Nervosa



Note. This figure was created by the author to illustrate the biopsychosocial factors contributing to the maintenance and development of anorexia nervosa.

2.1 Biological Factors

The two main biological factors contributing to AN are genetics and puberty. Family and twin studies have found evidence that genetics contribute to the development of AN. Watson et al. (2019) conducted a landmark study with over 16,992 participants diagnosed with AN and 55,525 controls, which identified eight genetic loci associated with the disorder. Puberty has also been indicated as a biological risk factor. During puberty, an increase in adipose tissue in females can increase body dissatisfaction, especially in early menarche, when development leads to a different body shape from peers (Gulliksen et al., 2017).

2.2 Psychological Factors

The main psychological factors are overvaluation of eating, weight, shape and their control (Karlsson et al., 2021). One model that captures this and is the basis for an ED intervention is Fairburn's Transdiagnostic Model (2003).

Fairburn's Transdiagnostic Model

Fairburn et al.'s (2003) Transdiagnostic Model of EDs is the theory on which CBT-E intervention is based. This model argues that EDs have the same core psychopathology. This core psychopathology involves judging self-worth almost exclusively based on weight, shape, eating habits, and the ability to control those three factors, which is called overvaluation. As a result, dietary control, thinness, and weight loss are actively pursued, whilst overeating and weight gain are avoided. From this core psychopathology stems associated behaviours that serve to maintain the core psychopathology of EDs. These behaviours include strict dieting and other weight-control behaviours, binge eating, and compensatory vomiting/laxative misuse. Fairburn et

al. (2003) also proposed that individuals with an eating disorder may have one or more of the four additional maintenance processes, including clinical perfectionism, core low self-esteem, mood intolerance, and interpersonal difficulties. NICE (2017) recommends CBT-E as one of the most efficacious ED treatment models (Fairburn et al., 2015).

Curzio et al. (2018) also found that perfectionism, low self-esteem, and mood intolerance were associated with eating disorder symptoms across eating disorder diagnoses, lending support to the validity of this model. Women with AN are known to observe and assess body-related stimuli, paying significant attention to their appearance, as well as the bodies of those around them (Daly, 2016; Fairburn, 2008; Kaplan & Garfinkel, 1999; Lowell & Meader, 2005; Rance et al., 2014). This makes the central nature of this core psychopathology relevant to the present research as it raises questions about whether this attention to the appearance of others means that these clients may extend this assessment of innate worth based on their body and their ability to control this to their therapist.

2.3 Social Factors

The social factors that have been identified as contributing to the development and maintenance of AN are adverse childhood experiences, poor peer relationships and internalisation of body ideals (Fergusson et al., 2014; Kovács-Tóth et al., 2022; Waller & Mountford, 2015)

2.3.1 Adverse Childhood Experiences

Adverse childhood experiences (ACEs) increase the risk of developing AN. These are traumatic events that occur before the age of 18, such as emotional abuse, physical abuse, family dysfunction, and sexual abuse (Kovács-Tóth et al., 2022). Kovács-Tóth et al. (2022) found that

adolescents who had undergone four or more ACEs were 5.7 times more likely to develop an ED compared to those who did not report any ACEs. Emotion dysregulation caused by ACEs may mediate the relationship between the development of AN and ACEs, as AN can serve as a coping mechanism to manage distress (Moulton et al., 2015; Racine & Wildes, 2015).

2.3.2 Peer Relationships

Quantitative studies highlight that peer competition has been associated with body dissatisfaction in adolescent girls, a factor strongly associated with the development of AN (Ferguson et al., 2014; Waller & Mountford, 2015). Through direct interviews, participants with AN also attributed poor relationships and bullying, particularly aimed at body weight and appearance from peers, as causal factors for the development of their AN (Hubert Lacey et al., 1986; Nilsson et al., 2007).

2.3.3 Internalisation of Thin Ideals, Body Dissatisfaction, and Social Comparison

Body dissatisfaction is one of the most well-established risk factors for the development of AN (Waller & Mountford, 2015). Body dissatisfaction is defined as the discrepancy between an individual's "ideal" body and their "actual" body (Cash & Szymanski, 1995). According to cognitive-behavioural models, body dissatisfaction fuels maladaptive cognitions such as, "If I am not thin, then I am worthless", which may lead to disordered behaviours, including dieting and compensatory behaviours associated with AN (Vitousek & Hollon, 1990).

According to the sociocultural model of eating pathology, the perception of an "ideal" body is shaped by cultural standards (Brytek-Matera & Czepczor, 2017). This ideal is a thin body in Western societies, associated with social rewards such as acceptance and happiness

(Cash, 1990; Stice, 1994). This message is perpetuated and strengthened by women's fashion magazines, social media, and television, which promote unattainable beauty standards through images of digitally altered women who are often young, tall, and extremely thin (Aparicio-Martinez et al., 2019; Grabe et al., 2008; Tiggemann, 2011).

The link between the internalisation of thinness ideals and body dissatisfaction has mostly been demonstrated through traditional and social media literature, showing that exposure to images of thin bodies leads to the internalisation of thin ideals, resulting in body dissatisfaction. This has been demonstrated through correlational (Grabe et al., 2008; Levine & Murnen, 2009) and experimental research (Groesz et al., 2002; Want, 2009). Furthermore, media literacy programs that educate women about image retouching have been found to reduce body dissatisfaction by reducing the internalisation of the thin ideal, further supporting the link between social media exposure and body dissatisfaction due to the internalisation of this unrealistic thinness ideal (Wilksch & Wade, 2009; Wilksch et al., 2015).

Social comparison has consistently been identified as a mediator between exposure to thin-ideal imagery in traditional or social media and body dissatisfaction (Holland & Tiggemann, 2016). Social comparison theory posits that individuals evaluate their self-worth by comparing themselves to others, particularly in the absence of objective benchmarks (Festinger, 1954). This theory has since been expanded to include comparisons of physical appearances, which are strongly influenced by Western beauty ideals in the case of AN (Homan & Lemmon, 2014; O'Brien et al., 2009). Two primary types of social comparison exist: upward and downward. Upward comparison occurs when individuals compare themselves to those perceived as superior, such as women comparing themselves to thinner individuals. Downward comparison involves

evaluating oneself against individuals perceived as inferior, such as those with larger bodies (Festinger, 1954).

Several studies have demonstrated that frequent upward body comparisons, particularly via social media, are associated with heightened body dissatisfaction and eating disturbance (Corning et al., 2006; Dittmar & Howard, 2004; Tiggemann et al., 2009). These comparisons are also linked to lower self-esteem (Bailey & Ricciardelli, 2010; Duchesne et al., 2017) and negative emotional outcomes, including depression, stress, guilt, and reduced happiness (Fardouly et al., 2017; So & Kwon, 2023; Stice & Shaw, 1994).

As highlighted throughout this section, most literature looks at the link between social comparisons, thinness ideals, and body dissatisfaction within traditional media and social media rather than in-person comparisons. This is surprising, given that social comparison theory suggests that individuals are more likely to compare themselves to similar rather than dissimilar others (Heinberg & Thompson, 1995). This suggests that women may be more likely to compare themselves to other women in their immediate environment, including their therapist, during treatment rather than to social media figures who may be perceived as unattainable (Fardouly et al., 2017). The focus on media comparisons within the literature may be due to the rapid evolution of digital platforms and their measurable impact on body dissatisfaction, making this a relatively new area of interest for researchers (Fardouly et al., 2017).

Fardouly et al. (2017) conducted one of the few studies directly exploring body-related social comparison with social media, traditional media, and, importantly, in women's everyday interactions. Fardouly et al. (2017) investigated the frequency and impact of appearance comparisons among 160 female first-year psychology students in Australia. The study showed that upward comparisons were more common than downward comparisons across all contexts.

Notably, upward comparisons on social media were linked to greater body dissatisfaction than in-person comparisons, likely due to the more considerable perceived discrepancy between one's appearance and idealised social media images. These findings align with previous research demonstrating the negative impact of social media comparisons on mood and self-perception (Fardouly et al., 2015; Kramer et al., 2014; Sagioglou & Greitemeyer, 2014). However, Fardouly et al. (2017) found that in-person comparisons are the most common. This is particularly relevant to the therapeutic setting, where another woman's body (the therapist) is salient within the client's experience, as frequent body comparisons may occur. Although these comparisons may have less impact on body dissatisfaction than social media comparisons, the effect is still present and may significantly impact their experience.

Interestingly, while body-related social comparisons are widely recognised as a mediating factor between the internalisation of thinness ideals and body dissatisfaction, which is a risk for AN development, little research has examined the experience of social comparison in those who already have AN, which is the focus of the present study. This gap is significant because, from the little research that has been done, it is clear that individuals with EDs engage in more frequent and intense body-related social comparisons in their daily lives than their asymptomatic peers (Corning et al., 2006; Hamel et al., 2012; Keinanen, 2024). Furthermore, the body-related social comparisons that those with EDs engage in resulted in more self-defeating self-appraisals as a result of this comparison than those without EDs. This shows the significant impact that the body-related social comparisons had on their body dissatisfaction in comparison to those without an ED.

Investigating this within a New Zealand context is also important, given that New Zealand is a multicultural society that includes the indigenous Māori population (Mika et al.,

2022). Traditionally, Māori have valued larger body sizes due to their associations with beauty, social standing, health, and wealth (Brewis & McGarvey, 2000; Haua & Enari, 2023). However, despite these traditional values, research has indicated that Māori have a higher lifetime prevalence of AN (3.1%) compared to the general New Zealand population (1.7%) (Oakley Browne et al., 2006). This paradox suggests that the increasing influence of thinness ideals, driven by globalisation and the rise of social media, may contribute to body dissatisfaction among Māori (Murray & Price, 2011; Swami, 2015). This makes it interesting how body comparisons within the therapeutic context may differ across cultures, as the body ideals held may differ.

2.4 Chapter Summary and Rationale

Looking at the aetiology and maintenance of AN, it becomes clear that those with AN are likely to be hyper-aware of their therapist's appearance. Women with AN are known to observe and assess body-related stimuli, paying significant attention to their appearance, as well as the bodies of those around them (Daly, 2016; Fairburn, 2008; Kaplan & Garfinkel, 1999; Lowell & Meader, 2005; Rance et al., 2014). This makes the central nature of Fairburn's (2003) core psychopathology relevant to the present research as it raises questions about whether this attention to the appearance of others means that these clients may extend this assessment of innate worth based on their body and their ability to control this to their therapist.

Furthermore, from the little research that has been done, individuals with eating disorders engage in more frequent and intense upward body-related social comparisons in their daily lives than their asymptomatic peers (Corning et al., 2006; Hamel et al., 2012; Keinanen, 2024). The body-related social comparisons that those with eating disorders engage in also result in more self-defeating self-appraisals as a result of this comparison than those without eating disorders.

The frequency and intensity of these in-person social comparisons for those with AN highlight that this may be relevant to their in-person treatment, where the therapist's body is salient to their experience. Lastly, the thinness ideal that underpins the social comparisons that occur for those with AN differs across cultures. Therefore, it is imperative to investigate this in New Zealand as all previous research has only been done on those with the Western thinness ideal.

CHAPTER THREE: The Importance of The Therapist's Body During Anorexia Nervosa Treatment

This chapter will outline the existing literature on the importance of the therapist's body during AN treatment. To start with, a review of the existing literature on the importance of appearance in treatment, in general, will be outlined to showcase the natural inclination we, as humans, have towards using visual-based information, such as the appearance of our therapists, to form assumptions and make judgements. This chapter will then move on to outline the literature showcasing the importance of the therapist's body to the experience of those with EDs, in particular during treatment. This literature review presents the relevant literature for those with EDs in general, rather than AN in particular, as the literature within this area is sparse, and there is no literature investigating this in AN only. This section of the literature review will first present the therapist's perspective, as opinion pieces and therapist observations make up the majority of this research, followed by the only two pieces of literature that examine the ED client's perspective of their therapist's body during treatment, with only one of those using a qualitative approach. To end, this chapter will summarise the relevant information from all the chapters so far, highlighting the gap in the literature that this thesis intends to address and the research question that will guide the present research.

3.1 The Importance of Physical Appearance for All Clients

Bodily appearance can indicate physical appearance (i.e., body size, shape, weight or dress), as well as comfort in one's body (i.e., calm or anxious), and both are equally important in clinical settings, especially around disclosures (Daly, 2014). Research consistently demonstrates that physical appearance shapes our perceptions of others. Appearance researchers argue that the

physical characteristics we first encounter when we see another person, such as body size and shape, hair colour, and attire, serve as powerful cues for inferences, assumptions, and judgments which are formed in less than thirty-nine milliseconds (Johnson et al., 2002; Howlett et al., 2013; Rumsey & Harcourt, 2005). Evidence from a wide range of treatment settings supports this view. Lovell et al. (2013) found that sports dietitians who were perceived as obese by their clients were assumed to be less knowledgeable about sport and nutrition and, therefore, less competent to provide advice in comparison to their non-obese counterparts. Similarly, within medical settings, patients were found to associate formal attire with clinical competence, professional expertise, and a caring attitude (Menahem & Shvartzman, 1998; Nihalani et al., 2006; Wittman-Price et al., 2012). These findings suggest that physical appearance, whether consciously acknowledged or not, informs perceptions of the professional credibility and trustworthiness of helping professionals.

Within psychology and counselling contexts, the importance of appearance in shaping the client's perception of the therapist is equally evident. Therapists often become key figures for their clients, who scrutinise their physical appearance for signs of safety, containment, and trustworthiness (Kahn, 2010; Kohut, 1977; Wallins, 2007). For example, quantitative studies in counselling psychology suggest that clients' perceptions of a therapist's effectiveness, competence, and trustworthiness are partially based on the therapist's physical attractiveness (Kunin & Rodin, 1982; Zlotlow & Allen, 1981). This aligns with broader psychological research demonstrating the 'halo effect', wherein individuals perceived as physically attractive are also assumed to possess other positive traits, such as intelligence, warmth, and competence (Dion et al., 1972). While these quantitative studies offer breadth, they often fail to capture the nuanced ways appearance influences therapeutic relationships.

King's (2018) qualitative study addresses this gap by revealing that in the absence of personal information about therapists, clients actively scrutinise their therapist's appearance for evidence of safety and professionalism. Many participants described forming assumptions about their therapist's competence based on physical presentation. For instance, a therapist who dressed professionally and maintained a well-groomed appearance was often perceived as more trustworthy and competent. Conversely, therapists who appeared unkempt or dressed too casually were sometimes viewed as less capable or invested in their role. Furthermore, for many participants, these judgments were not entirely conscious; they often struggled to articulate what they noticed about their therapist's appearance, only later realising how attributes such as attire, age, gender, and attractiveness shaped their feelings of trust in their therapist. One participant described feeling suspicious upon meeting a therapist whom she did not trust. It was only later, when reflecting on that experience that she realised that due to the therapist's age and male gender, this therapist evoked memories of her father, highlighting how prior relational experiences influenced her responses to the therapist's body.

King's (2018) research underscores the importance of acknowledging how implicit biases and unconscious associations shape the therapeutic encounter. Findings from these fields also suggest that these negative initial judgments based on the therapist's appearance impact the development of a collaborative relationship and the willingness of the individual to engage in treatment (Lovell et al., 2011; Lubker et al., 2005; Rance et al., 2014; Wittman-Price et al., 2012).

Another concept relevant to this topic, and particularly to the unconscious associations and implicit biases previously described, is transference (Freud, 1912). Transference is one of the cornerstones of psychodynamic theory, one of the many disciplines prevalent within the psychological space. Traditionally, transference refers to projecting or redirecting internalised,

unconscious relational patterns onto a therapist, who is regarded as a blank screen (Freud, 1912; Gelso & Hayes, 2007). Transference can influence the therapeutic relationship in both positive and negative ways. Positive transference might involve feelings of love, trust, and admiration, whereas negative transference can be expressed through emotions such as hatred, anger, hostility, mistrust, disgust, and resentment (Gelso & Hayes, 2007). By bringing unconscious emotions and conflicts into the therapeutic space, transference offers a valuable window into the client's internal world, where these insights can be analysed and worked through (Plotnikova, 2024).

There is also an increasing amount of research focusing on mechanisms and factors that contribute to therapeutic success (e.g. Alva et al., 2024). Much of this focuses on all the factors or success in relation to one particular treatment modality with very little specifically on how the body of the therapist is influencing the process. Importantly, the therapist is no longer viewed as a neutral entity but as someone actively involved in the therapeutic encounter (Alexander, 1954; Erb, 2020; Orchbac, 2004). This means that the therapist's physical presence, including their body, face, voice, age, and other non-verbal factors are not thought to evoke deep-seated bodily memories, unconscious associations, and feelings from the client's past experiences and relationships, which are projected onto the therapist (Alexander, 1954; Erb, 2020; Orchbac, 2004).

Collectively, this body of research underscores the argument that the therapist's appearance is not a neutral or inconsequential factor. Rather, it actively shapes clients' perceptions, judgments, and assumptions of their therapist's competence and trustworthiness, consciously and unconsciously. Despite recognising the importance of the therapist's appearance in the client's experience of their therapist, this is often overlooked in contemporary research. Erb (2020) noted that focusing on bodily appearance is sometimes dismissed as it is considered

superficial in a profession that traditionally emphasises internal mental processes, meaning that contemporary research has shifted away from this focus. Moreover, transference is a psychodynamic concept, meaning that not all therapists are equally aware of or utilise it to interpret therapeutic experiences, contributing further to its limited presence in the literature.

3.2 The Importance of the Therapist’s Body for Clients with Eating Disorders

In the context of eating disorders, a therapist's appearance, specifically their body, may hold increased significance for clients during treatment. Evidence supports this notion, as individuals with AN tend to observe and assess body-related stimuli closely. They pay significant attention to their appearance and the bodies of those around them (Daly, 2016; Fairburn, 2008; Kaplan & Garfinkel, 1999; Lowell & Meader, 2005; Rance et al., 2014). Additionally, clients with eating disorders often engage in frequent in-person social comparisons and overvalue appearance, making them particularly aware of their therapist's body (Warren et al., 2009).

Despite this, the existing lived experience literature on AN treatment does not mention the importance of the therapist's body in shaping clients' experiences (Rance et al., 2017). If it is an important element of the client's experience, one possible explanation is that clients may fear offending others or consider the topic “off limits”. Discussing another's body may be a particularly sensitive issue for many with EDs, as bullying, primarily related to body weight and appearance, has been established as a causal factor for the development of EDs, which may make these individuals reluctant to comment on a therapist's body for fear of replicating that harm (Hubert Lacey et al., 1986; Nilsson et al., 2007).

Moreover, research has increasingly shifted away from appearance-based topics, which are sometimes perceived as "superficial" (Erb, 2020). As a result, lived experience research has not included questions about the therapist's body. For example, Rance et al. (2017) focused on participants' histories of their eating disorders, their understanding of their causes, and their experiences in seeking treatment, steering discussions away from topics related to the therapist's body. There may also be concern that discussing a therapist's body might inadvertently prescribe an "ideal" body type for therapists, an outcome that is not intended in the current research. Instead, the goal is to explore how clients with AN experience their therapist's body, with the hope that this will inspire further research that may inform therapeutic practices that create supportive environments for change, where open dialogue can occur, irrespective of therapists' physical appearances. Consequently, such insights may only emerge when the topic is directly addressed, which is the aim of this study.

From the limited available literature on the importance of the therapist's body to ED treatment, the following section will first highlight the therapist's experience of this issue, followed by the limited research on clients' perceptions of their therapist's body.

3.2.1 The Therapist's Perspective

The earliest studies investigating the relevance of the therapist's body to clients with EDs were from the therapist's perspective. This meant that the significance of the therapist's body to clients was understood only through the therapist's lens. Nevertheless, these accounts suggested that the therapist's body was indeed relevant to clients with eating disorders, according to therapists. For example, 83% of practitioners reported feeling that their appearance was monitored, examined, or evaluated by their clients, and approximately 25% shared instances where clients had directly commented on their physical appearance (Warren et al., 2009). Furthermore, self-identified "thin" therapists reported receiving compliments on their "culturally

admired" bodies but also described being subjected to feelings of envy, anger, and hatred from clients. These experiences often left therapists feeling vulnerable and wishing they looked different (Lowell & Meader, 2005). Therapists speculated that, in some cases, compliments were genuine attempts to strengthen the therapeutic relationship. Conversely, critical comments were interpreted as efforts by clients to challenge the power dynamic that typically exists between practitioners and clients (Warren et al., 2009). It was concluded that patients' observational activities might lead them to make 'therapy interfering judgments'; for example, a client may see an 'overweight' therapist as incompetent, and that it may distract them from what the therapist is saying as it is at the forefront of their experience, making engagement in treatment difficult.

Similarly, Surtees (2009) wrote about her experiences of 'slimness' as a nurse in an inpatient ED unit. She highlighted her belief that "the presence of thin bodies is always... troublesome in.. [an] ED unit because an objective, inner truth is not visible; hence both eating – and/or not eating – can act as signs of an eating disorder" (Surtees, 2009, p. 162). This highlights that her clients would assume that she had an eating disorder, regardless of her actual eating behaviours, due to her thin body. When served a "markedly smaller" portion by the hospital kitchen during a supported meal she was eating with the women from the unit, Surtees (2009) described how the women had been: "Catching each other's eyes, directing their gazes on my plate, and then returning the gaze meaningfully towards each other" (Surtees, 2009, p. 163-164).

Kenyon (2017) explored how therapists construct their own bodies when working in ED spaces. Kenyon (2017) found that there were four key areas that the therapists identified. Firstly, that the bodies in the room impact each other (impacting on and being impacted by). Secondly, the therapists did feel seen and watched. Thirdly, there was tension coming from talking about and not talking about bodies in the sessions. Fourthly, the therapists struggled with two dominant frames of reference - the healthy professional and the pathologised other. Thus, overall the

research does suggest that from the therapist's perspective, clients observe and evaluate their therapists' bodies. While these studies confirm the prevalence of such interactions in therapeutic settings, they remain speculative regarding the emotions, functions, and consequences underlying clients' attention towards their therapist's body.

3.2.2 The Client's Experience

To date, only two studies have directly explored the client's experience of their female therapist's body in ED treatment. Vocks et al. (2007) conducted the first of these two studies, adopting a quantitative approach to investigate the relevance and preference of female therapist's bodies to female clients with EDs. Thirty-four women receiving outpatient treatment for AN, binge eating disorder, and ED not otherwise specified at Ruhr-University Bochum and Johannes-Gutenberg-University therapy centres, along with a control group of 30 women with anxiety disorders, were asked: "If you imagine the ideal female therapist for the treatment, which figure would she have?". Participants then used the Contour Drawing Rating Scale (CDRS; Thompson & Gray, 1995), which comprised nine female silhouettes of increasing size, to indicate their preference. Participants also rated the importance of the therapist's figure using a 5-point Likert scale (1 = not at all important, 5 = very important). The findings of this study were that all participants preferred female therapists with an 'average' body, corresponding to the middle silhouette. However, clients with an ED indicated that their therapist's body was more important to them in comparison to those in the control group. This was the first study to show that the female therapist's body seems to be more relevant to clients with EDs when compared to a control group of participants without an eating disorder. The study's systematic use of the CDRS and Likert scales is a notable strength, offering a standardised method of assessing participants' preferences for their therapist's figure (Thompson & Gray, 1995). However, the CDRS represents body shape in a simplified manner, potentially failing to capture the complexity of the

client's preferences for their therapist's body. A more nuanced approach, such as a qualitative methodology, could provide greater scope for clients to indicate what a "preferred" body for their therapist looks like. This approach can also provide insight into the participant's rationale for their body preferences, as well as why their therapist's body is important to them. Furthermore, although the authors highlighted that all 34 women were receiving outpatient treatment for their EDs at the time this study was conducted, there was no indication as to their specific stage of recovery. Even though recovery is an ill-defined term, it can be useful to know whether the participants were severely impacted by their ED at the time, or if they were transitioning out of the service because they were further along in recovery (Bardone-Cone et al., 2018; Murray, 2020). This is important because the severity of the individual's ED may impact their thinking and, therefore, their preferences for body shape and how important their therapist's body is to them.

Partially addressing this gap in the research, Rance et al. (2014) conducted a qualitative study that closely resembles the research proposed in this thesis. To the best of my knowledge, it is the only study that explores ED client's experience of their therapist's body. Rance et al. (2014) conducted a semi-structured interview with eleven European female participants from the United Kingdom, diagnosed with AN or BN and had a history of restrictive eating behaviours. All participants had experience working with a female therapist, and the interview questions focused on their perceptions of their therapist's body size and relationship with food. Rance et al. (2014) conducted a thematic analysis on the interviews and found that the women not only observed, speculated, and made assumptions about their therapist's body but that these perceptions influenced their beliefs about the therapist's ability to help them, as well as their willingness to engage in therapy. The three interrelated themes that emerged from the analysis were 'Wearing

Eating Disorder Glasses’, ‘You're Making All Sorts of Assumptions as a Client’, and ‘Appearance Matters’, with each theme influencing the next.

The theme “Wearing Eating Disorder Glasses” captured the participants' predisposition to observe body and food-related stimuli. The sub-themes included the participant’s automatic and highly attuned observations of their therapist's body and eating habits, a tendency towards comparing their bodies to their therapist’s body, and an awareness of the skewed nature of their observations in hindsight (Rance et al., 2014).

The first subtheme captured how each of the women appeared highly attuned to body and food-related visual stimuli. The women also spoke about how specific body parts of their therapist’s stuck out to them, and that they each had different, personal reactions to these parts. For example, one participant noticed her therapist’s rounded stomach, which she found reassuring, and another spoke about distaste for “wobbly bits” in both therapist’s and women in general (Rance et al., 2014). Rance et al. (2014) also highlighted another subtheme, which captured how the women frequently made comparisons between what they saw during these highly attuned and automatic observations and themselves. This comparison also took place for food-related stimuli, with one participant highlighting that she was deeply upset at having to eat more than her therapist who was on a weight loss diet (Rance et al., 2014). As part of the “Wearing Eating Disorder Glasses” theme, Rance et al. (2014) also described how the women were aware of the skewed nature of the observations they made related to body size. For example, one participant shared that even though during treatment she felt her therapist was thinner than her, in reality, she was probably thinner than her therapist (Rance et al., 2014).

The second theme, “You’re Making All Sorts of Assumptions as a Client”, highlights the participant’s tendency to make assumptions about the observations they made in the previous theme (Rance et al., 2014). As part of this theme, Rance et al. (2014) highlighted that the women

made assumptions about therapists' bodies by drawing upon their understandings of the meanings and causes of both 'fatness' and 'thinness'. Therapists who were perceived to be 'fat' were assumed to eat too much - to have "lost control". Implicit in their narratives was the idea that being 'fat' was an unnatural, intolerable state that should be remedied. In contrast, 'thinness' was perceived by the participants as a universally desirable state. The women saw 'thinness' as either caused by a "natural" or "biological" state or as something that could be achieved by "forcing" or "maintaining" your body through diet (Rance et al., 2014).

Another sub theme within "You're Making All Sorts of Assumptions as a Client" included that the women seemed to use a therapist's size and character to make deductions about her diet and relationship with food. For example, some participants shared that her reserved therapist would have that same relationship with food - strict and unwavering. Some participants also seemed to project the type of relationship they had with food onto their therapist. For example, one participant's reference to her dietician looking like she would not allow her body "to gain an ounce of fat" was said with a disgust which mirrored the contempt that was evident when she spoke about gaining weight herself (Rance et al., 2014). An additional sub theme included that the women's perceptions of their therapist's size, ED history and body confidence either fostered or diminished their belief in the therapist's ability to help and understand them. Although none of the women had actually worked with a therapist they considered to be 'fat', they felt that if they did, they would doubt her ability to understand them. The women did not tend to link a therapist being 'thin' with an inability to understand or empathise (Rance et al., 2014).

The women's tendency to speculate about a 'thin' therapist having an ED history also resulted in ideas about their therapist's ability to help them. On the one hand, some participants shared that therapists with an ED history would have the ability to better understand them and

recognise the ways in which they might try to deceive their therapist. The women also believed that a therapist with an ED history would be easier to talk to and offer comfort because they would know how it felt. On the other hand, the women saw disadvantages of their therapist having an ED history, such as assuming that their experience would be exactly the same as their client's experience, meaning that they would not listen to differences they may have (Rance et al., 2014). The women also spoke about how their therapist's confidence, which they gauge both on her body language and self-presentation, influenced their opinion about her ability to help. For example, a therapist perceived to be uncomfortable and therefore unconfident was assumed to be incompetent and could not help (Rance et al., 2014). Overall, this theme outlined the ways in which the women made assumptions and speculated about their therapist's body and relationship with food. It also became clear that these speculations and assumptions shaped the women's belief of the therapist's ability to help.

The third and final theme, titled 'Appearance Matters', describes how the women's assumptions and speculations had the potential to influence their willingness to engage in therapy (Rance et al., 2014). Working (or the idea of having to work) with a 'thin' therapist was repeatedly presented as problematic by the women. Some of the participants said that their thin therapist's body was something they would aspire to, while others said it would be a source of envy, stating that they were jealous because she was born that way, or doing a better job at being thin than she was. Some women also stated that a thin therapist would cause them to question whether they needed help, as they felt they were of similar size to their therapist. Another participant shared that gaining weight would be difficult if their therapist was thin because it would seem unfair that the therapist could stay skinny. Working with a 'thin' therapist also seemed to cause negative feelings about themselves and the way the therapist might see them.

For example, one participant felt that if she shared that her problem was that she ate too much, the therapist would see her as greedy and would condemn her (Rance et al., 2014).

Working with ‘fat’ therapists also appeared to foster resistance to therapy. The women were particularly concerned that if they worked with a ‘fat’ therapist, they would end up bigger themselves. The women’s assumptions (previously described) about ‘fat’ therapists meant that they were unable to trust in a ‘fat’ therapist’s professional abilities and consequently felt that they should not listen to her. Another participant felt that she would be distracted by their large therapist’s size, describing how she would question whether her larger therapist was *really* comfortable with being that size, as well as with what she eats (Rance et al., 2014).

Another situation which seemed to hold the potential to reduce the participant’s willingness to engage in therapy involved working with a therapist who had an ED history (be it a disclosed one or a speculated one). Some participants felt that they had to get “even worse” because they assumed their therapist would be distracted by her own ED, meaning they had to get worse to gain their therapist’s attention. Some of the women also stated that they would feel the need to protect their therapist, worrying that they might trigger her to relapse by sharing details about their own experiences (Rance et al., 2014).

In contrast to the wealth of observations and assumptions which had a negative impact on the women’s willingness to engage in therapy, there were very few which seemed to have a positive impact. According to the women, a therapist of ‘healthy’ size could help make the prospect of weight gain and eating ‘normal’ foods more palatable, especially if she was happy at that weight. The women also seemed able to use their healthy-sized therapist as a benchmark to assess eating behaviours. Further, the women felt that by witnessing someone else appearing confident about her own body, they could be permitted to feel positive about their own body, opening up the possibility that you did not need to hate your body (Rance et al., 2014). To

summarise, the theme “appearance matters” showcased how thin and fat therapists fostered resistance to recovery and treatment, but “healthy” sized therapists had the potential to positively impact engagement and the women’s attitudes towards recovery (Rance et al., 2014).

Rance et al. (2014) study was the first of its kind, generating significant new findings in relation to how the therapist’s body impacts those with AN and BN, and providing a strong base for future research. Through the utilisation of a qualitative approach, this research established how the women in the study were attuned to their therapist’s body and food-related cues. They also made assumptions based on this, especially in relation to a therapist’s competence as a practitioner, and these assumptions impacted on their resistance towards, or engagement with, therapy and recovery, specifically, ‘thin’ and ‘fat’ therapist’s resulted in resistance, whilst ‘average’ weight therapist’s fostered engagement in treatment and recovery, aligning with Vocks et al. (2007) study, where a preference towards an ‘average’ figure was revealed.

Rance and colleagues (2014) study was done in the United Kingdom, and the demographic of these participants was that they were white, British, well-educated women of middle class. The demographic of these participants is therefore vastly different to cultural makeup to New Zealand (Enari & Haua, 2021). As stated in the “social comparison” section, this means that the thinness ideals underlying the client’s observations may differ, making it important to do a study like this in New Zealand. Furthermore, this study indicated that none of the participants had experiences with ‘fat’ therapists, and some of the experiences of therapists of ‘normal’ or ‘thin’ size were based on what the participants felt that it would hypothetically be like working with them, when they were in treatment. Consequently, their feelings about what it would be like to do so were conjectural rather than grounded in firsthand experience, making it important to explore the experiences of those who have worked with therapists who are in larger bodies. This makes utilising an approach grounded in their experience important, particularly

with a topic such as this one, where any research will be exploring this very new area. Lastly, this work stated that participants considered themselves to be 40-100% recovered at the time of their interviews, which is an arbitrary measure, and for the experiences they recounted, although it was stated they were in treatment, there is no indication as to the severity of their distress, which lends itself to the potential of differences in the participant's experiences based on the stage of recovery they were at. Therefore, although recovery is subjective, gaining an indication of the person's stage of recovery at the time of their experience is important to see whether this shifts their experience of their therapist's body during treatment.

3.3 Chapter Summary and Rationale

Both Vocks et al. (2007) and Rance et al. (2014) examined clients' perspectives of their therapists' bodies, confirming earlier research in which therapists believed that clients closely observed and evaluated their physical appearance. Vocks et al. (2007) quantitative study revealed that individuals with eating disorders preferred 'average' sized therapists and was the first to demonstrate that a female therapist's body holds particular relevance for clients with eating disorders when compared to a control group. However, this study also indicated the need for qualitative research to uncover the rationale behind these preferences.

Rance et al. (2014) addressed this gap by uncovering new insights into how a therapist's body influences individuals with AN and bulimia nervosa BN. Their findings showed that women in the study were highly attuned to their therapists' bodies and food-related cues. Additionally, clients made assumptions about therapists' competence based on body type, which influenced their willingness to engage in treatment and recovery. Specifically, perceptions of 'thin' or 'fat' therapists were linked to resistance toward therapy, whereas an 'average'-weight therapist promoted greater engagement and recovery. This aligns with Vocks et al. (2007) findings, reinforcing the preference for an average figure.

Despite these significant contributions, several research gaps remain. It is important for future studies to continue to build on this sole study, meaning that further qualitative research investigating this topic will be valuable. It is also important to study this topic across cultures to determine whether cultural differences alter how clients perceive their therapist's body. Moreover, research grounded entirely in participants' lived experiences, rather than conjecture about what it might be like to work with therapists of different body shapes and sizes, is essential in this emerging area of research. Finally, evaluating the stage of recovery of individuals at the time of their experience could provide further insight into how perceptions of a therapist's body may shift during treatment

Therefore, the research question guiding the present research is:

- 1) How do female-identifying clients in New Zealand experience and make sense of their female-identifying therapist's body during anorexia nervosa treatment?

CHAPTER FOUR: Methodology

This study examines how female-identifying clients with anorexia nervosa (AN) experience their female-identifying therapist's body during treatment in New Zealand. This chapter begins by outlining the rationale for selecting a qualitative approach, specifically the methodology of Interpretative Phenomenological Analysis (IPA) and its ontological and epistemological foundations of Hermeneutic Phenomenology. These foundations inform the methodological choices made for this research, which are detailed in the latter part of the chapter. This includes the research question, participant criteria, recruitment process, participant descriptions, reflexivity, interview process, ethical considerations, and analysis.

4.1 Research Design

A qualitative approach has been selected for this research for three main reasons. Firstly, the in-depth nature of qualitative research allows for the exploration of complex, nuanced, and subjective phenomena that cannot be easily captured through numerical data (Braun & Clarke, 2013). This includes the participant's subjective experiences of their therapist's bodies and meanings attributed to those experiences thus, a phenomenological approach fits well. Secondly, given the limited knowledge of this topic, this research aims to develop theory rather than test a predefined hypothesis. Therefore, an exploratory qualitative approach is appropriate as it provides the scope and flexibility to capture participants' complex, in-depth, and nuanced experiences and allows unanticipated themes to emerge (Boyatzis & Quinlan, 2008). Thirdly, qualitative research prioritises the participant's voice by placing them as the expert, allowing them to share their stories in their own words and contributing to a more authentic representation of their experience (Busetto et al., 2020). Therefore, the outcomes produced with a qualitative

approach align with the evolving shift in power dynamics associated with the person-centred, collaborative, and humanistic approaches adopted and recommended in the current treatment of anorexia nervosa and other mental distress (Nilsen et al., 2019). Historically, treatment was informed by the medical model, which revolves around diagnoses and empirically supported treatments, establishing a power imbalance in the therapeutic relationship. This imbalance has been particularly prominent in the AN space, with those receiving treatment often reporting feeling unheard, invisible, or worthless (Rankin et al., 2023; Reindl, 2001; Shelley, 1997). Therefore, it is important that their voice is heard through this research by using a qualitative approach.

4.1.1 Interpretative Phenomenological Analysis (IPA) and Hermeneutic Phenomenology

Interpretative phenomenological analysis (IPA) is a qualitative methodology that is directly informed by the ontology and epistemology of Hermeneutic Phenomenology (Shinebourne, 2011). IPA has three key theoretical underpinnings: Phenomenology, Hermeneutics, and Idiography (Smith et al., 2022). The ontology and epistemology of Hermeneutic Phenomenology share two of these three theoretical underpinnings: Hermeneutics and Phenomenology (Martin & Sugarman, 2001). The theoretical underpinnings of both IPA and Hermeneutic phenomenology focus on getting as close as possible to the lived experience of the participant and highlight that interpretation is required to understand meaning (Shinebourne, 2011; Smith et al., 2022). Finally, IPA adopts an idiographic approach, where detailed accounts and analytical methods are necessary to gain this understanding (Smith & Nizza, 2022).

4.1.1 Phenomenology

Phenomenology is the study of how individuals experience the world (Yüksel & Yıldırım, 2015). It seeks to fully understand, describe, and give meaning to participants' lived experiences of a phenomenon (Willig, 2013). This research uses an interpretative approach which explores the subjective meanings individuals attribute to their experiences (Matua & Van Der Wal, 2015; Smith et al., 2022). An interpretative approach is warranted because existing literature suggests that social comparison theory, thinness ideals, and other cognitive frameworks may shape how clients perceive, interpret, and experience their therapist's body. Furthermore, given that this topic remains underexplored, it is crucial to generate deep and holistic insights about the participant's experience and their interpretation of this to gain a holistic understanding of how they experience the therapist's body and whether other theories may be relevant.

The phenomenological underpinnings of IPA have been influenced by the work of Husserl, Heidegger, Merleau-Ponty, and Sartre (Shinebourne, 2011). Phenomenology was founded by Edmund Husserl, who highlighted that to examine experience, we need to move away from the unreflective mode of being immersed in that experience. Instead, we need to take a step outside the experience and reflect on it – called the unready-to-hand mode (Shinebourne, 2011). IPA examines experiences of major significance to the person, who then engages in a considerable amount of reflecting and thinking as they work through what it means for them (Smith et al., 2021). This aligns well with the current study as it is well established that the female therapists' body in AN treatment is of major significance and a point of reflection for female clients (Rance et al., 2014). Before meeting their female therapist, individuals who have been diagnosed with AN have been shown to speculate about what their therapist's body may look like, and during treatment, observe and assess body-related stimuli and derive assumptions

about their therapist based on these interpretations (Rance et al., 2014). For the current research, interviews will be conducted to obtain accounts of the participants' historical experience with their therapists' bodies, which allows participants to orient themselves to the experience in a way in which they can actively reflect on and make sense of their experience.

Heidegger, Merleau-Ponty, and Satre further contributed to Husserl's ideas, influencing the phenomenological and existential perspectives of IPA (Shinebourne, 2011). These contributions are directly informed by Hermeneutic Phenomenology's ontology, which considers the person as embodied and embedded in their life-world, sometimes known as the Dasein (Lavery, 2003; Shinebourne, 2011). This embeddedness is attributable to Hermeneutic Phenomenology's hermeneutic influence, as we use a lens of pre-understandings composed of our subjective experiences of current and historical sociocultural contexts to make sense of the world around us (Martin & Sugarman, 2001). Therefore, experiences are embedded in and a product of our sociocultural, subjective, and historical contexts (Martin & Sugarman, 2001). Many ontological assumptions stem from the concept of the Dasein, including that Hermeneutic Phenomenology does not deny objective reality but asserts that it cannot be uncovered as we interpret the world around us through this lens of pre-understandings (Martin & Sugarman, 2001). This aligns with the present study, which does not aim to uncover a universal human psyche but instead intends to explore the experience of the three female participants.

3.1.2 Hermeneutics

Hermeneutics, known as the theory of interpretation, is the second major theoretical framework of IPA introduced by Heidegger (Smith et al., 2022). Heidegger considers hermeneutics to be a prerequisite to phenomenology, with the necessity of this combination described by Smith et al. (2022, p. 37): “Without the phenomenology, there would be nothing to

interpret, without the hermeneutics, the phenomenon would not be seen”. Heidegger asserts that to understand the meanings that people attribute to their experiences, the concept of *Aletheia*, meaning to uncover or disclose via interpretation, is required (Shinebourne, 2011). From a Hermeneutic Phenomenology perspective, insight into the psychological experience of an individual is gained via interpretation, which involves a fusion of horizons (Smith et al., 2022). To reach an understanding, each person uses their own lens of pre-understandings as a framework to interpret the experience and provide possibilities for understanding the other. The new knowledge generated from this is integrated into their own horizon of intelligibility, which is used to make sense of future experiences. Thereby, the “double hermeneutic” is the researcher interpreting the participant’s interpretation of their experience meaning that there is a co-creation of knowledge (Smith et al., 2022). This double hermeneutic means that as the researcher, I can be considered a co-participant, as my understanding of the participants’ sense-making of their therapist’s body is presented within this research.

IPA asserts that humans have agency in making sense of the *Dasein* (Smith et al., 2022). To elaborate, this means that the frame of reference that people use to interpret their life-world does not wholly determine their interpretations or how they respond to them (Smith et al., 2022). This opposes cause-and-effect notions often present within empirical approaches (Martin & Sugarman, 2001). Therefore, although these shared contexts must always be considered as they contribute to the person’s interpretation of phenomena, these experiences cannot be reduced to the individual’s sociocultural contexts. Within IPA, we can attend to this agency by using data collection techniques that allow participants to disclose their experiences as they understand them instead of seeking objective truth (Smith et al., 2022). The current research has allowed for this by using a semi-structured interview schedule with open questions, which provides opportunities to share their experience and interpretation of their therapist’s body as they

understand it while also providing some structure that ensures the relevance of the interview discussion to the research (Smith et al., 2022).

4.1.3 Idiography

In contrast to nomothetic approaches, IPA is idiographic due to its focus on gathering rich, detailed accounts of individual experience rather than universal laws of behaviour (Smith & Nizza, 2022). Therefore, the immediate claims generated from these idiographic accounts are bound to individual participants. However, these claims may be cautiously extended across cases following this commitment to the individual case (Larkin et al., 2019). IPA's commitment to the particular is aligned with its phenomenological underpinnings, looking at the subjective experience of phenomena and how it is understood by particular people in particular contexts (Callary et al., 2015).

4.2 Research Question and Procedure

The following section outlines the research question, participant criteria, recruitment process, participant descriptions, reflexivity, interview process, ethical considerations, and the analytical approach adopted for this study.

The overarching research question was:

- 1) How do female-identifying clients in Aotearoa, New Zealand experience and make sense of their female-identifying therapist's body during anorexia nervosa treatment?

More specifically, the research questions focused on:

- Initial impressions

- Comparisons of their own recovering body and the therapist's body
- Whether their impressions changed over recovery

4.2.1 Participant Criteria

The participant selection criteria were created to facilitate a homogenous participant pool rather than a representative sample. IPA favours homogeneity so that differences between participants are more likely to be accounted for by individual characteristics than other factors such as demographics (Smith & Nizza, 2022). The desire for homogeneity must be weighed against practical constraints (Smith & Nizza, 2022). In cases where the topic is rare, homogeneity via experience of the phenomena of interest is sufficient as it enables investigators to capture idiographic accounts of a specific group of individuals who have experienced that phenomenon (Smith & Nizza, 2022). The present study adhered to Smith and Nizza's (2022) recommendation for a homogenous sample as much as practically possible.

For this study, participants were required to *have lived experience of anorexia nervosa and have received face-to-face treatment with a therapist*. This ensured that the participants had experienced the phenomenon of interest, upholding the minimum requirements for homogeneity in IPA (Smith & Nizza, 2022). To reflect the multidisciplinary nature of anorexia nervosa treatment, we defined the terms "therapist" and "treatment" broadly to include all practitioners involved in a client's treatment journey who may have provided support (Hay et al., 2014). This umbrella term encompasses but is not limited to, doctors, psychiatrists, nurses, dietitians, psychotherapists, counsellors, group facilitators, and psychologists who have offered any form of intervention or support. All these professionals play a critical role in recovery, and the client's experience of her body may be relevant to any of these interactions. There is currently no

evidence suggesting that the specific discipline of the therapist or the nature of the treatment impacts the client's experience of her body during treatment. Therefore, this broad definition was used which also broadened the number of eligible participants, which was important with a small participant pool. It was anticipated that most participants' experiences will pertain to psychologists and dietitians, as they tend to work with clients for the longest durations during recovery (Hay et al., 2014).

Participants were also required to *have received treatment in New Zealand and to reside in New Zealand*. To date, no research has explored how clients experience their therapist's body in the treatment of anorexia nervosa within New Zealand. To the best of my knowledge, the Rance et al. (2014) study is the only research that has investigated this topic, which took place in the United Kingdom. Conducting similar research in New Zealand is important because differing cultural body ideals may influence how clients perceive their therapist's body. For example, traditionally, Māori and Pasifika cultures have valued larger stature due to its association with beauty, social standing, health, and wealth (Brewis & McGarvey, 2000; Durie, 1988; Ringrose & Zimmet, 1979). Although thinness ideals are becoming increasingly common across cultures, more qualitative research is needed to investigate the complexities of this within and across cultures (Murray & Price, 2011; Swami, 2015).

Participants were required to *identify as female and have experience with a female-identifying therapist in the treatment of anorexia nervosa*. The lifetime prevalence of AN is three times higher among females (0.9%) compared to males (0.3%) (NIMH, 2016). Therefore, recruiting female participants was essential not only to contribute to the homogeneity of the sample but also to reflect the disproportionate impact of anorexia nervosa on females. The additional criterion of having therapists identify as female was based on foundational literature,

which indicates that women experiencing eating distress tend to analyse and compare their bodies to women, rather than men (Rance et al., 2014). The decision to use the inclusive terminology "female-identifying" acknowledges gender identity, recognising that a person may identify as female regardless of their biological sex (American Psychological Association [APA], 2015). This distinction is important for respecting the experiences of people who are gender non-conforming, transgender, or non-binary. By adopting this terminology, the research aims to create an inclusive environment, respecting participants' identities and experiences and aligning with contemporary understandings of gender.

Participants were required to *have experienced treatment after the age of 18*. This criterion contributed to the homogeneity of the sample by minimising variability associated with age, such as emotion regulation (Powers & Casey, 2015), and increased power differentials between adult therapists and younger clients, which may have impacted the experience of the participants (Powers & Casey, 2015). Additionally, individuals over the age of 18 are defined as adults, which ensures that participants have the legal capacity to provide informed consent independently.

Participants also needed to *identify as recovered*. To align with these findings, showing that recovery is an ill-defined term (Murray, 2020; Federici & Kaplan, 2008; Darcy et al., 2010), recovery status was self-reported by participants. Participants who identify as 'recovered' or 'on the road to recovery' were eligible for the study. This approach provides participants with the autonomy to determine whether they have reached a stage of recovery where they feel emotionally prepared to share their experiences of treatment. While the definition of recovery was left to the participants, eligibility criteria excluded those currently undergoing active treatment for anorexia nervosa. This criterion ensured that, in the unlikely event a participant

identifies as ‘recovered’ while still in active treatment, the study does not interfere with their ongoing therapeutic process.

4.2.2 Recruitment process

Participants were initially recruited through Facebook groups. After receiving approval from group administrators, an advertisement (Appendix A) was posted in various online ED support groups, including “Eating Disorder Recovery NZ,” “Eating Disorder Recovery Support,” “Anorexia Recovery Support,” “Anorexia, Bulimia, and Binge Eating,” “Anorexia, Depression and Anxiety Support Group,” “Anorexia Problems,” as well as the “Massey University Postgraduate Students” Facebook page. From these groups, one participant was recruited. After four months, with no further interest and discussions with my research supervisors, I considered broadening the participant criteria to include other EDs such as BN. However, after finding out about the current research through word of mouth from colleagues and friends, two other women whom I had prior connections with reached out and both agreed to participate, making adjustments to the participant criteria unnecessary.

In the advertisement, whether posted in Facebook groups or emailed to potential participants, interested individuals were invited to contact me via my Massey University email. Upon initial contact, they received an information sheet (Appendix B) detailing the study and to reach out via email or phone if they were still interested, providing a second opportunity to opt out. If interested, participants were invited to a screening phone or Zoom call to confirm their suitability and address any questions they may have had. If they met the study criteria, an interview was scheduled during the call, though they also had the option to arrange it later via email to allow more time for consideration.

Three participants were recruited for this research. Clarke (2010) recommends this sample size for master 's-level IPA studies, as it allows time for in-depth data collection and analysis, maintaining IPA's idiographic commitment by facilitating a rich understanding of each participant's lived experience (Smith et al., 2022). This sample size was also pragmatic, given the low lifetime prevalence of anorexia nervosa in New Zealand (approximately 0.56%; Anorexia New Zealand, n.d.), meaning that recruiting more participants may have been difficult. Moreover, after conducting the interviews, it was clear that they had generated ample quality data to uphold IPA's idiographic commitment.

4.2.3 Participant Descriptions

A brief summary of each participant is outlined below. Given the low lifetime prevalence of anorexia nervosa in New Zealand (approximately 0.56%; Anorexia New Zealand, n.d.), careful consideration was given to the possibility that readers, particularly therapists, might identify the study participants. Therefore, participant privacy was prioritised in their descriptions, with details such as age and years recovered provided as a range. This decision did not impact the analysis and discussion. This approach is also consistent with an Interpretative Phenomenological Analysis (IPA) framework, which focuses on the participants' experiences rather than on the causes or background factors contributing to those experiences, meaning that extensive background detail is not necessary (Laverty, 2003).

Daisy

Daisy is a middle-aged Pākehā woman who was first diagnosed with anorexia nervosa in mid-life. Her treatment involved hospital, inpatient, and outpatient care. Daisy noted that most of the therapists she worked with were occupational therapists. Although she experienced anorexia

nervosa for a few years, she considers herself to have been recovered for around a decade. While she has experience with other eating disorders that at times overlapped with her anorexia nervosa, she chose to keep that information separate from the interview.

Erin

Erin is a young adult Pākehā woman who began developing anorexia nervosa in high school. Erin first received treatment in her early teens at an outpatient clinic, and throughout her distress, she underwent inpatient, outpatient, and hospital treatment. Most of the therapists she worked with were psychologists. Erin noted that she has been recovered for a few years.

Talia

Talia is a young Pākehā young woman who grew up in New Zealand. Talia noticed changes in her eating habits from late childhood, although she was not diagnosed until her late teens. Talia mentioned that her anorexia nervosa briefly shifted to another eating disorder, but she kept this time separate from the experiences she recounted in the interview. Talia has been recovered for a few years. Her treatment involved inpatient, outpatient (with dietitians, psychologists, and support groups), and hospital care provided by multiple types of therapists.

4.3.5 Interview Process

The interview schedule (Appendix C) was designed to be conducted as a semi-structured interview. This approach utilises the schedule as a flexible guide rather than a rigid script which interviewers can use to facilitate the natural flow of conversation (Smith et al., 2022). This worked well as it allowed for a deep exploration of the participants' experience, as well as space for unanticipated themes to arise while maintaining a focus on the participants' experience of their therapists' bodies.

The interview guide consisted of six main questions which focussed on the participants' experience of her therapist's body, and what this meant for her. Each participant was asked to think of one therapist's body that strongly comes to mind, to facilitate a detailed, rich account of the participant's experience (Smith et al., 2022). However, a question was included to allow space for participants to talk about other therapists if this was relevant. For example, "How did your experience of this therapist's body compare to your experience with other therapist's bodies?". There was also reference made to how the participant's experience may have changed over time, for example "How did this initial experience of your therapist's body compare to other points during your treatment with her?", as this was a strong theme that emerged from the literature.

The interview schedule was structured using a funnelling approach, beginning with broad, descriptive questions. For example: "*When you first met your therapist, what, if anything, stood out to you about them?*". As the interview progressed, more analytic and reflective questions were asked such as "*What was that experience like (of the therapist's body)?*".

Starting with a descriptive, broad question before moving into questions that required reflection about the participant's experience worked well because it allowed the participants the opportunity to settle into the interview and become used to talking about their therapist's body. Questions were open and leading questions were avoided as far as possible, to facilitate in-depth discussions where the participant could talk about what was meaningful to them, rather than pushing the researcher's agenda, upholding the idiographic and inductive principles of IPA (Smith et al., 2022). Prompts were included under each focal question. These were developed to elicit detail, and to elaborate on the question if required by the participant (Smith et al., 2022).

To ensure the interview questions were sensitive and appropriate for this potentially delicate topic, the interview schedule was also reviewed by an “expert by experience”, a woman with lived experience of anorexia nervosa, known to Dr. Kathryn McGuigan, whose identity remains anonymous to protect her privacy. This review was particularly valuable, as she provided suggestions regarding terminology. For example, she advised avoiding the repeated use of the term "recovery journey," explaining that it implies a linear progression, and that “recovery” is not a universally agreed-upon experience for all individuals with anorexia nervosa. Lastly, a practice interview was conducted with a university peer who had lived experience with anorexia nervosa. This interview served to assess whether the questions were appropriate and relevant while giving me the opportunity to practice my interviewing skills. Although I have experience facilitating psychological assessment interviews and therapeutic groups, which involve some overlapping skills (e.g., rapport building, using open questions, and minimal encouragers), this interview allowed me to familiarise myself with the interview schedule, and practice framing questions to elicit meaning-making and interpretation. This practice interview was also particularly helpful because I learned that I needed to preface the study by normalising the discussion of therapist bodies, so participants would feel comfortable sharing their thoughts without fear of judgment.

Conducting the Interview

The participants all opted to have their interview take place over Teams. This worked well as each person confirmed that they had a quiet and uninterrupted place where they felt safe to freely speak (Alase, 2017; Smith et al., 2022; Smith & Osborn, 2008) freely. To begin the interview, all three participants were asked if they wanted to follow Māori tikanga with opening the interview, however none of them identified with this culture as they were Pākehā, so to be

responsive to their needs, we began with a general “getting to know each other” conversation. This was important for settling in and whanaungatanga (relationship building).

I then outlined the interview structure to ensure the participants were comfortable about the structure and the questions and then read out a short blurb that was developed to encourage participants to focus on a few select experiences, so that a detailed account could be obtained. This blurb also prefaced the interview by explaining that they are considered as experts and that there are no right or wrong answers (Smith & Nizza, 2022). Lastly, I included a short statement that everyone has reactions to other people’s bodies, allowing them to feel as though they could speak freely. The women were prompted to think of one therapist’s body that stood out in particular, to facilitate a detailed, and rich description of their therapist. It should be noted that all three women felt that every therapist’s body stood out to them, so they all referred to multiple therapists.

Each interview lasted between one and a half to two hours, providing ample time for an in-depth exploration of each participant’s experiences. A single interview was chosen to maintain conversational flow and avoid fragmentation (Smith et al., 2022). No follow-up interviews were required. The interview was video recorded and transcribed via Teams, as well as voice recorded on an app called Otter.ai on my phone, providing a backup recording in case of technical difficulties. This transcription was checked against the recording and manually amended in case of errors. Before the interview, permission was granted from the participants, to allow for the recording and transcription of their interview

4.3.6 Ethical Considerations

Due to the sensitive nature of this topic and its potential to cause distress, full ethical approval was obtained from the Massey University Northern Ethics Committee (OM2 23/43). This section outlines the ethical considerations unique to this study. Universal ethical practices, such as obtaining informed consent, maintaining confidentiality and privacy, and addressing cultural factors, were thoroughly addressed in the complete ethics application but are not detailed here. Their omission in this section does not diminish their importance, but they have been omitted due to the word limit of this research.

Minimising harm

Unintended harm may occur when discussing sensitive topics, such as a person's experience of their therapist's body during treatment (Smith et al., 2022). This risk arises not only because commentary on others' bodies can cause embarrassment and distress because of the awareness of potential harm, including eating distress, which can be caused (Fardouly et al., 2015) but also because recalling treatment experiences can be especially challenging. The treatment period for anorexia nervosa is often marked by a loss of autonomy, the confrontation of challenging beliefs, and distress related to weight gain (Broomfield & Tchanturia, 2021).

To reduce the risk of harm, all participants were required to self-identify as "recovered." This self-identification was necessary given that the concept of anorexia nervosa "recovery" is ill-defined in the literature (Darcy et al., 2010; Federici & Kaplan, 2008; Murray, 2020). Additionally, this process afforded participants the autonomy to determine whether they felt resilient enough to discuss this topic. This approach respects the participant's autonomy and

dignity, especially considering that individuals with anorexia nervosa may have experienced a profound loss of autonomy during treatment (Broomfield & Tchanturia, 2021).

To minimise potential harm, the inclusion criteria required that participants should not be receiving treatment at the time of the research. This criterion ensures that in the unlikely event a participant identifies as "recovered" while still undergoing treatment, the study does not interfere with their ongoing therapeutic process. This precaution was important because discussing experiences related to their therapist's body during treatment could introduce new issues that might distract them during therapy or negatively impact their relationship with their therapist. It is important to note, however, that all three participants who identified as recovered had maintained their recovery for multiple years and were not currently receiving treatment for anorexia nervosa or any other eating disorder.

Once participants confirmed their willingness to participate in the research, a copy of the interview questions (Appendix C) was emailed to them. This was intended to minimise any potential surprise regarding the topics discussed during the interview and to provide them with an opportunity to ask questions or identify any triggering questions they did not want to discuss.

Before proceeding with the interview, I highlighted that having thoughts and feelings about other people's bodies is normal and that the interview was a non-judgemental space to reduce any distress or embarrassment about discussing other people's bodies. Participants were also informed that they could take breaks at any time, skip questions, or even stop the interview altogether if they experienced distress or discomfort. No explanation was required for their decisions.

After each interview, I spent 5–10 minutes speaking with the participants to ensure that each session ended on a calm note and to check in on their well-being. I informed them that they

might feel more tired or emotionally vulnerable than usual afterwards, pre-empting any delayed distress so that it would not cause alarm. I also discussed their plans for self-care following the interview.

In the event that a participant became distressed, I was prepared to provide support by outlining the resources listed in the information sheet, contacting my supervisors, and, if necessary, developing a safety plan to ensure their well-being, which I have extensive experience with from my role as a programme facilitator. Follow-up emails were sent to all participants several hours after the interview to check in, and a phone call was offered one week later if they continued to experience distress. Thankfully, none of the participants showed signs of distress, and all reported that they were fine during the follow-up check-ins. All three participants expressed gratitude for the opportunity to share their stories and were excited to contribute to a study that could potentially help others in the future.

Privacy and Confidentiality

Special consideration was given to the privacy and confidentiality of participants in this study. Given that AN is relatively uncommon in New Zealand, there was a risk that readers, particularly therapists, could inadvertently identify individual participants. In addition to standard measures (such as using pseudonyms and removing identifying details), only essential information for analysis and discussion was included in participant descriptions, with details such as age and years recovered presented as ranges to ensure that participants could not be identified.

In the interviews, I reiterated that any information participants shared would remain strictly within the bounds of this study and would not be shared outside this forum. These assurances were intended to help the participants feel confident and comfortable sharing their

experiences without fear that personal details might reach others in their lives. I also emphasised that their participation was entirely voluntary and that they had the right to withdraw from the study at any time without any negative consequences. This measure was taken to prevent any feelings of obligation or undue influence. All three participants opted to have their interviews conducted on Teams. Therefore, privacy and confidentiality were maintained by ensuring that each participant and I chose a private space to meet in where no other people could overhear our conversation.

Cultural Considerations

Cultural consultation was conducted prior to ethics submission with a Māori staff member. This was a useful process to consider the complexities of research through genuine engagement with the Treaty of Waitangi and my positionality in the research. Some of the issues we discussed in this meeting were around processes and some about relational ethics. In practice in the interviews to foster autonomy and acknowledge the diverse cultural backgrounds and varying connections to culture in New Zealand, participants were given the opportunity to open and close the interview in a manner that was meaningful to them. Specific consideration was given to whether sharing kai (food), a practice within Māori tikanga, during the opening process would be appropriate for this research, particularly given the potential risk of triggering participants (Riva et al., 2021). To minimize harm and uphold participants' rangatiratanga and autonomy, the choice was offered during the pre-interview screening meeting about whether they wanted to share kai, water, a hot drink, or to omit this step before the interview. Since all three interviews were held over Teams, this face-to-face sharing of kai was not a consideration. I did offer to open and close with Karakia but they all noted that they did not want to have any

opening tikanga process, and a general chat at the start of the meeting would be most meaningful and appropriate for them.

4.3 Reflexivity

Rather than attempting to separate the researcher's biases and assumptions from the participant's experience, as phenomenological approaches do, Interpretative Phenomenological Analysis (IPA) captures experiences as subjectively experienced by both the researcher and the participants (Smith & Flowers, 2022). The double hermeneutic in IPA underscores that there is no subject-object separation (Smith & Flowers, 2022). Consequently, IPA researchers bracket in their biases by reflecting on and documenting how these biases inform the research rather than attempting to eliminate them (Callary et al., 2015). This approach acknowledges that knowledge is inherently shaped by researchers' preconceptions and interpretative frameworks (Callary et al., 2015). Therefore, it is crucial for researchers to reflect on their biases, preconceptions, and assumptions and consider how these factors influence every stage of the research process (Smith & Flowers, 2022).

Dodgson (2019) highlighted the importance of researchers explicitly describing how their background, experiences, and beliefs influence the research process. Therefore, for this reflexivity section, I will outline my positionality in relation to the participants, my personal history and motivation for undertaking this research, my assumptions regarding individuals with EDs and the ED treatment system, and the potential influence of three specific factors.

As a forensic programme facilitator, my experience related to this research is drawn from the perspective of the therapist, rather than the client. Nonetheless, I have observed many parallels between my work and the work of therapists with clients who have been diagnosed with

AN. Therefore, although I do not have experience with AN or being a client, I have brought certain assumptions into this study which have informed this research, based on my forensic experience. This included the resistance to treatment engagement, and also the high importance that both groups place on the therapeutic alliance. Furthermore, I have worked with clients who express scepticism about my ability to provide support due to my age (26 years old) and assumed lack of life experience. Therefore, from my prior knowledge and the resulting assumption that bodies play a significant role in the AN experience, before starting this work, I assumed that similar dynamics might influence client engagement, based on the therapist's body. Although I have recognised that I brought these assumptions to my research, I actively worked to remain neutral and inductive through the use of my reflexive journal and supervision to monitor any potential biases.

Initially, I considered myself an outsider in this research due to my lack of personal experience with AN. Upon further reflection, I realised that as a female living in NZ, which is influenced by Western thinness ideals, and having experienced the effects of body comparison through social media, I shared some lived experiences with my participants. Deutsch (1981) argues that "we are all multiple insiders and outsiders" (p. 174), which resonated with my evolving understanding of my positionality. While I lacked firsthand experience with AN, my familiarity with societal body image pressures enabled me to bring empathy and compassion to the study. Despite this, I feel that I ultimately identified as an outsider and assumed that participants would view me as such.

Given my outsider status (Finefter-Rosenbluh, 2017), I considered whether to disclose this to participants who inquired about my interest in the topic. Although no formal ethical guidelines dictate such disclosures, some researchers advocate for transparency (Oakley, 1981). I

reflected on whether participants' awareness of my outsider status would impact the research. While insider researchers may elicit deeper disclosures due to perceived shared experiences, they also risk participants withholding information under the assumption that the researcher already understands their perspective (Dwyer & Buckle, 2009; Hockey, 1993). Conversely, outsider researchers may be seen as more objective, allowing participants to feel less pressure to conform to presumed expectations (Smith & Nizza, 2022). Ultimately, I chose not to disclose my status unless explicitly asked, trusting that my training as a counselling psychologist would enable me to build rapport effectively. None of the participants in this study inquired about my personal experience, though it is possible that my outsider status was inferred through my language and non-verbal cues.

A key consideration in designing this research was how my own body might impact participants' comfort in disclosing information and how my presence could influence our interactions. As a petite, 'thin' female, I was concerned that participants might hesitate to express their thoughts due to fear of offending me, particularly when discussing therapist body types. I initially considered addressing this explicitly during in-person interviews by emphasising the non-judgemental nature of the space. However, as all three interviews were conducted via Microsoft Teams, participants only saw me from the shoulders up, minimising the potential impact of my body on the interaction. To further mitigate concerns, I reassured participants at the outset that this was a safe space where it was natural to have assumptions about others' bodies. Despite these efforts, I found some comments challenging and noticed moments where participants' statements triggered personal reflections. These instances underscored the importance of my reflexive practices in maintaining awareness of my own reactions and ensuring they did not interfere with data collection.

Reflexivity refers to the ongoing process of self-reflection in which researchers examine their behaviours, thoughts, assumptions, and expectations to understand their influence on the research (Darawsheh, 2014). To facilitate this, I maintained a reflexive journal and engaged in regular discussions with my supervisors, continuously reflecting on biases, assumptions, emotions, and insights throughout the research process. This practice allowed for the explicit identification of assumptions and their potential impact on the study (Callary et al., 2015; Smith & Nizza, 2022). Ultimately, this commitment to reflection and self-awareness enhanced the rigour of this study by ensuring transparency, honesty, and accountability (Darawsheh, 2014; Dodgson, 2019). Engaging in reflexivity throughout this research allowed me to critically examine my role and its influence on the study. By acknowledging and documenting my biases, assumptions, and positionality, I aimed to enhance the transparency and rigour of this research, ensuring that the voices of participants remained at the forefront of the analysis.

4.4 Data Analysis

The framework for IPA analysis described by Smith et al. (2022) was used for this research. This includes seven steps for IPA data analysis, which have been outlined below.

Step One: Reading and Re-Reading

The first step of IPA analysis requires the researcher to immerse themselves in the original data (Smith et al., 2022). This involved reading and re-reading the transcript of one single participant while simultaneously playing the interview recording (Smith et al., 2022). The interview recording (audio and visual) was included in this step as it provided a deeper understanding of the participant's experience through their non-verbal communication, such as tone, cadence, and facial expressions (Smith et al., 2022). This first step ensured that IPA's

phenomenological focus was upheld by allowing the researcher to fully engage and become familiar with the participant's account, thereby prioritising their lived experience (Smith et al., 2022).

Step Two: Exploratory Notes

The transcript was transferred onto a table in a Word document, and an additional column was added to the right for exploratory notes (Appendix D). Exploratory notes were recorded during a close, line-by-line transcript analysis, documenting initial thoughts and observations made in the right-hand column. Exploratory notes were divided into descriptive, linguistic, and conceptual categories to ensure a detailed analysis (Smith & Nizza, 2022). A colour-coding system was implemented to distinguish between these categories: descriptive notes were marked in pink, linguistic notes in purple and conceptual notes in orange. Specifically:

- Descriptive notes involved recording keywords, phrases, and explanations provided by the participant.
- Linguistic notes focused on the participant's use of language (e.g., pauses, repetition, and tone) and its contribution to understanding their experience.
- Conceptual notes involve a deeper exploration of the material, questioning and exploring the underlying significance of the participant's experience rather than their explicit claims.

It is important to note that this process occurred through a back-and-forth process between a holistic and line-by-line interpretation of the transcripts (Palmer et al., 2010). This allowed for a hermeneutic circle between the parts and whole of the text, where the holistic understanding of the participant's account was used to make sense of the parts through a fusion

of horizons, which then gives rise to new understandings for the holistic account (Palmer et al., 2010). This ensured that the interpretations were grounded in the context of the whole interview, preserving the participants' meanings rather than looking at decontextualised lines of text. As with all stages of the analysis, a reflective journal was kept to ensure I had an open mind when noting anything of interest, avoiding commenting on only what I expected to see (Smith et al., 2022).

Step Three: Developing Experiential Statements

Smith et al. (2022) note that emergent themes are now called experiential statements to reflect IPA's commitment to grounding interpretations in the participant's experience. At this stage, the task was to reduce the volume of detail from the exploratory notes and transcript by transforming the experiential statements into themes, while still capturing the complexity of the participant's experience (Smith & Nizza, 2022). These experiential statements were recorded in a column to the left of the transcript (see Appendix E). This meant that the transcript remained in the middle column, which helped ensure that the participant's words were central to understanding her experience (Smith et al., 2022).

Step Four: Searching for Connections Across Experiential Statements (ESs)

In random order, the experiential statements were individually pasted into text boxes in a Word document. This disrupted their original sequence, facilitating a search for a higher-level conceptual grouping since the participants' understanding of their experience may not follow the exact order in which it is recounted (Smith et al., 2022). The experiential statements were examined for connections between them and rearranged to form clusters based on an overarching theme (Smith et al., 2022).

Step Five: Naming and Consolidating of Personal Experiential Themes (PETs)

Each cluster was assigned a title, or personal experiential theme, which captured the key characteristics of the experiential statements it contained. These personal experiential themes were arranged alongside the experiential statements, with accompanying quotes and page numbers from the original transcripts. Including all of this information ensured that the theme remained firmly grounded in the participant's experience and that its essence was preserved throughout the analysis (Smith et al., 2022).

Step Six: Moving to the Next Individual Case

Steps one to five were repeated for the next individual case. Each case was treated as an independent entity to preserve the idiographic nature of the analysis (Smith et al., 2022). The reflective journal was used to note any biases and assumptions I had, which helped to ensure that I engaged directly with the current participant's experience rather than relying on expectations from earlier cases (Smith et al., 2022).

Step Seven: Analysis Across Cases

Once all the individual cases had been analysed, an iterative process was carried out. This involved ensuring that the selected quotes and experiential statements were strong representations of each PET and that they could be directly linked back to the original transcript, maintaining the participant's experience as central. At times, themes were renamed or quotes replaced to better capture the participant's experience.

Next, I examined patterns of similarities and differences across the Participant Experiential Themes (PETs) and the accompanying experiential statements and quotes. To do this, I pasted the PETs, as well as their accompanying ESs and quotations with page number into

text boxes in a Word document in a random order. I then reorganised, moved, and sometimes renamed them as new connections emerged. Throughout, I made sure to continuously refer back to the ESs, experiential narratives (ENs), and the transcript to keep the PETs grounded in the participant's experience. I would also occasionally zoom in on an experiential statement (ES) and then zoom out again, discovering that it fits better under another emerging pattern.

Finally, labels for each Group Experiential Theme (GET) were created. The main organising principle in the table of GETs. This was to demonstrate both the convergence in participants' experiences and the unique, individual ways in which they reflected that theme (Smith et al., 2022). ESs and Quotations from the participant's transcript, along with the relevant page numbers from the transcript, to ensure that all elements stayed firmly rooted in the original data.

4.5 Approach to Validity and Quality

Validity and quality is assessed using Yardley (2000) and Elliott et al.'s (1999) concepts of sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. The way I managed these concepts in my research was through a commitment to idiographic principles with a focus on recruiting participants with a particular lived experience. I remained engaged with my research participants with sensitivity to their individual experiences throughout the process. In the data analysis I included a number of verbatim extracts from the participants' material to support my interpretation but also made sure their stories were privileged. In many ways my part-time status for my Masters allowed me a prolonged and sustained engagement with the data and the project, adding to the value. This was particularly important for analysis and writing the discussion, balancing my position with the participants' voices and then relating my analysis back to the existing literature. What I am particularly proud

of is the relevance and importance of this research, as there is very little research in this specific area despite body weight and shape judgements playing an important role in aetiologies, social comparison theories, and recovery for AN.

CHAPTER FIVE: Findings

The objective of this research was to explore how female-identifying clients in NZ experience their therapist's body during AN treatment. From these findings, it became clear that the therapist's body played a significant role in all three participants' experiences during treatment. When asked to think about one therapist's body that stood out, the women said that it was too difficult to choose one, so opted to describe multiple therapists instead. For example, Erin said;

"I feel like they all stood out to me...I had some sort of reaction to the way all of them looked" (Erin).

What this meant in practice is that I used a pseudonym for specific therapists that were mentioned, otherwise I have referred to therapists in a general sense if the participant's experience related to therapists in general. Additionally, all the therapists discussed were females unless I have specifically stated otherwise. The therapist role e.g. occupational therapist, psychologist or dietitian were only mentioned when a specific therapist was being discussed.

This chapter presents the study's findings in Table 1. These findings included that the therapist's body impacted treatment engagement for the women in the study. This main theme had two sub-themes, which captured the women's experience of feeling similar or different to their therapist based on the comparison of her body to their own, each had subthemes and codes that outlined the assumptions and judgements that occurred which impacted the women's willingness to engage in treatment.

Table 1*Summary of Group Experiential Themes, Subthemes and Codes*

Section	Theme	Subtheme	Code
Body Comparison Impacted Treatment Engagement	We are the Same: Her Body is Like Mine so She Thinks Like I do	Assumptions: She's Thin, So She Has Anorexia Nervosa and Thinks like I do	She's Manipulating Me She's Hypocritical She's Picking Me Apart
	We are Different	Assumptions: Her Larger Body Looks Like Mine Used To, So She Will Be Easily Triggered To Develop Anorexia Nervosa Like I Was	She Is Thinner Than I Am, So She Will Not Take Me Seriously She Just Won the Genetic Lottery
		She Is Thinner Than I Am: Competition and Shame	
		Her Body is Larger: I Have No Right to Feel Uncomfortable With My Weight Gain	
		Role Modelling	Her Body is Larger than Mine: She is a Suitable Role Model Her Body is Larger than Mine: She is Not a Suitable Role Model

5.1 Body Comparison Impacted Treatment Engagement

This section introduces two themes that describe how the three women's willingness to engage with their therapist was impacted by body comparison. The first theme outlines the

assumptions the participants made based on the familiarity they felt between themselves and their therapist, titled "We are the Same: Her Body is Like Mine so She Thinks Like I Do", resulting in a reduced willingness to engage with their therapist. The second theme outlines how the women's willingness to engage with their therapist was negatively, and in one instance, positively impacted based on the assumptions and judgements that resulted from seeing themselves as different from their therapist, titled "We are Different".

5.1.1 We Are the Same: Her Body Is Like Mine, So She Thinks Like I Do

All three women shared that a key part of their experience was assuming that because their therapist had a body similar to their own, their therapist must think the same way that they do. This resulted in two main assumptions about the way they felt the therapist must be thinking. The first assumption, shared by all three participants, was that their therapist had AN because she was thin like they were. The second assumption was specific to Daisy. Although Daisy's therapist was larger than she was at the time, she felt a sense of familiarity with her because she had also once been larger. As a result, Daisy assumed that her therapist, like her past, larger self, would be easily triggered into developing AN. This meant that she could not trust her therapist because she could not fully open up to her. These two assumptions, and how they created resistance to engagement in treatment will be outlined, in turn, below.

5.1.1.a Assumptions: She's Thin, So She Has Anorexia Nervosa and Thinks like I do

All three participants inferred from their therapist's thin body that she, too, must have AN. This inference led them to conclude that her disordered thinking mirrored their own, which reduced their willingness to engage with her. For Erin, this manifested as a belief that her therapist was manipulative, meaning that she could not trust her therapist. Both Erin and Talia

interpreted the assumed disordered thinking as evidence of hypocrisy. They thought that it was unfair for someone with the same disordered thinking to hold a position of authority and offer reliable guidance for recovery. Additionally, Talia and Daisy felt their therapist would scrutinise and criticise them. The following sections discuss these three interpretations of their therapist's body in detail.

“She’s Manipulating me”

During treatment, Erin assumed that her therapist, Edith, was manipulating her, which created feelings of panic and distrust. Described as "very tall" and "very thin", Edith was the first psychologist that Erin worked with, which was at a time when Erin's AN was severe. Erin compared her body to Edith's and experienced a sense of "sameness" as they both appeared thin. Erin interpreted this similarity as evidence that Edith also had AN and therefore shared the same disordered thinking patterns. As a result, Erin concluded that Edith could not be trusted as she had malicious intent - to manipulate Erin into gaining weight so that Edith could be the smallest person in the room.

"Initially...I kind of couldn't trust her or confide in her or...believe her advice...because I was just like, no, if you're too skinny... you're just manipulating me...It kind of felt like... I've not got to take her advice or listen to her anyway, because...I bet she has an eating disorder too. So I... didn't put...trust in her... I've never thought about this until right now...I thought that she wanted me to be fatter because she wanted to feel skinnier because...I liked trying to...know that I was skinnier than like everyone else in the room"
(Erin).

This assumption of Erin's was the first that came to mind during her interview. The salience of this experience highlights how this assumption was arguably the most important

factor that disrupted her therapeutic trust across her recovery journey. This experience also gave rise to a particularly strong sense of panic, not only because she did not feel her therapist was trustworthy but because of the contrast between this experience and her belief, before coming to therapy, that Edith would be someone that she would feel safe with. Moreover, Erin's remark, "I've never thought about this until right now," indicates that she only began to understand the origins of her distrust during the interview rather than during treatment. This suggests she did not know the cause of her distrust and panic toward Edith during treatment, which was both distressing and confusing for her.

Erin's use of the word "initially" indicates that this assumption not only shaped her first impression of Edith but also hinted at the multiple layers of distrust that developed with her over time. This will be explored in the findings to follow. Although Erin acknowledged that her distrust was multifaceted, she emphasised that this early experience played a significant role in her eventual decision to change therapists. This underscores the significance of this assumption for Erin, as well as how the impact of her initial mistrust persisted throughout their time together.

“She’s Hypocritical”

Another layer that contributes to understanding Erin’s distrust of Edith was her belief that Edith was hypocritical. Erin assumed that Edith had AN, too, and, as a result, could not be trusted to provide credible support or advice for recovery because she shared the same disordered thinking.

“When she'd be like, 'OK, you need to gain two kilos,' I would be like, 'YOU need to gain two kilos'... I viewed her as being so skinny that, yeah, she was being hypocritical... I've not got to take her advice or listen to her anyway, because like, I bet she has an eating disorder too” (Erin).

Erin's repeated emphasis on Edith's hypocrisy throughout the interview highlights the intensity of her reaction when making sense of the comparison of Edith's body to her own. Erin thought that she could not recover by following the advice of someone she perceived as also having AN, meaning that she dismissed the support and guidance offered by Edith. Interestingly, Erin was aware that she felt Edith was hypocritical during treatment. This lies in contrast to the retrospective sense-making that Erin had about her assumption that Edith was manipulative. Although both assumptions negatively impacted Erin's trust, at the time of treatment, she was consciously aware only of the perceived hypocrisy.

Talia shared a similar assumption about her thin therapist, Penny - a dietician who led a support group for AN. By comparing Penny's body to her own, Talia assumed that Penny also had AN because she was thinner than she was. Based on this assumption, Talia felt it was unfair and hypocritical that Penny could continue engaging in the behaviours that Talia was forced to receive treatment for. This was the first experience Talia discussed during her interview, marking it as a significant factor which impacted her willingness to engage in treatment.

"I was like, but they're doing it, and I'm not allowed to do it" (Talia).

Talia's words highlight the difference in experience between herself and Erin. Although they both felt they did not want to engage with their therapist because she was hypocritical, Erin's primary concern was that Edith's hypocrisy undermined the credibility of her advice, meaning that she could not trust her. However, Talia's focus was on the envy and resentment she felt towards her therapist because her therapist was "allowed" to continue with what Talia perceived as disordered eating while she had to undergo treatment. This feeling of resentment and that she had been treated unfairly reduced Talia's willingness to engage in treatment as she did not feel like she needed to be there.

“She’s Picking Me Apart”

Stemming from the assumption that their therapist's thinness meant that she also had AN, Talia and Daisy experienced intense panic, fearing that she would scrutinise and judge their bodies. This mirrored the way they scrutinised other women’s bodies when their disordered thinking was present.

"I felt panic.....I think maybe...going into a room of people who...are super body conscious... you're like, oh, are they gonna...pick me apart?" ... "Everyone's just staring at everyone and assessing each other up.... 'cause you know that's how your mind works"... "I just didn't turn up to a lot of sessions...I don't think I made progress in the group" (Talia).

This excerpt further illuminates Talia's experience in the support group led by Penny. The women in the support group were regarded as "therapists" in this research due to the supportive role they played within that space. Talia's account highlights the pervasive panic she felt in the group, driven by her awareness of her own tendency to critique other people's bodies during this time. This prevented her from forming a trusting therapeutic alliance with Penny or the others, as she felt deep shame at the prospect of being assessed. For Talia, her sense of self-worth at the time was derived from her thin physique, and having others notice flaws about her body threatened this. Talia's use of the phrase "I think maybe" suggests that she made sense of her overwhelming panic and shame during the interview rather than in the moment of treatment. Nonetheless, the experience was so powerful that she missed sessions and ultimately left the group, which was a decision that she felt stalled her recovery progress.

Daisy had a similar experience with her thin key worker and occupational therapist, Stacey, though hers occurred in one-to-one therapy and at a later stage of recovery. Daisy

interpreted Stacey's thinness, combined with comments she made (outlined below), as evidence that Stacey had AN and was judging Daisy's body. This assumption arose from a sense of familiarity between Daisy's past, thinner, less recovered self, and Stacey's current appearance. Consequently, Daisy believed that Stacey would adopt the same judgmental thought patterns she had experienced in the past when her AN was more severe.

During this time, Daisy felt uncomfortable in her recovering body, which was larger than what she was used to. She described this discomfort to Stacey as feeling like she was in a "stranger's body" and expressed concern about fitting into a bridesmaid dress for a friend's wedding. In response, Stacey shared her own worries about fitting into a wedding dress. Although Stacey's comment was likely an attempt to connect with Daisy through shared experience, it reinforced Daisy's fear of being judged, further disrupting the trust between them.

"[I was] scared [I wasn't] gonna fit it anymore...and then she started talking about how, ah, well, if I thought that was bad, she was having... her second wedding and she had to make sure that she was still able to fit into her wedding dress" (Daisy)... "I felt that she was judging my body...I immediately did not feel safe with her" (Daisy).

While Talia's distress was triggered by the presence of a thin therapist, Daisy's interpretation was shaped by both Stacey's comments and her thin appearance. In both cases, the resulting panic and shame disrupted the therapeutic relationship. Daisy appeared to process these feelings in real time during treatment, possibly due to the overt nature of Stacey's remarks. Daisy's experience seems to differ from the previous ones described, where the participants were in an early stage of recovery and already resistant to treatment as Daisy was further along in recovery, meaning that she wanted to engage in the treatment. However, Stacey's comments influenced her interpretation of her body, overriding the influence of her later stage of recovery.

5.1.1.b Assumptions: Her Larger Body Looks Like Mine Used To, So She Will Be Easily Triggered to Develop AN Like I Was

A unique assumption for Daisy was that her therapist would be easily triggered into developing AN. Although this theme was only relevant to Daisy, it surfaced multiple times during her interview, signalling its importance to her experience. Daisy described this experience in relation to Lucy, one of her key workers but she highlighted that she had this experience with all of her larger-bodied therapists.

Daisy shared that as a child, her friends made comments about her larger body, which she identified as the start of her body focus, contributing to her development of AN. Consequently, when working with Lucy, Daisy recognised similarities between her larger, past self and her therapist's larger body and assumed that Lucy would think the same way she did in the past. This meant that Daisy assumed that expressing her discomfort in her own larger, recovering body might trigger Lucy to develop AN too.

“Yeah...Petrified...like the thought that I could possibly damage someone else's way that they view themselves”...“so I...felt like I had to like monitor what I was saying and how I was feeling...because I didn't want to upset her.”...“I found myself...like restricting more...Feeling like I was about to have a fucking breakdown” (Daisy).

Daisy's use of the word "petrified" underscores the overwhelming panic she felt at the thought of triggering her therapist. This fear meant that rather than viewing Lucy as an objective person whom she could trust and open up to, she felt forced to carefully monitor what she was saying to protect her. The resulting distress was so profound that she began to restrict her food intake further and felt on the verge of a "breakdown".

Daisy's intense feelings of worry about triggering someone else into developing AN were so powerful that they resurfaced multiple times during the interview. This struggle was apparent in her hesitation and pauses when describing any therapist as having a “larger body”. This parallel process revealed that she considered labelling other bodies as "larger" to be off-limits, anxious that such descriptions might trigger negative reactions, even for the interviewer.

Daisy noted that the significance of Lucy's body in her experience shifted over the course of her recovery. During their initial interaction, when Daisy was hospitalised due to her severely low weight, Lucy's physical appearance was not a focus. During that time, Daisy was only attuned to Lucy's warmth and care as if she had tunnel vision due to her “survival mode”. However, Daisy later explained that as her brain function improved, she began to experience panic about triggering her therapist:

“She didn't know me...but she spoke to me in a way that...she sat with me...like my brain function wasn't great...and then [when I was] refed...that's when I started to have...the uncomfortable feelings of not wanting to offend” (Daisy).

Towards the very end of her recovery journey, her therapist's body played a much smaller role in her experience again:

“By the end of our time together, I wasn't...like focusing on her body, I wasn't focusing on that...as my brain got healthier, like as my brain got more nourished... I was able to.... just not look at her body, but I found that with every single one of the females in particular” (Daisy).

When Daisy talked about her brain getting healthier and having less focus on her therapist's body during treatment, there was a sense of relief there that mirrored how she felt during her therapeutic interactions. It felt as if treatment was a consistent struggle and an uphill

battle where she would search for reasons to disengage, particularly relating to her therapist's body. When she recovered, there seemed to be a switch where she was more willing to engage, and the therapist's body moved out of the tunnel vision focus so she could focus on getting better. In summation, her therapist's body became less of an object in terms of her sense-making in her interactions, and it played a far smaller role in her experience once she was further along in recovery.

During the discussion around her fear of triggering the therapist, Daisy also highlighted how she wished that her therapists would openly discuss their weight as a strategy to mitigate her fear of offending them:

“I would have been so much more comfortable if it had been a situation where they had addressed their bodies or whatever, like my mum does... That could have been helpful at the start... to make me feel more comfortable and maybe I could have been more open”
(Daisy).

Daisy described her mother as being very open about her weight, making jokes and bringing it up in casual conversation. By talking about how she was in a bigger body, her mother unintentionally front-footed Daisy's fear of offending her by bringing this potentially taboo topic to light and showing that she would not be offended by discussions about her body. Daisy noted that it would be helpful for therapists to do the same. This meant that if therapists had an open conversation about their bodies at the start of their time together, it would demonstrate their awareness of their bodies and that it was not something they would be easily offended by if she made comments about her discomfort in her growing, recovering body during therapy. As previously described, Stacey's openness about being nervous about fitting into her wedding dress conveyed feelings of insecurity and judgement about her body. This meant that Daisy interpreted

these comments in conjunction with Stacey's thin body to mean that Stacey would also pick her body apart, negatively impacting the trust she felt towards her. Therefore, the therapist's body type and the content she shared about her body were essential to Daisy in influencing the trust she experienced towards her and, subsequently, her willingness to engage in treatment.

5.1.2 Summary

All three participants experienced a deep lack of willingness to engage with their therapist, which was rooted in the comparison of their body with hers. They assumed that, because their therapist's body resembled their own, either as it appeared during treatment or, in Daisy's case, as it had in her past, the therapist must think as they do (or did). This sense of familiarity led to several specific assumptions, three of which stemmed from believing their thin therapist also had AN at the time of treatment. These assumptions included that Erin felt her therapist was manipulative and therefore could not be trusted; both Erin and Talia believed that their therapist was hypocritical, leading to Erin thinking that she could not trust her therapist's advice and Talia feeling resentment and envy as she felt that she did not belong in treatment. Lastly, Talia and Daisy sensed that their therapist was "picking them apart", producing intense feelings of panic and shame, which meant they could not trust their therapist. For Daisy, the therapist's behaviour (i.e., her comments) and the comparison to her body, supported this assumption. Uniquely, Daisy compared her therapist's larger body with her own past larger self, leading her to fear that any expression of discomfort might trigger her therapist into developing anorexia nervosa, prompting her to closely monitor how she spoke about her discomfort during treatment, meaning that she could not fully engage in the process.

All of these assumptions were closely linked with intense, visceral emotions - panic, jealousy, shame, and resentment - which contributed to their lack of willingness to engage in

treatment, with the majority of these experiences (bar Talia's assumption that her therapist was hypocritical), resulting in the participants feeling that they could not trust their therapist. Notably, some of these insights (such as Daisy's perception of manipulation and Talia's assumption about her therapist judging her) were only developed and made sense during the interviews rather than at the time of treatment. As recovery progressed, Daisy highlighted how the focus on her therapist's body diminished, showing that there was a shift over time. This aligned with the other participants' accounts, as the assumptions and emotions they experienced occurred when their AN was severe.

The alignment of the assumptions, meaning that the participants could not trust their therapist, therefore reducing their willingness to engage in treatment, aligned with the participant's early stage of recovery. Therefore, it appears as if the participant's initial lack of willingness to engage in treatment influenced the assumptions the participants formed about their therapist, based on the interpretation of the comparison of their body to hers, in a way that reinforced their resistance to treatment engagement coming into the interaction.

5.1.3 We Are Different

All three participants also described how the comparison to their therapist's body led to perceived differences. These perceived differences resulted in assumptions and judgments about their therapist, which impacted their willingness to engage in treatment.

5.1.3.a Assumptions

Talia and Daisy also formed assumptions about their therapist based on feeling different to her. These assumptions included that they believed their therapist would not take them seriously because she was thinner than they were and that she "won the genetic lottery", implying that although her body was thin like theirs was, she was fundamentally different from

them. Both of these assumptions negatively impacted their willingness to engage in treatment in ways that will be outlined below.

I'm Larger Than Her, So She Will Not Take Me Seriously

Daisy and Talia both described experiences where they noticed that their therapist was thinner than they were and interpreted this size difference to mean that she would not take them seriously. Daisy highlighted this experience about her treatment with Stacey, her key worker and occupational therapist, late in her recovery journey:

“I understand that was all me...I felt like I needed to be smaller than her for her to take me seriously...” (Daisy).

Daisy compared her body to Stacey's and thought that her own body was larger. From this, Daisy assumed Stacey would not view her as 'sick enough' to warrant treatment. This assumption made Daisy feel embarrassed and ashamed, as she imagined Stacey would think she was wasting her time by being there. Consequently, instead of being fully present during her sessions with Stacey, Daisy found herself preoccupied with these anxious thoughts, with the strong need to “prove” she was worthy of being there. Daisy's words, “I understand that was all me”, highlight the difference between how she interpreted her therapist's body in the moment during treatment and the research interview. In hindsight, Daisy knew that Stacey did not indicate that she did not take her seriously and that this assumption was made solely because she recognised that Stacey was smaller than her.

This belief contradicts Daisy's previously described experience of Stacey's body, where she assumed that Stacey's thinness meant she had AN. However, this makes sense when examining the context of these two interpretations. When Daisy first saw Stacey, she was acutely aware of the limited time and resources available for AN treatment in NZ. Therefore, Stacey was entering therapy, already with the concern that she had to “prove” she was worthy of being there.

This meant that when she saw Stacey in a thinner body, she assumed Stacey would believe she was not “sick enough” to warrant treatment.

Daisy’s earlier described assumption about Stacey having anorexia arose later during their treatment together. This interpretation was triggered by Stacey’s comment about her concern about fitting into her wedding dress and her thin body. Ultimately, Daisy’s fluctuating interpretation of Stacey’s thin body was determined by the additional contextual information she had in that situation, whether that was prior knowledge about the lack of resources, or a comment made by Stacey about fitting into a dress.

Talia shared a similar experience with her dietitian, Penny. Talia felt that because her body was larger than Penny’s, it meant that Penny would think she did not need treatment:

“...or then maybe I felt that I’m too fat to be here” (Talia).

Talia’s assumption provided another reason for her to disengage from treatment with Penny. Previously, she expressed that it felt “unfair” that Penny, who was assumed to have AN, could remain thin while she was required to undergo treatment. These assumptions align with Talia’s early stage of recovery. As she was resistant to treatment, she sought “excuses” or “permission” to disengage from the support group. Consequently, her response to the assumption that her therapist would not take her seriously differed from Daisy’s. While Daisy experienced embarrassment and shame in response to this assumption, as she was motivated to engage in treatment due to her later stage of recovery, Talia felt a sense of relief as it meant that she could disengage from treatment.

She Just Won the Genetic Lottery

Daisy and Talia's assumption that their therapist “just won the genetic lottery” is unique within the “We are Different” theme. Although they recognised that their therapist was slim and

thus shared a similar body type, they still experienced a sense of separation and difference based on how they believed she attained her thinness, meaning that they could not trust her. They assumed that their therapist "won the genetic lottery," meaning she was naturally thin rather than having achieved thinness through AN.

Daisy shared her experience working with Jenna (dietician) during one of her hospital admissions for her severely low weight. Daisy interpreted Jenna's slim body as evidence that she "won the genetic lottery", maintaining her naturally thin physique effortlessly due to her genetics. This interpretation of Jenna's body led Daisy to feel misunderstood. She believed that Jenna could not relate to the struggle of having to actively "work" to stay thin through restrictive behaviours. This assumption also led to a deep mistrust and fear about following Jenna's advice, fuelled by Daisy's fear of gaining weight at this early stage of recovery. Daisy felt the habits that worked for Jenna would make her body too large because Daisy had to actively "work" to stay thin, while Jenna was genetically "gifted" and would remain thin no matter what.

"Genetics were really good to her... she was telling me...I just needed to eat this and eat that, and it was like, well, that might work for you, but fuck... I felt... a little bit misunderstood"... and frustrated that she could do it all right" (Daisy).

Daisy's use of language here clearly highlights how her experience of feeling misunderstood was also associated with a sense of anger and frustration that clouded her interactions with Jenna. There was also a sense of jealousy that her therapist could naturally "do it all right" as she maintained her slim physique without having to endure the struggle of AN.

Stemming from Daisy's assumption that Jenna was naturally thin, she also feared that her therapist would judge her for having AN and for struggling to stay thin. Daisy noted:

"I was embarrassed that I was... struggling"... "I just felt like she had everything together and she knew everything... I was petrified of letting her down" (Daisy).

To Daisy, assuming that Jenna was "naturally" thin came with the assumption that she was perfect and could do no wrong. Daisy found this intimidating and felt that her perceived "perfection" set a standard that she had to live up to, or she would be disappointed and judged for the effort she had to expend to maintain her weight. The repeated use of the word "petrified" in her interview illustrates how frozen and overwhelmed she felt at the thought of letting Jenna down. Ultimately, this created an atmosphere of "keeping up appearances" - a façade that prevented her from trusting Jenna with sensitive information, including her struggle with food.

Talia made a similar assumption about her dietician's body, Jane, believing that she was naturally thin, which disrupted the trust that she felt towards her therapist:

"And that other dietitian...I think she's just naturally thin" (Talia).

This comment was made about whether Talia felt she could use Jane's body as a goal post to gauge how much weight she needed to gain to be considered "recovered" (see role modelling theme below). Talia disregarded Jane's body as a landmark for recovery as she viewed her as naturally thin. For Talia, this meant that Jane would not serve as a healthy role model as she knew her body did not naturally sit at that very thin weight, and to get there, she would have to continue restricting her eating. This was the only comment that Talia made about Jane in the interview. The succinct and direct way she expressed this reflects how quickly she dismissed Jane as someone she could trust and use as a role model for recovery during treatment.

Although both Daisy and Talia felt they could not trust their "naturally thin" therapists, albeit for different reasons, it is interesting that something about their therapists' bodies signalled to them that their thinness was innate rather than the result of restrictive behaviour. Both Daisy and Talia believed they had an intuitive ability to discern whether a person's thin physique was natural, a judgment that ultimately influenced their trust in their therapist.

5.1.3.b She Is Thinner Than I Am: Competition and Shame

Both Talia and Erin compared their bodies to their therapists' and experienced a sense of competition as they perceived their slim figures to be smaller than their own. This dynamic undermined their trust in her by threatening their sense of self-worth, ultimately leading to feelings of insecurity and shame during their interactions.

Talia highlighted this experience when she first met Abby, a therapist she described as "normal weight" and "slim". Talia recalled her initial impression of Abby:

"I was like, oh, she's quite slim...and yeah, I felt like I was massive" (Talia).

Early in Talia's recovery journey, she derived her sense of self-worth from being the smallest in the room. As a result, she frequently compared herself to and competed with other women. Upon comparing her body to Abby's, Talia experienced an overwhelming sense of insecurity and shame because she felt larger than Abby. Talia's use of the word "massive" highlights how much this impacted her self-perception. She did not just describe herself as larger than her therapist but used the word "massive". This elicits the idea that walking into the room and comparing herself to her therapist, who had a slim body, made her feel like she was substantially larger than she was and took up so much more space than the therapist, which caused shame that consumed her in that interaction.

Erin had a similar experience with her thin therapist, Edith, whom she too felt a sense of competition with to be the smallest in the room. As per Erin's previous description, during this time, early in her recovery, she assumed that Edith also had AN, which meant that she liked trying to be thinner than everyone else and was trying to manipulate her. Therefore, Erin's sense of competition adds to the understanding of her distrust of Edith. She felt she was being manipulated by Edith, and she felt a sense of competition to be the smallest in the room at the time, which was threatened by Edith because she was also thin.

"I liked trying to... know that I was skinnier than everyone else in the room" (Erin).

Erin's sense of competition with all women, including her therapist, revealed that her sense of self-worth was closely tied to being thinner than others. Therefore, when she saw that Edith's body was also thin, she was threatened by her. This created feelings of anxiety and shame, which, along with her fear of being manipulated, added to her resistance to engage in treatment. Due to Edith's thin body, Erin did not feel comfortable in the therapeutic space as she was not the thinnest in the room, which was her comfort zone.

5.1.3.c Her Body is Larger: I Have No Right to Feel Uncomfortable with my Weight Gain

Daisy shared that after comparing herself to her larger therapist and noticing that her body was smaller, Daisy experienced shame about feeling discomfort in her growing body during recovery. This was distinct from the previously described fear of triggering her therapist because Daisy's invalidation of her feelings was unrelated to whether she expressed them to her therapist or not. Instead, it was focused on the internal invalidation of her own experience based on the difference between her therapist's body and her own.

"I was also growing into a bigger body and...feeling uncomfortable with it...it [felt] like a stranger's body". "I didn't feel...like I was in any position to think or say anything"
(Daisy).

These statements were not specific to one therapist but reflected Daisy's consistent experience over the years of working with therapists who were larger than her. It is evident that throughout her recovery, Daisy felt a strong sense of discomfort and disconnection between herself and her changing body as she started to put on weight. This disconnect was so strong as her changing body represented a shift from her identity as someone with a thin body, which she viewed as most desirable, to a larger, more undesirable body in her view. The intense distress that she felt due to this disconnect was captured by her description of her recovering body as

belonging to a “stranger”.

While working with larger therapists, Daisy did not allow herself to acknowledge or feel this discomfort in her new, recovering body. Instead, when she noticed herself starting to have those feelings, she felt extreme guilt and thought that she was unjustified in this discomfort because her therapist was larger than her, invalidating and repressing her feelings as a result. For Daisy, larger therapists shaped the emotions she felt she was “allowed” to feel, meaning that she did not view the therapist as an objective person that she could trust but rather a source of guilt for her own experience, which she consequently repressed.

5.1.3.d Role Modelling:

From the comparison of their body to their female therapist’s body, all three participants described concluding whether their therapist was a suitable role model. The therapist’s body determined the women’s willingness to engage in treatment based on whether they wanted to have a body like hers or to be confident like her.

Her Body is Larger Than Mine: She is a Suitable Role Model:

Talia and Erin made sense of the difference they felt between themselves and their therapist, who was in a larger body than theirs, by thinking that she could be a role model for them. For the most part, this had a positive impact on their willingness to engage in therapy. However, there was one instance, as explained by Talia, where this was just a superficial willingness to engage, with no genuine intent to recover. This willingness to use their therapist’s body as a role model was expressed in two different ways by the participants, which will be outlined in turn; “The Therapist’s Confidence in her Larger Body was Inspiring” and the “Therapist’s Average Sized Body as a Yardstick for Health.

i) The therapist’s Confidence in her Larger body is Inspiring

Erin and Daisy had experiences with large therapists, further along in recovery, which increased their willingness to engage in therapy because her confidence made recovery seem less frightening. Daisy and Erin both assumed that when they eventually reached recovery, they would loathe their bodies. Therefore, seeing a larger, confident therapist who liked her body helped ease their fears about recovery and gave them hope that they too could feel that way about their recovered bodies. For both Erin and Daisy, this marked a significant “turning point” in their recovery where they were no longer afraid to gain weight:

"That was so helpful for me...knowing that she actually really loved her own body...that was just something that I kind of never even thought was possible"... "Knowing that like people can like themselves without being stick-thin was like an awakening for me" (Erin).

Erin's experience with her psychologist, Amelia, took place when she was a teenager, beginning to explore the idea of recovery, after months of resistance. Erin described Amelia as being in her 20s to early 30s and of a “*healthy, average weight*” - larger than Erin was at the time. Amelia's confidence challenged Erin's belief that confidence was tied solely to being underweight. Instead, Amelia showed that one could feel happy and comfortable in their skin regardless of size. Erin recalled, *"It was like an awakening for me"*, highlighting the immediate shift in her perspective and the relief she felt upon seeing someone who embodied both a healthy weight and confidence. This experience marked a pivotal moment in Erin's recovery, giving her hope that she need not be trapped in lifelong self-hatred and that she could feel more positively about the idea of recovery. Erin came to view Amelia as a role model and aspired to develop the same sense of confidence.

With regards to this experience, Erin also highlighted that Amelia's openness to discussing how she felt about her body was integral to helping her understand that she was

actually comfortable and confident in her own body. Therefore, Amelia's openness was the factor that led to Erin feeling inspired and motivated to recover:

"She was so honest and open with me... like I could just ask her... "So do you think that you're fat" and she'd be like "no, I don't think I'm fat" And I'm like, oh, OK, then that's good to know."... "I think [it's important to]... to talk about it... let's say they were a little bit chubbier...[she] could be like "Yeah, like I know I'm not the skinniest, but like I actually am really happy with my body" (Erin).

This demonstrates how the therapist's willingness to be transparent about her feelings toward her own body allowed Erin to challenge her previous beliefs about how people feel about themselves when in larger bodies. It was important for the therapist to not only feel confident, but to be open to conversations where Erin could ask her about this, which facilitated her willingness to engage in treatment as she was no longer afraid of recovery.

Daisy shared this experience, highlighting that she also felt inspired and increasingly optimistic about recovery due to her therapist's confidence. She stated:

"I was...envious of her because she was so confident... She didn't care that her body was bigger, like she was comfortable in herself and her body, and who she was and... I wanted that" (Daisy).

Daisy's experience was similar to Erin's, where she experienced what can be described as 'helpful envy' - an aspiration to embody the confidence that her occupational therapist, Taylor, displayed. At this later stage in her recovery, Daisy's admiration for Taylor marked a turning point. It signalled the moment when she was ready to commit to her recovery, 'tipping over' the precipice of the ambivalence she had previously experienced. She experienced a shift in

perspective and opened up to the possibility of feeling confident and comfortable in her body at the end of recovery. For her, this meant that recovery was not such a daunting prospect, as she could feel comfortable and confident in a bigger body.

ii) “Therapist’s Average Sized Body as a Yardstick for Health

Erin and Talia viewed their average-sized therapist as a role model, using her habits and body size to gauge what they considered "healthy". However, their motivations differed. Erin was determined to fully overcome her AN, while Talia aimed to gain only the minimum amount of weight necessary to exit treatment - reflecting the different stages of their recovery.

Erin viewed Amelia, her previously mentioned "healthy, average weight" therapist, as a role model again, but in a different way. At this time, Erin was much further along in her recovery than her previously described experience with Amelia. However, years of disordered eating left her uncertain about what constituted a healthy, normal lifestyle and body. Thus, having a therapist she perceived as a "healthy" size - one she did not consider too big - provided a tangible benchmark that was not too daunting for her. Amelia's habits and lifestyle became a yardstick for Erin, offering a clear model of the behaviours and attitudes she could adopt to live a healthy, recovered life.

"...she was so open and honest with me. She's like "oh, yes, some weeks I go to the gym or some weeks I go for a run, but sometimes there's like three weeks where I just feel tired and I don't go at all". So just knowing like that she did normal things like she exercised but she didn't always exercise..." (Erin)

This extract highlights Erin's previously deeply ingrained thinking about exercise and food. Her fear of becoming large was so overwhelming that she was terrified even a single

misstep, such as skipping a gym session, might cause her to gain a large amount of weight. Erin was shocked that someone she perceived as being of a healthy, normal weight could maintain a balanced approach without rigidly obsessing over diet and exercise. Amelia's average, healthy size reassured Erin that she did not need to fear looking like her if she used her as a role model. More importantly, Amelia's openness about her habits made it possible for Erin to have a clear benchmark for what a balanced lifestyle entailed. In this way, Amelia acting as a yardstick for health sparked another "awakening" for Erin, opening up the exciting and inspiring possibility that she, too, could be like that, solidifying her already established intent to recover.

Talia had a similar experience with her "normal weight/slim" therapist, Abby. She explained,

"I kind of kept her body as... a measure of... how big I have to be before I can get out of here" (Talia).

Unlike Erin who used Amelia's body and habits as a roadmap for genuine recovery, Talia employed Abby's body as a benchmark for the bare minimum weight gain required for discharge, with no real intention to recover or genuinely engage in treatment. For Talia, Abby represented the slimmest someone could acceptably be before AN behaviours would be questioned, reflecting her very early stage in recovery. Interestingly, within the "Competition and Shame" theme, Talia described Abby as someone she felt "massive" in comparison to, implying that she saw herself as much larger than Abby. However, as this experience highlights, she also used Abby's body as a yardstick for the minimum weight gain required for discharge, suggesting that she viewed Abby as thinner than herself. This incongruence can be explained by Talia's initial reaction to Abby, in comparison to her experience of her body as she continued to work with her. As previously outlined, when Talia first entered the room and saw Abby, who was "normal

weight/slim”, her self-worth was threatened, and she had the reaction of feeling that she was “massive” in comparison to her therapist. However, as Talia spent more time with Abby and this initial shock wore off, she viewed Abby's body in a more realistic manner, slim but still larger than hers.

Her Body is Larger than Mine: She is Not a Suitable Role Model

In contrast to the previous sub-theme, Talia and Erin described how they struggled in the early stages of recovery to trust and engage with their larger therapists because she represented a body type they considered “gross” and feared this body for themselves.

Talia recounted her experience with Maria, a psychologist in a "much larger" body than her own, during a period when her AN was severe:

"I think 'cause... she was bigger, I was like, well...I don't want to trust you... why would I listen to you...[it] reinforced the eating disorder mind in a way...my brain was like if you eat, you'll be massive" (Talia).

Talia highlighted the role that her ‘eating disorder mind’ played in her experience with Maria. The role of this ‘brain’ meant that she felt sheer panic about the thought of being overweight and would do anything to avoid this, and that Maria's body represented the body that she most feared for herself. Therefore, she felt that following any advice or spending any time working with Maria would directly result in becoming large. The quote "if you eat, you'll be massive" highlights how extreme this belief was, demonstrating her view that if she did even one thing that Maria suggested, taking even one bite of food, she would automatically become large like her. She could not trust Maria’s advice.

Talia also reflected on how Maria's body influenced her engagement in treatment. She

admitted that she put in only the bare minimum effort to get through therapy and be discharged as quickly as possible. She also noted that following this experience, she lost even more weight, indicating that her anorexia nervosa worsened. Her aversion to becoming large, like Maria, reinforced restrictive behaviours. Talia further reinforced this point, commenting that her willingness to engage in therapy and trust her therapist was primarily determined by whether she wanted to look like them. She described what she would have considered an "ideal" therapist at that time when her anorexia nervosa was severe:

"Someone in the normal range of weight...would be less scary...like, OK, maybe I'll eat it and it won't be that terrible...I think for me, I'd be like, oh, if I ate that other strawberry, I'll be obese...so that's going on in your head and then someone's telling you to eat, and like in your mind they're massive and it's hard to be like "yeah". It's hard to trust what they're saying" (Talia).

Erin also experienced fear and disgust toward her larger-bodied therapists early in her recovery, which led her to distrust their advice and disengage from treatment. For example, she recalled her psychologist Sally, a therapist with a larger body, as follows:

"At the beginning, I thought she was a little bit... that sounds awful... but a little bit like gross. I [felt] kind of like, 'oh, you're a little bit fat, you're a bit yucky', which I thought about everyone who I considered to be overweight at the time. So I... wouldn't have taken what she said on board as much because I perceived her as like, oh, she probably eats too much. Or like, oh, I bet she like, you know, is obsessed with the food or, like, eats too much cake or eats too much chocolate or like something like that" (Erin).

In this account, Erin's deep-seated fear of weight gain is evident. Her "eating disorder mind" led her to view larger bodies as "gross" and out of control, making Sally seem like an

unsuitable role model. Erin feared that by trusting Sally's advice, she might end up looking like her. Notably, her description of this perspective during treatment as "awful" during the interview indicates a shift in her perspective over time. At the time of the interview, she did not have strong feelings towards larger bodies, but during the early stages of her treatment, her "eating disorder mind" seemed to dominate her thinking, making her fear weight gain by perceiving those as overweight as "gross" and out of control.

Talia's experience contrasts with Erin's and Daisy's, who found inspiration in their larger therapist's confidence. Unlike Talia, they were at a later stage of recovery, allowing them to recognise the positive aspects of weight gain and its associated freedom. Their "anorexia brain" no longer dictated their entire experience, meaning they could see beyond the fear of gaining weight and engage more fully in therapy.

5.1.4 Summary

The "We Are Different" theme captured the participants' feeling of difference from their therapist after comparing their bodies. This was based on either having a different body or by feeling that their participant acquired their physique differently - winning the "genetic lottery". Overall, it became clear that the stage of recovery appeared to influence how the participants interpreted their therapist's body. Specifically, in the early stages, their "eating disorder mind" was active. This meant that they made sense of the difference between their therapist's body and their own in ways that provided reasons to disengage from treatment and avoid weight gain as far as possible. However, when the women were later in recovery, their "eating disorder mind" no longer dictated their assumptions and judgements, meaning that these aligned with their willingness to engage in treatment.

CHAPTER SIX: Discussion

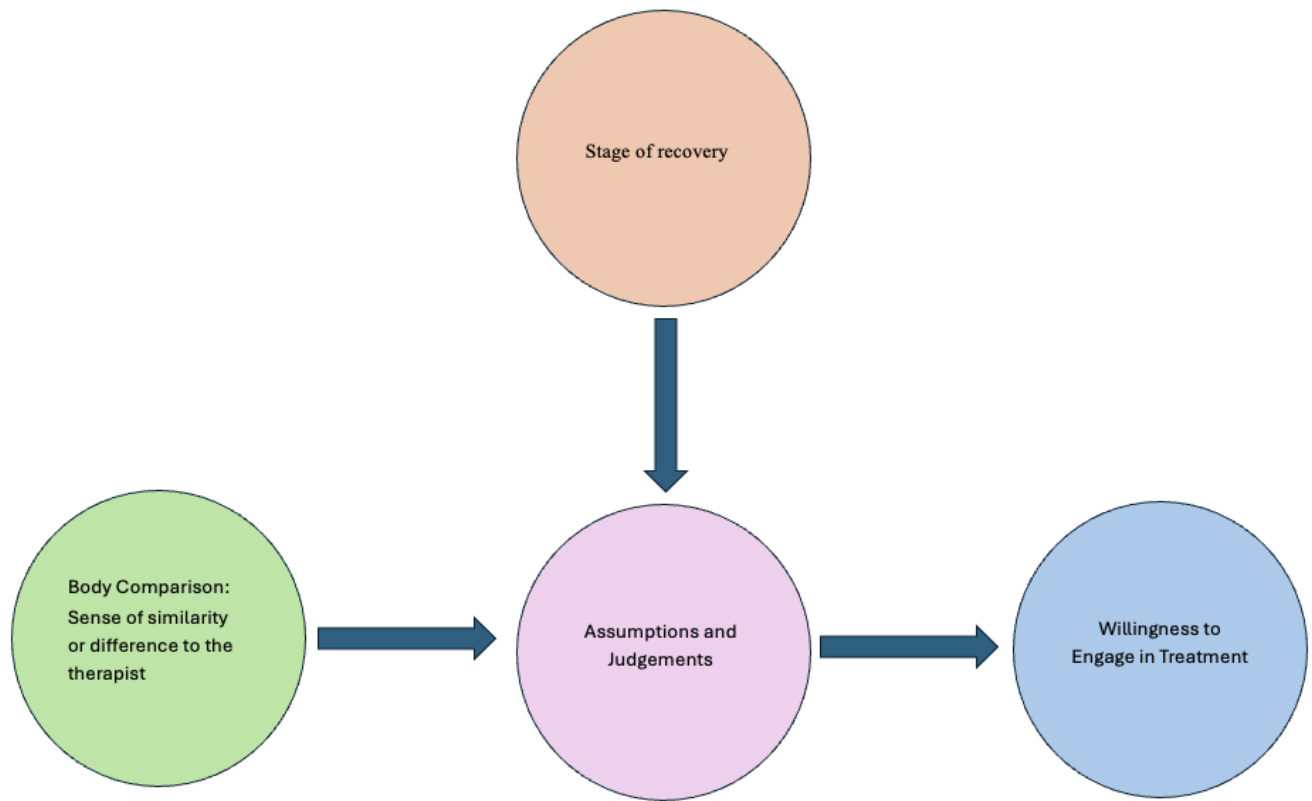
This chapter summarises the main findings of this research and examines them within the context of the limited existing literature. Throughout this discussion, there will be a focus on comparing and contrasting the findings with Rance et al.'s (2014) study, as it most closely aligns with the present research. Finally, this chapter will address the study's limitations and offer recommendations for future research and clinical practice.

6.1 Summary of Findings

This study explored how female-identifying clients in NZ experience and make sense of their female therapist's body during AN treatment. All the therapists mentioned were classified as female by the participants. The research found that participants engaged in body comparisons with female therapists during treatment which impacted their treatment engagement. These comparisons led participants to either feel that their therapist was similar to them or that she was different from them, which in turn influenced the assumptions and judgments participants formed about their therapist. However, it was also found that the participant's stage of recovery impacted these assumptions and judgements.

The findings offer preliminary evidence of a significant process occurring within the therapeutic interaction (Figure 4). When looking across the findings, a cognitive process appears to be at play regarding how participants make sense of their therapist's body. This process is summarised in the visual model below (Figure 4). Due to the methodology, this model is very preliminary and would require quantitative evaluation with larger samples to establish this theory. Nevertheless, the value of this model lies in its ability to show potential mechanisms and processes that may have been influencing participants' willingness to engage in treatment.

Figure 4. Representation of the core process that occurred for the participants as they made sense of their female therapist's body.



Note: This figure was created by the author.

The core aspect of all three participants' experiences was the comparison of their bodies to their female therapist's bodies (green circle in Figure 4). This comparison led to either a sense of similarity or difference, triggering assumptions and judgements about their therapist (pink circle in Figure 4). Notably, the participants' stage of recovery (orange circle in Figure 4) also shaped the participant's assumptions and judgements about their therapist, in response to this body comparison. In the early stages of recovery, the women's assumptions and judgements towards their therapist were influenced by their "eating disorder mind". This state of mind was characterised by a heightened fear of weight gain and, therefore, a reduced willingness to engage in treatment. This meant that they interpreted their therapist's body in a way that provided

reasons for them to disengage from treatment. Conversely, participants further along in recovery were more open to engagement and less influenced by these fears, meaning that their assumptions and judgements further encouraged their engagement in treatment. Thus, the combination of the sense of similarity or difference from the comparison to the therapist's body and the participant's stage of recovery led to the formation of assumptions and judgments about the therapist that impacted their willingness to engage in treatment (blue circle in Figure 4). It is not known, yet, if the arrows would be bidirectional or how this model might work within something like the transdiagnostic model.

6.2 Contextualising the Findings Within the Existing Research

The following section examines the various aspects of participants' experiences of their therapists' bodies. As the summary above highlights, these elements appear to be interconnected and to influence one another. Therefore, while they are presented separately to facilitate discussion in relation to existing literature, they should not be viewed in isolation.

6.2.2 Body Comparison

The findings indicate that all three participants exhibited a strong tendency to compare their bodies to their therapists' bodies to assess their similarities and differences. This aligns with previous research showing that the therapist's body is significant to clients with EDs (Vocks et al., 2007), that practitioners felt their appearance was being monitored, examined, or evaluated by clients (Warren et al., 2009), and that clients with EDs are highly attuned to their therapist's body (Rance et al., 2014). The current findings add to this understanding that attention may be paid to the female therapist's body, showing that these women were comparing themselves to their therapists.

Although Rance et al. (2014) identified body comparison as part of the women's attunement to their therapists' bodies, they also found that this attunement was sometimes unrelated to body comparison. Additionally, Rance et al. (2014) reported that clients were attuned to both their therapist's overall body size (e.g., whether she was thin, average, or fat) and specific body parts (e.g., the therapist's stomach). In contrast, the women in the present study appeared to always engage only in holistic body comparisons, assessing their similarities or differences to their therapist based on overall body size rather than individual body parts.

Several possible explanations exist for the difference between Rance et al.'s (2014) study and the current study's findings. Firstly, Rance et al. (2014) included participants with both AN and BN, whereas this study focused solely on individuals with AN. Individuals with AN may be more inclined to perceive bodies holistically, whereas those with BN may focus on specific body parts. However, this theory is challenged by research on body checking, which suggests that individuals with AN frequently examine specific body parts (e.g., arms or thighs) to monitor perceived changes in weight (Bijsterbosch et al., 2022). This tendency suggests that those with AN do pay attention to specific body parts, making the solely holistic comparisons observed in this study somewhat unexpected. Given this, the holistic nature of body comparisons in this study may be better explained by methodological factors. The current study employed an IPA approach rather than a Thematic Analysis, as Rance et al. (2014) used. This IPA approach, which seeks to explore how participants make sense of their experiences (Smith et al., 2022), may have naturally led participants to describe their comparisons in an integrated and holistic manner, for example, with the research questions aimed at sense-making of the participant's experience of their therapist's body. Furthermore, the interpretations of the participants' accounts may have been framed similarly, meaning that holistic experiences, rather than fragmented observations of specific body parts, may have been highlighted.

Existing literature suggests that social comparison theory (Festinger, 1954) might explain why female clients compare their bodies to their therapist's bodies. The evidence for this view came from findings that women with AN typically engage in frequent and intense upward body-related comparisons in daily life (Corning et al., 2006; Hamel et al., 2012; Keinanen, 2024). These upward comparisons are grounded in the thinness ideal proposed by sociocultural theory, which posits that thinner individuals are attributed higher social 'worth' (Brytek-Matera & Czepczor, 2017). Therefore, before conducting this study, it was assumed that this tendency would extend into the therapeutic setting, where the therapist's body is a salient object for comparison. Although this study provides some evidence that this process occurs in therapy, it does not fully account for what appears to be the primary function of these comparisons. Instead of merely evaluating their social worth, clients appear to be determining whether they perceive themselves as similar to or different from their therapist to gain information about them.

Three key participant experiences aligned with social comparison theory. Talia and Edith both engaged in upward comparisons by measuring themselves against their thinner therapist, which evoked feelings of competition, inadequacy, and shame, ultimately undermining their willingness to engage in treatment. In contrast, Edith also reported engaging in a downward comparison, describing her larger therapist as "gross" and rejecting her as a role model out of fear of developing a similar body.

The core premise of social comparison theory, which states that individuals compare themselves to others to evaluate their self-worth, does not appear to be the primary driver of the comparisons observed in the current study. Instead, the majority of these comparisons seem to serve as an information-gathering process, meaning that clients used their therapist's body to determine whether they were similar or different from her. From this information, participants

then formed assumptions based on this information, as well as their stage of recovery, which ultimately impacted their willingness to engage in treatment. This will be unpacked in the section below, titled “Assumptions and Judgements”.

By employing IPA, this study identified the types of body comparisons occurring in therapy and provided a deeper exploration of the underlying meaning-making processes associated with this body comparison. Unlike the thematic analysis used in Rance et al.’s (2014) study, which focused on identifying patterns across participants, IPA allowed for a more nuanced examination of how these comparisons function as a tool for forming assumptions about the therapist based on perceived similarity or difference. Consequently, while the tendency of individuals with AN to compare themselves to others persists in therapy, these comparisons appear to serve less as a means of self-evaluation and more as a way to gather important information about their therapist.

6.2.3 Assumptions and Judgements

All three participants formed assumptions and judgements about their therapist, which impacted their willingness to engage in treatment. These assumptions and judgements were based on the similarities or differences they perceived by comparing their bodies to their therapists’ bodies. These assumptions were also shaped by the participants’ stage of recovery, which is finding that will be explained below.

This section will begin by explaining two theories that may underpin the tendency for the participants to form assumptions and judgements about their therapists. Then, an explanation about how the participant’s stage of recovery also influenced the assumptions and judgements the participants had about their therapists will be presented. Although the client’s assumptions

and stage of recovery have been presented separately here, from the findings, it was clear that the interaction between these two elements impacted their willingness to engage with their therapist.

Assumptions and Judgements as a Response to Limited Information

The first and simplest explanation for the participants' assumptions and judgments about their therapist is that they were responding to a lack of information. When faced with uncertainty, people rely on observable cues, such as physical appearance, to fill in the blanks, to make the other person more known to them (Howlett et al., 2013; Johnson et al., 2002; Rumsey & Harcourt, 2005). In therapy, where personal disclosure from the therapist is minimal, clients have been shown to scrutinise their therapist's physical appearance for clues about their competence, trustworthiness, and relatability (King, 2018).

The findings of this study suggest that the women compared themselves to their therapist to assess similarities or differences, using this comparison as a means of gathering information about her. How the women made sense of these perceived similarities or differences and how they influenced their willingness to engage in treatment was also determined by their stage of recovery, which will be outlined shortly.

Transference as an Alternative Explanation

Another possible explanation for the assumptions and judgments made by participants is the psychodynamic process of transference. These findings support the evolving conceptualisation of transference, which no longer views the therapist as a neutral entity. Instead, the therapist's physical presence, including their body, is understood to evoke deep-seated bodily memories, unconscious associations, and emotions from the client's past experiences and

relationships, which are then projected onto the therapist (Alexander, 1954; Erb, 2020; Freud, 1912; Orbach, 2004).

This perspective aligns with the present study's findings, particularly within the theme “We Are the Same: Her Body Is Like Mine, So She Thinks Like I Do”. In this context, transference may explain why some participants who perceived their therapist as similar to themselves experienced negative reactions. For instance, some participants assumed that a thin therapist must also have AN, a finding also in Rance et al.’s (2014) study, which reduced their trust and willingness to engage with her. However, it was found that they also felt the therapist would assume their experience was the same as theirs, meaning they would not be listened to. In the present study, the assumption that their thin therapist had AN meant that she thought the same way they did (manipulative, hypocritical, and would pick them apart), meaning that she could not be trusted and provided a reason not to engage in treatment. Therefore, the present study adds depth to the understanding of what it was like for these women when they assumed their therapist also had AN, adding to the strength of evidence that transference was occurring here.

Stage of Recovery

The findings indicate that the participants’ stage of recovery significantly influenced the assumptions and judgments they formed about their therapists. In other words, whether these assumptions were driven by transference or a need for information, they were also shaped by the participants’ recovery stage. Before exploring this further, it is important to note that this conclusion was primarily drawn from comparisons between participants at different stages of recovery, meaning that personal differences may have influenced these findings. Ideally, these insights would have been derived from examining how each participant’s assumptions and

judgments evolved throughout their own recovery. It should be noted that this research was exploratory in nature, meaning that how participants made sense of their therapist's body was the main focus, with only part of the aim being to investigate how this may have changed over recovery. Despite this limitation, at least one clear example of change within a single participant's account (Daisy) was identified and will be outlined below.

Participants in the early stages of recovery, marked by a heightened fear of weight gain, often referred to as the "eating disorder mind", tended to interpret their therapist's body in ways that justified their disengagement from treatment, regardless of her body size. Similarly, Rance et al. (2017) described this phenomenon in their exploration of the lived experience of AN, noting that individuals with severe AN often felt "controlled" by their disorder, which involved distorted cognitions and an intense fear of weight gain. Over time, as clients progressed in their recovery, the influence of the "eating disorder mind" appeared to diminish, leading to shifts in their perception of their therapist, as well as the reduced importance of their therapist's body to their experience. Specifically, as the participants recovered, it appeared that their therapist's body was less important to their experience, and they began to view their therapist's body as a reason to engage in treatment, with the similarities and differences they perceived aligning with their increasing willingness to recover.

Daisy's narrative provides specific evidence for how the stage of recovery influenced the importance of the therapist's body to her experience. Initially, when Daisy's AN was severe and she was severely malnourished, she reported that her therapist's body held little importance to her because her brain was not fully functioning. However, as she regained cognitive function but remained deeply entrenched in her AN, her therapist's body became a focal point of concern, reducing her willingness to engage in treatment. Later, as her recovery progressed, the

significance of her therapist's body diminished once again. This pattern aligns with Rance et al. (2014), who found that once recovered, participants' body-related attunement, comparisons, and distorted perceptions became far less significant. However, Rance et al.'s (2014) study only captured participants' recollections of their experiences during and after treatment, rather than across different stages of recovery. In contrast, the present study offers new insight by highlighting how these perceptions evolved over time through comparisons across participants' accounts. Specifically, it illustrates how Daisy's focus on her therapist's body lessened as she reached the later stages of recovery.

Beyond Daisy's individual experience, other participants' narratives also suggested that their stage of recovery shaped their perceptions of their therapists, with assumptions shifting over time. This shift was not necessarily about how significant the therapist's body was to them but rather how they interpreted it. For example, Erin, in early recovery, struggled to trust and engage with her larger-bodied therapist. She did not view her as a role model for recovery due to her fear of gaining weight and looking like her, perceiving larger bodies as "gross". In contrast, Daisy, at a later stage of recovery, interpreted her larger therapist's confidence as "inspiring," which motivated her to recover and engage in treatment. This suggests that the meaning participants assigned to their therapist's body changed depending on their stage of recovery. In early recovery, their interpretations tended to justify disengagement from treatment, whereas later in recovery, their therapist's body was interpreted in ways that reinforced their commitment to treatment. However, this remains a tentative conclusion, as it is drawn from comparisons across participants rather than tracking changes within a single individual.

Similarly, differences in how Daisy and Talia responded to having a smaller-bodied therapist further illustrate this pattern. Daisy, in a later stage of recovery, experienced panic and

felt she had to "prove" she was worthy of staying in treatment. In contrast, Talia, in an earlier stage of recovery, felt relief, interpreting her therapist's size as implicit permission to disengage from treatment. These examples demonstrate that therapists with similar body sizes were interpreted in vastly different ways depending on the participant's stage of recovery. This highlights how, for individuals with AN, body comparison occurred, but its meaning was shaped by their stage of recovery rather than by the therapist's body itself. This finding contrasts with Rance et al. (2014), who suggested that the therapist's body size directly determined clients' interpretations.

Erin's experience with her larger-bodied therapist aligns with Rance et al.'s (2014) findings, in which therapists perceived as "fat" were consistently assumed to have lost control over their eating. This suggests that participants in Rance et al.'s (2014) study may have recalled these perceptions from the early stages of recovery. Additionally, Rance et al. (2014) did not explore participants' experiences with larger-bodied therapists, meaning that the present study provides additional insight based on direct participant experience. The findings indicate that larger-bodied therapists were not universally perceived negatively or as a barrier to engagement, as Rance et al.'s (2014) study suggested. Rather, these perceptions were shaped by the participants' stage of recovery.

Interestingly, one assumption persisted for Daisy regardless of her stage of recovery. This appeared to be the only assumption or judgment in the study that was not influenced by the recovery stage. Specifically, Daisy feared that expressing discomfort about her weight gain might trigger her larger-bodied therapist to develop AN. This was a significant concern, as Daisy described the profound impact it had on her ability to engage in treatment, stating that she felt on the verge of a "breakdown" due to the constant monitoring of her words. This aligns with Rance

et al.'s (2014) findings, where participants expressed a need to protect their therapist, fearing that sharing their experiences might trigger a relapse, particularly if they assumed the therapist had a history of an eating disorder. Similarly, Watterson (2020) found that many clients with EDs expressed concern about the emotional impact of their disclosures on their therapist, worrying that discussing their distress in depth could negatively affect them or even contribute to disordered eating behaviours. This persistent apprehension aligns with the lived experience of AN, which the participants in Rance et al. (2017) study described as being marked by isolation and shame. Daisy may have been particularly attuned to this and, as a result, was reluctant to place her therapist in a similarly distressing position, to develop AN.

For Daisy, the general pattern of the stage of recovery impacting the assumptions and judgements made was altered by what her therapist shared with her. At a later stage of recovery than the other participants, she assumed her therapist had AN. This belief emerged in response to a comment her therapist made about fitting into a wedding dress, which Daisy interpreted as body concerns. For Daisy, this led to the assumption that her therapist also had AN. As a result, her trust in the therapist was disrupted, and she became less willing to engage in treatment despite being in a more advanced stage of recovery. This highlights that assumptions were shaped by the therapist's body and the participant's recovery stage and by what the therapist said.

In summary, clients' reactions to their therapist's body appear to reflect their stage of recovery. Specifically, the way they interpreted their therapist's body influenced their decision to engage or disengage from treatment. While body comparison did occur, leading clients to make assumptions, either through transference or by filling in gaps, these assumptions were shaped by the personal significance of the therapist's body to them rather than by the therapist's body itself.

Despite this overarching pattern, the fear of offending the therapist persisted for Daisy regardless of her recovery stage. Additionally, the therapist's words played a role in shaping how Daisy interpreted her therapist's body.

6.2.1 Willingness to Engage in Treatment

A key outcome of the women's sense-making was how their assumptions and judgements impacted their willingness to engage in treatment. Given the well-documented high attrition rates for AN treatment (DeJong et al., 2012), this finding is particularly important as it may help to partly explain why this occurs.

The Therapeutic Alliance:

The therapeutic alliance measures mutual engagement between the therapist and client (Horvath & Symonds, 1991). Given this, the concept of the therapeutic alliance may help explain the women's willingness to engage in treatment. This connection becomes particularly evident when considering that the assumptions and judgments the women formed about their therapist often influenced their level of trust in her. Trust is a key component of the therapeutic bond, which is one of the three elements of the therapeutic alliance proposed by Bordin (1971).

In the context of the wider literature, the consistent emergence of trust as an important factor for clients is unsurprising. Trust in the therapist is widely recognised as one of the most crucial aspects of treatment engagement across various diagnoses (Wilkins, 2018; Zaitsoff et al., 2015). Research examining the role of physical appearance in therapist-client interactions found that trustworthiness was one of the key traits participants attempted to infer from their therapist's appearance, highlighting its significance to clients (King, 2018).

Although the literature acknowledges that trust in the therapeutic relationship is difficult to define, partly due to its subjective nature and dependence on individual perceptions, Rogers (1951) described trust as confidence in another person's character or behaviour, independent of observable evidence. Trust fosters a therapeutic space that encourages vulnerability, allowing clients to feel safe expressing and discussing their emotions (Rogers, 1951). Therefore, when trust is compromised, clients may struggle to engage in treatment as it no longer feels like a safe space for them. This aligns with the experiences of women in this study, as a perceived lack of trust was associated with a reduced willingness to engage in treatment. In some instances, the women chose to leave treatment altogether when the assumptions or judgements about their therapist negatively impacted their trust in her. These findings further support the crucial role of trust in the therapeutic alliance, and highlight how the body comparison and the participant's stage of recovery can impact this.

In addition to trust, feeling understood was also a key factor in the women's engagement in treatment. This also aligns with the therapeutic bond described in Bordin's (1979) model of the therapeutic alliance. When participants did not feel understood by their therapist due to the assumptions and judgments they formed about her, their willingness to engage in treatment decreased. For example, Daisy assumed that her therapist had "won the genetic lottery", believing that because the therapist was naturally thin, she could not truly understand the struggle of AN. This aligns with existing literature on the lived experience of AN, which describes a profound sense of loneliness stemming from the belief that those with AN are fundamentally different from others and that society does not truly understand their distress (Rance et al., 2017). This suggests that the need to feel understood may not only be a general therapeutic necessity but may be especially crucial for individuals with AN during treatment.

The concept of feeling “understood” is closely linked to empathy, which is consistently associated with positive therapeutic outcomes, including treatment engagement, across various disorders (Elliott et al., 2018; Watson, 2016). While empathy has been defined in multiple ways, Finset and Ørnes (2017) describe it as “the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another” (p. 2). This definition captures the depth of understanding that participants in this study valued in their therapists. However, while participants appreciated their therapist’s ability to understand them, there were important caveats to this. One might expect that if a therapist had personal experience with AN, this would enhance the participant’s sense of being understood. Although this may be the case for historical experience with AN, participants in this study found this assumption unhelpful, specifically when they assumed their therapist also had AN at the time of treatment. They feared that a therapist with assumed AN would hold the unhelpful thought patterns that they themselves did, which would negatively impact the therapeutic interaction (e.g. thinking that the therapist is being manipulative as Erin did).

6.3 Limitations and Recommendations for Future Research

Although every effort was made to conduct methodologically sound research, several limitations arose, highlighting areas for further investigation in future studies. Firstly, the study had a small number of participants. While this is in line with Interpretative Phenomenological Analysis (IPA) research, further studies are needed to explore the experiences of a more diverse group of individuals with AN. Much of the existing literature reflects perspectives from therapists rather than from those with lived experience. Expanding research to include a broader range of voices is essential to fully understand the complexities of how the therapist’s body may impact treatment engagement in AN.

One key finding of this study was that participants' stage of recovery appeared to influence their assumptions and judgments about their therapist, which in turn affected their willingness to engage in treatment. However, as previously noted, only Daisy's account provided direct insight into how these perceptions changed over the course of her recovery. For the other participants, conclusions were drawn across their experiences at different stages of recovery rather than by gaining an account of these changes throughout recovery for each participant. Therefore, future research should specifically examine how clients' interpretations of their therapist's body evolve throughout their recovery journey. This could be achieved by conducting longitudinal studies that track participants' perspectives from the beginning to the end of treatment.

All participants in this study were Pākehā women. This was an unavoidable limitation due to the small number of individuals willing to participate. Future research in Aotearoa, New Zealand, should aim to explore cross-cultural differences. A valuable starting point would be to conduct a similar study with Māori participants to determine whether significant differences emerge in how they make sense of their therapist's body. Additionally, broader cross-cultural investigations into how clients interpret their therapist's body would provide further insight into potential cultural influences on treatment engagement (Brewis & McGarvey, 2000; Durie, 1988; Haua & Enari, 2023; Ringrose & Zimmet, 1979). The same research should also be conducted with Men, exploring how men with AN experience their therapist's body. Participants in this study were given the freedom to choose which therapist they discussed, knowing they had received support from multiple professionals during their recovery. All participants referred to female therapists from various professional backgrounds. Rance et al. (2014) suggest that female clients compare their bodies to female therapists but not to male therapists, as male bodies are perceived as too different to serve as a point of comparison. Future research could explore the

impact of male therapists' bodies on male clients with AN. This is a crucial area of investigation, as male body ideals differ from female body ideals, with Western culture emphasizing muscularity rather than thinness (Lavender et al., 2017). It is possible that male clients may make sense of their male therapist's body in a way that influences their treatment experience, but further research is needed to explore this hypothesis.

Finally, this study focused solely on AN. Future research should examine whether similar patterns occur in individuals with other EDs or mental health disorders related to body image concerns. Broadening the scope of research would help determine whether the impact of the therapist's body is specific to AN or whether it plays a role in other forms of psychological distress related to body image.

6.4 Recommendations for Therapists

The recommendations in this section are presented tentatively, acknowledging that the findings are based on the experiences of only three women. Nonetheless, their experiences suggest several ways in which therapists working with women diagnosed with AN may support their client's engagement in treatment.

As discussed, the assumptions and judgments clients form about their therapist appear to be influenced by both their stage of recovery and their perception of similarities or differences in relation to the therapist's body. Given this, it is crucial for therapists to take proactive steps to front-foot and address potential assumptions or judgments their clients may hold about them. With the knowledge that this process may be occurring, therapists should create a space within treatment to openly discuss clients' reactions to their therapist's body. Doing so allows these reactions to be processed in a supportive way that may foster engagement. One possible approach is to use psychoeducation to normalise these assumptions and judgments, explaining

that they are common and may reflect the client's stage of recovery. By acknowledging and addressing these comparisons, assumptions, and judgments, therapists can help clients work through the thoughts and emotions that arise. This prevents such concerns from becoming unspoken barriers to engagement.

Another key recommendation is for therapists to model body confidence. Demonstrating a positive relationship with one's body may help challenge clients' negative perceptions of recovery and illustrate that confidence in all body shapes is possible. Additionally, reassuring clients that they can ask questions about these topics may foster open dialogue and allow clients to gain information about the therapist's own confidence in her body. However, therapists must exercise caution in sharing personal information to avoid conveying information that can be misinterpreted as indicative of an eating disorder (e.g., discussing difficulties with clothing fit).

Finally, it is beneficial for therapists to demonstrate that they are not easily unsettled by discussions about body image, reinforcing their stability and ability to support the client effectively. By reducing the sense of taboo around these topics, therapists can create a more open and supportive environment. This approach may enhance the therapeutic process and improve the client's engagement in treatment by reassuring clients that they do not need to fear triggering their therapist to develop AN.

6.5 Conclusion

The women's experiences from this study revealed that the therapist's body may play a key role in influencing the clients' treatment engagement. Most notably, participants compared their bodies to their therapist's body, which created a sense of similarity or difference. This comparison, in combination with their stage of recovery, led to assumptions and judgments about

their therapist which influenced their willingness to engage in treatment. Specifically, at the early stages of recovery, when their anorexia nervosa was severe, participants interpreted body comparisons through the lens of their “eating disorder mind”, making assumptions and judgments that reduced their willingness to engage in treatment. In contrast, participants at later stages of recovery, who were motivated to recover, formed different assumptions and judgements, fostering a greater willingness to engage. The therapeutic alliance underpinned the participants' treatment engagement, meaning that the participants' sense of trust and feeling understood were also crucial to treatment engagement. Participants recommended strongly recommended that therapists acknowledge and discuss their bodies with clients and adopt a transparent approach. These findings provide preliminary evidence that the therapist's body influences the client's experience and engagement in treatment. Therefore, therapists should consider and address these reactions to support client engagement effectively.

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Appendices

Appendix A: Advertisement for Participant Recruitment



Anorexia Nervosa Treatment: Did your Therapist's Body Matter?

Have you received treatment for anorexia nervosa in Aotearoa, New Zealand? If so, you are invited to participate in this important study, exploring how you experienced your female therapist's body.

Why Participate?

Your participation will be important to advancing our understanding of this under-researched area. I hope that this project will raise the profile of this important topic and lead to more research that will help to improve treatment outcomes for anorexia nervosa in Aotearoa, New Zealand.

As an acknowledgment of your time and contribution to this study, you will be gifted a \$40 petrol or supermarket voucher if you choose to participate.

Who can take part?

This study welcomes female-identifying participants living in Aotearoa, New Zealand, who received face-to-face treatment for anorexia nervosa with a female therapist after 18 years old in New Zealand. This includes any intervention or support provided by any female practitioner involved in your recovery (e.g., doctors, psychiatrists, nurses, dieticians, psychotherapists, counsellors, group facilitators, and psychologists).

Participants must also self-identify as either recovered or on the road to recovery from anorexia nervosa.

When and where?

In-person interviews (face-to-face or via Zoom) will take place in a private meeting room at a location and time convenient to you. Interviews will last approximately 60-90 minutes.

Any information identifying you will be kept confidential, and your data will be anonymised.

How do I get involved?

If you would like to know more, please do not hesitate to contact me via the email address listed below. I would love to chat about this research project, answer any questions you might have, and send you more detailed information via the project information sheet.

Student Researcher: Jayde Kelly
Email: jayde.kelly.1@uni.massey.ac.nz

Appendix B: Information Sheet



Information Sheet

Exploring Female Clients' Experience of Their Female Therapist's Body During Anorexia Nervosa Treatment.

Thank you for your interest in this research project. My name is Jayde Kelly and I am a student completing my Master of Science (Psychology) qualification at Massey University.

Project Description:

This research aims to explore female client's perceptions of their female therapist's body during previous anorexia nervosa treatment.

If you choose to participate in this project, you will take part in an interview where you will be asked about your experience of your female therapist's body during treatment.

Before the interview, I will send you a copy of the questions to review and will be available to discuss any questions you may have. The interview will be semi-structured, which means that I will ask you to tell me some stories that reflect your experiences rather than having questions that are more specific and closed in nature. We will meet in a private, quiet location, such as your home or in a public area that will ensure your privacy. I welcome you to bring anyone or anything that makes you more comfortable (including whānau members, friends, or objects). If you do not want to meet in person or live outside of Auckland, we can meet via Zoom (or another online method). I expect that each interview will last between 60-90 minutes.

About You:

I am inviting participants to take part in this study who:

- Identify as female
- Reside in Aotearoa, New Zealand
- Have lived experience of anorexia nervosa
- Have received face-to-face "treatment" with a female "therapist" for anorexia nervosa in New Zealand over the age of 18 years old
 - "Therapist": In this research, the term "therapist" includes any practitioner that was involved in your recovery from anorexia (e.g., doctors, psychiatrists, nurses, dieticians, psychotherapists, counsellors, group facilitators, and psychologists).
 - "Treatment": In this study, "treatment" includes any intervention or support by a "therapist" (above) for your anorexia nervosa. For example, "treatment" could be group therapy, one-to-one therapy, or meetings with your dietician.
- Self-identify as "recovered". I understand that recovery is an ill-defined process. The purpose of this is to establish whether you feel "recovered enough" to discuss your treatment experience and to ensure that you are not currently seeking treatment for anorexia nervosa so this research does not impact your therapy.

Benefits and Risks of This Research:

There is little known about how female clients experience their female therapist's body, and there is evidence to show that therapists do not usually consider this during treatment. The hope for this research is that the experiences you share will contribute to this significantly under-researched area which will have the potential to raise the profile of this topic so that further research may be done. It is also my hope that from this, therapists may be able to develop strategies to manage any impact this may have on treatment, and therefore improve treatment outcomes. You will be offered a \$40 petrol or supermarket voucher to acknowledge your time and contribution to the study.

During the interview, you will discuss how you experienced your therapist's body. Recalling details from when you were actively experiencing distress could bring up unpleasant feelings or thoughts. However, you will be provided the questions before the interview and will have multiple opportunities to ask questions or raise any concerns that you may have before, during, and after the interview. You will also have the right to decline any question you do not wish to answer and can stop the interview at any time. You do not have to explain why you want to stop.

If you find the interview distressing, information regarding support is provided at the end of this sheet.

Data Management:

Your confidentiality and privacy are important. Therefore, all names and identifying information will be removed from the transcripts, data, and the write-up of this research. Our conversation will be recorded (visual and audio) so that I can transcribe it into a written document. I will use pseudonyms when transcribing our discussion and will remove any other identifiable information. Your transcripts will be stored within a password-protected file on a password-protected computer. Two weeks after our interview, I will arrange to meet again and show you the transcript or email it to you. You will be given the opportunity to edit this if you wish to. Once you have approved the transcript, I will delete the recording of our interview.

I will store consent forms with your real name on them in a locked filing cabinet. Thereafter, I will digitise the consent forms, password-protect the files, and store them on a password-protected computer. Upon completion of the research project, all documents will be destroyed following Massey University's document destruction policies. I will also provide you with a summary of the research findings if you request this.

Participant's Rights:

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- *Decline to answer any particular question;*
- *Withdraw from the study up to two weeks after your interview;*
- *Ask any questions about the study at any time during participation;*
- *Ask for the recorder to be turned off at any time during the interview;*
- *Provide information on the understanding that your name will not be used;*
- *Be given access to a summary of the project findings when it is concluded.*

Contact Details:

My research supervisors are Dr. Kathryn McGuigan (primary supervisor), Lecturer at Massey University, and Dr. Joanne Taylor, Associate Professor at Massey University and Clinical Psychologist.

If you have any questions about the study, please contact me or one of my supervisors.

<p>Jayde Kelly Student, School of Psychology Albany Campus Massey University Email: jayde.kelly.1@uni.massey.ac.nz</p>	<p>Dr. Kathryn McGuigan Email: k.mcguigan@massey.ac.nz</p>	<p>Dr. Joanne Taylor Email J.E.Taylor@massey.ac.nz</p>
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Support Information:

If you find the interview distressing, please use your existing support services. It can also be useful to talk with your GP or other medical professionals that you have a good relationship with. The following support lines and resources can also be used:

- **1737, need to talk?** If you're feeling anxious, down, overwhelmed or that you need to talk with someone, you can call or text the helpline for free, anytime (24 hours, 7 days a week) 0800 1737 1737 – free call
- **Anxiety Helpline** (0800 2694389)
- **The Depression Helpline** (0800 111 757) or text 4202
- **Healthline** (0800 611 116)
- **Lifeline** (0800 543 354)
- **Samaritans** (0800 726 666)
- **The Lowdown** www.thelowdown.co.nz or free text 5626
- **Health and Disability Commissioner**
<https://www.hdc.org.nz/mental-health-addictions/where-to-find-help-and-support/>
- **Mental Health Foundation website**
<https://www.mentalhealth.org.nz/get-help/in-crisis/support-groups/>

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 00/00. If you have any concerns about the conduct of this research, please contact A/Prof Fiona Te Momo, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800, x 43347, email humanethicsnorth@massey.ac.nz

Appendix C: Interview Schedule

Interview Schedule

Kia ora (insert name), thank you for taking the time to meet with me. Before we begin, let's briefly go over what we will be covering in our meeting today. We will begin by taking some time to get to know one another. We will then move on to the interview questions which you have seen. The whole interview will last between 60-90 minutes but you can stop at any time if you are feeling uncomfortable or if you would like to take a break. Just to reiterate again, you do not have to answer any questions if you do not feel comfortable doing so, and you do not need to give me a reason for this. Before we begin, do you have any questions?

I would also like to check again that you consent to taking part in this interview - are you still feeling comfortable to take part?

Opening Karakia/process of the participants choice as stated in the screening interview (i.e. karakia, prayer, saying, or this may be omitted).

Karakia/Prayer for Kai (Omit if the meeting is online, or if the participant wishes to omit)

Whanaungatanga/Introduction

- I will share my pepeha here if the participant would like to include this in the whanaungatanga process. If not, I will move on to introduce myself, sharing a little bit of information about who I am. Here I will explain my current studies (Master of Science student), as well as my background working in mental health and my current role at Corrections. If asked, I will also share a little bit about my placement in the eating disorder space as an outsider.

- I will then ask the participant to share some information about herself
 - Prompts:
 - Where did you grow up?
 - What do you do for work/study?
 - What are your hobbies/interests?

Turn audio-recording on (let the participant know).

Interview/ Kaupapa:

As you know, the aim of this research is to explore your experience of your therapist's body during anorexia nervosa treatment. Before exploring your experience of your therapist's body, it would be helpful to learn a bit about your background with anorexia nervosa. What do you feel comfortable sharing?

- Prompts:
 - How old were you when you first started to notice a change in your thinking around food/ when were you diagnosed?
 - Why did you decide to seek support?
 - What type of treatment did you engage in?
 - Did you see multiple therapists? Which kinds?
 - Did you have input into who your therapist was?
 - How long were you in therapy for?
 - What was your experience with this support?
 - How effective do you think this support was? Why?
 - Why did you seek support from a female therapist?

- What does recovery mean for you? Where are you sitting with this now?

I am now going to move on to more specific questions about your experience with your therapist's bodies.

Before we start, it is important for me to highlight that this is a safe place to talk about your experience, including your thoughts and feelings about other people's bodies. Everyone has thoughts and feelings when it comes to other people's bodies.

When answering the following questions, think of one therapist that jumps out to you or that comes to mind. When talking about your experiences, try to be specific about the therapist you are talking about and their role - remembering it can be anyone that was involved in your recovery journey e.g. a dietitian, psychologist, psychiatrist, support group facilitator etc.

1) When you first met your therapist, what, if anything, stood out to you about them?

- Prompts:
 - What was it about your therapist's body that stood out to you? (Underweight, overweight, healthy weight, certain body parts?)
 - Did anything about your therapist's body capture your attention?

2) What was that experience like?

- Prompts:
 - What were your thoughts and feelings towards her body?
 - What assumptions, if any, did you have about your therapist based on her body?
 - What did her body mean to you?
 - How did it make you feel?

- Why do you think you had those thoughts and feelings?

3) How did this initial experience of your therapist's body compare to other points during your treatment with her?

- Prompts:
 - Did your initial experience of your therapist's body change over time?
 - How do you make sense of this change?

4) How did your experience of this therapist's body compare to your experience with other therapist's bodies?

- Prompts:
 - What stands out for you when comparing your experience of these therapist's bodies?
 - Why do you think this was the case?
 - How do you make sense of this?

5) Why do you think you had these experiences?

- Prompts:
 - How do you make sense of the way you experienced your therapist's bodies?
 - What do you think shaped this reaction/experience?

6) How do you understand your experience of your therapist's body in relation to your treatment experience as a whole?

- How, if at all, did your experience of your therapist's body influence how you felt about treatment?

- In what ways, if any, did your experience of your therapist's body shape how you engaged in therapy?
- How did your experience of your therapist's body relate to your therapeutic relationship?
- Did your experience of your therapist's body influence your perception of her ability to help you? If so, in what way?

7) Is there anything else you would like to add that you think would be important?

Turn audio-recording off (let the participant know).

Check-in:

That brings us to the end of our interview. How are you feeling?

- Ask for permission to contact the participant for a follow-up check in call and let them let them know that they can contact me if there are any follow up questions or if any other thoughts come up that are relevant to the interview.
- If the participant is not feeling well, follow the procedure outlined in the safety plan

Closing

Thank you so much for your time today, I really appreciate it. I hope that you enjoyed our session together. I will email you a transcript of our interview in the next few days and you will have two weeks to make any changes to it. If you have any questions at all, please feel free to email me.

Closing Karakia (if preferred by participant)

Appendix D: Exploratory Notes

Interview Transcript	Exploratory noting
<p>Erin 38:42</p> <p>Thank you. Yeah. And I think during that time, like I can think of what my thoughts were then, but they wouldn't be the same as what they are now. And I think when I was struggling with anorexia, like I would say I was quite like fat phobic,</p> <p>it wasn't just about me, but I had this strange perception of people's bodies and like what that means about them and I would not think that way now. But I know I had those thoughts before., it is what it is. That's the way I thought. Yeah.</p> <p>Erin 41:04</p>	<p>Thoughts have changed over time about her therapist's body</p> <p>As she has recovered - her brain functions differently</p> <p>Since being recovered - she is less judgemental of people's bodies.</p> <p>Now that she is recovered, people's bodies have less of an impact on her.</p> <p>Since recovery, she thinks more positively towards all body types.</p> <p>Fat phobic towards others when struggling with anorexia (thoughts have changed over time)</p> <p>had negative feelings towards people in general that were overweight (not just therapists).</p>

<p>I feel like they all stood out to me so I probably wont just answer based on one of the people that I worked with, I'll probably use different therapists because I would say I had some sort of reaction to the way all of them looked.</p>	<p>Was fat phobic towards herself too.</p> <p>Sees her views of other's bodies at the time of AN as "strange" - judgemental/ looks down on her past self.</p> <p>Perception of peoples bodies carried weight about them as a person.</p> <p>Would tie personal characteristics/traits/value to the person based on body weight</p> <p>Thinks differently about people's bodies now that she has recovered.</p> <p>Laughter here and speaking quite quickly talking about her previous views of women's bodies - feeling uncomfortable about with having those views towards larger bodies previously - that sense of dissonance between how she thinks now vs then - judgemental of past self</p> <p>The therapist's body was always something</p>
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	<p>that stood out to her.</p> <p>The therapists weight was an important factor about how she perceived them</p> <p>Had a reaction to how all therapist's looked.</p> <p>Repetition - showed how important the therapist's body was to her in her perception of them.</p>
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Appendix E: Experiential Statements

Experiential Statements	Interview Transcript	Exploratory noting
<p>Attitudes towards bodies changed over recovery.</p>	<p>Erin 38:42</p> <p>Thank you. Yeah. And I think during that time, like I can think of what my thoughts were then, but they wouldn't be the same as what they are now.</p> <p>And I think when I was struggling with anorexia, like I would say I was quite like fat phobic,</p> <p>it wasn't just about me, but I had this strange perception of people's bodies and like what that means about them and I would not think that way now.</p> <p>But I know I had those thoughts before., it is what it is. That's the way I thought. Yeah.</p>	<p>Thoughts have changed over time about her therapist's body</p> <p>As she has recovered - her brain functions differently</p> <p>Since being recovered - she is less judgemental of people's bodies.</p> <p>Now that she is recovered, people's bodies have less of an impact on her.</p> <p>Since recovery, she thinks more positively towards all body types.</p> <p>Fat phobic towards others when struggling with anorexia (thoughts have changed over time)</p>

<p>Assumptions were made about personal characteristics based on body size e.g. no control over self, gross, had an ED themselves.</p>	<p>Erin 41:04</p> <p>I feel like they all stood out to me so I probably wont just answer based on one of the people that I worked with, I'll probably use different therapists because I would say I had some sort of reaction to the way all of them looked.</p>	<p>had negative feelings towards people in general that were overweight (not just therapists).</p> <p>Was fat phobic towards herself too.</p> <p>Sees her views of other's bodies at the time of AN as "strange" - judgemental/ looks down on her past self.</p> <p>Perception of peoples bodies carried weight about them as a person.</p> <p>Would tie personal characteristics/traits/value to the person based on body weight</p> <p>Thinks differently about people's bodies now that she has recovered.</p>
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<p>Therapist's body played a large role in Erin's perception of her.</p>		<p>Laughter here and speaking quite quickly talking about her previous views of women's bodies - feeling uncomfortable about with having those views towards larger bodies previously - that sense of dissonance between how she thinks now vs then - judgemental of past self</p> <p>The therapist's body was always something that stood out to her.</p> <p>The therapists weight was an important factor about how she perceived them</p> <p>Had a reaction to how all therapist's looked. Repetition - showed how important the</p>
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		therapist's body was to her in her perception of them.
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