CHANTELLE E MCKENZIE BSc Hons

INVESTIGATING TURNING POINTS AND FACILITATING EATING DISORDER RECOVERY

Section A:
Turning points in eating disorder recovery: A systematic review of qualitative literature
Word Count: 7985 (328)

Section B:
“It's literally like been life-changing”: An Interpretative Phenomenological Analysis of a motivational chairwork intervention for the treatment of Anorexia Nervosa
Word Count: 7994 (268)

Overall Word Count: 15,979 (596)

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

September 2023

SALOMONS INSTITUTE FOR APPLIED PSYCHOLOGY
CANTERBURY CHRIST CHURCH UNIVERSITY

Acknowledgements

I would like to thank my supervisors for making this project possible and for their support. I would like to thank members of the eating disorder team for going above and beyond, without them this project would not have happened. Thank you to my partner, family, and friends for their ongoing encouragement. Additionally, I would like to thank my trainee colleague of the concurrent study for her support. I would like to thank the participants for taking part and sharing their experience. Finally, thank you to past clients who have motivated me to research this area.

Statement

Section A and B are on slightly different topics due to the plethora of eating disorder literature reviews, meaning creativity was required to find something novel. That said, both parts A and B focus on how shifts in motivation and perceived ability to change may be best achieved and facilitated for people with Anorexia Nervosa.

Summary of Major Research Project

Section A:

Literature states that a “turning point” (TP) may be significant in eating disorder recovery. The review elucidated how TPs are defined, how they lead to recovery and to explore whose recovery narratives are included or excluded. Nineteen studies were reviewed, quality assessed and synthesised thematically. TPs were defined in a plethora of ways. The process by which TPs led to recovery was explored. It was found that literature on TPs under-reports demographics resulting in uncertainty on the degree of homogeneity in recovery narratives. The author argued that understanding recovery outside of the TP narrative may aid understandings of recovery.

Section B:

Many people with Anorexia Nervosa experience ambivalence towards recovery. Chairwork is a psychotherapeutic technique incorporating the position, dialogue, and movement between ‘self parts’ placed in different chairs to elicit change. The ‘future selves’ chairwork intervention (FSCI), aims to increase motivation by role-playing, dialoguing, and interacting with a future ‘non-recovered self’ and ‘recovered self’, utilising movement between chairs. Nine people living with Anorexia were interviewed, and an interpretative phenomenological analysis was conducted, to explore acceptability and change processes. Changes in motivation were facilitated through emotional experiencing and embodiment when enacting ‘future selves’. Participants described an evocative response, which led to realisations and new understanding.

Contents

List of Tables and Figures

Part A

Part B

List of Appendices

Section A:

Turning points in eating disorder recovery: A systematic review of qualitative literature

Word count: 7985 (328)

Abstract

Objective: Understanding the recovery process from eating disorders (EDs) is important and literature states that a "turning point" (TP) may be significant in recovery. This systematic review of qualitative literature aimed to understand how TPs are defined in the literature, how they lead to recovery and to explore whose recovery narratives are included or excluded.

Method: Four databases were searched. Nineteen studies were reviewed, quality assessed using the Critical Appraisal Skills Programme (CASP) and synthesised thematically.

Results: It was found that literature on TPs under-reports participant demographics and there was no consensus of the definition of TPs. The synthesis found that there are a range of change-processes associated with TPs.

Conclusions: It is unclear who has been included or excluded in narratives in the reviewed literature, due to the under-reporting of social demographics. The definitions of TPs are expansive and imprecise. The change processes helped to elucidate how TPs led to change, however questions are raised as to the utility of the TP concept. This author argues that the TP concept is superficial, thus recommends that future research limit the use of the TP concept or, if used, researchers should ensure it is defined clearly alongside explicit meaningful change processes.

Key terms: Eating disorder, Recovery, Social Demographics, Turning point, Review.

Introduction

Eating disorders (EDs) are serious mental health conditions with high mortality rates (Arcelus et al., 2011). The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association [APA], 2013) states that EDs are characterised by negative beliefs about eating, weight and shape, leading to individuals engaging in ED behaviours to manage these beliefs. DSM-5 (APA, 2013) recognises several different EDs, including Bulimia Nervosa (BN), Anorexia Nervosa (AN) and Other Specified Feeding or Eating Disorder (OSFED). EDs are arguably trans-diagnostic, meaning the maintenance processes between AN, BN and atypical eating overlap (Fairburn et al., 2003).

It has been argued that EDs are on the rise, with a recent report finding that between 2015/16 and 2020/21, hospital admissions for EDs increased by 84% (Royal College of Psychiatrists, 2022). Therefore, research and literature reviews are vital to understanding how best to support those who live with an ED. Research has emphasised quantitative outcomes and standardised measures of recovery, which do not always encompass recovery factors that are important to those who live with EDs (Stockford et al., 2019). In addition, quantitative methods may miss critical change processes by focusing on the existence of a causal relationship rather than how that relationship occurs (Elliott, 2010). Instead, qualitative methods can illuminate the personal experiences of ED recovery, emphasising meaning and interpretation (Barker et al., 2015). Clinicians can utilise this to better understand recovery.

Impact of ED stereotypes on understanding recovery

Historically, eating disorders were stereotyped as impacting white, affluent females (Huryk et al., 2021, Mitchsion et al., 2017, Waller et al., 2009). This is despite research on the contrary to these stereotypes. Research has found that EDs are increasing more rapidly in those with lower social economic status than higher (Mitchison et al., 2017). Also, around 25% of people with an ED are male (National Institute for Health and Care Excellence [NICE], 2017). One US study found that African Americans were more likely to engage in bulimic behaviours than white individuals (Goeree et al., 2011). This stereotype has an impact on those living with EDs. For instance, Waller et al. (2009) hypothesised that this stereotype might prevent access to services for minoritised groups. Additionally, a review by Burnette et al. (2022) found that research in psychotherapy trials on EDs in the US were mostly conducted on white women.

Thus, it is important to include diverse participants and to report on their social demographics to better understand who is included or excluded from research. One recent report found that only 45.2% of manuscripts reviewed reported "race" or ethnicity of participants (Egbert et al., 2022). Burnette et al. (2022) highlighted the under-reporting of data on "race", social economic status (SES) and sexual orientation in ED trials. Consequently, it is unclear who has been included or excluded from research thus where gaps may exist.

Recovery definition

There is a lack of consensus on what constitutes recovery from an ED. Clinicians may focus on objective measures such as weight to define recovery (Eaton, 2020). In contrast, those who live with an ED define recovery in several ways, such as acceptance of the body and connecting with emotions (Pettersen & Rosenvinge, 2002). Some argue that recovery is not possible or that for someone living with an ED, "the voice is always there" (Jenkins &

Ogden, 2011, p.15) and that recovery is not an endpoint but an ongoing process. (Pettersen & Rosenvinge, 2002).

The recovery journey

The journey to recovery is complex and prolonged, with motivation said to build over time (Venturo-Conerly, 2020). It is well documented that those living with an ED sometimes experience ambivalence towards recovery and lack motivation to recover (Reid et al., 2008; Schmidt & Treasure, 2006). The transtheoretical model of change (Prochaska & DiClemente, 2005) theorises that change is a cyclical process, and motivation is significant in this process. They propose that individuals move through stages before entering a stage where increased motivation leads to behavioural change (Prochaska & DiClemente, 2005).

Due to the back-and-forth nature of recovery and possible reluctance to change, recent qualitative reviews investigating the recovery process have attempted to identify important factors in recovery to illuminate the process. Furthermore, to demystify ED recovery, it is vital to consider the subjective experience of recovery rather than relying solely on standardised measures (Eaton, 2020). Stockford et al. (2019) found that there were three stages in the process of recovery: (1) the experience of AN and the fragmented sense of self, (2) the turning point, and (3) recovery and the reclamation of self. However, it excluded mixed disorder samples, where individuals may have been diagnosed with AN and other EDs. Eaton (2020) completed a meta-ethnography review of the literature, benefitting from a broader range of participants than the review by Stockford et al. (2019) by including those with EDs other than AN, and male participants. Eaton (2020) used a swimming metaphor to conceptualise the experience of an ED, positing that those living with an ED use it as a life jacket, meaning the ED is used as a coping mechanism. As individuals move through the

recovery journey, they recognise the consequences of the ED and eventually 'swim' the path towards recovery.

The idea of a turning point (TP), sometimes referred to as a 'tipping point', has been proposed to be important in ED recovery. The TP was understood as a process that led individuals to commit to pursuing recovery, characterised by three themes in the review by Stockford et al. (2019): (1) acknowledging the consequences of AN (the individual understands that AN is a problem), (2) commitment to recovery (the individual takes responsibility for their recovery), and (3) self-awareness (the individual sees themselves beyond AN). Eaton (2020) described a TP within their understanding of recovery phases. The author explained that participants reach a TP which is unique to the individual. Examples may include suicidal thoughts or the death of someone in ED treatment. The TP was argued to lead to change whilst in the contemplating recovery phase.

Despite a TP in recovery being noted as key, various definitions exist within the literature with no clear consensus. For example, LaMarre and Rice (2021) defined a TP as an "illuminating event" (p.714), whereas Arthur-Cameselle and Curcio (2018) named TPs as the "initial period in the recovery process" (p. 596). These divergencies are problematic, especially since Stockford et al. (2019) argued that "to move towards recovery, the individual *must* reach a 'turning point'" (p. 363). Thus, understanding TPs is fundamental.

Summary

Recovery from EDs is complex, and TPs appear important (Stockford et al., 2019; Eaton, 2020), particularly when considering the complexity of ED recovery (Eaton, 2020; Venturo-Conerly, 2020; Reid et al., 2008; Schmidt & Treasure, 2006). Accordingly, how TPs are

conceptualised and how they lead to change, including for marginalised groups, is significant. Qualitative research may add a valuable perspective by emphasising the voice of service users, elucidating diversity of experience and accentuating personal sense-making (Barker et al., 2015). However, to the best of our knowledge, no such reviews exploring the phenomenon of TPs in ED exist.

Research questions:

1. How is a TP defined in the literature?
2. What are the change processes associated with a TP?
3. Whose recovery narratives have been analysed when understanding the concept of a TP, and whose voices are missing?

Methods

Searches

A systematic search was completed in June 2023 in the following electronic databases: PsycINFO, Medline, Web of Science and Assisa. These were chosen to capture a range of literature throughout social sciences. In the year 2000, changes to ED classification occurred due to the publication of the Diagnostic and Statistical Manual of Mental Disorders 4th edition text revision (American Psychiatric Association [APA], 2000). Thus, only studies after the year 2000 were included. This also aligns with comparable reviews: Stockford et al. (2019) included papers between 2002 and 2017, while Eaton (2020) included papers between 2011 and 2018. Once the suitable studies had been found, their reference lists were hand searched for additional articles that may have been missed in the initial search. No additional journal articles were identified.

Search terms

Search terms used were:

Recover* OR Remission OR Tipping Point OR Turning Point

AND (Eating Disorder* OR Anorexi* OR Bulimi* OR Other Specified Feeding or Eating Disorde* OR Eating Disorder Not Otherwise Specified) AND (qualitative* OR interview* OR Narrative OR Grounded theory OR Interpretative Phenomenological Analysis).

See Table 1 for Inclusion and exclusion criteria, and Figure 1 for the Preferred Reporting Items for Systematic reviews and Meta-Analyses (Page, 2021) diagram.

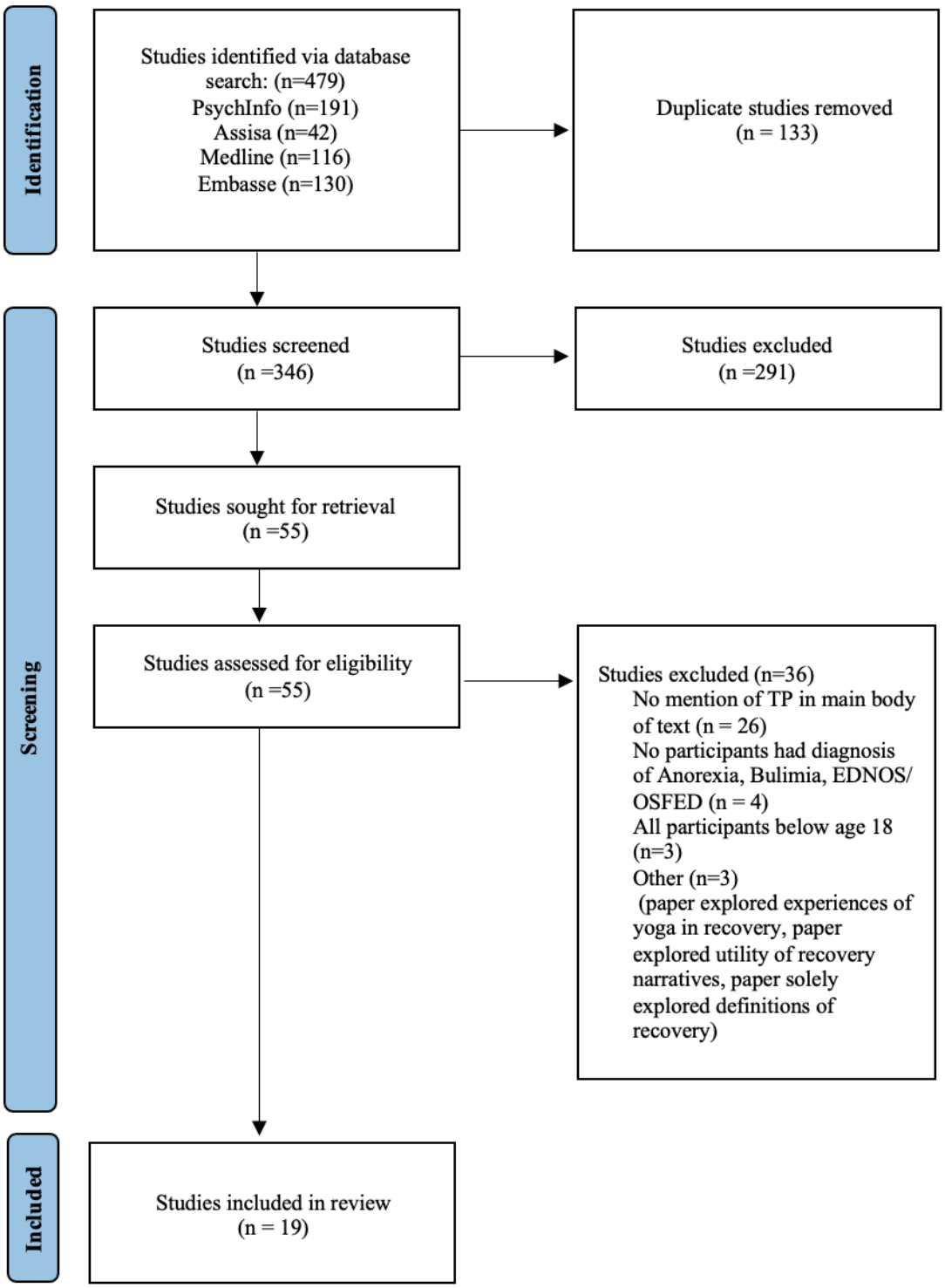
Table 1:

Inclusion and exclusion criteria

Inclusion	Exclusion
Qualitative	Quantitative
Diagnosis of Anorexia, Bulimia or EDNOS/ OSFED.	Not peer reviewed (e.g., dissertation or book)
Reference to a tipping point or turning point in main body of the text	All participants below 18
Adult participants	-
Written in English	-

Figure 1

Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) diagram of literature search results



Structure of this review

The research questions were answered in order. Research questions one ("How is a TP defined in the literature?") and two ("What are the change processes associated with a TP?") were examined using thematic synthesis. Research question one and two are arguably similar, however they emphasise different aspects. Question one highlights *what constitutes* a TP, question two illuminates *how* the proposed TPs led to change. Research question three ("Whose recovery narratives have been analysed when understanding the concept of a TP, and whose voices are missing?") was explored by summarising the reporting of social demographics in the relevant literature.

Approach to quality appraisal

The Critical Appraisal Skills Programme (CASP; 2018) was used for quality assessment to score each paper. The CASP is a ten-item framework incorporating evaluative criteria (Appendix A). Each CASP criteria was marked and rated out of three as adapted from the quality assessment used in the review by Stockford et al. (2019). A paper was given three points if the evaluation question was well addressed, two for adequately addressed, one for poorly addressed and zero for not addressed. An overall score for each study was then created: studies that scored 75-100% were given a +++ grade; studies that scored 50-74% were given a ++ grade; studies that scored below 25-50% were given a + grade, and studies at 0-25% were given a - grade.

There is debate about whether using the CASP tool in this way is appropriate. For example, Booth et al. (2016) argue that checklists are helpful but may be problematic when applied too strictly. Thus, the current review recognises that a failure to describe details does not necessarily mean a study has a flawed methodology.

Approach to thematic synthesis

Since no dominant theory of the TP phenomenon exists, and no prior reviews have been completed on this topic to the author's knowledge, this review aimed to provide a 'snapshot' of how a TP is defined in the current research literature. Thus, a thematic synthesis approach to systemic review was deemed appropriate (Booth et al., 2016). The three-stage method described by Thomas and Harden (2008) was utilised to integrate the findings of the studies. The first stage involves line-by-line coding of the text. As the present review was interested in whether or how TPs are discussed in the literature, only information related to TPs were included. The second stage involves generating descriptive themes; this was completed by grouping or separating codes based on similarities or differences between them. There was additional interpretation completed at this stage as codes were validated against the context of the paper as a whole and its parts. This ensured the review was data-driven and remained close to the original texts without imposing a priori framework. The third stage involved generating analytical themes, thus at this stage some interpretation was required to answer the review questions, especially with regards to extricating authors' definition of TPs from authors' description of the change process associated with the TP. The current review also cross-referenced the analytical themes with the initial codes to guarantee that references to TPs in each paper were fully and accurately represented.

First-order constructs (original participant narratives) are presented in *italics*, thus distinguished from second-order constructs (study author interpretations) which are not italicised (Barnett-Page & Thomas, 2009; Merten et al., 2015). Additionally, third order constructs (synthesis from this author) are offered in generation of themes and sub-themes.

Approach to demographic reporting

Following the thematic synthesis, data on the reporting of social demographic factors were gathered and presented to generate a representation of which social demographic factors have been reported in the literature.

Description of studies

This review included nineteen qualitative papers. The papers were based on participants across a narrow range of Western locations, limited to Australia, USA, UK, Canada, New Zealand, Sweden, and Norway. The papers included those with a range of ED diagnoses including AN, BN, OSFED, binge eating disorder (BED), orthorexia and a mix of these. A summary of the papers can be seen in Table 2.

Table 2:

Summary of reviewed literature

Study (author, year, title, location)	Study aims	Participants (n, ED diagnosis)	Design	Main findings/ themes
1. Arthur-Cameselle & Curcio, 2018 Turning the corner: A comparison of collegiate athletes' and non-athletes' turning points in eating disorder recovery. USA	To identify TPs in ED recovery in college athletes, in comparison to non-athletes.	n=29. AN (n=17), BN (n=3), BED (n=1), AN and BN (n=8).	Interviews. Inductive coding using consensual qualitative research for analysis.	There was commonality between TPs described by athletes and non-athletes. The most frequent being insight/self-realisation. For athletes, the next three most frequent TPs were: sport performance, confrontation, and support from others. For non-athletes, the next three most frequent TPs were: professional treatment, hitting a low and support/ concern from others.
2. D'Abundo & Chally, 2004 Struggling with recovery: Participant perspectives on battling an eating disorder. USA	Provide an exploratory schema about recovery	n=20 Self-identified. participants described symptoms of both AN and BN.	Interviews, participant observation at a support group and a focus group. Grounded theory.	Recovery included cyclical patterns and rarely returned to normal eating behaviours. The components of the pattern included increasing severity, the circle of acceptance, and decreasing severity. Relapses also occurred.
3. Dawson et al., 2014 "Doing the impossible.": The process of recovery from chronic anorexia nervosa. Australia	Aimed to explore recovery process of those who had recovered from chronic AN.	n=8 AN	Interviews, Narrative inquiry.	Four phases of recovery 1) Unready and/or unable to change, 2) The tipping point of change, 3) Active pursuit of recovery, and Reflection and rehabilitation

4. Fogarty & Ramjan, 2017 The tipping point of change in Anorexia Nervosa (AN): Qualitative findings from an online study. Australia and UK	Understanding important factors in treatment and/ recovery from AN, with emphasis on the tipping point of change.	n=67 Self-reported AN.	Online questionnaire. Conventional content Analysis.	Themes that motivated individuals at the 'tipping point of change'. 1) The realisation of the loss of something valuable, 2) The risk of losing something valuable, 3) Something for which to live for/stay well.
5. Hay & Cho, 2013 A qualitative exploration of influences on the process of recovery from personal written accounts of people with anorexia nervosa. Australia	Aimed to investigate written published narratives of AN recovery during the tipping point.	n=31. AN (with or without another ED, such as BN).	Framework approach to thematic analysis.	Four themes: 1) Desire for recovery (including a turning point), 2) Positive experiences in treatment, 3) An aspect of life outside of work or study, 4) Positive/ helpful experiences with new or renewed relationships
6. LaMarre & rice, 2020 The eating disorder recovery assemblage: Collectively generating possibilities for eating disorder recovery. Canada	Explore affective-discursive-material aspects of ED recovery.	Those in recovery (n=20), supporters of those in recovery (n=14). EDs.	Interviews. Reflexive thematic analysis.	Those with EDs and their supporters were interviewed about ED recovery. Themes identified: 1) Mobilizing trust (generating trust in relationships) 2) Mobilizing love (the experience of supporting loved ones) 3) Becoming attuned.

7. LaMarre & Rice, 2021 Recovering uncertainty: Exploring eating disorder recovery in context. Canada	To explore the complexity in understanding of ED recovery with regards to timelines, processes, endpoints, and versions of recovery.	n=20 EDs.	Interviews. Thematic analysis.	Recovery was understood within four themes: 1) Fuzzy logics of time, 2) Not only recovered, 3) Recovery is not all sunshine and rainbows, 4) The life of recovery.
8. Lewke-Bandara et al, 2020 It also taught me a lot about myself": A qualitative exploration of how men understand eating disorder recovery. USA, Australia, and New Zealand	Aimed to explore how men define ED recovery and what aspects of their recovery process are pertinent.	n = 8 AN (n=4), BN (n=3), orthorexia (n=1).	Interviews Inductive thematic analysis.	Recovery was understood as a journey with no endpoint, but with improvements in functioning. The participants were at varying points in their recovery journey. Two main themes: 1) Psychological recovery – improved relationship with food and body image, 2) Recovery is not clear – lacks definition.
9. Lindgren et al., 2014 A qualitative study of young women's experiences of recovery from Bulimia Nervosa. Sweden	Investigated experiences of recovery from BN among young women who had undergone treatment.	n = 5 BN	Narrative interviews. Qualitative content analysis	Recovery is unique and non-linear. Regaining health is achieved by improving self-esteem and finding tools to manage emotions. Four themes: 1) Feeling stuck in BN 2) Getting ready to change 3) Breaking free from BN 4) Grasping a new reality
10. Matoff & Matoff, 2001 Eating disorder recovery. USA	To examine the coping skills and important elements in the ED recovery journey.	n=1. AN (binge-purge subtype).	Case study. Interviews.	There were three key elements to the recovery process: seeking professional help, avoiding destructive relationships, and gaining empowerment to battle the ED. Four key TP were discussed. Pertinent aspects of therapy, useful coping strategies and lessons learned are shared by the authors.

11. Matusek & Knudson, 2009 Rethinking recovery from eating disorders: Spiritual and political dimensions. USA	Aimed to present rich, process-orientated stories of recovery.	n=8 EDs	Interviews. Performative writing approach.	Overcoming an ED requires attention to the whole self, including mental, emotional, physical, social, and spiritual aspects. Core components of recovery stories included engagement with social activism and spirituality.
12. McCallum & Alaggia, 2020 Achieving recovery through resilience: Insights from adults in midlife living with anorexia nervosa. Canada	Aimed to understand experience of adults in "midlife" living and recovering from AN.	n=19 AN	Interviews. Constructivist grounded theory.	There are barriers to seeking help or remaining in recovery for those in midlife with AN. The experience of living with AN highlighted three themes: 1) The complexities of midlife, 2) Increased stigma, 3) Pathway to resilience – wisdom gathered over a life half-lived.
13. Nilsson & Hägglöf, 2006 Patient perspectives of recovery in adolescent onset anorexia nervosa. Sweden	To describe recovery from AN.	n=68 AN	Interviews. Content Analysis.	Those who recovered described clear TPs. Participants also described factors that were important to their recovery, which included friends, own decisions, activities, treatment, family or origin and own family. People who were unrecovered were searching for things that could aid recovery.
14. Patching & Lawler, 2009 Understanding women's experiences of developing an eating disorder and recovering: a life-history approach. Australia	Aimed to gain understanding of developing, living with and recovering from ED.	n=20. AN (n=6), BN (n=2) or both (n=12).	Life-history interviews. General qualitative analysis.	Key themes concerning control, connectedness and conflict were pertinent in the ED emerging and ED recovery journey. Recovery occurred when individuals re-engaged with life and when they were ready to make this choice.

15. Pettersen & Rosenvinge, 2002 Improvement and recovery from eating Disorders: A patient perspective. Norway	To described factors that contribute to ED recovery, how to define recovery and to relate the subjective experience with symptoms, health control and other items.	n=48. AN (n=10), BN (n=10), BED (n=8), AN + BN (n=20).	Interviews, questionnaires, and scales. Interviews were coded according to a system, developed by the authors, and previous research.	Factors that contributed to ED recovery were a wish to change, professional treatment, nonprofessional care, and important persons. Recovery was defined as improved self-acceptance, relationships, problem-solving ability and body satisfaction.
16. Roberts & Skipsey, 2022 Exploring occupation in recovery from bulimia nervosa: An interpretative phenomenological analysis. UK	Aimed to explore recovery of BN and how their accounts reflect the assumptions and characteristics of occupation.	n=6 BN	Interviews. Interpretative Phenomenological Analysis (IPA).	Two key themes emerged, from an occupational therapy lens: 1) Occupation emerged by committed action, 2) Recovery from BN can be constructed as an occupation. These themes highlighted important factors for occupational therapy including, self-care, modification of home, work and social environment and setting goals.
17. Shohet, 2007 Narrating anorexia: "Full" and "struggling" genres of recovery. USA	To investigate narrative processes through which women treated for AN understand their illness and recovery.	n=3 AN	Interviews. Narrative analysis.	Through exploring narrative processes with those who had experienced full recovery and those who were struggling to recover, the author found that recovery may not be desirable for some. But full recovery is experienced as a disconnection between past and present selves characterised by empowerment, and a clear beginning and end. Stories from those who have recovered vs not differ on the following dimensions: 1) Epistemic certainty, 2) Affiliation with clinical typification's and master narratives of the disorder, 3) Continuity between past and present selves, 4) Linearity of temporal and causal progression of events.

18. Smethurst & Kuss, 2018 'Learning to live your life again': An interpretative phenomenological analysis of weblogs documenting the inside experience of recovering from anorexia nervosa. UK	To explore recovery from AN through blogs, with a focus on pros and cons of recovery.	n=8 AN	Data extracted from blogs. IPA.	Three key themes were found: 1) Barriers to recovery, 2) Factors increasing the likelihood of recovery, 3) Support.
19. Weaver et al., 2005 Understanding women's journey of recovering from anorexia nervosa. Canada	To understand the recovery process in the context of family, community, or society.	n=12 AN	Interviews Grounded theory	A journey of self-development to recovery, where the individual moved from 'perilous self-soothing', through the turning point of 'finding me' to 'informed self-care'.

Results: Quality appraisal

Overview of studies

A summary of quality assessment ratings can be found in Table 3. The studies used a range of data collection approaches. Two studies utilised published accounts (Hay & Cho, 2013; Smethurst & Kuss, 2018) and one used an online questionnaire (Fogarty & Ramjan, 2017). D'abundo and Chally (2004) used interviews, a focus group and participant observation. The remaining literature interviewed participants. Studies also used various qualitative analysis methods, including grounded theory, narrative analysis, and Interpretative Phenomenological Analysis (IPA).

Strengths

All studies were deemed to be of high enough quality to be included. All had clear aims and used qualitative methodology appropriately. Most articles had a clear statement of findings. Shohet (2007) did not mention aims. However, the author noted that this study was part of a larger study that used participant observation. Thus, the study by Shohet (2007) arguably could fulfil the triangulation criteria.

Limitations

Eleven studies did not mention saturation of data (Dawson et al., 2014; LaMarre & Rice, 2020; LaMarre & Rice, 2021; Lingren et al., 2014; Matoff & Matoff, 2001; Matusek & Knudson, 2009; Nilsson & Hägglöf, 2006; Patching & Lawler, 2009; Pettersen & Rosenvinge, 2002; Smethurst & Kuss, 2018, Fogarty & Ramjan, 2017). However, D'abundo and Chally (2004) argued that saturation might never occur as ED recovery is unique to the individual. Roberts and Skipsey (2022) did report on saturation. Still, they justified not achieving saturation due to their use of interpretative phenomenological analysis (IPA), in

which “themes emerge due to their significance rather than prevalence, saturation, or pervasiveness across participants” (p.489). This may explain why Smithurst and Kuss (2018) did not discuss saturation, as they also utilised IPA.

Discussion of the relationship between researcher and participants could also be improved in thirteen studies as the relationship between the author and participant was either absent or could have been made clearer (Dawson et al., 2014; Fogarty & Ramjan, 2017; Pettersen & Rosenvinge, 2002; LaMarre & Rice, 2020; LaMarre & Rice, 2021; Lewke-Bandara, 2020; Matoff & Matoff, 2004; Nilsson & Hägglöf, 2006; Patching & Lawler, 2009; Hay & Cho, 2013; Shohet 2007; Matusek & Knudson, 2009; Weaver et al., 2005).

Table 3:

Quality assessment ratings

Study (author, year)	Quality assessment rating
1. Arthur-Cameselle and Curcio, 2018	+++ (90%)
2. D'Abundo and Chally, 2004	+++ (93%)
3. Dawson et al. 2014	+++ (80%)
4. Fogarty and Ramjan, 2017	+++ (77%)
5. Hay and Cho, 2013	+++ (82%)
6. LaMarre and Rice, 2020	+++ (76%)
7. LaMarre and Rice, 2021	+++ (83%)
8. Lewke-Bandara et al. 2020	+++ (87%)
9. Lindgren et al., 2014	+++ (87%)
10. Matoff and Matoff, 2001	++ (70%)
11. Matusek and Knudson, 2009	+++ (76%)
12. McCallum and Alaggia, 2020	+++ (93%)
13. Nilsson and Hägglöf, 2006	++ (70%)
14. Patching and Lawler, 2009	+++ (76%)
15. Pettersen and Rosenvinge, 2002	+++ (83%)
16. Roberts and Skipsey, 2022	+++ (96%)
17. Shohet, 2007	++ (60%)
18. Smethurst and Kuss, 2018	+++ (80%)
19. Weaver et al. 2005	+++ (83%)

Results for question one: How is a TP defined in the literature?

The thematic synthesis found that TPs were defined within three themes and five sub-themes (Table 4). These factors relate specifically to the use of the words TP or 'tipping point' in the literature and how it has been defined and used by respective authors. The use of the words TP or 'tipping point' was expansive and perhaps vague at times. The themes and descriptions below reflect the arguably perplexing and contradictory use seen in the literature.

Table 4:

TPs definition themes

Themes	Sub-themes
Support.	Relationships with others. Treatment.
A transitional phase.	Shifting internal processes. A marker between past and present. A catalyst tipping the balance.
Event-specific.	-

1. Support

In some of the literature, informal support from friends or family, and formal support through treatment, were defined as a TP.

1.1 Relationships with others

Relationships acted as TPs and stimulated recovery. For instance, support and concern from coaches were a TP for athletes. In contrast, recovered role models were a TP for non-athletes in one study (Arthur-Cameselle & Curcio, 2018): "*I started talking to my cousin…I had someone that was almost like a sister telling me that she had the same problem and I listened."* (p. 605)

Confrontation and ultimatums by others were considered a TP by Arthur-Cameselle and Curcio (2018). Ultimatums included “not being allowed to compete” for athletes (p.604, Arthur-Cameselle and Curcio, 2018).

Nilsson and Hägglöf, (2009) defined TPs as “an unpredictable or unusual experience like a special moment of emotional meeting or significant event” (p. 306), noting that these events often involved significant others such as friends. They stated outside influences were “important at the beginning of the recovery” (p. 310). However, the conceptualisation of how others become a TP was poorly defined: “important persons mentioned in the TPs of our study were family members, persons related to treatment, friends, and boyfriends.” (Nilsson & Hägglöf, 2009, p 308). Nonetheless, all their participants described a TP as “when the recovery started” (p.307) and that these experiences were significant and “vivid” (p.309).

1.2 Treatment

Treatment experiences were named as a TP in some literature. Shohet (2007) described how one participant’s mother removed her from college and sent her to treatment. The author interpreted treatment as “the propitious stabilising force that, by refeeding her, allowed her to grow” (p. 370).

Arthur-Cameselle and Curcio (2018) also found that utilising treatment was a TP. One participant stated that they were “not able to make progress toward recovery until they sought treatment” (Arthur-Cameselle & Curcio, 2018, p. 604), although the detailed change process, for instance, factors that aided engagement with therapy or specifics about how this change occurred in therapy were vague in this study. Nonetheless, helping to “interrupt the ED cycle” (Arthur-Cameselle & Curcio, 2018, p. 604) was cited as one way that professional

treatment was considered a TP. Further exploration may have provided insights into how the interruption of the ED cycle occurred or what helped or hindered this process.

2. A transitional phase

For some, TPs were defined as moving from one stage to another. The movement is the essential factor in this definition of the TP. Although, the nature of these definitions means there is arguably some overlap with the broader change process – which is debatably useful.

2.1 Shifting internal processes

Moving through stages was achieved by transformational internal processes. Weaver et al. (2005) developed a theory of ED recovery. Starting with "perilous self-soothing" (p. 191), "finding me" (the TP) (p. 191) and then moving towards "informed self-care" (p. 191). The TP of "finding me" represented a time when internal changes occurred.

Dawson et al. (2014) described moving from being able to "maintain energy to being worn out by AN" (p. 499), where negative feelings accumulated and individuals could "no longer maintain energy for the disorder" (p. 499), which was sometimes described as "*hitting rock bottom"* (p.499) as a TP.

Crisis was said to act as a transitional moment, thus a TP leading to change: "*I almost died... when I came out I was a real person, you know, I'm not a façade"* (Shohet, 2007, p. 365). However, Shohet (2007) also found that these "dramatic encounters" (p. 374), which were considered TPs for some, did not lead to change for others. This divergence highlights the need to elucidate the change process and consider individual differences (and factors driving that) in how TPs lead to change, in line with question two of this review.

2.2 A marker between past and present

Shohet (2007) suggested that recovery is made up of progressive stages. The TP stage was a transition period where “transformation occurred” (p. 366) and a “transition phase” (p. 365), a marker between present and past, leading to a recovered future. Shohet (2007) stated that narratives from those who had fully recovered versus those who were struggling to recover differed in how individuals portrayed their past, present, and imagined future selves. A fully recovered participant displayed this “break between past and present, devaluing the former in favour of the latter” (p. 363). In contrast, those struggling to recover did not narrate in this manner.

2.3 A catalyst tipping the balance

Some defined TPs as a factor that sped up or tipped the balance towards favouring recovery. Dawson et al. (2014) described TPs as a stage in a four-part recovery journey wherein various intrinsic changes occur. Stages included: 1) being unready to change, 2) the tipping point, 3) active pursuit of recovery, and finally, 4) reflection and rehabilitation. The tipping point was where the balance “tipped in favour of pursuing recovery” (p. 499). The authors suggested that “for some, this was one discreet moment in time; for others, it was a series of moments. At this stage, the trajectory of the AN was disrupted; motivation increased, and meaningful change was triggered" (p. 499).

Fogarty and Ramjan (2017) built upon Dawson and colleagues’ (2014) study described above. Fogarty and Ramjan (2017) developed a questionnaire to clarify Dawson and colleagues’ (2014) tipping point stage. Fogarty and Ramjan (2017) defined a TP as “the point at which the illness trajectory is interrupted, motivation increases, and change occurs because

the ‘balance’ tips toward the pursuit of recovery rather than a continuation of the illness” (p. 1051).

D’abundo and Chally (2004) utilised grounded theory (Charmaz, 2008) to create a model of recovery and emphasised how TPs speed up recovery. They highlighted the increasing severity of the eating disorder, followed by a pinnacle, “often followed by a TP” (p. 1099) before a decrease in severity occurred. The TP was defined as events or people that “acted as catalysts to recovery” (p. 1099).

3. Event-specific

Some studies defined specific events as a TP. LaMarre and Rice (2021) defined a TP as an “illuminating event” (p. 714) in line with this theme. However, they found their participants did not describe TPs.

Having a child was described as a “positive life event” (p. 67) thus as a TP by Pettersen and Rosenvinge (2002) as it increased “motivation to recover and view life as meaningful” (p. 67). For Arthur-Cameselle and Curcio (2018), the event of moving out of the family home or having a shared bathroom in college was defined as a TP:

> A Division I tennis player said that recovery began when, *“I moved out of my house… I definitely could not get better in that environment”* … A non-athlete who recovered from bulimia stated, “*I didn’t really feel comfortable purging in* [the suite bathroom] *because someone might walk in*”. (p. 605)

Spirituality and an associated epiphany were described as a TP in one study. Matusek and Knudson (2009) defined a TP as "identified moments of epiphany" (p. 698), as participants emphasised spirituality and social activism.

> *Turning point in my recovery from anorexia happened in the most unlikely place—the master bathroom…I happened to glance over and see my naked body reflected in the big mirror... I saw for the first time, and the only time, as others saw me—emaciated... It really was a revelation of sorts. … I see that really as a gift from God. For in that moment, He granted me the grace to see me as I truly was* (Matusek & Knudson, 2009, p. 701).

The authors stated that the understanding of this TP "*as a present from God*" [was] in retrospect, not when it happened at age 16" (p. 704). Thus, in this study, the TP was the epiphany associated with viewing the emaciated self, but the meaning-making of the situation was in the context of spirituality, but only in retrospect.

Autonomous changes to diet and exercise were cited as a TP by one study. One participant was described as becoming a vegan, thus cutting out animal products: "*As soon as [I] cut lactose out… the bloating went down …that was a turning point*" (Arthur-Cameselle & Curcio, 2018, p. 603).

Results for question two: what are the change processes associated with a TP?

Question two is differentiated from question one in its emphasis: question two highlights *how* the proposed TPs led to change, rather than *what constitutes* a TP, as in question one. Though, there was some overlap between questions as each change process encompassed TPs across the range of definitions outlined in question one. The thematic synthesis found the literature described TP change processes within three themes and six sub-themes (Table 5).

Table 5:

Themes for the TPs change processes

Themes	Sub-themes
Gaining knowledge.	Understanding the role of the ED. Understanding the consequences of the ED on values. Understanding the consequences of ED on health.
Acceptance.	ED is a problem. Acceptance of others. Accepting self and needs.
Active participation in recovery.	-

4. Gaining knowledge

Increased knowledge about the ED and its consequences was considered a fundamental change process associated with TPs.

4.1 Understanding the role of the ED

Arthur-Cameselle and Curcio (2018) noted that the most frequent TP was a realisation, which initiated recovery. The authors stated that the realisation specifically concerned "the role of the ED in their life, their sense of identity, or their priorities acted as a turning point" (p. 602): "*I definitely didn't want to be a person with an eating disorder… that's not part of my identity"* (p. 602).

Patching and Lawler (2009) found that change occurred through ideas around control, connectedness, and conflict. Conflict was said to relate to the aetiology of the ED. Understanding how control was utilised for disordered eating to cope and subsequently relinquishing this idea was said to provide happiness.

Dawson et al. (2014) explored the change process underlying the tipping point of change (see section 2.3, p. 35 for definition). They described the change process of moving from "lack of awareness to insight" (p. 500), where individuals understood more about the function of the ED.

4.2 Understanding the consequences of the ED on values

Several authors understood the ED's impact on valued aspects of life as a critical change process in TPs. For instance, the realisation of consequences and resulting emotional impact was defined as a TP by Arthur-Cameselle and Curcio (2018):

> *I think that I realised one day that I was not going down a good path and so I told my mom. I was like, 'I need to get help'. I'm really scared of what I'm going to do to myself.* (Arthur-Cameselle & Curcio, 2018, p. 603)

Experiencing and realising that a change in sports performance had occurred was also defined as a TP for athletes who valued their sports performance. This change may have been realised internally by the individual or highlighted by external others. Generally, this occurred through a process that "tip[s] the balance towards recovery" (p. 606).

> A Division I soccer player…said, '*I lost confidence and I played really small too.'* Acknowledging that her reduced performance was due to being underweight and underfed was the critical turning point for her. She said, '*It was just the harshest realisation that probably saved my life …. I want to be strong'* (p. 604).

Matoff and Matoff (2001) stated that a TP occurred following a suicide attempt when the realisation that the participant "did not want to make psychiatric hospitalisations a way of life" (p.48), thus acknowledging ED's detrimental impact on their well-being.

Realising "that life is time-limited" (McCallum & Alaggia, 2020, p.624) and thus the consequences that ED has had on life was considered a TP for some 'midlife' participants as it created an urgency to recover. For others, this realisation had the opposite effect, resulting in participants using their ED "*to help with the discomfort of ageing*" (p. 624), thus obstructing recovery. This demonstrates the importance of understanding the change process in more detail, including what it is about this TP that leads to change for some but not others. Equally, it raises questions about the utility of understanding recovery from ED within a TP framework, as factors that lead to recovery can be nuanced and personal to the individual.

Fogarty and Ramjan (2017) found three themes that motivated participants at the tipping point of change: 1) the realisation of the loss of something valuable, 2) the risk of losing something valuable and 3) something for which to live/stay well. Factors one and two demonstrate how a renewed understanding of the consequences of the ED and subsequent impact on values can impact the tipping point. They suggest that "it is highly probable that individuals will have their internal view of when the loss of health or life is 'too much', and change is needed" (p. 1056). The realisation of the loss of something valuable was centred on actual losses related to health and death, along with the realisation of loss of life experiences deemed important to the individual, such as career opportunities. The risk of losing something valuable motivated individuals to reach the tipping point of change, and this focused on potential future losses such as sports or the risk to a loved one.

Fogarty and Ramjan (2017) came to this discovery by asking participants to "describe the TP (or light bulb moment) for your journey towards recovery" (p. 1053) in an online questionnaire. Only 41.6% of the sample answered this question. The authors named limitations of the sample as being self-selected, and the sample included those who were both recovered and non-recovered, which may explain why some participants did not respond. One could also infer that some individuals could not recall any TPs, or TPs were not considered significant for some participants, but the authors did not mention this.

4.3 Understanding the consequences of the ED on health

Being cognisant of the physical impact of the ED was found to be significant in the change process associated with the TP for some. For instance, medical emergencies, including "severe eating disorder symptoms" (Pettersen and Rosenvinge, 2002, p. 65), were said to be a TP associated change process. Congruently, Lewke-Bandara et al. (2020), who investigated the experiences of males, defined TPs as the realisation of negative consequences of the ED followed by a changed commitment to recovery. Similarly, being afraid of possible effects of the ED, such as "passing out, ulcers, cardiac arrest" (p.1100), scared participants (D'abundo and Chally, 2004).

Furthermore, Arthur-Cameselle and Curcio (2018) stated that one participant identified being "*rushed to the hospital*" (p. 604) and being "*cold all the time*" (p. 604) as a TP. Similarly, Patching and Lawler (2009) found that the realisation of physical consequences and, ultimately, the fear of death (e.g., through physical health complications or suicide) acted as a TP for some. Equally, Lindgren et al. (2014) stated that a "crisis or TP was important to taking the first step." (p. 866).

5. Acceptance

Acceptance of self and others and that the ED is a problem was found to be a critical TP change process.

5.1 ED is a problem

Gaining awareness and accepting that the ED is a hindrance rather than a help was significant TP chance process. D'abundo and Chally (2004) stated that the TP change-process was that it led to "acceptance of the disease" (p.110) as a problem. Confrontation similarly highlighted that the ED is a problem as it acted as a "wake-up call about the severity of their ED" (p. 604), which led participants to "*question what I was doing"* (p. 605), leading to the initiation of recovery in the study by Arthur-Cameselle and Curcio (2018). This aligns with question one's theme 'relationships with others' (section 1.1, p. 32), however goes beyond the idea that relationships *constituted* a TP, instead highlighting *how* the confrontation from others stressed 'ED as a problem' and thus led to change.

Similarly, Weaver et al. (2005) found that within the theme "finding me" (the TP) (p. 191), a critical process occurred, where participants moved "from seeing AN as a solution to recognising it as a problem" (p.195) and "seeing the big picture" (p. 195).

5.2 Acceptance of others

Change processes related to significant others was another key theme, and how significant others led to change is encompassed here. Again, this aligns with questions one's theme 'relationships with others' (section 1.1, p. 32). Accommodating others "imperfections and vulnerabilities in a more realistic framework" (Matoff & Matoff, 2001, p. 48) leading to acceptance, trust, and subsequent relationship changes was a hypothesised change process associated with TPs.

Similarly, D'abundo and Chally (2004) stated that "acceptance of a relationship with another person" (p.1101), such as a counsellor or family member, was vital in the TP stage. Similarly, "the opportunity to rebuild trust and acceptance with her psychiatrist" (p. 48) was considered an additional TP change process in the study by Matoff and Matoff (2001). This may align with question one's 'treatment' theme (section 1.2, p.33), and perhaps may explain *how* treatment led to change.

Equally, Hay and Cho (2013) also highlighted that "new and improved relationships" (p. 373) promoted the tipping point. They stated that these relationships could include a pet or a "higher spiritual being" (p. 737).

5.3 Accepting self and needs

Some studies described a process whereby a TP led to an acceptance of self. However, studies differed in how this self-acceptance occurred. D'abundo and Chally (2004) found that self-acceptance occurred through accepting spirituality as "acceptance of spirituality enabled participants to accept themselves and their bodies" (p.1011).

The TP phase in the study by Weaver et al. (2005) cited that change occurs through moving "from disengagement to (re)connection with self and others" (p.195) and "encountering self" (p. 196). Here the individual develops their self-expression and acquires important knowledge about their self, such as key childhood factors (e.g., "not having their needs met", p.196).

Shohet (2007) found TPs lead to a period of self-growth as the ED "comes to be defined not only as a threatening and unwelcome interruption but also a crisis that becomes the source and opportunity for moral growth and transformation" (p. 366).

6. Active participation in recovery

Committing to actively engaging in recovery was found to be a TP change process. It included recognising that one has autonomy over recovery and subsequently committing to achieving it.

Weaver et al. (2005) found that in the TP phase, participants move "from passivity to active participation in recovering" (p. 195), where the individual commits to and prioritises recovery. Similarly, Matoff and Matoff (2001) explored the recovery process of one participant in detail and identified that the "realisation that continued weight loss [would] threaten her marriage and her career" (p. 48) resulted in the understanding that she had choices and control over her life.

Congruently, Dawson et al. (2014) found that as insight increased through the tipping point, participants moved "from internalisation to externalisation" (p. 500), for example, moving from the belief that AN was *"controlling me"* (p. 500), to something external that participants could *"break out"* of (p. 500). Consequently, during the tipping point of change, critical factors aligned to tip the balance towards recovery. Dawson et al. (2014) called this "when locus of control becomes internal and motivates change"(p. 501). The authors suggested that at this point, participants made a "conscious decision to recover" (p. 501).

Roberts and Skipsey (2022) defined TPs within the context of engagement and attitude toward recovery. The authors studied BN recovery within the context of occupation, with the

aim of informing occupational therapists. The theme *"once I committed"* (p. 490) represented reaching a phase where participants favoured rather than opposed recovery and committed to change: "Once I committed is suggestive of the intersection between crisis and start of recovery signifying a 'turning point' toward recovery unlike any other attempt" (p. 492).

Results for question three: Whose recovery narratives have been analysed when understanding the concept of a TP, and whose voices are missing?

Demographic reporting summary and critical appraisal

The literature had varying degrees of reporting of social demographic factors, (Table 6). The two articles by LaMarre and Rice (2020; 2021) appear to use the same sample of participants, thus the total number of participants is not equal to the total number of participants in the papers. All identified studies reported on gender or sex. Most did not differentiate between gender and sex, so it is unclear how many included transgender or cisgender participants. However, three studies (16%) did refer to either cisgender, gender non-conforming or gender fluid participants. Seven (37%) of the studies reported on "race"/ ethnicity. Two (11%) studies reported on sexuality. Five (26%) reported aspects related to social economic status, such as household income or education level. Five (26%) reported factors related to family, such as relationship status and one (5%) reported religion.

Where demographics were reported, most participants were white and female. The underreporting of social demographics may be considered problematic, as it was unclear whether the narratives around TPs related to some groups and not others. This was noted by LaMarre and Rice (2021) who stated:

> "While a turning point may well hold significant meaning for individuals navigating eating disorder recovery, it is important to consider which stories of recovery have been analysed when compiling definitions of the concept— and whose recoveries might be left out" (p. 721)

This query will continue to hold true while studies underreport the social demographics of their participants.

Table 6: How social demographics are reported in the identified studies

How social demographics are reported in the identified studies.

Study (author, year)	Number of participants (n)	Age (years)	Gender or sex	Ethnicity/ "race"	Sexual orientation	Social economic factors	Other factors reported
1. Arthur-Cameselle & Curcio, 2018	n=29	Mean: 20.1	Females	White (n = 28), Hispanic/White (n = 1).	Not reported	Not reported	Not reported
2. D'Abundo & Chally, 2004	n=20	Range: 17-46	Females	White (n=17) Black (n=2) Hispanic (n=1)	Not reported	Some college (n=10) College graduates (n=5) Graduate degrees (n=3) Finished high school (n=1) High school diploma (n=1)	Single (n=15) Married (n=3) Divorced (n=2)
3. Dawson et al., 2014	n=8	Range: 31-64	Females	Not reported	Not reported	Not reported	Not reported
4. Fogarty & Ramjan, 2017	n=67	Mean: 25.11	Females	Not reported	Not reported	"Majority were students" (p.1053)	Not reported
5. Hay & Cho, 2013	n=31	Mean: 34 Range: 18–57	Females (n=29) Males (n=2)	Not reported	Not reported	Not reported	Not reported

6. LaMarre & Rice, 2020	n=20	Mean: 28 Range: 19–41	Identified as women (n=19) Gender nonconforming (n=1)	White (n=15) Asian (n=4) Greek (n=1)	Heterosexual (n=14) Pansexual/ bisexual or sexually fluid (n=6)	Not reported	Not reported
7. LaMarre & Rice, 2021	Those in recovery (n=20), Supporters of those in recovery (n=14).	Not reported	People in recovery: "Largely identified as women" (p.237) Gender fluid (n=1) Supporters: "Six male partners, one father, one friend (gender/sex undefined), two sisters, and four mothers." (p. 237)	People in recovery: White (n=15) Asian (n=4) Greek (n=1) Supporters: White (n=11) Greek (n=2) Chinese (n=1)	Not reported	Not reported	Not reported
8. Lewke-Bandara et al, 2020	n=8	Range: 20-33 (1 participant unspecified age)	Males	From USA (n=5) Australian (n=2) From New Zealand (n=1)	Heterosexual (n=5) Not specified (n=2) Gay (n=1)	Not reported	Single (n=4) Partnered (n=2) Married (n=1) Not specified (n=1)
9. Lindgren et al., 2014	n=5	Range: 23–26	Females	Not reported	Not reported	"All of them were employed or studied" (p.863)	In a relationship (n=2) Had children (n=1)
10. Matoff & Matoff, 2001	n=1	37	Female	Not reported	Not reported	Attended college. Working – but job not specified	Married

11. Matusek & Knudson, 2009	n=8	All age 18+. The three women presented were Participant one: 46 Participant two: 24 Participant three: 57	Females	Not reported	Not reported	Participant one: Nurse Participant two: social work student Participant three: massage therapist	Participant one: married with two children. Participant two: in a committed relationship, in the process of adopting two children. Participant three: Divorced, one daughter, one grandchild.
12. McCallum & Alaggia, 2020	n=19	Range: 40 to 64 Mean: 50.6)	Cisgender females (n=18) Cisgender male (n=1)	Caucasian (n=15) East Indian (n=1) Aboriginal (n=1) Mixed race (n=2)	Not reported	Employed full-time (n=11) Employed part-time (n=4), On leave due to their illness (n=3) Unemployed (n=1) Education levels ranged from high school to completion of postsecondary graduate studies. Household incomes: CDN$100,000 to CDN$149,999 (n=7), CDN$20,000 to CDN$49,999 (n=6) CDN$150,000+ (n=4) CDN$50,000 to CDN$99,000 (n=2)	Married/ common-law (n=12) Single (n=3) Divorced (n=3) Separated (n=1) Had children (n=12) Had children living at home (n=7)

13. Nilsson & Hägglöf, 2006	n=68	Not reported	Females	Not reported	Not reported	Not reported	Not reported
14. Patching & Lawler, 2009	n=20	Range: 24-51	Females	Not reported	Not reported	Not reported	Not reported
15. Pettersen & Rosenvinge, 2002	n=48	Mean: 27.6 Range: 20–38	Females	Not reported	Not reported	Students or employed (n=46) Living on sick pension (n=2)	Single (n=24) Had a partner (n=25) Had children (n=9)
16. Roberts & Skipsey, 2022	n=6	Mean: 33 Range: 28-43	Females	Not reported	Not reported	Not reported	Not reported
17. Shohet (2007).	n=3	Range:19-29	Females	"Euro-American" (p.347)	Not reported	"Highly educated, middle-class" (p.347)	Not reported
18. Smethurst & Kuss, 2018	n=8	Mean 23.9 Range:19-29	Females (n=7) Male (n=1)	Not reported	Not reported	Not reported	Not reported
19. Weaver et al., 2005	n=12	Range: 14-63	Females	"A mix of White and biracial heritages (one woman was of French and Aboriginal descent)" (p. 191)	Not reported	"These women were more highly educated than the general population." (p. 191)	"Catholic, Protestant, Jewish, and agnostic religious beliefs." (p. 191) Single (n=6) Married (n=3) Divorced or separated (n=3) Had children (n=4).

Discussion

This review aimed to elucidate the concept of a TP in recovery from ED, focusing on how TPs are defined in the literature and how they lead to change. The literature defined TPs in several ways: some were unique to each study, some overlapped between studies and at times, studies defined TP in multiple ways in a single study. TPs were defined within the themes: ‘support’, ‘a transitional phase’ and ‘event-specific’. Change process themes were: ‘gaining knowledge’, ‘acceptance’ and ‘active participation in recovery’.

Several definitions of TPs aligned with metaethnography by Eaton (2020) and Stockford et al. (2019). For example, ‘recognising consequences’ was a theme in both Eaton's (2020) and Stockford's reviews (2019). Reconnecting to essential others was present within the theme ‘swimming: the path toward recovery’ (Eaton, 2020) and ‘reclamation of self’ theme by Stockford et al. (2019). Some literature, however, found that participants did not describe TPs. The idea that those with EDs *need* to reach a TP to recover (Stockford et al., 2019) was challenged by literature by both LaMarre and Rice (2021) and Lindgren et al. (2014), who found that TPs were not relevant for their participants, adding to an idea that TPs are perhaps a superficial concept. This finding is consistent with recent recovery literature, arguing that emphasising the journey's uniqueness is essential (LaMarre et al., 2023; Kenny & Lewis, 2023).

The uniqueness of recovery was also demonstrated by the notion that a TP for one person led to positive change, but for another individual, it contributed to the maintenance of the ED and prevented recovery and change (Shohet, 2007; McCallum & Alaggia, 2020). Schema therapy, which has been argued to be relevant to treating EDs (Oldershaw et al., 2019), suggests that various schema modes influence how we interpret events. For example, those with EDs are

said to have strong ‘inner critic’ mode, which may interpret events punitively rather than in a way that is adaptive and could motivate (Simpson & Smith, 2020). This may explain why some found the same TP motivating and others did not. The idea that identified TPs help some but hinder others raises questions of utility. Additionally, it highlights how TPs cannot predict who will recover or not, further demonstrating the inconsequential nature of TPs.

TP definitions

The definitions of TPs were relatively expansive and arguably vague. For example the ‘event-specific’ theme conceptualises a range of unique events which were specifically defined as TPs in the literature and perhaps uniquely meaningful for individual participants. When TPs were defined (to answer question one) they arguably lacked depth. This raises questions as to whether TPs are a meaningful concept.

Other TP definitions were broader, for instance ‘support’ was defined as a TP (Arthur-Cameselle & Crucio, 2018; Nilsson & Hägglöf, 2009 and Shohet, 2007). The importance of social support is unsurprising and is considered an important for ED recovery (Leonidas & Santos, 2014). Additionally, those with AN, for instance, describe less contact with friends when unwell (Westwood et al., 2016). This may be because social anxiety is a common co-morbidity across ED diagnoses (Kerr-Gaffney et al., 2018). Treatment being defined as a TP is promising, however arguably ED treatments require optimisation (Wade et al., 2021; Gregertsen et al., 2017) due to high treatment drop-out and relapse (Fernández-Aranda, 2021; Berends et al., 2018).

TP’s being defined as a transitional phase aligns with recovery research in other areas such as addiction (Patton & Best, 2022; Brookfield et al., 2019). Furthermore, TPs defined as a ‘catalyst tipping the balance’ aligns with ideas around motivational interviewing (Miller &

Rollnick, 2002). Motivational interviewing is a therapeutic technique that recognisees ambivalence as part of change. Therapists *roll with resistance* to explore the pros and cons to change aiming to facilitate this 'tipping the balance' idea (Miller & Rollnick, 2002). The MI style is used in NICE (2017) recommended treatments such as the Maudsley Model of Anorexia Nervosa Treatment for Adults (Schmidt et al., 2012; 2014).

TP change processes

The change processes associated with TPs possibly offered more clinical utility than TP definitions as they exposed *how* TPs led to change. Gaining knowledge appeared to be a significant theme where participants developed understanding of the ED. However, it has been argued that people with ED, particularly AN, may *know* the consequences but not *feel* them; thus, individuals may value the ED over its negative consequences (Gregertsen et al., 2017). Understanding this process more would further clarify the change process.

Acceptance of the ED, self and other was also found to be a key TP change process. This aligns with ideas from Acceptance and Commitment Therapy (ACT). ACT facilitates acceptance through self-compassion, identification of values and promotion of behaviours in accordance with those values (Hayes & Strosahl, 2004). ACT is a therapy that has been efficacious for a range of difficulties, including hoarding (Fang et al., 2023), and obsessive-compulsive disorder (Capel et al., 2023). A recent study found that compassion-focused ACT was helpful for women with restrictive eating (Hill et al., 2020), thus this TP change process appears to have clinical utility.

Finally, 'active participation in recovery' as a TP change process was found to be significant as participants acknowledge their autonomy and control over change and consequently

commit to it. This aligns with self-determination theory, which states that autonomous motivation (engaging in behaviour change based on one's own choice) is vital in sustaining behaviour change (Deci & Vansteenkiste, 2004). Thus, arguably promotion of autonomy may be beneficial in facilitating ED recovery, in comparison to coercive treatments sometimes used in ED treatment (Mac Donald et al., 2023).

TPs as a whole

The literature is arguably unclear about what constitutes a TP, whether TPs occur or the resulting change process that leads to recovery. Thus, highlighting how the concept of TPs, despite its use throughout much of the recovery literature, is superficial and lacking in clinical utility. LaMarre and Rice (2020) make an important argument that literature on recovery from EDs may focus too much on "recovery as an individual achievement with a specific, predetermined endpoint" (p. 233), rather than delving into the "multiplicity of forces" (p. 234) that comprise recovery. Most of the literature acknowledges recovery as a complex journey. For example, Matoff and Matoff (2004) utilise the TP narrative throughout their paper but also believe that "eating disorder recovery [is] a process over time rather than a measured outcome" (p. 52). However, given the discussed problems with the TP concept, this author argues that understanding recovery outside of this narrative may open the possibility of personal understanding of recovery. This may provide more insight into the change process, which is increasingly needed due to the rise in EDs (Royal College of Psychiatrists, 2022).

Social demographic reporting

There was under-reporting of social demographics, meaning it is unclear whose recovery narratives have been excluded or included. Discrimination has been found to impact ED symptomology (Nelson et al., 2023). Additionally, some groups have been found to have

culturally specific factors that impact EDs (Sun et al., 2023). Thus, including diverse participants and reporting on social demographics is essential to elucidate critical concepts, such as TPs.

The lack of social demographic reporting demonstrates a lack of evidence for the concept being universally relevant to all. It also has an additional impact of potentially perpetuating stereotypes of who lives with an ED and who does not. Such stereotypes are problematic as they may lead to less recognition of EDs in those who do not meet these stereotypes; importantly, clinicians are not immune from holding such stereotypes (Reas, 2017). Systems perpetuating stereotypes can be defined as institutionally racist by disadvantaging groups (McKenzie & Bhui, 2007).

Clinical implications

Despite problems with the TP literature, as TPs were considered in the reviewed papers, clinicians could work with clients to identify and explore potential TPs. The literature provides an idea of what TPs could be. Thus, clinicians could explore these ideas with clients as they could represent pivotal moments leading to change. Additionally, it may be beneficial to explore what recovery means to individuals, aligning with ideas around the uniqueness of the recovery journey (LaMarre et al., 2023; Kenny & Lewis, 2023).

Spirituality was a concept that ran throughout several themes, including when TPs were defined as ‘event-specific’ and within themes related to acceptance in the TP change process. Integrating spirituality and religion into mental health care has utility (Malviya, 2023), although research into spirituality, religion, and eating disorders is lacking currently.

The reviewed literature does not indicate which interventions may be helpful. However, interventions that focus on dimensions associated with the change process may have utility. For instance, understanding the role of the ED and its consequences was a TP change process; thus, clinicians could explore this with clients using psychological formulation (Johnstone and Dallos, 2013). The TP change processes described aligned with evidenced-based treatments for ED. For instance, the marginalisation of essential aspects of life (such as family, work, and hobbies) outside of the ED are explored in Enhanced Cognitive Behavioural Therapy for ED (CBT-E) (Fairburn, 2008) to highlight the EDs impact. This supports the sub-theme 'understanding the consequences of the ED on values' (section 4.2, pg. 39) where athletes, for instance, understood the ED consequences on their athletic ability (Arthur-Cameselle & Curcio, 2018).

Nonetheless, gaining more understanding of the TP change process would be beneficial for clinicians. To illustrate, 'treatment' was a generated sub-theme when exploring how TPs were defined. Still, it remains unclear which aspects of treatment were helpful or even what led individuals to accept and commence treatment. This understanding would be useful, as premature treatment drop-out is high (Fernández-Aranda et al., 2021). Literature outside of this review suggests that the therapeutic relationship (Mital et al., 2022) and early intervention are essential treatment factors (Koreshe et al., 2023, Potterton et al., 2021).

Research implications

Broadly, it could be argued that to understand what is helpful about experiences that lead to recovery, research using change process methods should be considered. Elliott (2011) argues that qualitative change process research has utility in understanding how and why change

occurs, and for interventions this is useful in gaining a rich understanding of which parts of the experience leads to change.

Further research should also explore which TPs or change processes will likely lead to a TP. Additionally, further research should aim to include diverse participants. Also, all research should aim to report on crucial social demographic factors of participants in line with recommendations by Burnette et al. (2022).

Methodology critique of this review

The reviewed literature was from a narrow range of Western countries, partly as an inclusion criterion was that the articles were written in English. Understanding how countries outside these conceptualise TPs and recovery from EDs would be interesting.

Another limitation is that the results were analysed not from raw data but from qualitative studies. The author attempted to remain close to the data. However, it could be argued that meanings were inferred and accessing the raw data may have been of benefit.

The included studies in this review had participants with a range of diagnoses, which is arguably of benefit due to the transdiagnostic nature of EDs (Fairburn et al., 2003). However, one study utilised a participant with orthorexia (Lewke-Bandara et al., 2020). Orthorexia is characterised by beliefs about healthy eating leading to distress and eating disturbance (Zickgraf & Barrada, 2021). However, orthorexia is not currently a diagnosis within DSM-5, and there is no consensus on how it should be described or a criterion for diagnosis (Atchison & Zickgraf, 2022). Thus, it could be argued that participants who state they have orthorexia should be excluded due to a lack of a standardised definition.

Additionally, many of the studies included participants who self-defined as having an ED and self-defined recovery, which has been argued to be a limitation in ED research (Stockford et al., 2019). However, the philosophical ethos of qualitative research includes understanding and recognising individual experiences and interpretations of the world (Barker et al., 2015). Thus, this author has included these participants in line with the philosophical background of qualitative methods. Furthermore, the LaMarre and Rice (2020; 2021) papers appear to have utilised the same sample of participants, meaning the total number of participants in this review may not be equal to the total number of participants across the papers. The author of this review has chosen to treat each paper individually due to their different reporting of demographics. For example, LaMarre & Rice (2020) has reported sexuality, but LaMarre & Rice (2021) has not.

Conclusion

TPs have been explored in the literature; however, it is unclear who has been included or excluded in recovery narratives in the reviewed literature, due to the under-reporting of social demographics. The definitions of TPs are expansive and imprecise. Some of the reviewed literature also stated that TPs were not relevant for their participants. The change processes helped to elucidate how TPs led to change, however questions are raised as to the utility of the concept as a whole. This author argues that the TP concept is superficial, demonstrated by its expansive and, at times, contradictory use. Due to this, the concept cannot aid understanding in predicting who will or will not recover from an ED, limiting its clinical utility and further demonstrating the inconsequential nature of the literatures use of the TP concept. Furthermore, this author argues that understanding recovery outside of TP narratives may have utility. This author recommends that future research limit the use of the TP

concept, or if it is used, ensure that it is defined clearly alongside explicit meaningful change processes.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision). https://doi.org/10.1176/appi.books.9780890423349

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Arcelus, J., Mitchell, A. J., Wales, J., & Nielsen, S. (2011). Mortality rates in patients with anorexia nervosa and other eating disorders. *Archives of General Psychiatry*, *68*(7), 724-731. https://doi.org/10.1001/archgenpsychiatry.2011.74

Arthur-Cameselle, J. N., & Curcio, M. (2018). Turning the corner: A comparison of collegiate athletes' and non-athletes' turning points in eating disorder recovery. *Journal of Clinical Sport Psychology*, *12*(4), 595–613. https://doi.org/10.1123/jcsp.2018-0030

Atchison, A. E., & Zickgraf, H. F. (2022). Orthorexia nervosa and eating disorder behaviors: A systematic review of the literature. *Appetite*, *177*(1), 1-23 https://doi.org/10.1016/j.appet.2022.106134

Barnett-Page, E., & Thomas, J. (2009). Methods for the synthesis of qualitative research: a critical review. *BMC Medical Research Methodology*, *9*(1). https://doi.org/10.1186/1471-2288-9-59

Barker, C., Pistrang, N., & Elliott, R. (2015). *Research methods in clinical psychology: An introduction for students and practitioners* (3rd ed.). Wiley-Blackwell.

Berends, T., Boonstra, N., & Van Elburg, A. A. (2018). Relapse in anorexia nervosa. *Current Opinion in Psychiatry*, *31*(6), 445–455. https://doi.org/10.1097/yco.0000000000000453

Booth, A., Sutton, A., & Papaioannou, D. (2016). *Systematic approaches to a successful literature review* (2nd ed.). SAGE Publications Ltd.

Brookfield, S., Fitzgerald, L., Selvey, L. A., & Maher, L. (2019). Turning points, identity, and social capital: A meta-ethnography of methamphetamine recovery. *International Journal of Drug Policy*, *67*(0), 79–90. https://doi.org/10.1016/j.drugpo.2019.02.002

Burnette, C. B., Luzier, J. L., Weisenmuller, C. M., & Boutté, R. L. (2022). A systematic review of sociodemographic reporting and representation in eating disorder psychotherapy treatment trials in the United States. *International Journal of Eating Disorders*, *55*(4), 423–454. https://doi.org/10.1002/eat.23699

Capel, L. K., Ona, P. Z., Moller, C., & Twohig, M. P. (2023). An open trial of acceptance and commitment therapy with exposure and response prevention in an intensive outpatient setting for adults with OCD. *Cognitive and Behavioral Practice*, *30*(2), 218–228. https://doi.org/10.1016/j.cbpra.2022.01.004

Charmaz, K. (2008). Grounded theory as an emergent method. In Hesse-Biber, S. & Leavy, P. (Eds.). *Handbook of emergent methods*, (pp. 155 -172). New Yoek: The Guilford Press.

D'Abundo, M., & Chally, P. (2004). Struggling with recovery: Participant perspectives on battling an eating disorder. *Qualitative Health Research*, *14*(8), 1094–1106. https://doi.org/10.1177/1049732304267753

Dawson, L., Rhodes, P., & Touyz, S. (2014). "Doing the impossible.": The process of recovery from chronic anorexia nervosa. *Qualitative Health Research*, *24*(4), 494–505. https://doi.org/10.1177/1049732314524029

Deci, E. L., & Vansteenkiste, M. (2004). Self-determination theory and basic need satisfaction: Understanding human development in positive psychology. *Ricerche Di Psicologia*, *27*(0), 17–34. https://lirias.kuleuven.be/handle/123456789/113911

Eaton, C. M. (2020). Eating disorder recovery: A metaethnography. *Journal of the American Psychiatric Nurses Association*, *26*(4), 373–388. https://doi.org/10.1177/1078390319849106

Egbert, A. H., Hunt, R. A., Williams, K. L., Burke, N. L., & Mathis, K. J. (2022). Reporting racial and ethnic diversity in eating disorder research over the past 20 years. *International Journal of Eating Disorders*, *55*(4), 455–462. https://doi.org/10.1002/eat.23666

Elliott, R. (2010). Psychotherapy change process research: Realizing the promise, *Psychotherapy Research*, 20(2), 123-135. . https://doi.org/10.1080/10503300903470743.

Elliott, R. (2011). Qualitative methods for studying psychotherapy change processes in D. Harper & A. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*, (pp. 69–81). John Wiley & Sons

Fairburn, C. G. (2008). *Cognitive behavior therapy and eating disorders*. The Guilford Press.

Fairburn, C. G., Cooper, Z., & Shafran, R. (2003). Cognitive behaviour therapy for eating disorders: a "transdiagnostic" theory and treatment. *Behaviour Research and Therapy*, *41*(5), 509–528. https://doi.org/10.1016/s0005-7967(02)00088-8

Fang, S., Ding, D., Zhang, R., & Huang, M. (2023). Psychological mechanism of acceptance and commitment therapy and rational emotive behavior therapy for treating hoarding: Evidence from randomized controlled trials. *Frontiers in Public Health*, *11*(0), 1-14 https://doi.org/10.3389/fpubh.2023.1084467

Fernández-Aranda, F., Treasure, J., Paslakis, G., Agüera, Z., Giménez, M., Granero, R., Sánchez, I., Serrano-Troncoso, E., Gorwood, P., Herpertz-Dahlmann, B., Bonin, E., Monteleone, P., & Jiménez-Murcia, S. (2021). The impact of duration of illness on treatment nonresponse and drop-out: Exploring the relevance of enduring eating disorder concept. *European Eating Disorders Review*, *29*(3), 499–513. https://doi.org/10.1002/erv.2822

Fogarty, S., & Ramjan, L. M. (2017). The tipping point of change in Anorexia Nervosa (AN): Qualitative findings from an online study. *Women & Health*, *58*(9), 1050–1061. https://doi.org/10.1080/03630242.2017.1372846

Goeree, M. S., Ham, J. C., & Iorio, D. (2011). Race, social class, and bulimia nervosa. *SSRN Electronic Journal*. https://doi.org/10.2139/ssrn.1877636

Gregertsen, E. C., Mandy, W., & Serpell, L. (2017). The egosyntonic nature of anorexia: An impediment to recovery in anorexia nervosa treatment. *Frontiers in psychology*, *8*(0), 1-9. https://doi.org/10.3389/fpsyg.2017.02273

Hay, P. J., & Cho, K. (2013). A qualitative exploration of influences on the process of recovery from personal written accounts of people with anorexia nervosa. *Women & Health*, *53*(7), 730–740. https://doi.org/10.1080/03630242.2013.821694

Hayes, S. C., & Strosahl, K. D. (2004) (Eds.). *A Practical Guide to Acceptance and Commitment Therapy*. Springer Science & Business Media.

Hill, M. C., Schaefer, L. W., Spencer, S. T., & Masuda, A. (2020). Compassion-focused acceptance and commitment therapy for women with restrictive eating and problematic body-checking: A multiple baseline across participants study. *Journal of Contextual Behavioral Science*, *16*, 144–152. https://doi.org/10.1016/j.jcbs.2020.04.006

Huryk, K. M., Drury, C. R., & Loeb, K. L. (2021). Diseases of affluence? A systematic review of the literature on socioeconomic diversity in eating disorders. *Eating Behaviors*, *43*(0), 1-16. https://doi.org/10.1016/j.eatbeh.2021.101548

Jenkins, J., & Ogden, J. (2011). Becoming 'whole' again: A qualitative study of women's views of recovering from anorexia nervosa. *European Eating Disorders Review*, *20*(1), 23–31. https://doi.org/10.1002/erv.1085

Johnstone, L. and Dallos, R. (Eds.). (2013) *Formulation in Psychology and Psychotherapy: Making sense of people's problems*. Routledge.

Kenny, T. E., & Lewis, S. P. (2023). More than an outcome: a person-centred, ecological framework for eating disorder recovery. *Journal of Eating Disorders*, *11*(45), 1-14. https://doi.org/10.1186/s40337-023-00768-1

Kerr-Gaffney, J., Harrison, A. S., & Tchanturia, K. (2018). Social anxiety in the eating disorders: a systematic review and meta-analysis. *Psychological Medicine*, *48*(15), 2477–2491. https://doi.org/10.1017/s0033291718000752

Koreshe, E., Paxton, S., Miskovic-Wheatley, J., Bryant, E., Le, A., Maloney, D., National Eating Disorder Research Consortium., Touyz, S. & Maguire, S. (2023). Prevention and early intervention in eating disorders: findings from a rapid review. *Journal of Eating Disorders*, *11*(1). 1-20. https://doi.org/10.1186/s40337-023-00758-3

LaMarre, A., & Rice, C. (2020). The eating disorder recovery assemblage: Collectively generating possibilities for eating disorder recovery. *Feminism & Psychology*, *31*(2), 231–251. https://doi.org/10.1177/0959353520941353

LaMarre, A., & Rice, C. (2021). Recovering uncertainty: Exploring eating disorder recovery in context. *Culture, Medicine, and Psychiatry*, *45*(4), 706–726. https://doi.org/10.1007/s11013-020-09700-7

LaMarre, A., Healy-Cullen, S., Tappin, J., & Burns, M. (2023). Honouring differences in recovery: Methodological explorations in creative eating disorder recovery research. *Social Sciences*, *12*(4), 251-270. https://doi.org/10.3390/socsci12040251

Leonidas, C., & Santos, M. a. D. (2014). Social support networks and eating disorders: an integrative review of the literature. *Neuropsychiatric Disease and Treatment*, *10*(0) 915-927. https://doi.org/10.2147/ndt.s60735

Lewke-Bandara, R. S., Thapliyal, P., Conti, J., & Hay, P. (2020). "It also taught me a lot about myself": A qualitative exploration of how men understand eating disorder recovery. *Journal of Eating Disorders*, *8*(1), 1-9. https://doi.org/10.1186/s40337-020-0279-6

Lindgren, B. M., Enmark, A., Bohman, A., & Lundström, M. (2014). A qualitative study of young women's experiences of recovery from Bulimia Nervosa. *Journal of Advanced Nursing*, *71*(4), 860–869. https://doi.org/10.1111/jan.12554

Mac Donald, B., Gustafsson, S. A., Bulik, C. M., & Clausen, L. (2023). Living and leaving a life of coercion: a qualitative interview study of patients with anorexia nervosa and multiple involuntary treatment events. *Journal of Eating Disorders*, *11*(1), 1-19. https://doi.org/10.1186/s40337-023-00765-4

Malviya, S. (2023). The need for integration of religion and spirituality into the mental health care of culturally and linguistically diverse populations in australia: A rapid review. *Journal of Religion & Health*. *62*(1), 98-116 https://doi.org/10.1007/s10943-023-01761-3

Matoff, M. L., & Matoff, S. A. (2001). Eating disorder recovery. *Women & Therapy*, *23*(4), 43–54. https://doi.org/10.1300/j015v23n04_04

Matusek, J. A., & Knudson, R. M. (2009). Rethinking recovery from eating disorders: Spiritual and political dimensions. *Qualitative Health Research*, *19*(5), 697–707. https://doi.org/10.1177/1049732309334077

McCallum, L. A., & Alaggia, R. (2020). Achieving recovery through resilience: Insights from adults in midlife living with anorexia nervosa. *Qualitative Health Research*, *31*(4), 619–630. https://doi.org/10.1177/1049732320978202

McKenzie, K., & Bhui, K. (2007). Institutional racism in mental health. *The BMJ*, *334*(7595), 649-650.

Merten, S., Hilber, A. M., Biaggi, C., Sécula, F., Bosch-Capblanch, X., Namgyal, P., & Hombach, J. (2015). Gender Determinants of Vaccination Status in Children: Evidence from a Meta-Ethnographic Systematic Review. *PLOS ONE*, *10*(8), e0135222. https://doi.org/10.1371/journal.pone.0135222

Miller, W. R., & Rollnick, S. (2002). Motivational interviewing: preparing people for change. *Guilford Press eBooks*. http://ci.nii.ac.jp/ncid/BA63388171

Mital, R., Hay, P., Conti, J., & Mannan, H. R. (2022). Associations between therapy experiences and perceived helpfulness of treatment for people with eating disorders. *Journal of Eating Disorders*, *10*(1), 1-9. https://doi.org/10.1186/s40337-022-00601-1

Mitchison, D., Basten, C., Griffiths, S., & Murray, S. (2017). Beneath the tip of the iceberg: Why so many people with eating disorders are not referred for treatment. *Australian Family Physician*, *46*(7), 539-540. https://search.informit.org/doi/abs/10.3316/INFORMIT.919926867748528

National Institute for Health and Care Excellence. (2017). *Eating disorders: recognition and treatment* [NICE guideline NG69]. https://www.nice.org.uk/guidance/ng69

Nelson, J. D., Martin, L. N., Izquierdo, A., Kornienko, O., Cuellar, A. E., Cheskin, L. J., & Fischer, S. (2023). The role of discrimination and adverse childhood experiences in disordered eating. *Journal of Eating Disorders*, *11*(1), 1-12. https://doi.org/10.1186/s40337-023-00753-8

Nilsson, K., & Hägglöf, B. (2006). Patient perspectives of recovery in adolescent onset anorexia nervosa. *Eating Disorders*, *14*(4), 305–311. https://doi.org/10.1080/10640260600796234

Oldershaw, A., Startup, H., & Lavender, T. (2019). Anorexia nervosa and a lost emotional self: A psychological formulation of the evelopment, maintenance, and treatment of anorexia nervosa. *Frontiers in Psychology*, *10*(0), 1-22. https://doi.org/10.3389/fpsyg.2019.00219

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T., Mulrow, C. D., Shamseer, L., Tetzlaff, J., Akl, E. A., Brennan, S., Chou, R., Glanville, J., Grimshaw, J., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E., Mayo-Wilson, E., McDonald, S., Moher, D. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ*, n71. https://doi.org/10.1136/bmj.n71

Patching, J., & Lawler, J. (2009). Understanding women's experiences of developing an eating disorder and recovering: a life-history approach. *Nursing Inquiry*, *16*(1), 10–21. https://doi.org/10.1111/j.1440-1800.2009.00436.x

Patton, D., & Best, D. (2022). Motivations for Change in Drug Addiction Recovery: Turning Points as the Antidotes to the Pains of Recovery. *Journal of Drug Issues*, *2*(10) 36-43. https://doi.org/10.1177/00220426221140887

Pettersen, G., & Rosenvinge, J. H. (2002). Improvement and recovery from eating Disorders: A patient perspective. *Eating Disorders*, *10*(1), 61–71. https://doi.org/10.1002/erv.425

Potterton, R., Austin, A., Flynn, M., Allen, K. L., Lawrence, V., Mountford, V., Glennon, D., Grant, N., Brown, A., Franklin-Smith, M., Schelhase, M., Jones, W., Brady, G., Nunes, N., Connan, F., Mahony, K., Serpell, L., & Schmidt, U. (2021). "I'm truly free from my eating disorder": Emerging adults' experiences of FREED, an early intervention service model and care pathway for eating disorders. *Journal of Eating Disorders*, *9*(1), 1-14. https://doi.org/10.1186/s40337-020-00354-9

Prochaska, J. O., & DiClemente, C. C. (2005). The transtheoretical approach. In Norcross, J. C., & Goldfriend, M, R (Eds.), *Handbook of psychotherapy integration*, 147–171. https://doi.org/10.1093/med:psych/9780195165791.003.0007

Reas, D. L., Gulliksen, K. S., Levallius, J., & Isomaa, R. (2017). Letter to the editor: health professionals' attitudes toward individuals with eating disorders: who do we think they are? *Journal of Eating Disorders*, *5*(1), 2-3. https://doi.org/10.1186/s40337-017-0150-6

Reid, M., Burr, J., Williams, S., & Hammersley, R. (2008) Eating disorders patients' views on their disorders and on an outpatients service: A qualitative study. *Journal of Health Psychology*, 13(7), 956- 960. https://doi.org/10.1177/1359105308095070

Roberts, E., & Skipsey, J. (2022). Exploring occupation in recovery from bulimia nervosa: An interpretative phenomenological analysis. *British Journal of Occupational Therapy*, *85*(7), 487–495. https://doi.org/10.1177/03080226211045289

Royal college of psychiatrists. (2022). *Hospital admissions for eating disorders increased by 84% in the last five years* [Press release]. Retrieved May 1, 2023, from https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2022/05/18/hospital-admissions-for-eating-disorders-increased-by-84-in-the-last-five-years

Schmidt, U., & Treasure, J. (2006). Anorexia nervosa: Valued and visible. A cognitive-interpersonal maintenance model and its implications for research and practice. *British Journal of Clinical Psychology*, *45*(3), 343–366. https://doi.org/10.1348/014466505x53902

Schmidt, U., Oldershaw, A., Jichi, F., Sternheim, L., Startup, H., McIntosh, V. V., Jordan, J., Tchanturia, K., Wolff, G., Rooney, M. K., Landau, S., & Treasure, J. (2012). Out-patient psychological therapies for adults with anorexia nervosa: randomised controlled trial. *British Journal of Psychiatry*, *201*(5), 392–399. https://doi.org/10.1192/bjp.bp.112.112078

Schmidt, U., Wade, T. D., & Treasure, J. (2014). The maudsley model of anorexia nervosa treatment for adults (MANTRA): Development, key features, and preliminary evidence. *Journal of Cognitive Psychotherapy*, *28*(1), 48–71. https://doi.org/10.1891/0889-8391.28.1.48

Shohet, M. (2007). Narrating anorexia: "Full" and "struggling" genres of recovery. *Ethos*, *35*(3), 344–382. https://doi.org/10.1525/eth.2007.35.3.344

Simpson, S., & Smith, E. (Eds.). (2020). *Schema therapy for eating disorders: Theory and practice for individual and group settings*.

Smethurst, L., & Kuss, D. (2018). 'Learning to live your life again': An interpretative phenomenological analysis of weblogs documenting the inside experience of recovering from anorexia nervosa. *Journal of Health Psychology*, *23*(10), 1287–1298. https://doi.org/10.1177/1359105316651710

Stockford, C., Stenfert Kroese, B., Beesley, A., & Leung, N. (2019). Women's recovery from anorexia nervosa: a systematic review and meta-synthesis of qualitative research. *Eating Disorders*, *27*(4), 343–368. https://doi.org/10.1080/10640266.2018.1512301

Sun, V., Soh, N., Touyz, S., Maguire, S., & Aouad, P. (2023). Asian students in the anglosphere – unravelling the unique familial pressures contributing to eating pathology: a systematic review. *Journal of Eating Disorders*, *11*(1). https://doi.org/10.1186/s40337-023-00733-y

Thomas, J.D. & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews, *BMC Medical Research Methodology*, *8*(1), 1-10 https://doi.org/10.1186/1471-2288-8-45

Venturo-Conerly, K. E., Wasil, A. R., Dreier, M. J., Lipson, S. M., Shingleton, R. M., & Weisz, J. R. (2020). Why I recovered: A qualitative investigation of factors promoting motivation for eating disorder recovery. *International Journal of Eating Disorders*, *53*(8), 1244–1251. https://doi.org/10.1002/eat.23331

Wade, T. D., Hart, L. M., Mitchison, D., & Hay, P. (2021). Driving better intervention outcomes in eating disorders: A systematic synthesis of research priority setting and the involvement of consumer input. *European Eating Disorders Review*, *29*(3), 346–354. https://doi.org/10.1002/erv.2759

Waller, G., Schmidt, U., Treasure, J., Emanuelli, F., Alenya, J., Crockett, J., & Murray, K. (2009). Ethnic origins of patients attending specialist eating disorders services in a multiethnic urban catchment area in the United Kingdom. *International Journal of Eating Disorders*, *42*(5), 459–463. https://doi.org/10.1002/eat.20631

Weaver, K., Wuest, J., & Ciliska, D. (2005). Understanding women's journey of recovering from anorexia nervosa. *Qualitative Health Research*, *15*(2), 188–206. https://doi.org/10.1177/1049732304270819

Westwood, H., Lawrence, V., Fleming, C. C., & Tchanturia, K. (2016). Exploration of Friendship Experiences, before and after Illness Onset in Females with Anorexia Nervosa: A Qualitative Study. *PLOS ONE*, *11*(9), 1-16 https://doi.org/10.1371/journal.pone.0163528

Zickgraf, H. F., & Barrada, J. R. (2021). Orthorexia nervosa vs. healthy orthorexia: relationships with disordered eating, eating behavior, and healthy lifestyle choices. *Eating and Weight Disorders - Studies on Anorexia, Bulimia and Obesity*, *27*(4), 1313–1325. https://doi.org/10.1007/s40519-021-01263-9

Section B:

“It's literally like been life-changing”: An Interpretative Phenomenological Analysis of a novel motivational chairwork intervention for the treatment of Anorexia Nervosa

Word count: 7994 (268)

Proposed journal for publication: European Eating Disorders Review

Abstract

Objective: Many people with Anorexia Nervosa experience ambivalence and impoverished motivation to change, yet current motivation enhancing interventions lack empirical support. Chairwork is a collection of therapeutic techniques, which broadly incorporates the position, dialogue, and movement between chairs to elicit change. The 'future selves' chairwork intervention (FSCI), aims to highlight the consequences of sustaining versus changing to increase motivation by role-playing and interacting with a future 'non-recovered self' and 'recovered self', utilising movement between chairs representing each self.

Method: People living with Anorexia completed the FSCI and nine were interviewed about their experience. An interpretative phenomenological analysis was conducted, using change process research methods to explore acceptability, feasibility, and associated change processes.

Results: The following Group Experiential Themes (GETs) were identified: 'Delivery and Task factors', 'Motivation towards a demanding recovery journey', 'Intense and strange emotions led to realisations' and 'Living as the future self''.

Conclusions: The findings suggest that FSCI is acceptable and feasible, although more research would be beneficial. Changes in motivation were facilitated through experiencing emotion and embodiment. Participants described an evocative response, which led to realisations and new understanding.

Key words: Anorexia Nervosa, motivation, ambivalence, chairwork, change process research.

Introduction

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association [APA], 2013) states anorexia nervosa (AN) is characterised by restriction of energy intake leading to low body weight, intense fear of weight gain and body shape disturbance. Atypical AN is diagnosed where all other criteria are met, but despite weight loss, the individual's weight is not below normal range.

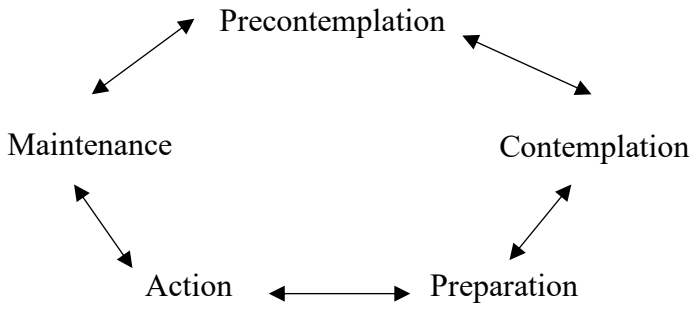
Eating disorders (ED) are rising (Royal College of Psychiatrists, 2022). EDs have the highest mortality rate of all mental health problems and AN has the highest mortality compared to other EDs (Arcelus et al., 2011). However, those living with an ED experience ambivalence towards recovery (Reid et al., 2008; Schmidt & Treasure, 2006; Nordbø et al., 2012).

Motivation and ambivalence

Motivation in AN has been described as "deceivingly complex" (Rankin et al., 2023, p. 2), and ambivalence is a common block to change (Pugh, 2019). The Transtheoretical Model ([TTM], Prochaska & DiClemente, 2005) theorise that change is cyclical (Figure 1).

Figure 1

The Transtheoretical Model



Individuals move back-and-forth between stages before motivation leads to behaviour change. The "precontemplation" stage is characterised by lack of recognition of a need for

change, whereas the "contemplation" stage is characterised by acknowledgment of a problem but ambivalence towards change (Prochaska & DiClemente, 2005). People living with AN will likely be in the precontemplation or contemplation stage when starting treatment (Treasure & Schmidt, 2001).

Recommended treatments for AN

The National Institute for Health and Care Excellence ([NICE], 2017) recommends enhanced Cognitive Behavioural Therapy for ED (CBT-E; Fairburn, 2008). CBT-E aims to address ED cognitions and integrates motivational tasks into the intervention. NICE (2017) also recommends the Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA; Schmidt et al., 2012; 2014). MANTRA addresses AN maintenance factors with a motivational interviewing style to resolve ambivalence (Schmidt et al., 2012; Miller & Rollnick, 2002). However, optimisation of these interventions is needed (Wade et al., 2021; Gregertsen et al., 2017). Additionally, treatment drop-out and relapse remains high across ED interventions (Fernández-Aranda, 2021; Berends et al., 2018).

Motivation-specific interventions for AN

Motivation-specific interventions have been suggested. For instance, a motivation-enhancing adjunct to MANTRA was researched. No effect on ED symptoms, well-being, or adjustment were found, but participants' confidence in their ability to change increased (Cardi et al., 2020). Motivational interviewing (MI; Miller & Rollnick, 2002) can be used to enhance motivation. Therapists highlight how current behaviour may differ from clients hopes for the future. This exploration is considered a catalyst for change. However, adapting standard MI for people living with Anorexia lacks empirical support (Pugh & Salter, 2018; Waller, 2012).

Chairwork

Chairwork represents a collection of therapeutic techniques that incorporate dialogue and movement between chairs to elicit change (Pugh, 2020). Chairwork has roots in psychodrama (Moreno, 2008) and Gestalt therapy (Perls, 1969). Chairwork can be interpreted through the lens of dialogical self-theory (DST). DST theorises that the self is a dynamic multiplicity of positions. Thus, the self contains different positions (e.g., "I" as a mother and "I" as a professional). These self-parts can interact, thus exchange knowledge (Hermans, 2001). DST also theorises that self-parts can be organised along temporal dimensions meaning one can interact with future self-representations (Barresi, 2012).

Chairwork broadly aims to facilitate interactions with self-parts to enable change and is underpinned by three therapeutic processes: 'self-multiplicity' (the self conceptualised as parts), 'embodiment and personification' (the parts humanised) and finally 'dialogue' (discussion between or with parts) (Pugh & Salter, 2018). How the therapeutic processes are facilitated depends on modalities (Pugh, 2020) but broadly, chairwork utilises various dramatisations, role-plays, re-enactments, and dialogues (Pugh, 2017). For example, Bell et al. (2019) researched a Compassion Focused Therapy (CFT) chairwork intervention to improve self-compassion. Participants dialogued between three role-played self-parts ('self-critic', 'compassionate self' and 'criticised self'), (Bell et al., 2019).

The "future selves" chairwork intervention (FSCI) aims to resolve ambivalence by role-playing and interacting with a future 'non-recovered self' (NRS) and 'recovered self' (RS), utilising movement between chairs representing each. This aims to highlight the consequences of sustaining versus changing to increase motivation (Pugh & Salter, 2018). Research indicates that chairwork is efficacious (Shaher et al., 2012; Greenberg, 2017), and

studies suggest that chairwork can help resolve ambivalence (Greenberg & Watson, 1998). However, FSCI is a novel approach thus requires investigation (Pugh & Salter, 2018).

Change process theories

Interacting cognitive subsystems

The model of interacting cognitive subsystems (ICS) can explain the chairwork change process (ICS; Teasdale & Barnard, 1993). ICS proposes two processing levels, a propositional code or 'analytical processing' and an implication code or 'affective processing'. Gregertsen et al. (2017) state that affective processing may be impaired, resulting in people living with Anorexia recognising the negative consequences of AN on an analytical level but not on an affective level, resulting in reluctance to change. They suggest that people living with Anorexia may need to move from *knowing* the consequences to *feeling* them (Gregertsen et al., 2017) which could help move from precontemplation to contemplation TTM stages (Prochaska & DiClemente, 2005; Gregertsen et al., 2017).

ICS propositions that affective processing is linked with multisensory inputs (movement, sound, sight) and that body-state systems have equal status as analytical and affective processing systems (Teasdale & Barnard, 1993; Pugh & Salter, 2018; Park et al., 2011). Thus, emotionally evocative techniques that engage affective processing with sensory inputs may have utility (Pugh & Salter, 2018).

Experiencing emotions

Facilitating people living with Anorexia's attunement to emotions may be important. People living with Anorexia may rely on maladaptive strategies to manage emotions, such as non-acceptance of emotions and suppression (Drinkwater et al., 2022; Leppanen et al., 2022); rather than adaptive strategies, such as acceptance of emotions (Leppanen et al., 2022). These

maladaptive strategies may result in AN maintenance, and recovery may, therefore, be supported through changing how people living with Anorexia relate to emotions (Drinkwater et al., 2022). Emotion-focused therapy (EFT) proposes that experiencing emotions can lead to identifying needs and, consequently, action and that this can be achieved using chairwork (Elliott & Greenberg, 2021), thus attunement to emotions may be significant. Where dissonance occurs between behaviour and values, this attunement could intensify the discrepancy to stimulate behaviour change, aligned with MI (Miller & Rollnick, 2002). The idea that emotions can be adaptive and motivate is also emphasised by other modalities such as CFT. For instance, anxiety may motivate individuals to avoid dangerous situations (Bell et al., 2021; Gilbert, 2020).

Retrieval competition

Another influencing theory is that of retrieval competition, wherein mental representations compete for retrieval from long term memory (Brewin, 2006). For some, negative mental self-representations may outcompete positive self-representations ordinarily. Therefore, to improve recovery motivation, enhancing the accessibility of positive representations of recovery may have utility (Pugh & Salter, 2018). This could be achieved by strengthening positive representations through rehearsal (Brewin, 2006). Furthermore, constructing attention-grabbing representations can aid retrieval competition (Brewin, 2006). The importance of attention-grabbing experiences is also congruent with EFT's notion that mild emotions will not be attention-grabbing enough to facilitate accessibility of information about needs and action that the emotion conveys (Elliott & Greenberg, 2021).

Change Process Research

Qualitative change process research (CPR) goes beyond whether there is a causal relationship to understanding how change occurs and what parts of the intervention were meaningful (Elliott, 2012). This is beneficial as investigating change mechanisms in AN treatment has been recommended (Leppanen et al., 2022). Qualitative CPR also aligns with the NHS values of 'working together for patients' and 'everyone counts' (Department of Health, 2021) because it emphasises the service user's voice.

Study rationale

Many people living with Anorexia experience ambivalence and impoverished motivation to change (Nordbø et al., 2012). Current motivational interventions lack empirical support for restrictive EDs (Pugh & Salter, 2018). Chairwork is a collection of techniques used in various modalities (Pugh, 2020). FSCI is a novel intervention which may resolve ambivalence (Pugh & Salter, 2018). The study aims to explore the acceptability, feasibility, and associated change processes.

Research questions

1. How do participants experience FSCI?
2. How do participants make sense of the change process of the task?
3. What do participants think may have facilitated or hindered the change process?

To elaborate, research question one relates to the *felt experience* of the task, including changes. Research question two emphasises *how* the change process may occur. Question three conceptualises *helpful or unhelpful* factors in the proposed change process.

Method

Design

The study followed a qualitative design utilising semi-structured interviews from a phenomenological epistemological position, thus aimed to understand participants' personal experiences of the task (Barker et al., 2015). Interpretative Phenomenological Approach (IPA) is an approach interested in a nuanced exploration of phenomena (Smith et al., 2022). It was considered appropriate due to the nature of the research questions and the complexity of motivation in AN, as IPA produces detailed understanding. Furthermore, IPA has utility in CPR in homogenous samples (Elliott, 2012). For these reasons, it was favoured over thematic analysis, which produces breadth rather than depth (Braun & Clarke, 2021) and alternative explanatory or theory building methods such as grounded theory (Charmaz, 2008).

Expert by experience involvement

One expert by experience (EBE) was recruited through the university EBE group. They supported the creation of concise but thorough research documentation. A second EBE was recruited through the participating ED service. They were consulted and subsequently endorsed the research rationale. They also supported the creation of the interview schedule and procedure, for example they suggested the inclusion of a break during interview. Both EBEs were paid.

The intervention

The FCSI is a modified version of Pugh & Salter's (2018) original task, updated by the research supervisors for this research (Table 1). Pre-session, participants write letters from a future NRS and RS. In the task, the client embodies these selves. Dialogue occurs between therapist, client, and selves with movement between chairs (Figure 2).

The FSCI was not used in the participating eating disorder service prior to this research, thus this research facilitated both the implementation of the FSCI and subsequent investigation.

Table 1:

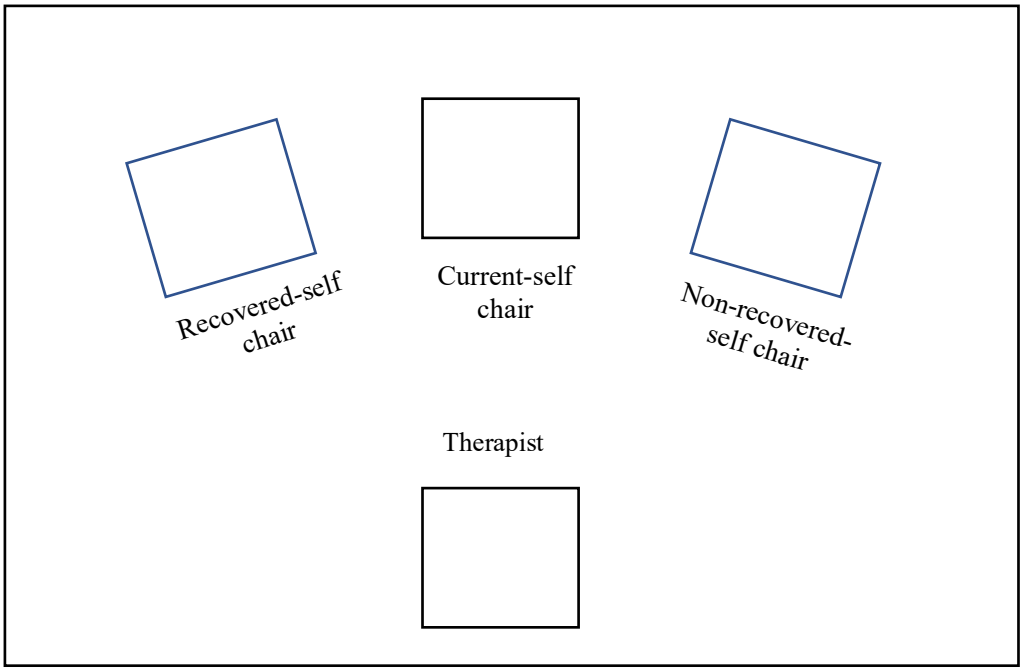
Phases of the future selves chairwork intervention (FSCI)

Phase number and name	Explanation
1) 'Letters from the future' homework task	Before the chairwork task, participants write two letters as if ten years have passed. Letters are from the perspective of the non-recovered self (NRS) and another from the recovered self (RS) perspective. The letters reflect on life ten years in the future and the impact of AN.
2) Reviewing letters	The participant letters are reviewed in session. Either the therapist or client can read out the letter.
3) The non-recovered self	The participant is first introduced to the NRS by imagining them in an empty chair. The participant is asked to describe them and ask how they feel towards them. The participant then moves into this chair and enacts the non-recovered self. Once in the NRS chair, the therapist sets the scene and states that ten years have passed. The therapist explains that they are bumping into each other coincidently. The therapist then interviews the NRS about their life since they last saw them. Finally, the non-recovered self is asked to advise the current self before returning to the current-self seat.
4) The recovered self	The task is repeated as in step three but with the RS.
5) Debrief	At the end of the task, the participant returns to the original current-self chair and reflects on their experience.

Note. Further adjustments were made as required. For example, a participant with Attention Hyperactive Deficit Disorder (ADHD) and Autism Spectrum Condition (ASC), requested additional prompts for the letter writing task and clear and simple language use.

Figure 2:

Representation of chairs in the future selves chairwork intervention



Note. If the intervention was online, the client shifted side-to-side.

Measures

A modified Eating Disorder Examination Questionnaire (EDE-Q) version 6 was used (Fairburn & Beglin, 1994; Appendix B). The EDE-Q was modified by removing a section that asks about personal characteristics, such as weight, to minimise distress. Thus, this information was gathered from the participating eating disorder service. The EDE-Q is a 24-item self-report questionnaire; it assesses ED severity over the past 28 days, with higher scores representing higher severity (Fairburn & Beglin, 2008). Scores over four indicated clinical significance (Fairburn et al., 2008). Participants' mean EDE-Q score was 4.53 (SD 0.65). The EDE-Q has been found to have good reliability and discriminate validity (Berg et al., 2011; Aardoom et al., 2012).

Participants

Smaller homogenous sample sizes allow for rich analysis and more valid results (Pietkiewicz & Smith, 2014). Six to twelve participants are recommended for psychotherapy CPR (Elliot, 2009). Six to ten interviews are recommended for doctorate IPA research (Smith et al., 2022). So, the nine participants recruited were deemed appropriate. Participants self-reported their social demographics, and their clinical history was obtained from the service.

Inclusion and exclusion criteria

Included participants had a diagnosis of AN confirmed by the participating eating disorder service (Table 2). They were over body mass index (BMI) 15 as low weight can negatively impact cognition; thus, engagement in the interview (Russell et al., 2009; Hamatani et al., 2016). In discussion with the participating eating disorder service and the research team, it was felt that participants should be excluded if undertaking NICE (2017) recommended treatment as it may interfere with the findings. To ensure the research did not impact service access, participants were on the waiting list for therapy, and inclusion in the study neither expedited or delayed treatment. Participants were English speaking as the ethics board felt that the use of an interpreter might have put a negative strain on the participant. Additionally, the ethics board recommended excluding participants who received nutritional supplementation due to associated health risks (Royal College of Psychiatrists, 2022).

Table 2:
Inclusion and exclusion criteria

Inclusion	Exclusion
Over 18 years of age	Under the age of 18
Anorexia diagnosis (including atypical, sub-types and multiple diagnoses)	Diagnosis other than Anorexia
Accepted into the participating service and on the waiting list for psychological support	Not accepted into the participating service or currently undertaking a NICE (2017) recommended treatment
Body mass index over 15	Body mass index below 15
English speaking	Receive nutritional supplementation via a feeding tube

Recruitment

This research was one part of a two-part study. The concurrent study analysed video recordings of the intervention using task analysis (Greenberg, 2007; Elliott, 2010). Participants could complete one or both study parts, or the task only, outside the research.

Participants were purposively recruited through the participating eating disorder service and had no prior relationship with the research team. The participating eating disorder service assessed participants' capacity to consent and interest. The author for this or the concurrent study then telephoned potential participants to provide information and to offer further appointments to discuss (Appendix C). Participants then attended a consent appointment where they signed consent forms (Appendix D) and could chose pseudonyms which were used throughout. Upon return of consent forms, participants completed measures. Participants were then contacted by their allocated FSCI therapist, a participating eating disorder service employee, to arrange the intervention. Participants could choose to complete the intervention online or in person.

Some participants had prior relationships with the FSCI therapist; for example, monthly check-ins while waiting for therapy, some did not. This difference was due to service setup and was not influenced by the research team.

Clients in ED services often have traumatic experiences of coercive treatment (Mac Donald et al., 2023). Thus, given the potentially emotionally demanding nature of the FSCI and interview, financial incentives were deemed inappropriate thus not offered to diminish coercion.

Thirty-two participants were approached, and eleven participants completed the FSCI. Nine were subsequently interviewed individually (Figure 3). Participants were from a range of backgrounds (Table 3).

Figure 3:

Consort diagram of participant involvement

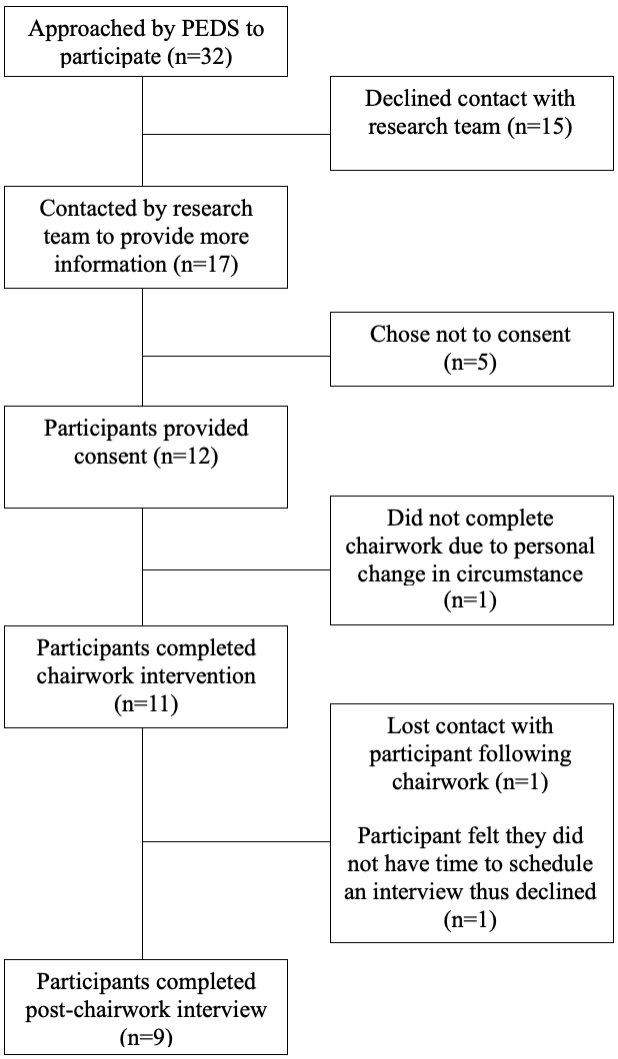


Table 3:

Demographics and clinical information

Age (Average, range)	Gender	Ethnicity	Self-reported social economic status***	Sexual orientation**	Reported body mass index, kg/m2. (Average, range)	Diagnosis
28 (21-41)	Cisgender male (n=1) Cisgender female (n=6) Non-binary* (n=2)	White British (n=8) Mixed ethnicity*** (n=1)	Middle class (n=2) Lower middle class (n=1) Upper working class (n=1) Working class (n=4) Not sure (n=1)	Heterosexual (n=7) Asexual (n=1) Bisexual (n=1)	21.33 (17.3-26.7)	Anorexia Nervosa (n=3) Atypical Anorexia (n=4) Atypical Anorexia Nervosa, Autism Spectrum Condition and Attention Deficit Hyperactivity Disorder (n=1) Anorexia Nervosa and Bulimia Nervosa (n=1)

* They/them pronouns are used for these participants
**Participants reported this using language of their choosing
***Ethnicity not elaborated on further to maintain a level of anonymity

Interview

Procedure

Participants opted for online interviews, in a private space. Interviews were audio recorded. The average time between FSCI and the interview was 23 days, (range: 8-74 days). The participant interviewed after 74 days had a changeable work schedule, leading to the interview rescheduling. The interviews lasted 40 – 75 minutes, depending on speech speed and detail shared. Following the interview, a participating eating disorder service staff member was informed of participants attendance to ensure participants were supported post-interview.

Schedule

The interview was flexible and semi-structured, in line with a "conversation with a purpose" (Smith et al., 2009, p.57). An interview guide (Appendix E) was created by modifying the change interview (CI; Elliott, 2012). The CI aims to elicit helpful or unhelpful parts of therapy, alongside the change process (Elliott, 2010). The CI has been used successfully in assessing acceptability of interventions (Leeuwerik et al., 2020) including in EDs (Torres et al., 2020). The CI was designed for a course of therapy thus was modified (Appendix F). The interview started with a warm-up question and then explored the FSCI experience. Data collection was successful, and thus no amendments to the interview process occurred.

Data analysis

Data analysis followed Smith et al.'s (2022) IPA guidance. The author transcribed interviews, and immersion in the data was achieved by reading transcripts whilst listening to recordings. Next, detailed Exploratory Notes (ENs) were made to highlight key ideas (Appendix G). ENs were then grouped into similar concepts called Experiential Statements (ESs) (Appendix H); ES attempted to create a concise summary of the EN, reflecting participants' words and the

author's interpretation. Personal Experiential Themes (PETs) for each participant were generated by searching for connections and divergence across ES that suggested significant descriptions. Later, Group Experiential Themes (GETs) and sub-themes were developed, which provided structure to the data. These were generated by finding the shared and unique descriptions of the FSCI across participants. The data was considered across all levels, moving between transcript, ESs, and PETs, so the resulting GETs were grounded in the data (Appendix I; Smith et al., 2022).

Quality assurance and reflexivity

The FSCI was manualised, and therapists received training from research supervisors. The therapists included one cognitive behavioural therapist and two assistant psychologists experienced in treating EDs. Therapists received monthly supervision with research supervisors in addition to their usual supervision. Therapists were deemed appropriately skilled by the participating eating disorder service. Therapists could also contact the research team for additional support.

Quality was considered using guidelines from Smith et al. (2022) and Elliott et al. (2010). For example, the generation of ES, PETs and GETs were discussed with research supervisors with extensive research and ED treatment experience. 'Mini-audits' were conducted with research supervisors, for example by sharing the first interview transcript with initial ENs and ESs. The supervisor then checked these and added additional notes in line with guidelines to improve rigour (Smith et al., 2022). Furthermore, a research diary was kept to record the emergence of interpretations (Cutcliffe & McKenna, 1999) (Appendix J). This was particularly important as the author had worked in ED services.

The author completed a bracketing interview with a trainee colleague to benchmark knowledge before data collection and analysis (Roulston, 2010; Appendix K). This interview was important as in IPA, the researcher is making sense of what the participant is making sense of. Thus, bracketing aided understanding of preconceptions (Alase, 2017).

Ethical considerations

This research was approved by the university (Appendix L), the NHS research ethics committee (Appendix M) and the participating Trust's research and development team (Appendix N).

All participants provided informed consent and were able to withdraw up until analysis. No participants withdrew following interview. Participants were informed that their information would be confidential unless it posed a risk to themselves or to others. No risk issues arose. Participants were encouraged to answer questions only in as much detail as they felt comfortable.

Results

Four GETs, and fifteen sub-themes were generated (Table 4) to answer the three research questions: 'how do participants experience FSCI?', 'how do participants make sense of the change process of the task?' and 'what do participants think may have facilitated or hindered the change process?'.

Table 4:

Group Experiential Themes and sub-themes.

Group experiential themes	Sub-themes
Delivery and task factors.	The therapist made me feel comfortable. The letters were helpful, but only with the chairwork. Additional therapeutic use of letters. Online or in-person. Ten years or five years. Post-session support.
Motivation towards a demanding recovery journey.	The task was motivating for most. Recovery is demanding.
Intense and strange emotions led to realisations.	A strange experience. From suppressing emotions to it all coming out. A varied emotional response. Emotions were a response to interpretation connected to past and present. Feeling emotions made me realise…
Living as the future self.	Differentiating non-recovered and recovered selves. Consideration of the future.

1. Delivery and task factors

This theme relates to how the FSCI was delivered.

1.1 The therapist made me feel comfortable

All participants noted that therapist factors were significant, with many describing their FSCI therapist as "nice". This had a valuable impact, including in reducing embarrassment:

"[therapist] was really really nice and made me feel comfortable. So, I didn't feel embarrassed" (Emma).

Participants had differing views on the impact of utilising a known therapist. For Kara, her prior relationship with the therapist facilitated acknowledging the AN: "*until that point, I hadn't actually been able to say the word Anorexia… I've done a few sessions with her, so I feel like it was nicer to like that I was a bit more familiar."*

Conversely, Megan noted that she preferred having no prior relationship with the therapist, demonstrating difference between participants: "*they have no preconceived, I guess perspective of you… someone that doesn't know any of those narratives you can- being more like, just talk about what you're thinking."*

1.2 The letters were helpful, but only with the chairwork

Most participants described writing the letters as very challenging and that they would have benefited from more emotional support in writing them. Taylor reported the letter-writing task as *"unhelpful",* apart from its role in setting up the chairwork task.

For Megan, writing from the RS was helpful as it *"clarified to me like my values, what's important to me",* which motivated her. However, she stated that the letters were only meaningful with the addition of the chairwork:

> *I think it only became important because of the chairwork.... cause I guess you have to think about it more and you have to like actually feel- I guess it is just a feeling element of it.*

1.3 Additional therapeutic use of letters

An additional benefit of the letters was how participants used them outside the FSCI. Holly suggested her partner read the letter which helped him to understand her struggle. Kara looked at the letters post-task to maintain motivation. Megan went a step further:

> *Every morning… I would just read through the letters, both of them and then I would pick like two or three things from the recovered letter that I would focus on... it's kept that feeling and that motivation going.*

1.4 Online or in-person

Some participants preferred the task in-person, others online. There appeared to be benefits and disadvantages to either form of delivery as captured by Ari, who completed it online: "*I think it would have been easier [in-person] in regards to this setup... but at the same time, I don't know if I'd have been able to get into that kind of non-recovered space."* Ari felt that the online nature, and consequently that the FSCI therapist could not see Ari's body shape, was helpful.

1.5 Ten years or five years

Generally, participants found the timeframe of ten years acceptable, "*that's enough time for me to really work on myself"* (Rosie). However, Kara felt that five years may have been more acceptable. Kara stated that it is not uncommon for someone of her young age (age 23) to be unsure of what the future will hold, with or without AN.

1.6 Post-session support

Participants described wanting post-session support for emotions and processing. Frankie emphasised they had been nervous pre-task to experience emotions: "*I think it could have*

been helpful, like when I was worrying about things before, to know, 'okay, like if I am feeling quite down afterwards, I can talk things through with someone." This may have prevented them from fully engaging in the task. Enhanced emotional experiencing may have been facilitated if Frankie had felt safer to allow themself this, such as through further support or exploration with a therapist. Other participants described that post-task support would be beneficial to sense-make: *"give it a couple of days to a week to have like a nice session to go over what had been processed"* (Ari).

2. Motivation towards a demanding recovery journey

This theme comprises participants description of the impact of motivation and how challenging recovery can be.

2.1 The task was motivating for most

Taylor was one of two participants who reported not finding the task motivating. He conceptualised the impact as leading to him being more *"conscious"* of his purging behaviours, which led to an increased desire to stop purging, but he felt this was not akin to increased motivation. Taylor stated that he struggled to *"put myself like in that [RS] position I guess",* he hypothesised that it could be as he felt *"observed",* possibly as the FSCI was filmed for the concurrent study-part. When exploring his experience of being in the RS he stated: *"it's not me".* One could speculate that there was a lack of connection to the RS, which may be related to a limited embodied and emotional response he experienced, discussed further below.

Similarly, Ari did not describe an increase in motivation. Ari described themself as confused in their recovery journey and stated: *"I don't know if it changed my motivation, but I think it did give me the tools to look into why I'm not motivated".* Ari described wondering whether a

future with AN would be positive or negative: "*I want to recover because I want this-. I want to be happy that's the crux of it. But then the eating disorder is like 'yeah but you'll be happy if you keep this up'."* They also felt that they were still able to "*glamourise"* a future with AN; arguably, in acknowledging this, they recognised an inaccuracy in their perception of the benefits of AN. To summarise, both Taylor and Ari described no change in motivation and seemed to describe grappling with the RS, and their relationship to it.

The remaining participants described the task as motivating. Megan stated *"-it's literally like been life-changing"* and described extensive behavioural changes: "*honestly, so much has changed since".* In contrast, Frankie described an increase in motivation, but it was not long-lasting: "*I had that yeah, good week where I did feel more motivated and was like really trying... after that it was kind of a bit up and down of like sort of letting the stress get to me".* Frankie stated that they went on to have another increase of motivation following speaking to a participating eating disorder service staff member highlighting the back-and-forth nature of motivation, but they were unsure if they could attribute this renewed motivation to the FSCI.

2.2 Recovery is demanding

Kara expressed how the task emphasised that she would like to recover but that recognising this is hard: *"Even though it's still hard to say, like I do need to [recover]".* Charlotte stated that the FSCI acted as a catalyst to understanding just how hard recovery will be:

> *To go to kind of deal with something it's gonna get harder before it gets better. So, I think that [by completing FSCI], almost you reach the harder point probably sooner than you would otherwise because it's an acknowledgement of the situation.*

However, *"the fear of failure"* (Charlotte) and a lack of self-belief remains a barrier: *"I definitely want to be there, it's just, I guess, like that doubt in my own capability*" (Frankie). When asked what would help with self-belief, Frankie stated, "*I would hope that I would*

work through [this] in therapy," demonstrating both the challenges of recovery and the possible benefits of further therapy. Ari described that they learned that due to the demanding nature of recovery they would need additional family support: *"I kinda just realised that the kind of major thing that's holding me back is feeling like it's something that I'm gonna have to go through on my own".* They later discussed this with a participating eating disorder service team member: *"she was able to come up with some solutions, and she said I can bring my mum along to a session."*

3. Intense and strange emotions led to realisations

This theme encompasses the change processes. Particularly the emotional experiencing and subsequent learning.

3.1 A strange experience

All participants commented on how strange the task was: *"like it was very strange for me and like acting it out was very weird"* (Taylor). The novelty of the task encouraged Emma to attend: "*wow like this isn't normal stuff that I think about..... I was just a bit like intrigued to find out how this can help me".* (Emma)

Although Megan stated that she was initially put off by the role-play: "*[at] times I was put off or wanted to like pull out of doing it before I did it… [because of] like that whole role-play thing and being self-conscious".* Megan said the task could be improved by "*not letting people be put off by [the role play]",* although she stated, "*I don't know how you'd fix this".* In addition to the strangeness of the task, many commented on the unexpectedness of it being an emotional experience: *"a lot more emotional than I thought it was gonna be… I started like crying, and I was like, what is happening?"* (Charlotte).

3.2 From suppressing emotions to it all coming out

Several participants described an emotional journey. Moving from suppressing emotions, *"I was suppressing everything beforehand"* (Holly), to experiencing emotion: *"it was really good for me to get out actually like how I'm feeling because I feel like I've not- I hadn't addressed some of those things before"* (Kara).

Most participants described expressing emotions in the task; however, Holly noted that she suppressed her emotions during the task *"I felt a little bit like emotional, but I hid it because I was like 'no, this is an interview I need to. I can't. I can't get emotional'",* yet emotions emerged following the task:

> *I had a really tough week with not only food, with emotions, with friendships … it all coming out, but I had a breakdown with [therapist] …she said she was happy to see that emotional side of me because I hadn't shown that in the interviews.* (Holly)

Experiencing and then exploring the non-acceptance of emotions with a known therapist appeared to have facilitated a new understanding of the importance of emotions.

3.3 A varied emotional response

The extent to which participants experienced emotions differed. For example, Emma described the emotional experience as *"intense",* whereas Frankie and Taylor described the least emotional response and minimal motivation changes compared to other participants. The varied emotional experience was clear during interviews. Those who had a stronger emotional experience left the author feeling captivated and enthralled by the motivation changes. In comparison, those who had a lesser emotional response left the author feeling indifferent, echoing the more modest changes in motivation. Indeed, across the data a possible link was observed between more intense emotional experiencing leading to greater

change in motivation. Frankie and Taylor did describe some emotional experiencing, nonetheless, particularly attributed to the NRS: *"I did have like an emotional response of 'ohh like my life in 10 years time without being recovered sounds really depressing, and I don't want that'"* (Frankie). However, their descriptions of the task were far less emotive than other participants.

3.4 Emotions were a response to interpretation connected to past and present

Participants attributed the emotional experience to their unique interpretation of aspects of the task. Emma was particularly emotional as the NRS because she drew upon memories of being unwell with AN ten years prior: "*I feel like to go and think about that ten years ago, it was quite emotional."* Similarly, Megan connected the experience of the NRS, to the past: *"it's kinda just that feeling of like dread and hopelessness that I had at the start of recovery... it brought that kind of feeling back."* (Megan)

For Ari, they were emotional as they appreciated that: *"[I've] just been really horrible to myself, and that kind of hit a nerve a bit".* Ari stated that this was in the context of receiving treatment for childhood cancer prior to AN treatment, thus Ari recognised the prolonged time they have been unwell and what they had missed, resulting in *"mourning"*.

3.5 Feeling emotions made me realise that…

Participants described gaining realisations from experiencing emotions.

3.5.1 I am struggling

Many participants described that the strong emotions that they felt as and towards the NRS and RS led to a realisation that they were currently struggling, as they had previously

believed they were not: *"the task made me accept a bit more about my situation….which has made me realise like it's okay to feel those feelings. You're in this situation now. Let's take like little steps to sort of get to that place." (*Kara). For Kara, this realisation led to a change in motivation: *"you don't make any changes, or you don't really consider like what you have to do to change, or you don't want to change, I guess. Which is like where the motivation came in."* Holly also realised that she was struggling "*it was more of like a realisation of you know 'crap, actually, I am sad and struggling still, and I'm not cured'."* This was in the context of being diagnosed with Atypical AN, which had contributed to her il-legitimating her experience: *"I thought, do you believe me? … And then I thought maybe I don't believe myself.... she said no, you do have atypical anorexia"*. Additionally, through experiencing the strong emotions that she had not previously been attuned to, Megan had a similar realisation: "*Oh my God, I've still got this huge like-I've come far, but it's like I've still got this huge hill to climb, and I don't wanna have that hopeless feeling forever."* (Megan)

This could be interpreted as a demonstration of a pertinent but harrowing realisation for participants. An awareness that their lives were unsatisfactory - not aligned with their values. Interestingly, this theme was relevant for those at different phases of their recovery. Kara stated that she was at the very beginning of her recovery journey. Megan said she was in "*the last sprint at the end of the marathon,"* and Holly was likely somewhere between the two, yet they all described reaching a realisation of 'I'm struggling'.

3.5.2 I can choose recovery

For Charlotte, the emotional experience reinforced that recovery from AN is a choice she can control: "*That's probably why it was emotional cause I was like 'this is just a choice'"*. For

Charlotte, this was in the context of lifelong congenital physical health problems, which were not a choice.

Megan also experienced this realisation: *"I think that gave me the motivation cause it was like hang on, I can actually choose to engage in these behaviours and stay where I am and not be able to live how I wanna be living and get to those points".* Holly similarly referenced this idea: *"I could either choose this path -of being this way".*

Ari also discussed the notion of choice, but in a distinctive way. They shared that previously a staff member would *"give me these ultimatums and tell me... 'do you wanna be ugly? Do you want your hair to fall out?'"* This led to frustration for Ari as "*I'm not waking up every day and choosing this".* Ari stated that in comparison, the task was set up *"a bit like here is your two options, recovery and not recovery… you've gotta make this decision now."* They described this as helpful because *"I think you need to be able to see those two black and white sides to be able to evaluate the place or I needed to be able to evaluate the place I was at".*

Thus, one can interpret the idea of choice in recovery as contentious. For Ari, choice had historically been presented to coerce them towards recovery. Whereas the task facilitated understanding that Megan and Charlotte have autonomy over AN. Thus, the task may have allowed participants to generate a renewed relationship with choice.

3.5.3 I want recovery

For some, the emotional experience led to recognising that recovery is desirable, as they had been ambivalent. Rosie described feeling jealous of the recovered self, "*how come she's there already and I'm not"* (Rosie). Her sense-making of this was that it *"brought it to the front of my mind that it was like this is obviously something you really want".* Similarly, Emma

stated, "*I found it quite hard, but it was helpful as well cause it made me realise that how far I have come and what I'd never wanna go back to again".* Participants described that connecting to emotions in the task acted as a driving force for recovery, "*like it probably just built up all those little things over time, and then it just all came out, which was good, and it drives you more to kind of stick to what you want"* (Charlotte). Charlotte tried to make sense of this: "*the fact that you allowed yourself to get that emotional that you clearly care like you- it's it's not like a happy emotion... so you want to grow and kind of leave that behind."*

4. Living as the future self

This theme encompasses narratives around the embodied experience.

4.1 Differentiating non-recovered and recovered selves

Participants described embodied feelings related to the future. The non-recovered self (NRS) was felt to be negative, but the recovered self (RS) embodied experience was: "*content with life" (Frankie)*, *"calmer"* (Emma) and *"clearer"* (Megan). In the interview participants embodied this, presenting as brighter when discussing the RS and lower when discussing the NRS. Some participants were shocked to experience this difference: "*I was just amazed at how I physically and mentally felt like different"* (Rosie). Rosie reported that "*looking at the empty chairs and the feelings that I got... when I actually moved into those chairs ...that feeling in like in my chest that physical kind of- the sadness and the hollow"* is precisely what led to a change in motivation. Getting into these roles was helped by moving between chairs for Emma: *"you're not just shifting the chair; you're shifting yourself to be that person".*

The extent to which participants embodied the selves differed, and it is possible that a more evocative emotional response enabled a stronger embodied response and/or vice versa. Holly, who described a significant emotional experience post-task, said, *"even my posture changed"*

between selves and described *"living"* as the positions. This was echoed during interview, where Holly appeared to relive the experience, changing her posture and tone of voice when in discussion. Comparatively, Frankie described less of an emotional experience than other participants; they explained that they had to "*play"* versions of themselves, meaning "*I sort of tried to then come off as quite tired and quite down"*. In line with this, Frankie described FSCI as *"acting out that mood board, and it sort of, I guess, brings to life your goals, and I think that's quite motivational."* At interview Frankie presented as flatter whereas Holly presented as dynamic and effused.

4.2 Consideration of the future

Considering the future generally was meaningful, as most recounted that they had not considered the future in a detailed way previously: *"I've never really thought about what my life might be like when I'm recovered."(Emma).* Ari and Emma described that embodying the future RS *"felt really hopeful"* (Ari), which was unexpected for them. In comparison, embodying the NRS emphasised ideas that: "*if you're not recovered or you're just in the same position that you were"* (Charlotte).

Embodying, in comparison to analytically considering the future-self arguably facilitated affective processing, resulting in motivation:

> *That time to consider what my life would be like if I didn't recover and -and then sitting in that chair and having that really horrible emotional response has definitely given me more push towards like 'you can't let that happen'* (Kara).

For both Holly and Charlotte, the enactment of bumping into the therapist in ten years was particularly motivating. It added to the feeling of realness and connected to familiar

experiences. For instance, Charlotte's congenital health problems had previously left her feeling *"very much stuck"* compared to peers, and "*I don't wanna feel like in 10 years' time that I am still embarrassed to say what I do".* Thus, this motivated her.

Discussion

This study aimed to assess whether the FSCI is acceptable and feasible. The study also aimed to understand the mechanisms of change using CPR. The GETs generated were 'Delivery and task factors', 'Motivation towards a demanding recovery journey', 'Intense and strange emotions led to realisations' and 'Living as the future self''.

1. How do participants experience FSCI?

This question related generally to the *felt* experience of the task for participants, including what changed. Most participants reported an improvement in motivation. Of those who did not, one said they became more conscious of their ED behaviours (Taylor), and another gained an understanding of their ambivalence (Ari). For Taylor and Ari, TTM may indicate movement from pre-contemplation to contemplation stages. In comparison, other participants may have moved towards the action stage. Participants also described the task as unexpectantly emotional and experienced a felt embodied contrast between selves, these experiences resulted in realisations and discoveries.

Looking across the data, participants appeared to experience the task differently depending on the emotional and embodied response. Participants seemed to describe a relationship between emotions and embodiment, where more emotional experiencing led to more embodiment, then more emoting and so on. For those who had an evocative experience this co-occurred with an ability to access arguably more profound information, for instance, the idea that one has choice over recovery; in comparison to perhaps *surface level* realisations that recovery is beneficial, for example. Whilst some realisations may have arguably been more *surface level*, they were meaningful for the participant, nonetheless. The possibly, more profound realisations, were consonant with themes with ED recovery narratives. For

example, a common theme from those who have recovered is that recovery is a choice but not an easy one (Patching & Lawler, 2009; Dawson et al., 2014; Stockford et al., 2019) and that the demanding nature of recovery and utility of AN means that motivation is changeable (LaMarre & Rice, 2021; Prochaska & DiClemente, 2005). In comparison, the idea that being recovered is better than being unwell with AN is possibly a less nuanced discovery, and further insights may be needed to facilitate recovery. Especially considering the courage, hard work and high commitment required to recover (Eaton, 2020). The idea that those who had a more evocative experience cooccurred with an ability to access arguably more profound information affirms notions that more attention-grabbing experiences improve accessibility to deeper information (Brewin, 2006; Elliott & Greenberg, 2021). This was echoed in my interview experience. Those who described a more emotionally intense and embodied response provided a more nuanced and detailed account of the task congruent with affective processing, in comparison to those who had a less evocative experience (Teasdale & Barnard, 1993, Gregertsen et al., 2017; Park et al., 2011).

Interestingly, participants experienced realisations and motivation changes across various stages of recovery. This opposes the idea that motivational interventions should only take place at later stages. For example, CBT-E proposes that writing a list of reasons for change from the perspective of five-year times to address ambivalence be completed between sessions 10-17 of a 20-session intervention (Fairburn, 2008).

2. How do participants make sense of the change process of the task?

Research question two emphasised *how* the change process occurred. Participants described a change process whereby the task elucidated the benefits of sustaining versus changing. This was achieved by embodying future selves and discovering whether each aligned with their

values. This is like MI (Miller & Rollnick, 2002), with the addition of an emotional and embodied experience. The task may have also prepared participants for action, in line with literature (Bell et al., 2021; Gilbert, 2020; Elliott & Greenberg, 2021). For instance, Megan described making extensive changes following the task. Furthermore, potentially the rehearsal and retrieval of positive future representations of recovery may help participants outcompete negative representations of recovery thus facilitate increased motivation (Brewin, 2006; Pugh & Salter, 2018). This is also important when Frankie described *playing* parts instead *being* the parts, as this rehearsal alone may still have been beneficial despite the diminished embodiment.

Participants emphasised a relationship between emotions and the change process. The FSCI facilitated emotional experiencing and, for some, identification of needs. For instance, the task may have aided Ari in finding what EFT calls the "core pain" (e.g., loneliness) and the subsequent need of the core pain (e.g. connection) (Elliott & Greenberg, 2021). This aligns with recovery narratives whereby people living with Anorexia develop more meaningful relationships (Stockford et al., 2019). Similarly, Drinkwater et al. (2022) found that participants recovering from AN began to recognise their emotional needs as significant and deserving of being met.

Furthermore, participants described coming to the task fearful of emotions in line with literature (Drinkwater et al., 2022; Leppanen et al., 2022), and experiencing emotions during and following the task facilitated new realisations, such as 'I am struggling' and aided the change process. The multisensory inputs of moving, sound and sight may have further facilitated the change process, affective processing, and embodied response, in line with ICS (Teasdale & Barnard, 1993; Pugh & Salter, 2018; Park et al., 2011).

3. What do participants think may have facilitated or hindered the change process?

Question three conceptualised what may be helpful or unhelpful in the proposed change process. Delivery factors appeared to influence participants' ability to engage in the FSCI, but participants had diverging views. For example, some preferred the task in-person versus online, with the set-up being easier in-person. This aligns with therapists' attitudes toward delivering online chairwork (Pugh et al., 2021). In addition, participants shared views that having a "nice" therapist facilitated the change process, congruent the importance of the therapeutic relationship in AN treatment (Ramjan & Fogarty, 2019). Some participants had a prior relationship with the FSCI therapists; others did not. It was evident that some participants benefited from this; however, one participant argued that having no relationship facilitated the change process. This has implications for practical delivery and choice over the task process, including whether the task could be a single-session therapy. Although, single-session chairwork (SSC) has potential, (Pugh, 2021) these results imply the need for additional research on SSC.

Some participants stated that having a post-session check-in or debriefing may have been helpful. Participants found the letters emotionally demanding and recommended more support in writing these, which perhaps reflects emotion avoidant processes reported by people living with Anorexia (Drinkwater et al., 2022; Leppanen et al., 2022). Re-engagement with letters facilitated the change process by aiding motivation and connection with significant others. Engaging with therapeutic letter writing has utility in ED treatment, and it has been suggested that letters can be beneficial as tangible reminders (Davidson & Birmingham, 2001).

Strengths and limitations

The exploration of a novel and much-needed motivational intervention for people living with Anorexia is a strength of this research (Pugh & Salter, 2018; Waller, 2012). This and the concurrent study facilitated the implementation of this intervention, alongside the service and research team. Therefore, an additional strength was facilitating access to the FSCI to a group of NHS clients, who may otherwise not have had the opportunity.

Elucidating the change process aided understanding of *how* change occurred in addition to *if* it did. CPR has the additional benefit of highlighting the participants' voices and it affords greater opportunity to refine interventions in line with client experience and needs (Elliott, 2012; Elliott & Greenberg, 2021).

It has been argued that ED research under-reports participant demographics (Burnette et al., 2022). The reporting of social demographics is a strength. Including two participants from a minority gender was also a strength, although more research is needed on the impact of gender identity on emotion regulation in EDs (Leppanen et al., 2022). A limitation of the study is that there was only one ethnically minoritised participant and one male. It is hoped that future research will include more diverse voices. However, it is notable that a lack of participant diversity is a frequent limitation (Leppanen et al., 2022; Drinkwater et al., 2022, Burnette et al., 2022). Arguably, acknowledging this as a limitation does not go far enough. Future research should proactively seek diverse participants. In this study, as the participants were recruited through an ED service, lack of diversity may represent problems with service access. It may also demonstrate a broader problem; that males and minoritised individuals are less likely to be referred to mental health services generally, possibly due to institutional racism (McKenzie & Bhui, 2007) and stigma (Malova & Dunleavy, 2021).

An additional limitation is that the sample size was small and self-selecting. There may be various reasons for the low uptake in the FSCI generally. The intervention involved confronting an imagined future, which is emotionally demanding. The task involved a likely novel role-play-like dramatisation. Thus, potential participants may have benefited from being socialised to chairwork, for example. Future research could aim to understand barriers to uptake.

This research could have benefitted from utilising participants with BMIs under 15, as the review by Leppanen et al. (2022) suggests that low BMI impacts emotion regulation resulting in individuals being overly emotionally regulated. Therefore, including these individuals may have aided insight. Additionally, participants had different experiences of the FSCI, with some taking place online and some with known therapists. This may be a limitation; however, these factors were deemed acceptable by the research team to facilitate recruitment and participant choice. Furthermore, the research could benefit from a follow-up interview and quantitative methods could help to confirm objective improvements.

Clinical implications

This research demonstrates that the FSCI is acceptable and feasible, and services could consider using the FSCI in addition to evidence-based interventions. The task can be flexibly applied being feasible both on and offline and was acceptable when participants had no prior knowledge of the therapist and when they did. These factors may relate to personal preferences; therefore, clients should be offered the delivery choice. Adaptations could be made in line with the client's experience of what helped and hindered the task, for example, re-engagement of letters and support post-task. This research also supports the use and

investigation of emotion-focused interventions, in line with current studies (Oldershaw et al., 2022; Oldershaw & Startup; 2020).

Research implications

This research provides a first step in assessing the FSCI, more research is needed. Further research could re-interview participants to explore whether motivation and subsequent changes were maintained. Quantitative research could also elucidate objective changes in motivation. This research also highlights the need for more research on interventions that focus on emotions, in line with literature (Leppanen et al., 2022).

Conclusion

This research demonstrated the utility of the FSCI. It has shown that changes in motivation in the task were facilitated through experiencing emotion and embodiment. The experience of the task was said to improve motivation for most. Where motivation was not reported to increase, positive changes were still observed. Such as a greater consciousness of behaviours leading to an increased desire to reduce them and greater understanding of the lack of motivation.

The emotional and embodied response in the FSCI led to realisations and behavioural change. These were connected to personal life experiences and consequent sense-making of them. Participants differed in the intensity of the emotional and embodied response, with those experiencing more intensity arguably discovering more profound insights related to autonomy for instance. Nonetheless, the task had utility at various stages of recovery, and reported insights gained were personally meaningful. Several factors helped and hindered the change process, especially related to task delivery. Further research would be of benefit, such

as a follow-up interview or the addition of objective quantitative measures to assess whether motivation changes sustained. Nevertheless, this study has found that the FSCI can be considered acceptable and feasible.

References

Aardoom, J. J., Dingemans, A. E., Slof Op't Landt, M. C., & Van Furth, E. F. (2012). Norms and discriminative validity of the Eating Disorder Examination Questionnaire (EDE-Q). *Eating Behaviors*, *13*(4), 305–309. https://doi.org/10.1016/j.eatbeh.2012.09.002

Alase, A. O. (2017). The Interpretative phenomenological analysis (IPA): A guide to a good qualitative research approach. *International Journal of Education and Literacy Studies*, *5*(2), 9-19. https://doi.org/10.7575/aiac.ijels.v.5n.2p.9

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Arcelus, J., Mitchell, A. J., Wales, J., & Nielsen, S. (2011). Mortality rates in patients with anorexia nervosa and other eating disorders. *Archives of General Psychiatry*, *68*(7), 724-731. https://doi.org/10.1001/archgenpsychiatry.2011.74

Barker, C., Pistrang, N., & Elliott, R. (2015). *Research methods in clinical psychology: An introduction for students and practitioners* (3rd ed.). Wiley-Blackwell.

Barresi, J. (2012). Time and the dialogical self. In H. Hermans & T. Gieser (Eds.), *Handbook of dialogical self theory* (pp. 46–63). Cambridge University Press. https://doi.org/10.1017/CBO9781139030434.005

Bell, T., Montague, J., Elander, J., & Gilbert, P. (2019). "A definite feel-it moment": Embodiment, externalisation and emotion during chair-work in compassion-focused therapy. *Counselling and Psychotherapy Research*, *20*(1), 143–153. https://doi.org/10.1002/capr.12248

Bell, T., Montague, J., Elander, J., & Gilbert, P. (2021). Multiple emotions, multiple selves: compassion focused therapy chairwork. *The Cognitive Behaviour Therapist*, *14(22),* 1-17. https://doi.org/10.1017/s1754470x21000180

Berends, T., Boonstra, N., & Van Elburg, A. A. (2018). Relapse in anorexia nervosa. *Current Opinion in Psychiatry*, *31*(6), 445–455. https://doi.org/10.1097/yco.0000000000000453

Berg, K. C., Peterson, C. B., Frazier, P., & Crow, S. J. (2011). Psychometric evaluation of the eating disorder examination and eating disorder examination-questionnaire: A systematic review of the literature. *International Journal of Eating Disorders*, *45*(3), 428–438. https://doi.org/10.1002/eat.20931

Braun, V., & Clarke, V. (2021). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research*, *21*(1), 37–47. https://doi.org/10.1002/capr.12360

Brewin, C. R. (2006). Understanding cognitive behaviour therapy: A retrieval competition account. *Behaviour Research and Therapy*, *44*(6), 765–784. https://doi.org/10.1016/j.brat.2006.02.005

Burnette, C. B., Luzier, J. L., Weisenmuller, C. M., & Boutté, R. L. (2022). A systematic review of sociodemographic reporting and representation in eating disorder care. *BMJ, 334*(7595), 649–650. https://doi.org/10.1136/bmj.39163.395972.80

Cardi, V., Albano, G., Ambwani, S., Wang, Z., Crosby, R. D., Macdonald, P., Schmidt, U., & Treasure, J. (2019). A randomised clinical trial to evaluate the acceptability and efficacy of an early phase, online, guided augmentation of outpatient care for adults with anorexia nervosa. *Psychological Medicine*, *50*(15), 2610–2621. https://doi.org/10.1017/s0033291719002824

Charmaz, K. (2008). Grounded theory as an emergent method. In Hesse-Biber, S. & Leavy, P. (Eds.). *Handbook of emergent methods*, (pp. 155 -172). New Yoek: The Guilford Press.

Cutcliffe, J. R., & McKenna, H. P. (1999). Establishing the credibility of qualitative research findings: the plot thickens. *Journal of Advanced Nursing*, 30(2), 374-380. https://doi.org/10.1046/j.1365-2648.1999.01090.x

Davidson, H. C., & Birmingham, C. L. (2001). Letter writing as a therapeutic tool. *Eating and Weight Disorders-studies on Anorexia Bulimia and Obesity*, *6*(1), 40–44. https://doi.org/10.1007/bf03339750

Dawson, L., Rhodes, P., & Touyz, S. (2014). "Doing the impossible.": The Process of Recovery From Chronic Anorexia Nervosa. *Qualitative Health Research*, *24*(4), 494–505. https://doi.org/10.1177/1049732314524029

Department for Health. (2021). In *NHS Constitution for England*. Department of Health and Social Care. Retrieved June 16, 2023, from https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

Drinkwater, D., Holttum, S., Lavender, T., Startup, H., & Oldershaw, A. (2022). Seeing through the façade of anorexia: A grounded theory of emotional change processes associated with recovery from anorexia nervosa. *Frontiers in Psychiatry*, *13(1),* 1-24. https://doi.org/10.3389/fpsyt.2022.868586

Eaton, C. M. (2020). Eating disorder recovery: A metaethnography. *Journal of the American Psychiatric Nurses Association*, *26*(4), 373–388. https://doi.org/10.1177/1078390319849106

Elliott, R. (2012). Qualitative methods for studying psychotherapy change processes. In D. Harper & A. Thompson (Eds.), *Qualitative research methods in mental health & psychotherapy: A guide for students and practitioners* (pp. 69-81). John Wiley & Sons, Ltd. https://doi.org/10.1002/9781119973249.ch6

Elliott, R. J. (2009). Psychotherapy change process research: Realising the promise. *Psychotherapy Research*, *20*(2), 123–135. https://doi.org/10.1080/10503300903470743

Elliott, R. J., Fischer, C. T., & Rennie, D. L. (2010). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, *38*(3), 215–229. https://doi.org/10.1348/014466599162782

Elliott, R., & Greenberg, L. (2021). *Emotion-focused counselling in Action*. SAGE.

Fairburn, C. G. (2008). *Cognitive behavior therapy and eating disorders*. Guilford Press.

Fairburn, C. G., & Beglin, S. J. (1994). Eating disorder examination questionnaire. *PsycTESTS Dataset*. https://doi.org/10.1037/t03974-000

Fairburn, C., Cooper, Z., & O'Connor, M. (2008). Eating disorder examination. In C. G. Fairburn, *Cognitive behaviour therapy and eating disorders*. Guildford Press.

Fernández-Aranda, F., Treasure, J., Paslakis, G., Agüera, Z., Giménez, M., Granero, R., Sánchez, I., Serrano-Troncoso, E., Gorwood, P., Herpertz-Dahlmann, B., Bonin, E., Monteleone, P., & Jiménez-Murcia, S. (2021). The impact of duration of illness on treatment nonresponse and drop-out: Exploring the relevance of enduring eating disorder concept. *European Eating Disorders Review*, *29*(3), 499–513. https://doi.org/10.1002/erv.2822

Gilbert, P. (2020). Compassion: from its evolution to a psychotherapy. *Frontiers in Psychology*, *11*(0), 1-31. https://doi.org/10.3389/fpsyg.2020.586161

Greenberg, L. S. (2007). A guide to conducting a task analysis of psychotherapeutic change. *Psychotherapy Research*, *17*(1), 15–30. https://doi.org/10.1080/10503300600720390

Greenberg, L. S. (2017). Emotion-focused therapy of depression. *Person-centered and Experiential Psychotherapies*, *16*(2), 106–117. https://doi.org/10.1080/14779757.2017.1330702

Greenberg, L., & Watson, J. (1998). Experiential therapy of depression: Differential effects of service user-centred relationship conditions and process experiential interventions. *Psychotherapy Research*, *8*(2), 210–224. https://doi.org/10.1080/10503309812331332317

Gregertsen, E. C., Mandy, W., & Serpell, L. (2017). The egosyntonic nature of anorexia: An impediment to recovery in anorexia nervosa treatment. *Frontiers in Psychology*, *8*(0), 1-9. https://doi.org/10.3389/fpsyg.2017.02273

Hamatani, S., Tomotake, M., Takeda, T., Kameoka, N., Kawabata, M., Kubo, H., Tada, Y., Tomioka, Y., Watanabe, S., & Ohmori, T. (2016). Impaired social cognition in anorexia nervosa patients. *Neuropsychiatric Disease and Treatment*, *12*(0), 2527–2531. https://doi.org/10.2147/ndt.s116521

Hermans, H. J. (2001). The dialogical self: Toward a theory of personal and cultural positioning. *Culture & Psychology*, *7*(3), 243–281. https://doi.org/10.1177/1354067x0173001

LaMarre, A., & Rice, C. (2021). Recovering Uncertainty: Exploring Eating Disorder Recovery in Context. *Culture, Medicine, and Psychiatry*, *45*(4), 706–726. https://doi.org/10.1007/s11013-020-09700-7

Leeuwerik, T., Cavanagh, K., Forrester, E., Hoadley, C., Jones, A.-M., Lea, L., Rosten, C., & Strauss, C.. (2020). Participant perspectives on the acceptability and effectiveness of mindfulness-based cognitive behaviour therapy approaches for obsessive compulsive disorder. *PLOS ONE*, *15*(10), 1-27. https://doi.org/10.1371/journal.pone.0238845

Leppanen, J., Brown, D., McLinden, H., Williams, S., & Tchanturia, K. (2022). The Role of Emotion Regulation in Eating Disorders: A Network Meta-Analysis Approach. *Frontiers in Psychiatry*, *13*(0), 1-24. https://doi.org/10.3389/fpsyt.2022.793094

Mac Donald, B., Gustafsson, S. A., Bulik, C. M., & Clausen, L. (2023). Living and leaving a life of coercion: a qualitative interview study of patients with anorexia nervosa and multiple involuntary treatment events. *Journal of Eating Disorders*, *11*(1), 1-19. https://doi.org/10.1186/s40337-023-00765-4

Malova, E., & Dunleavy, V. O. (2021). Men have eating disorders too: an analysis of online narratives posted by men with eating disorders on YouTube. *Eating Disorders*, *30*(4), 437–452. https://doi.org/10.1080/10640266.2021.1930338

McKenzie, K., & Bhui, K. (2007). Institutional racism in mental health. *The BMJ*, *334*(7595), 649-650.

Miller, W. R., & Rollnick, S. (2002). Motivational interviewing: preparing people for change. *Guilford Press eBooks*. http://ci.nii.ac.jp/ncid/BA63388171

Moreno, J. L. (2008). *The essential Moreno: Writings on psychodrama, group method, and spontaneity.* Tusitala Publishing.

National Institute for Health and Care Excellence. (2017). Eating disorders: recognition and treatment [NICE guideline NG69]. https://www.nice.org.uk/guidance/ng69

Nordbø, R. H. S., Espeset, E. M. S., Gulliksen, K. S., Skårderud, F., Geller, J., & Holte, A. (2012). Reluctance to Recover in Anorexia Nervosa. *European Eating Disorders Review*, *20*(1), 60–67. https://doi.org/10.1002/erv.1097

Oldershaw, A., & Startup, H. (2020). Building the Healthy Adult in eating disorders. In Heath, G., & Startup, H., (Eds). *Creative Methods in Schema Therapy*. (pp. 287-300) Routledge. https://www.taylorfrancis.com/chapters/edit/10.4324/9781351171847-18/building-healthy-adult-eating-disorders-anna-oldershaw-helen-startup

Oldershaw, A., Lavender, T., Basra, R., & Startup, H. (2022). SPEAKS study: study protocol of a multisite feasibility trial of the Specialist Psychotherapy with Emotion for Anorexia in Kent and Sussex (SPEAKS) intervention for outpatients with anorexia nervosa or otherwise specified feeding and eating disorders, anorexia nervosa type. *BMJ Open*, *12*(2), 1-20. https://doi.org/10.1136/bmjopen-2021-050350

Park, R. J., Dunn, B. D., & Barnard, P. J. (2011). Schematic models and modes of mind in anorexia nervosa I: A novel process account. *International Journal of Cognitive Therapy*, *4*(4), 415–437. https://doi.org/10.1521/ijct.2011.4.4.415

Patching, J., & Lawler, J. (2009). Understanding women's experiences of developing an eating disorder and recovering: a life-history approach. *Nursing Inquiry*, *16*(1), 10–21. https://doi.org/10.1111/j.1440-1800.2009.00436.x

Perls, F. S. (1969). *Gestalt therapy verbatim*. Real People Press.

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological journal*, *20*(1), 7-14

Prochaska, J. O., & DiClemente, C. C. (2005). The transtheoretical approach. *Handbook of Psychotherapy Integration*, 147–171. https://doi.org/10.1093/med:psych/9780195165791.003.0007

Pugh, M. (2017). Chairwork in cognitive behavioural therapy: A narrative review. *Cognitive Therapy and Research*, *41*(1), 16–30. https://doi.org/10.1007/s10608-016-9805-x

Pugh, M. (2019) Resolving ambivalence and overcoming blocks to change: A multi-modal and schema informed approach. In Simpson, S., & Smith, E., Schema therapy for eating disorders: theory and practice for individual and group settings (pp. 187-204) *Routledge*

Pugh, M. (2020). *Cognitive Behavioural Chairwork: Distinctive Features*. Routledge.

Pugh, M. (2021). Single-session chairwork: overview and case illustration of brief dialogical psychotherapy. *British Journal of Guidance & Counselling*, 1–19. https://doi.org/10.1080/03069885.2021.1984395

Pugh, M., & Salter, C. (2018). Motivational chairwork: An experiential approach to resolving ambivalence. *European Journal of Counselling Theory, Research and Practice*. *2*(7), 1-15. https://doi.org/10.4324/9780429023927-25

Pugh, M., Bell, T., & Dixon, A. (2021). Delivering tele-chairwork: A qualitative survey of expert therapists. *Psychotherapy Research*, *31*(7), 843–858. https://doi.org/10.1080/10503307.2020.1854486

Ramjan, L. M., & Fogarty, S. (2019). Clients' perceptions of the therapeutic relationship in the treatment of anorexia nervosa: qualitative findings from an online questionnaire. *Australian Journal of Primary Health*, *25*(1), 37. https://doi.org/10.1071/py18032

Rankin, R., Conti, J., Touyz, S., Arcelus, J., Meyer, C., & Hay, P. (2023). Dancing with change: a qualitative exploration of in-session motivation to change in the treatment of anorexia nervosa. *Australian Psychologist*, 1–12. https://doi.org/10.1080/00050067.2022.2151338

Reid, M., Burr, J., Williams, S., & Hammersley, R. (2008) Eating disorders patients' views on their disorders and on an outpatients service: A qualitative study. *Journal of Health Psychology*, 13(7), 956- 960. https://doi.org/10.1177/1359105308095070

Roulston, K. (2010). *Reflective interviewing: A Guide to theory and practice*. SAGE.

Royal college of psychiatrists. (2022). *Hospital admissions for eating disorders increased by 84% in the last five years* [Press release]. Retrieved May 1, 2023, from https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2022/05/18/hospital-admissions-for-eating-disorders-increased-by-84-in-the-last-five-years

Russell, T. A., Schmidt, U., Doherty, L., Young, V., & Tchanturia, K. (2009). Aspects of social cognition in anorexia nervosa: Affective and cognitive theory of mind. *Psychiatry Research*, *168*(3), 181–185. https://doi.org/10.1016/j.psychres.2008.10.028

Schmidt, U., & Treasure, J. (2006). Anorexia nervosa: Valued and visible. A cognitive-interpersonal maintenance model and its implications for research and practice. *British Journal of Clinical Psychology*, *45*(3), 343–366. https://doi.org/10.1348/014466505x53902

Schmidt, U., Oldershaw, A., Jichi, F., Sternheim, L., Startup, H., McIntosh, V. V., Jordan, J., Tchanturia, K., Wolff, G., Rooney, M. K., Landau, S., & Treasure, J. (2012). Out-patient psychological therapies for adults with anorexia nervosa: randomised controlled trial. *British Journal of Psychiatry*, *201*(5), 392–399. https://doi.org/10.1192/bjp.bp.112.112078

Schmidt, U., Wade, T. D., & Treasure, J. (2014). The maudsley model of anorexia nervosa treatment for adults (MANTRA): Development, key features, and preliminary evidence. *Journal of Cognitive Psychotherapy*, *28*(1), 48–71. https://doi.org/10.1891/0889-8391.28.1.48

Shahar, B., Carlin, E., Engle, D. M., Hegde, J., Szepsenwol, O., & Arkowitz, H. (2012). A pilot investigation of emotion-focused two-chair dialogue intervention for self-criticism. *Clinical Psychology & Psychotherapy*, *19*(6), 496–507. https://doi.org/10.1002/cpp.762

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. SAGE.

Smith, J. A., Flowers, P., & Larkin, M. (2022). *Interpretative Phenomenological Analysis: Theory, method and research*. SAGE.

Stockford, C., Stenfert Kroese, B., Beesley, A., & Leung, N. (2019). Women's recovery from anorexia nervosa: a systematic review and meta-synthesis of qualitative research. *Eating Disorders*, *27*(4), 343–368. https://doi.org/10.1080/10640266.2018.1512301

Teasdale, J. D., & Barnard, P. J. (1993). *Affect, cognition, and change: Re-modelling depressive thought*. Psychology Press.

Torres, S., Sales, C. M. D., Guerra, M. P., Simões, M. P., Pinto, M. T., & Vieira, F. D. (2020). Emotion-Focused Cognitive Behavioral Therapy in Comorbid Obesity With Binge Eating Disorder: A Pilot Study of Feasibility and Long-Term Outcomes. *Frontiers in Psychology*, *11*. https://doi.org/10.3389/fpsyg.2020.00343

Treasure, J., & Schmidt, U. (2001). Ready, willing and able to change: motivational aspects of the assessment and treatment of eating disorders. *European Eating Disorders Review*, *9*(1), 4–18. https://doi.org/10.1002/erv.390

Wade, T. D., Hart, L. M., Mitchison, D., & Hay, P. (2021). Driving better intervention outcomes in eating disorders: A systematic synthesis of research priority setting and the involvement of consumer input. *European Eating Disorders Review*, *29*(3), 346–354. https://doi.org/10.1002/erv.2759

Waller, G. (2012). The myths of motivation: Time for a fresh look at some received wisdom in the eating disorders? *International Journal of Eating Disorders*, *45*(1), 1–16. https://doi.org/10.1002/eat.20900

Section C: Appendix of Support material

Appendix A: Critical Appraisal Skills Programme (CASP) criteria for qualitative research studies

Section A: Are the results of the study valid?

1. Was there a clear statement of the aims of the research?
2. Is a qualitative methodology appropriate?
3. Was the research design appropriate to address the aims of the research?
4. Was the recruitment strategy appropriate to the aims of the research?
5. Was the data collected in a way that addressed the research issue?
6. Has the relationship between researcher and participants been adequately considered?

Section B: What are the results?

7. Have ethical issues been taken into consideration?
8. Was the data analysis sufficiently rigorous?
9. Is there a clear statement of findings?

Section C: Will the results help locally?

10. How valuable is the research?

Appendix B: Amended and original Eating Disorder Examination Questionnaire (EDE-Q)

This has been removed from the electronic copy.

Appendix C: Participant information sheet

This has been removed from the electronic copy.

Appendix D: Consent form

This has been removed from the electronic copy.

Appendix E: The Change Interview

This has been removed from the electronic copy.

Appendix F: Interview Schedule

This has been removed from the electronic copy.

Appendix G: Example section of Holly's transcript with exploratory notes and experiential statements

This has been removed from the electronic copy.

Appendix H: Sample organisation of Holly's Experiential Statements into Personal Experiential Themes

This has been removed from the electronic copy.

Appendix I: Shortened sample of the development of a proposed Group Experiential theme from Personal Experiential Themes with corresponding Experiential Statements and quotes

This has been removed from the electronic copy.

Appendix J: Sample research diary entries

Entry 1

Speaking to a service user consultant was an incredibly useful experience, not only has it made me feel motivated to complete this research, but it has helped me think some more about nuances related to motivation tasks. It's generated some more questions for me:

- At what stage in their recovery journey is a motivation task useful or not?
- What type of change does it lead to?
    - Attending therapy compliantly vs meaningful every day change leading to weight gain or meaningful "recovery"
    - If the task is useful, how do we maintain that usefulness as time go on as recovery does take a long time

Speaking to the consultant has confirmed some of my beliefs about the rationale for the research project, but the consultant also shared some things that would be a limitation of the chair-work tasks, or maybe goes against some of the rationale for the task. It's really important that I hold onto the concepts that disconfirm my beliefs (e.g. she shared the need for on-going check-ins to help with motivation, something that our task does not offer). It is important to think about how do check-in on my confirmation bias, and important to think about how I can think about this when interviewing.

Speaking to the consultant has also reminded me the importance of feeding back to consultants once it has been completed as this is what she asked for.

Entry 2

What is reflexivity and how should I use it appropriately and in a meaningful way that prevents it from feeling like a tick-box exercise

I think its important to acknowledge my position as:

- Someone with no personal experience of having an eating disorder (will participants assume this is the case?)
- Someone who has worked in eating disorder services for a number of years (will participants assume this is the case?)
    - My experience of feeling frustrated with ambivalence and lack of motivation in clients who I think have lots of potential in life
    - Reading about not juts the physical impact of having AN long term, but also the social e.g. missing out on key life milestones whilst drifting in an our of treatment, including creating relationships, going to university, having a job and all the social impact that comes with this
    - My experience of understanding and recognising the journey needed to get to the *end point* of recovery, especially my experience of hearing people say they need to hit rock bottom one more time - and then genuinely going on to recover
- The experience of my living in my body and how service users will perceive my body as someone who is slim, and how this might affect the interview?
    - The taboo topic of talking about my body

Entry 3: Reflections following the first interview

Feeling worried that I wasn't a good enough interviewer, hoping that the data is rich enough. Worried that my questions were not open enough, or were leading. Although generally, I feel

like the information was interesting. I thought the participant found different aspects of the task helpful than what I expected.

- Meeting someone early on in their journey is interesting.
- I noticed that I was very conscious of making sure the participant didn't have to say anything she didn't want to share. Was very conscious that I didn't know them. At one point they stopped themselves speaking, after I gave them permission to do so, and I hope I shouldn't have pushed them more. Although on reflection, I'm glad I didn't push her more.
- I also think I should start by sharing that I understand AN, and have worked in it, so the participants have that context.
- I think it worked coming back to the unhelpful factors at the end, once we had more of a rapport.

Entry 4: Am I asking the right questions?

Following my first interview and after reviewing the recording I'm wondering and hoping that the information I have is meeting "change process research", and I hope it isn't just providing feedback for the intervention. It may be worth thinking through that before the next interview to think about whether I need additional questions or to ask my questions in a different way.

Post-re-reading relevant literature

Upon looking at Elliots, change interview there are different and more questions than what I've asked.

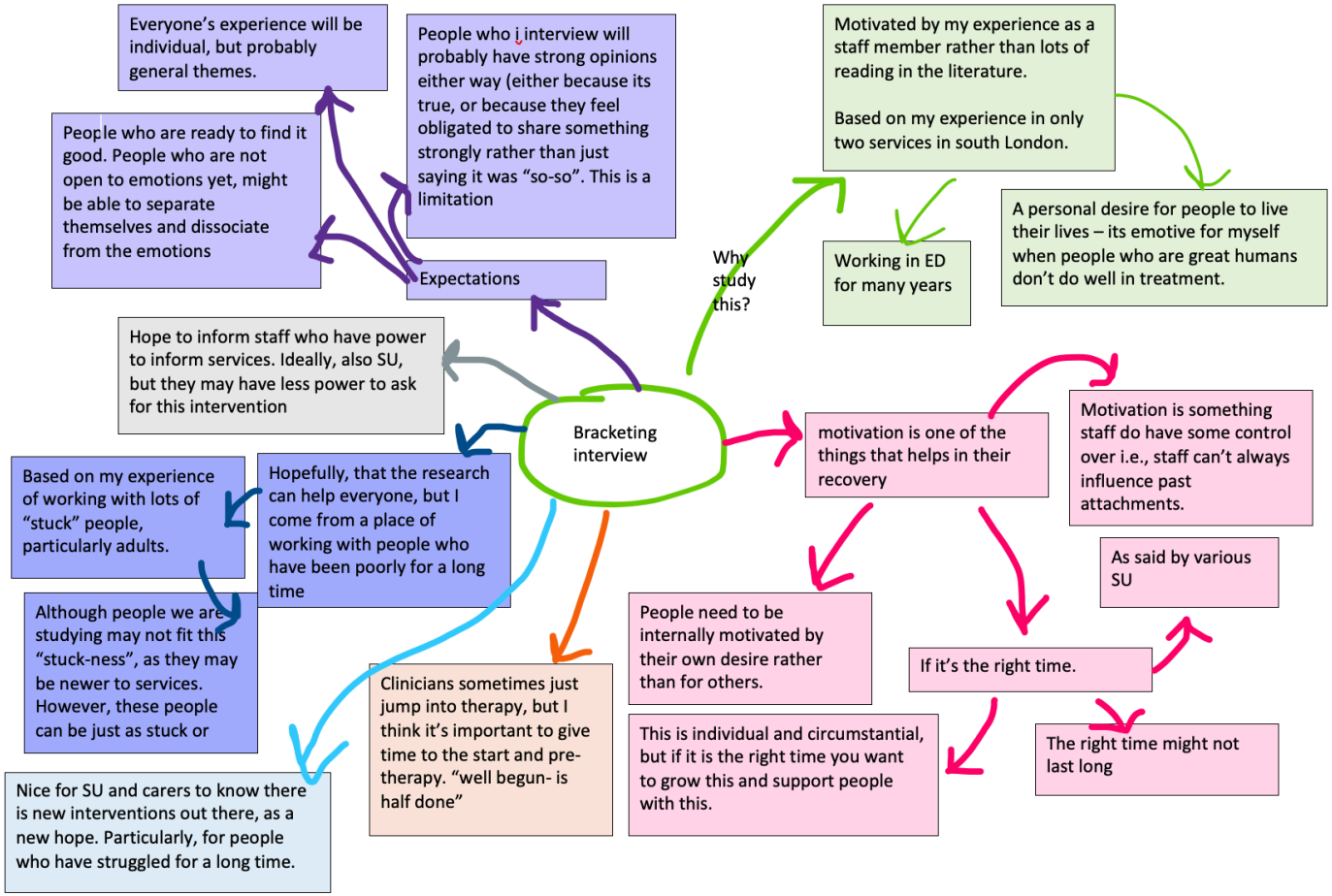
Post meeting with research supervisor to discuss

I think the sections I am concerned about would be relevant for a longer course of therapy. I am trying to focus in on the expertise in this one session. Asking more broadly means there is more likely going to be wider information brought in that doesn't relate to this session per se. There is an argument for including that, but also given the research the questions there is equally a clear argument not to, thus no need to change the questions for now. Can continue to review as more interviews take place.

Entry 5

How do I encapsulate the broad, varied and honest experience of the tasks in a way that gives justice to the participant and makes sense within a theme. A question for supervision and to keep reviewing and coming back to…

Appendix K: Mind map summarising key topics from the bracketing interview



Appendix L: University ethical approval

This has been removed from the electronic copy.

Appendix M: NHS ethical approval

This has been removed from the electronic copy.

Appendix N: Participating trust research and development approval

This has been removed from the electronic copy.

Appendix O: One completely coded transcript

This has been removed from the electronic copy.

Appendix P: Feedback to the ethics panel and participating trust research and development team

Evidence of feedback to ethics board, in line with ethics board guidelines:

NHS
Health Research Authority

Declaration of the end of a study

(For all studies except Clinical Trials of Investigational Medicinal Products)

To be completed in typescript by the Chief Investigator or sponsor representative and submitted to the Research Ethics Committee (REC) that gave a favourable opinion of the research within 90 days of the conclusion of the study or within 15 days of early termination

For questions with Yes/No options please indicate answer in bold type.

1. Details of Chief Investigator

Name:	REDACTED
Address:	Salomons Institute for Applied Psychology, Lucy Fildes Building, 1 Meadow Road
Telephone:	REDACTED
E-mail:	REDACTED@canterbury.ac.uk

2. Details of study

Full title of study:	Analysis of a motivational chairwork intervention

IRAS ID:	307827
Name of REC:	Bromley
REC reference number:	22/LO/0196
Date of favourable ethical opinion:	5th May 2023
Sponsor:	Salomons Institute for Applied Psychology | Canterbury Christ Church University Fergal Jones, fergal.jones@canterbury.ac.uk

3. Study duration

Date study commenced:	7th July 2022
Date study ended	1st March 2023
Did this study terminate prematurely?	No If yes, please complete sections 4, 5 & 6. If no, please complete section 4 and then go directly to section 7.

4. Recruitment

Number of participants recruited	Part A – 10 Part B - 9
Proposed number of participants to be recruited at the start of the study	Part A – 16-30 Part B – Around 10
If different, please state the reason or this	Therapists struggled to find time to complete the therapy, meaning some dropped out reducing the amount of time we had to recruit. Participants were generally harder to recruit than expected.

5. Circumstances of early termination

What is the justification for this early termination?	N/A

6. Potential implications for research participants

Are there any potential implications for research participants as a result of terminating the study prematurely? Please describe the steps taken to address them.	N/A

7. Final report on the research

Have you submitted a Final Report?	Yes

8. Declaration

*Signature or Electronic Authorisation of Chief Investigator/sponsor representative: *Please print below or insert electronic signature	REDACTED
Print name:	REDACTED
Date of submission:	05/07/2023

The ‘final report’ referenced above, included a copy of the below research summary.

Copy of research summary (information regarding concurrent study redacted):

Introduction and methodology

Many people living with Anorexia Nervosa experience ambivalence towards recovery. Chairwork is a psychotherapeutic technique incorporating the position, dialogue, and movement between 'self-parts' placed in different chairs to elicit change. The 'future selves' chairwork intervention (FSCI), aims to increase motivation by role-playing, dialoguing, and interacting with a future 'non-recovered self' and 'recovered self', utilising movement between chairs. Thirty-two participants were approached, and eleven participants completed the FSCI which was recorded for the purpose of the analysis. Ten participants completed pre- and post-intervention questionnaires measuring readiness towards change and nine were subsequently interviewed individually about their experience of the FSCI.

Part 1 analysis and results

[REDACTED]

Part 2 analysis and results

The average time between FSCI and the interview was 23 days, (range: 8-74 days). The interviews lasted 40 – 75 minutes, depending on speech speed and detail shared.

Part 2 of the analysis involved an interpretative phenomenological analysis of the nine interviews, using change process research methods to explore the acceptability, feasibility, and associated change processes to answer three research questions:

1. How do clients experience FSCI?
2. How do clients make sense of the change process of the task?
3. What do clients think may have facilitated or hindered the change process?

The following Group Experiential Themes (GETs) were identified: 'Delivery and Task factors', 'Motivation towards a demanding recovery journey', 'Intense and strange emotions led to realisations' and 'Living as the future self''. The findings suggest that FSCI is an acceptable and feasible, although more research would be beneficial. Changes in motivation were facilitated through experiencing emotion and embodiment. Participants described an evocative response, which led to realisations and new understanding.

Conclusions

This research demonstrates that the FSCI is acceptable and feasible, and services could consider using the FSCI in addition to evidence-based interventions. Adaptations could be made in line with the client's experience of what helped and hindered the task, for example, re-engagement of letters and support post-task. The change process model steps provide further guidance about important change steps for clinicians training in and delivering the FSCI. This research also supports the use and investigation of emotion-focused interventions for people living with Anorexia.

Confirmation of receipt from ethics board:

This has been removed from the electronic copy.

Research and development team signed

This has been removed from the electronic copy.

Summary as required by participating trust research and development team

This research was a two-part study investigating a chairwork intervention for people with anorexia nervosa which involves interviewing people in different chairs representing 'recovered' and 'non-recovered' future versions of the self to explore the impact of sustaining, versus changing, disordered eating and improve motivation. Ten participants, recruited from the [redacted], completed pre- and post-intervention measures of readiness towards change and filmed/recorded the chairwork intervention for the purpose of part one's analysis. Nine participants completed a post-intervention interview.

Part one [REDACTED]

Part two generated the following Group Experiential Themes (GETs): ‘Delivery and Task factors’, ‘Motivation towards a demanding recovery journey’, ‘Intense and strange emotions led to realisations’ and ‘Living as the future self’’. The themes emphasised changes that could be made to the task and the importance of the emotional and embodied experience in the tasks change process.

The study concluded chairwork offers a trans-modal medium for delivering interventions and proposed a model of the change process which participants mostly reported improved motivation. The findings imply services could use the chairwork intervention to enhance motivation and suggest emotion-focused interventions show therapeutic potential for people living with anorexia.

Confirmation of receipt of feedback

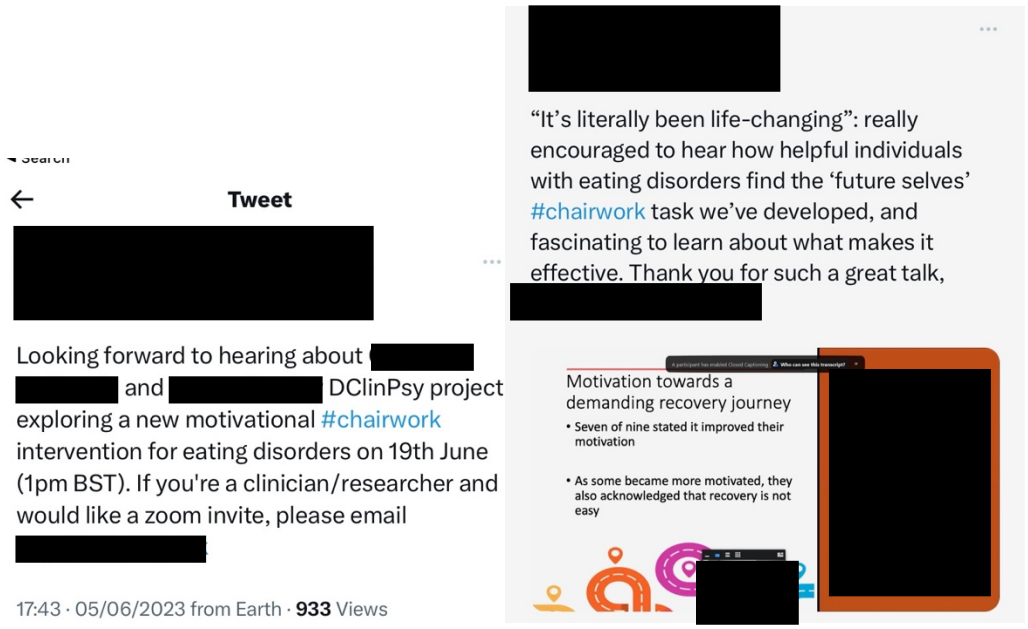
This has been removed from the electronic copy.

Appendix Q: Dissemination

The MRP preliminary findings were presented at two conferences, the first was the Southeast Eating Disorder Research Consortium (SERC) and the second was at the Eating Disorder Research Group at University College London (EDRG). Both were open to clinicians and researchers.

The anonymised poster advertising the talk for SERC is below.

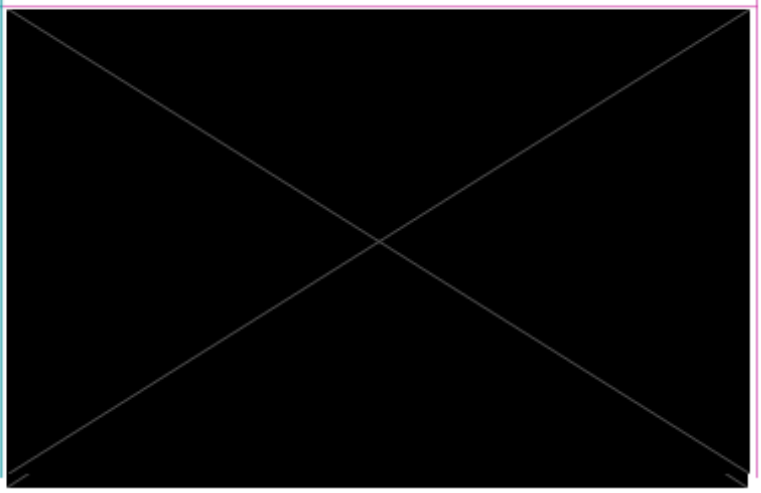
An anonymised invite and feedback from EDRG is below.

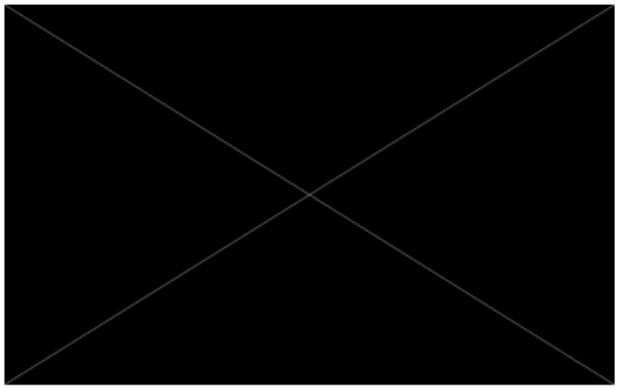


Below is an anonymised draft feedback poster for participants and EBEs. At the time of submission, it was under review by research supervisors. Information related to the concurrent study has been redacted.

Research Overview

Project Name:	
Evaluating the 'Future selves' chairwork task for those with living with Anorexia Nervosa	
Researchers:	[redacted]
Research supervisors:	[redacted]

Parts	Part one: Creating a preliminary model for how the task may work Part two: Interviewing participants about their experience
Rationale	The 'future selves' chairwork may improve motivation for people living with Anorexia . Chairwork may be helpful as it provides a more experiential or emotional approach than other interventions. However, the 'future selves' task required research to establish it as credible. Specifically, to start to understand its mechanisms of change and to clarify its acceptability and feasibility.
Part one results:	



Part two results:

Four main themes emerged:

Delivery and task factors:

Participants found it helpful having a nice therapist, using the letters following the task (e.g. re-reading them) and having the choice between whether they could do the task online or in person. Participants wanted more support with writing the letters and support after the task (e.g. a debrief to help with emotions or to think through the task). Participants found considering the future from 10 years generally acceptable, but considering the future from 5 years may be useful for younger participants.

Motivation towards a demanding recovery journey:

Seven of nine participants found the task motivating. Many acknowledged how difficult and demanding recovery is.

Intense and weird emotions led to realisations:

Participants found the task strange and some experienced intense emotions. Some found the task more emotional and some found it less emotional. Some people found it emotional as it connected them to the past and present experiences. Some people found that the emotional experience of the task led to realisations (e.g. i'm not cured and am still struggling).

Living as the future self

Several participants found that in the task they *embodied* the future selves (e.g. they felt like different people when they moved chairs or shifted position). Some described '*acting*' as the future selves, others described '*being*' the future selves. This experience helped to make sense of what the future may hold with or without anorexia. For some, thinking about the future was a new experience, meaning the task helped participants think and feel what the future may hold.

Conclusions

The task is generally acceptable and feasible, but changes could be made to improve it. It is possible that change occurs by; [redacted]

[redacted]

More research is needed to learn more about this task and to improve

What next?

The results have been presented to the eating disorder team.

Amendments will be made to the task and training based on your feedback.

[redacted] will submit the results as part of their training to become clinical psychologists. Markers will review their work, and [redacted] may make further changes based on the markers feedback.

[redacted] will aim to publish the results, so that other services can learn about the intervention and how to improve it.

A massive thank you - without your involvement this would not have been possible. We are incredibly grateful for your time and support in this project.

Appendix R: Author guideline notes for the European Eating Disorders Review

This has been removed from the electronic copy.