How do weight and shape attitudes emerge in therapy? Clinician reflections from eating disorder treatment

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Lay Summary

Paper 1: What are eating disorder clinicians' attitudes to weight and shape? A mixed methods systematic review

What is the problem?

In Western society, there is much pressure on women to be very thin and on men to be lean and muscular. This can lead to negative beliefs about larger-bodied people and make people worry about their weight and shape. Earlier studies have found that cultural beliefs about weight and shape influence people working in health care. This means they can make unfair assumptions about people because of their weight, which might result in patients having bad experiences when receiving care.

Clinicians working in eating disorders help patients of all sizes worry less about their weight and shape. At the same time, they might have been influenced by some of society's unhelpful messages about weight and shape. We do not know much about ED clinicians' attitudes to weight and shape, so I decided to find out more in this review.

What did I do?

I found studies that asked ED clinicians about their attitudes to weight and shape. This was done either through interviews, surveys, or experiments measuring bias. I created a list of words related to my topic and put these words into two different research databases, (Pubmed and PsychInfo). This helped me find 2832 papers, which I sorted through to find the ones related to my topic, which left me with 13 papers. I then used a

checklist tool to understand how well each study was run. Finally, I used a method called 'thematic synthesis' to examine the overall themes from the 13 studies.

What did I find?

654 clinicians took part in the 13 studies. The studies found that:

- The clinicians had all been influenced by society's messages about how you should look.
- The participants preferred thin bodies; some had negative beliefs about larger people and thought that patients with obesity would do less well in treatment.
- Clinicians varied in how much they had worried about their bodies in the past.
- Working in ED had helped clinicians accept their bodies more. They were more interested in nutrition and did not want to restrict their diets to lose weight anymore. Others felt worse about their bodies and had more disordered eating because of their work.
- Many clinicians thought that you work on your body image issues before you start work in ED, or else you might find the work upsetting.
- Many clinicians thought talking about their attitudes to weight and shape with their supervisors at work would be helpful.

What does this mean?

Managers and leaders in ED services need to encourage their staff to think about their attitudes to weight and shape and to support them if they have body image concerns. As a lot of the participants in the studies were White women, studies done in the future should look at the views of people from other cultures and men.

Paper 2: How do weight and shape attitudes emerge in therapy? Clinician reflections from eating disorder treatment

What is the problem?

The relationship between the therapist and the patient is important. It helps the patient feel safe and trust the therapist, and lots of research shows that a good therapeutic relationship is central to helping patients get better. Therapists often react strongly to clients because of their past experiences, beliefs, or something about the client that causes that response. This can damage the therapeutic relationship.

Therapists working in ED help their patients overcome their worries about their weight and shape. Sometimes, this means rejecting society's ideas about body size and healthy eating. This can be complicated for therapists to think about because they might be influenced by society's messages about dieting and how one should look.

We do not know much about how therapists reflect on their attitudes to weight and shape or society's messages about how you should look in their work. We also do not know much about whether the therapist's beliefs about weight and shape can impact the therapeutic relationship. I wanted to find out more about this in my study.

What did I do?

I interviewed eight therapists working in an ED service about their beliefs about weight and shape, their experiences of society's messages about how you should look, and how they think about this at work. When planning my study, a psychologist working in an ED

and two former patients helped me decide what questions to ask my participants. I recorded the interviews, transcribed them, and then analysed them using a technique called 'Interpretative Phenomenological Analysis' to understand the themes that came up in the interviews.

What did I find?

- All the therapists thought society pressures people to be thin; they had their own experiences of feeling bad about their bodies, and some of them had experienced an ED in the past.
- This experience helped them understand their patients and made them feel keen to help their patients. Although sometimes they felt that they should be able to help all their patients because of their experience, which felt stressful sometimes.
- The therapists all thought they were influenced by society's messages about weight and shape, but they tried to challenge unhelpful thoughts, so they didn't affect their patients.
- Sometimes, therapists felt self-conscious of their own bodies in therapy, or they felt jealous of their patient's body. But mostly, the therapists thought that working in ED had helped them feel more body confident.
- Therapists felt under pressure not to do any dieting behaviours. Sometimes, they seemed scared that doing so would make them a bad therapist.
- Therapists thought discussing this topic at work would be helpful. They thought it would be easier to do this in private, with their supervisor, rather than in a large group.

What does this mean?

This research shows that therapists have complicated beliefs about weight and shape, which can be hard for them to understand. We need to provide guidance on how ED clinicians can reflect on their attitudes to weight and shape, and NHS managers need to encourage them to do this. Future research should test whether this guideline is helpful.

Paper 3: Bringing it all together

In this paper, I summarise how papers 1 and 2 go together. I described how the findings of these two papers can help:

- ED clinicians to think about their attitudes to weight and shape
- Supervisors to help their staff to think about this topic
- People who create guidelines for people working in ED
- To create more research to understand this topic.

I also discussed the highs and lows of doing this research and how I felt during it. I also discussed a plan for sharing this research with others.

Chapter 1: Systematic Review

What are eating disorder clinicians' attitudes to weight and shape? A mixed methods systematic review

Abstract

In Western society, physical appearance is highly valued, and thin bodies are often perceived as attractive and desirable. This can result in people endorsing pro-thin, anti-fat attitudes, which may lead to marginalisation and discrimination against larger-bodied people. Such societal values can also cause individuals to experience body image concerns, which are known to contribute to the development and maintenance of ED. Societal narratives about weight and shape can also influence healthcare professionals by causing them to experience weight bias and make assumptions about individuals based on their body size. Appearance concerns are a crucial target symptom within ED treatment, with clinicians supporting patients to place less importance on the thin ideal. ED clinicians may benefit from reflecting on their attitudes to weight and shape, but more guidance is needed on how to do this. This review aimed to synthesise the literature on ED clinicians' attitudes to weight and shape. Searches were conducted on two databases, the search results were screened, which revealed 13 papers examining ED clinicians' attitudes to weight and shape to be included in the analysis. The findings were integrated and synthesised using thematic synthesis and the quality of the included papers were appraised. Thematic synthesis found that ED clinicians internalise the thin ideal to varying degrees, which sometimes resulted in negative attitudes towards larger-bodied patients and body image concerns. Despite this, there was an expectation that clinicians should feel secure within their bodies to work in ED and to explore their own beliefs within supervision and reflective practice. However, it was felt that there was a lack of opportunities to reflect on these issues with psychological safety. Clinicians' attitudes to weight and shape had also been impacted by their work in ED; it resulted in

improved body image and heightened awareness of their and other's bodies, but a significant minority of clinicians experienced greater body image concerns and disordered eating. It was hypothesised that this was related to unresolved pre-existing body image concerns, but no study established causality. Overall, studies varied in quality, but methodological issues highlighted a need for further research using controlled, experimental designs.

Introduction

Eating disorders (EDs) are complex mental health difficulties characterised by preoccupation with food, weight, and shape and eating too much or too little. Approximately 8.4% of women and 2.2% of men worldwide have been diagnosed with an ED (Galmiche et al., 2019). The aetiology of ED is complex, comprising biological, developmental and psychosocial factors (Berrettini, 2004). The internalisation of sociocultural norms about appearance ideals is a strong predictor of the development of ED (Izydorczyk & Sitnik-Warchulska, 2018). The overvaluation of weight and shape, often characterised by fear of fat, the pursuit of thinness and size-based self-esteem, is a key target of ED treatment (Fairburn, 2008). Thus, ED clinicians are situated within a unique position whereby a considerable proportion of their work may involve supporting patients to move on from the rigid pursuit of appearance ideals whilst simultaneously being exposed to the same narratives and potential internalisations of these.

Attitudes to weight and shape within society

In Western culture, physical attractiveness is highly valued, and specific characteristics deemed the most attractive are often promoted by the media and become a socio-cultural norm (Buote et al., 2011). The appearance ideal is a socially constructed set of standards defining beauty (Stice et al., 1994). Body size forms a part of appearance ideals, with other valued characteristics being clothing, skin and hair. Beauty ideals have evolved, often in response to the socio-political context (Moore, 2022) and vary depending on gender and cultural background. For example, male body ideals are less

rigid than female ones and more concerned with muscle mass than the ultra-thin female ideal (Buote et al., 2011). Despite this, for both men and women today, thin or lean bodies are highly valued, and larger, softer bodies can be denigrated (Hoff & Hancock, 2022).

The thin ideal internalisation reflects the extent to which one endorses the belief that thin bodies are attractive (Thompson & Stice, 2001). People begin to prefer thin and average-sized figures over overweight bodies at an early age (Tatangelo et al., 2016). Children are likely to associate thin people with happiness, intelligence, and kindness (Conway, 2013). Western societies also believe that thinness is an essential determinant of personal and economic success (Klaczynski et al., 2004). Due to the value placed on personal responsibility within Western culture, the belief that one can and should control one's body size through diet and exercise is prevalent, perpetuating the associations between thinness, discipline, and success. This view ignores that individuals naturally live in bodies of varied sizes and shapes despite having comparable diets and exercise regimens (Komaroff & Twain, 2016).

The thin ideal gives rise to weight bias, defined as negative attitudes and beliefs about others because of their weight. These attitudes are highly prevalent (Elran-Barak & Bar-Anan, 2018). Weight bias consists of at least two cognitive processes: implicit bias (unconscious preference for thin over fat[1] people) and explicit bias (conscious preference

[1] A note on language: the terms "fat", "overweight", and "obese" are used interchangeably throughout. The researcher has kept the terminology used in the original paper as the literature cited comes from both a biomedical and critical fat studies perspective. The critical fat studies literature is critical of the term "overweight", and the use of the BMI as this implies that there is a correct weight that one should be, which is deemed to be inaccurate within this school of thought. In these papers, the term "fat" is used as a neutral descriptor and replicated in this review. In papers from the biomedical literature, participants

for thin over fat people) (Phelan, 2015b). Weight bias can lead to weight stigma, defined as social stereotypes and misconceptions about people with obesity, which can result in exclusion, marginalisation, and inequities. A vital component of this is fatphobia, which encapsulates negative attitudes toward and stereotypes against fat people, especially the belief that they are lazy, unhealthy, unmotivated, or unattractive (Puhl & Suh, 2015). The myth that one can and should control one's body shape also feeds into the narrative that fat people do not meet the ideal simply because they lack self-discipline (Moore, 2022). Indeed, this becomes a self-fulfilling prophecy, with larger people often discriminated against during recruitment and having lower financial attainment than thin people (Fikkan & Rothblum, 2011).

The beginnings of modern weight stigma can be traced back to White supremacist beliefs. During the European colonial period, a narrative ascribing a big body to all Black women was created to justify the use of Black women for labour and to portray them as lesser (Gentles-Peart, 2018). Thus, it is important to consider weight stigma through intersectionality, as social categories can interact at individual and structural levels. Negative stereotypes towards racialised groups can be the same as stereotypes towards obesity (e.g. lazy, unintelligent) (Puhl & Heuer, 2010). Black, Hispanic, and Asian women do experience weight stigma (Himmelstein et al., 2017), but people from the Global Majority may also not endorse the thin ideal to the same extent as White people (Puhl & Heuer, 2010), and the rejection of the thin ideal has been seen as an act of resistance to racial discrimination (Gentles-Peart, 2018). Thus, differing identities intersect with

have often been divided into groups based on their BMI (i.e. underweight, 'normal' weight, overweight and obese), and thus, these terms are used when stating the results to avoid misrepresenting the findings. In circumstances which allow, the neutral terms "higher-weight" and "larger-bodied" are also utilised.

fatphobia in complex ways, either contributing further to the disadvantage or providing an emotional buffer.

Diet culture is seen to be a direct consequence of the thin ideal and associated weight stigma. It is defined as a system of beliefs which equate thinness to health and moral virtue (Harrison, 2019), comprising the pursuit of thinness to avoid discrimination (Moore, 2022). Dieting is common in Western cultures, with research showing that 60 to 70% of teenage girls diet to lose weight (Andersen, 2022). Diet culture is closely aligned with Eurocentric Protestant values, which place much importance on restraint and self-discipline, with gluttony being viewed as a sin (Moore, 2022). This has created a narrative that dieting is necessary (Vartanian et al., 2007), low-calorie foods are 'good', and high-fat or sweet foods are 'bad' (Contois, 2015). Therefore, dieting is more than the pursuit of thinness to be seen as attractive; it is a means of being morally pure, 'good,' and worthy of love (Moore, 2022).

Societal narratives about weight and shape can also impact how individuals view themselves. Body image is defined as the picture we hold in our minds of our bodies and the emotions associated with this (Slade, 1988). Poor body image can occur when individuals who internalise societal body ideals think that their appearance diverges from the ideal (Thompson et al., 1999). Due to beliefs about the controllability of body shape, deviations from the ideal can damage one's self-esteem, which is believed to be a factor in developing ED (Klaczynski et al., 2004). Poor body image tends to worsen in people with a high BMI (Fiske et al., 2014), but research shows that people of all sizes can be vulnerable to this process (Calzo et al., 2012).

Patient experiences of clinician attitudes to weight and shape

Clinicians in Western cultures experience the same narratives throughout their lives. Evidence shows that clinicians' unhelpful attitudes towards weight and shape have been experienced from the patients' perspectives and can be detrimental to outcomes. For example, in a reflective piece describing their experience during an inpatient stay as a patient with atypical anorexia, Harrop (2019) described clinicians disbelieving she was experiencing anorexia due to her body size, prescribing a restrictive diet which mimicked her ED behaviours and being told she was 'less sick' than her underweight counterparts. In Moore (2022), higher-weight ED patients reported microaggressions from their therapists, with therapists implying their responsibility for their size and distress, which resulted in a loss of trust in professionals and an increase in ED behaviours.

Experiencing weight stigma is known to contribute to poor health outcomes by increasing binge eating behaviour and psychological distress (Tomiyama, 2014). Higher-weight patients have noticed discrimination through the service set-up. This includes services not providing chairs to accommodate larger-bodied clients (Akoury et al., 2019) or incidences where the treatment aim for BED was weight loss, which caused patients to feel blamed and exacerbated their eating pathology (Salvia et al., 2023). Furthermore, people with obesity are known to avoid accessing care due to fears about being shamed about their weight, often based on negative past experiences with healthcare professionals (Phelan et al., 2015b). These findings highlight the presence and scope for negative effects of weight stigma in healthcare interactions, which may link to clinician's internalisation of anti-fat bias as well as institutional factors such as the environment and

stance of treatment. Weight stigma may lead to poorer treatment outcomes due to adding to the patient's distress and causing the patient to delay accessing treatment, which has been found to reduce the efficacy of treatment (Ambwani et al., 2020).

Lower-weight patients also notice clinicians' unhelpful attitudes towards weight and shape. Patients experiencing anorexia nervosa have reported being treated as another case of anorexia rather than as an individual and feeling blamed for their disorder (Tierney, 2008). In this study, patients reported a narrative on the ward of: "Just buckle up and get some food down you" (p. 371). One participant reported that a clinician asked them to give them a small amount of their illness so the clinician could lose weight for a holiday. This demonstrates several things. Firstly, the prevalence of personal responsibility beliefs regarding weight and shape and how, by buying into this narrative, clinicians risk dismissing the patient's psychological distress and other factors maintaining the ED. The value placed on personal responsibility is an integral part of diet culture narratives and plays a role in the development of ED (Joyce et al., 2019); so, these assumptions are potentially very harmful to patients. Secondly, clinicians expressing a wish to take on a 'bit of anorexia' to lose weight both trivialises the ED and colludes with the narrative that weight loss is desirable.

Patients experiencing anorexia nervosa report not receiving any care until they were dangerously low in weight, despite seeking support at an earlier point in the illness (Joyce et al., 2019; Tierney, 2008). Clients perceived this as 'not thin enough, not worthy enough,' which understandably reinforced their pathology (Joyce et al., 2019). This may reflect bias in individual clinician decision-making but further demonstrates how institutional set-

ups can play into dominant discourse. Given evidence that eating disorders become less responsive to treatment the more entrenched they are (Ambwani, 2020), these factors may also contribute to poorer outcomes for these patients. The lack of funding in the NHS raises the benchmark for who can access specialist services, thus colluding with the narrative that thinner makes one more worthy.

Patients who have received care from EDs also report missed opportunities for positive therapeutic conversations about body size and body-based oppression due to the clinician's anxiety about saying the wrong thing (Harrop, 2019). Weight stigma has been argued to be the last acceptable form of bias (Puhl & Brownell, 2001), it exists across multiple domains of living, including healthcare, education and employment (Puhl & Heuer, 2009). Weight bias is also unique in the sense that eating may create a context for weight stigma to occur, however, all people need to eat to live, meaning that people vulnerable to its effects may experience weight stigma (either internally or externally) multiple times per day (Tomiyama, 2014). Therefore not acknowledging body-based oppression runs the risk of not supporting patients to navigate unhelpful societal narratives and may impact their ability to stay well post-treatment. This highlights the importance of clinicians being aware of weight-based discrimination and how this intersects with other forms of oppression.

Weight and shape attitudes within healthcare

Healthcare professionals leaning into stereotypical views of clients based on their size, which may result in more negative attitudes towards patients and poorer quality of care.

Elevated levels of anti-fat bias have also been found among mental health professionals (Cain et al., 2017; Pratt et al., 2017). In one study, psychologists rated obese clients as more physically unattractive, more embarrassed, softer, and kinder than non-obese clients (Agell & Rothblum, 1991). Trainee doctors with higher levels of weight bias have been shown to predict poorer outcomes and were more likely to show frustration towards patients with obesity (Puhl et al., 2013b). Negative attitudes towards patients with obesity, particularly the assumption of poor adherence have been shown to negatively impact communication with patients, which is associated with poorer patient outcomes due to patient mistrust and impaired information giving (Phelan et al., 2015b). This demonstrates the importance of challenging clinicians' unhelpful attitudes to weight and shape.

Few studies have explored clinicians' internalisation of the thin ideal. However, psychologists are more likely to internalise the thin ideal than fitness instructors and nutritionists (Worsfold & Sheffield), and 50% of dieticians have been found to have orthorexic beliefs (Tremeline et al., 2017). Studies using Implicit Association Tests have also shown that medical doctors prefer thin bodies and are quicker at pairing 'thin' with adjectives such as 'perfect' (Sabin et al., 2012) This demonstrates that healthcare professionals of all disciplines and at all stages of their careers are vulnerable to internalising pro-thin bias. Studies have found that the egosyntocity of eating disorder pathology and working in a culture which promotes ED pathology can contribute to staff burnout (Warren et al., 2012), which demonstrates that internalisation of the thin ideal can also pose challenges to clinicians in addition to anti-fat bias.

Although most clinical training programmes offer training on inequality and provider bias broadly, few cover weight bias (Phelan et al., 2015a). Education is essential to communicate the acceptance of different body shapes and dispel common myths about shape and weight, so this lack of consideration may increase weight bias. Furthermore, clinical training textbooks are shown to show the disease model of obesity, omit research stating that diets do not work, and do not acknowledge the health implications of weight stigma (McHugh & Kasardo, 2012). Indeed, some treatment manuals for Binge Eating Disorder (BED) have been found to endorse stigmatising views, namely that binge eating is a psychiatric problem of poor self-management (Brown-Bowers et al., 2016). This demonstrates that anti-fat bias is held at both the individual level and institutional level, and opportunities to bring awareness to weight-based oppression are missed. As discussed above negative attitudes towards obesity impairs patient communication, resulting in poorer outcomes (Phelan et al., 2015b). The above example shows a potential mechanism by which this happens: the harmful, dominant discourse is perpetuated via training institutions and causes clinicians to be unaware of important information which may impact their patient's health. Thus, examining how cultural beliefs are endorsed on a personal and institutional level is crucial.

There are a few exceptions to the rule, however. Professionals endorsed fewer stigmatising attitudes towards an ED vignette if shown a biological rather than a psychosocial explanation of ED (Crisafulli et al., 2008). This shows that while cultural narratives are crucial in developing EDs, ignoring biological factors may wrongly imply that individuals are responsible for their disorders. Phelan et al. (2013) also found that medical students' implicit anti-fat bias was reduced after completing medical school

compared with at enrolment. This was explained using the contact hypothesis – that contact with marginalised groups can help to reduce prejudice (Allport et al., 1954). Interestingly, Phelan et al. (2013) also found that the students' explicit bias increased slightly after medical school compared to pre-enrolment levels, which may have resulted from clinicians becoming more self-aware. This demonstrates that education and experience can help to challenge internalised bias.

Throughout history, stigma has imposed suffering on vulnerable groups and impaired efforts to thwart the progression of the disease. For example, in the case of HIV or African Americans dying from tuberculosis, groups were blamed for their illness due to being 'sinful' or 'dirty' (Puhl & Heuer, 2010). The evidence discussed above has also demonstrated that conscious and unconscious weight-based beliefs may contribute to clinician burnout (Warren et al., 2012) and are linked to poorer patient communication and potentially erroneous clinical decision-making (Phelan et al., 2015b), both of which result in poorer outcomes (Hall et al., 2016; Maslack & Leiter, 1996). Within the context of ED, it is recommended that clinicians examine their beliefs regarding weight and shape to adequately challenge clients' distorted perspectives and avoid inadvertently communicating or reinforcing unrealistic beliefs and values to their clients (DeLucia-Waack, 1999). Thus, clinicians need to be aware of their attitudes to various groups of people, as buying into societal narratives can be harmful.

Existing reviews show us that stigma is a barrier to accessing treatment, and therapists can hold negative attitudes towards ED clients. In one review examining stigma towards EDs, clinicians expressed beliefs that EDs are treatment-resistant and that individuals

experience EDs because of their weak personalities and vanity (Thompson-Brenner et al., 2012). A review examining clinicians' knowledge and attitudes towards BED identified that professionals had limited understanding of this disorder, felt that it was less impairing than other EDs and attributed the causes to a lack of self-discipline (Reas, 2017). Puhl & Suh's (2015) review on stigma and ED also found that individuals, in general, have complex reactions to people with EDs, ranging from being attributed negative personality traits to feelings of envy.

However, thus far, no systematic review has evaluated ED clinician's attitudes to weight and shape. Given that ED clinicians exist within a milieu where part of their work is to support their patients to reappraise their attitudes to weight and shape but simultaneously exist within a society which perpetuates discriminatory ideas and there is evidence that unhelpful clinician beliefs can negatively impact outcomes, it is crucial to assess the beliefs of ED clinicians. Therefore, this systematic review seeks to synthesise the existing literature on ED clinicians' beliefs about weight and shape and critically appraise the quality of the existing literature.

The questions this review seeks to answer are:

1. What are ED clinicians' attitudes to weight and shape?
2. What is the quality of research investigating ED clinicians' attitudes to weight and shape?

Method

This review adhered to the updated Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA-P) guidelines (Page et al., 2021)

Study Eligibility Criteria

Inclusions and exclusion criteria were applied to the search to ensure the determination of study eligibility was rigorous and transparent. The inclusion criteria consisted of:-

1. Empirical research, e.g. the study collected and analysed data instead of commentaries, theoretical papers, or reviews.
2. Empirical research examining ED clinicians' attitudes to weight and shape. This could include data exploring clinician body image, attitudes to weight and shape, weight bias or any other reaction to a patient based on their body size. If data capturing these concepts arises incidentally despite this not being the focus of the study, then this will also be included.
3. Empirical research using professionals working in specialist ED services (including ED pathways in a general team or a private clinician specialised in working with ED)
4. Published empirical papers and unpublished theses
5. Qualitative or quantitative data
6. Empirical study designs included randomised control trials, quasi-experimental designs, and cohort analytics.
7. The study was reported in or translated into English.

The exclusion criteria for studies consisted of:-

1. Studies where the participants did not specifically work with EDs, including GPs, weight management and bariatric services
2. Studies where the outcome was attitudes to the ED, attitudes to patient characteristics, or clinician attitudes to eating with no mention of weight and shape,
3. Case studies or protocols for interventions
4. Commentaries, background articles, reflective pieces, observational studies, books, or chapters
5. Studies not evaluating individual beliefs.

Search Strategy

Studies were identified following the systematic search of electronic databases. Searches were conducted on 25 May 2023 on two electronic databases: PubMed and PsycINFO. PubMed was chosen due to its comprehensive coverage of biomedical and life sciences literature. As the review question aimed to examine the beliefs of ED professionals in general, and ED treatment is multidisciplinary, PubMed would capture studies from multiple disciplines. PsychInfo was chosen due to its focus on psychology, psychiatry and other behavioural and social sciences. Given that EDs are psychiatric disorders, and the review aimed to review attitudes and beliefs, which is a construct commonly examined within psychology and other social sciences, this database was also felt to provide appropriate coverage for this review. The researcher opted to search two databases in line with guidelines from their institution. Furthermore, two searches

generated over 2800 results; therefore, further searches on other databases were deemed inappropriate due to the scope of the review and time constraints on the researcher. The researcher did not carry out a grey literature search specifically, however PsychInfo also covers dissertations selected from Dissertation Abstracts International, which also enabled coverage of unpublished work.

Further to the search, reference lists from eligible papers and key existing meta-analyses were also reviewed for additional relevant studies. The search terms for each concept were defined from derivatives generated from common terminology used in the literature and after librarian consultation. Boolean operators and truncations were utilised to account for variations in terminology. Searches were conducted in the “Title” and “Abstract” fields to optimise the search relevancy. Database searches were conducted using the following terms.

Block 1–Disorder

“Eating disorder*” OR anore* OR bulimi* OR EDNOS OR OSFED OR “ED”:

Block 2–Population

Psychologist* OR Psychotherapist* OR counsellor* OR therapist* OR professional* OR "eating disorder service"

Block 3–Type of research

Attitude* OR views OR belief* OR value* OR ideal*

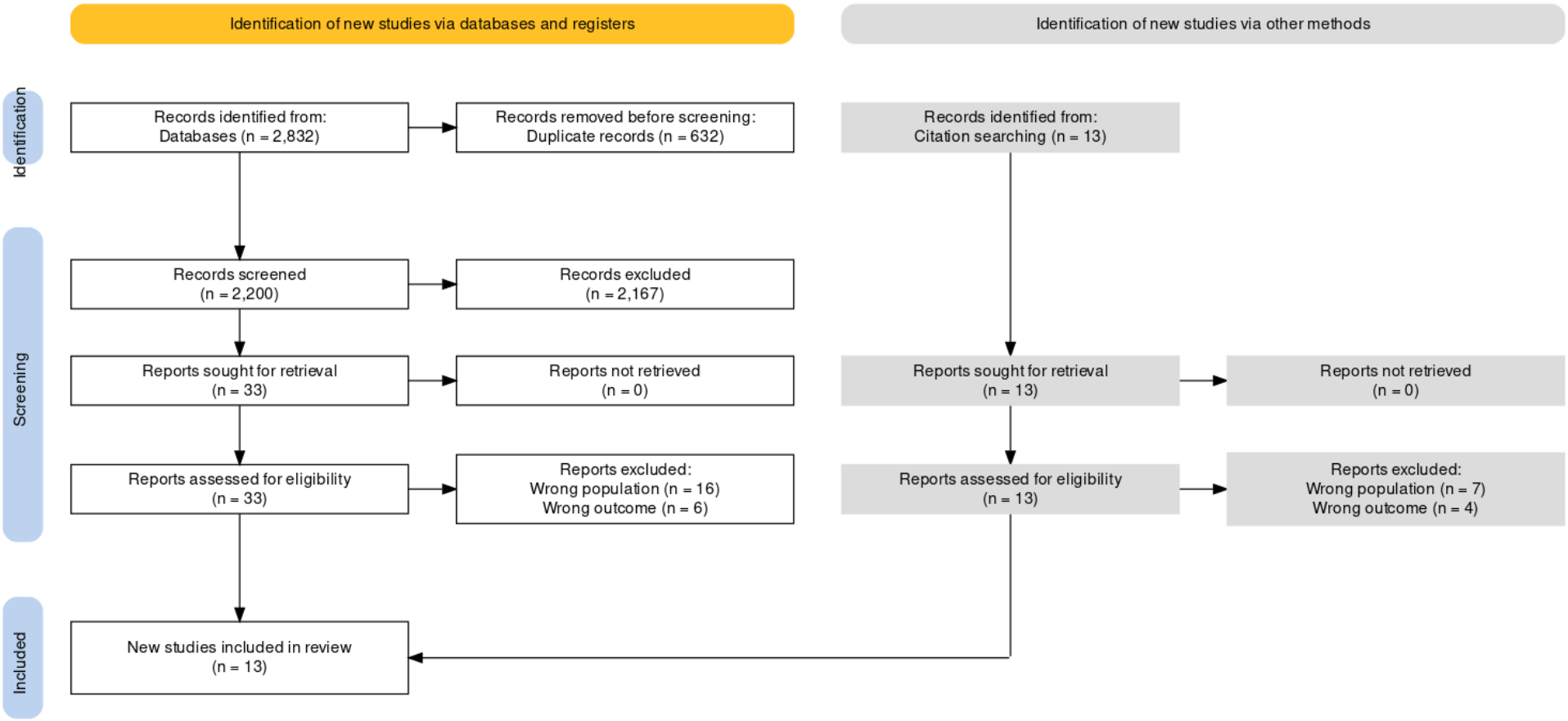
Block 4–Phenomenon of interest

Eating OR weight OR shape OR “body image” OR “body size”

Study Selection

In line with PRISMA-P (Page et al., 2021) guidelines, study selection included screening titles followed by a full-text review, which a single researcher carried out. To enhance rigour and reduce potential selection bias, 30% of papers screened at full text were randomly selected for screening by an independent reviewer, who screened title and abstract to assess whether the papers met the inclusion criteria. The researcher and the reviewer had a 100% agreement rate; Cohen's Kappa indicated a substantial agreement rate ($\kappa=1$, $p=<.001$). Figure 1 shows the process of study selection in diagrammatic format. This will be further explored in the Results section on p.34

PRISMA flow diagram showing the study selection process[2]



[2] Diagram generated by Shiny app for producing PRISMA 2020 compliant flow diagrams (Haddaway et al., 2022)

Data Extraction

For quantitative data, data extraction included sampling method, inclusion criteria, study design, setting, information about the sample; outcome measures investigating clinician attitudes to weight and shape, and the findings. For qualitative data, this included the sampling method, inclusion criteria, setting, participants, themes, and subthemes. Any themes or quantitative findings not relevant to the review question were excluded.

Quality Appraisal

Due to the range of methodologies in the studies, different quality appraisal assessment tools were utilised to appraise each study design. This was deemed more appropriate than a general tool, allowing a more specific and in-depth assessment. Qualitative studies were assessed using the Critical Appraisal Skills Qualitative Programme (Critical Appraisal Skills Programme, 2023). The JBI Checklist for Analytical Cross-Sectional Studies (Joanna Briggs Institute, 2020) was used for cross-sectional analytic quantitative studies. Finally, the mixed-method study was assessed using the Mixed Methods Appraisal Tool (MMAT) (Hong et al., 2018). These tools were selected as they are all recommended in the literature and have been shown to have good qualities (Ma et al., 2020; Noyes et al., 2018; Pace et al., 2012). Each tool utilised was accompanied by a comprehensive guide outlining the process.

The CASP (Critical Appraisal Skills Programme, 2023), JBI Checklist for Analytical Cross-Sectional Studies (Joanna Briggs Institute, 2020), and the MMAT (Hong et al., 2018) do not

include a global score in their appraisal. Therefore, for the CASP (2018), a scoring system based on Babb et al. (2022) was used to classify the paper's overall quality. Scores of 8+ received a good rating, indicating a low likelihood of methodological flaws. Scores of 4.5-7.5 received a moderate rating, indicating some likelihood of methodological flaws. Scores of 4 and below received a poor rating, indicating a high likelihood of methodological flaws.

The JBI Checklist (2020) contains eight questions answered with yes, no, unclear or not applicable. A scoring system based on Xu et al. (2022) was used to attribute an overall quality score to papers appraised with the JBI Checklist (2020). A score of "yes" five or more times indicated high methodological quality, three to four times indicated moderate quality, and zero to two times indicated poor quality.

For the MMAT, the Hong (2020) guidance was used, with five stars awarded or 100% quality criteria met, four stars for 80% quality criteria met, three stars for 60% quality criteria met, two starts for 40% quality criteria met one star for 20% quality criteria met. To easily compare the overall quality of papers, four and five-star studies were assigned as good quality, two and three-star ratings were assigned as moderate quality, and one-star papers were assigned as low quality.

An independent assessor appraised 40% (5) of the studies and included studies of all designs to ensure inter-rater reliability checks across all of the appraisal checklists. There was an 80% agreement, and Cohen's Kappa indicated moderate strength of agreement (κ=0.58, p=.05), and discrepancies were resolved via discussion. Guidance for the CASP

(2023), JBI checklist (Munn et al., 2020), and the MMAT (Hong et al., 2018b) recommends against just providing a global score and excluding studies with a low methodological score. Therefore, no studies were excluded based on their global quality score. Although a global quality score will be provided for ease of comparison, this will be accompanied by a detailed presentation of the ratings for transparency aligned with guidance from the CASP (2023), JBI checklist (Munn et al., 2020), and the MMAT (Hong et al., 2018b).

Data Synthesis

Because both quantitative and qualitative data can address the review question, a convergent integrated approach was used to synthesise the quantitative and qualitative data (Stern et al., 2021). This involves combining the extracted quantitative and qualitative data at the synthesis stage and interpreting them simultaneously. To integrate the two data sets, quantitative data were 'qualitised' in line with JBI recommendations (Stern et al., 2021). 'Qualitising' data comprises a narrative interpretation of quantitative results, that is converting numerical or statistical data into declarative, stand-alone sentences in a manner which answers the research question. The textual descriptions of quantitative data are then pooled with the qualitative data, the reviewer subsequently examines all of the data simultaneously to cluster together information which has a similar meaning. A more in-depth discussion of this process can be found in Stern et al. (2021).

Following data transformation, all data were synthesised using thematic synthesis based on the method by Thomas and Harden (2008). This method was chosen because it can

be used with both qualitative and quantitative data, and it focuses on synthesising the narrative findings, as opposed to meta-analysis of the data (Evans, 2002), which was aligned with the review's goal. Thematic synthesis comprised free line-by-line coding of the results of each paper, organising free codes into related areas to develop descriptive themes, and finally, generating analytical themes (Thomas & Harden, 2008). The software NVIVO was used for this process.

Reflexivity

The reviewer is a white British, middle-class, able-bodied, cis-gendered, heterosexual woman who is employed as a Trainee Clinical Psychologist. The reviewer has experience of working in an eating disorder service and has lived experience of an ED. The reviewer's position as an ED clinician with lived experience of the disorder contributes to their interest in this topic. The reviewer's experiences have shaped their assumptions that clinicians working with ED may internalise the thin ideal and experience weight bias. This may cause the reviewer to discount findings where participants report weight-inclusive beliefs or weight and shape attitudes which do not align with the dominant discourse.

The researcher's position as a White, British woman may cause them to privilege perspectives from a Western point of view and may cause them to marginalise narratives from the global majority or from people who do not identify as women. To avoid the review being unduly influenced by these biases and assumptions, the researcher endeavoured to bracket these preconceptions via journalling and reflective practice in supervision.

Results

The electronic database searched 2832 studies, and 13 studies were identified via other sources. References were imported into Rayyan referencing management software 22 to remove duplicates and screen studies. As shown in Figure 1, 653 duplicates were removed, and the remaining 2200 papers were screened by title and abstract against the eligibility criteria. Potential studies (46) were reviewed at full text, of which 13 met the inclusion criteria. Figure 1 describes the reasons for the exclusion of 20 studies.

Study characteristics

Study methodology

Table 1 illustrates each chosen study and its characteristics. Of the thirteen included studies, seven (54%) were qualitative (Ali, 2022; Bowlby, 2007; Levas-Luckman, 2014; Levy, 2013; Palmer, 2015; Rance et al., 2010), four were quantitative (31%) (Gorman-Ezell, 2009; Loewy, 1994; Puhl et al., 2013a; Shisslak et al., 1989; Toman, 2002), and one (8%) was mixed methods (Warren et al., 2008). Six (46%) of the studies were unpublished doctoral theses (Ali, 2022; Bowlby, 2007; Gorman-Ezell, 2009; Levas-Luckman, 2014; Levy, 2013; Loewy, 1994).

Study Context

All studies were published between 1988 and 2022. Ten (77%) studies took place in the USA (Loewy, 1994; Palmer, 2015; Puhl et al., 2013a; Shisslak et al., 1989; Warren et al., 2008), one (8%) in Australia (Walker & Lloyd, 2011), one (8%) in the UK (Rance et al., 2010) and one (8%) (Toman, 2002) in Switzerland.

Study Demographics

Study participants were predominantly female (88%). Five studies did not report the participants' ethnicities (Levy, 2013; Palmer, 2015; Rance et al., 2010; Toman, 2002; Walker & Lloyd, 2011); of the seven studies that did (Ali, 2022; Bowlby, 2007; Gorman-Ezell, 2009; Levas-Luckman, 2014; Loewy, 1994; Puhl et al., 2013a; Shisslak et al., 1989; Warren et al., 2008), 94% of participants were White.

Study Recruitment

Participants were recruited from a variety of backgrounds. One study recruited via social media (Ali, 2022); two studies recruited from the representative body for that profession (Gorman-Ezell, 2009; Palmer, 2015); two from conferences (Shisslak et al., 1989; Warren et al., 2008); one from the Yellow Pages (Loewy, 1994); one from a special interest group alone (Puhl et al., 2013a); one from a special interest group plus a local ED clinic (Bowlby, 2007). Three studies recruited from inpatient ED facilities (Levas-Luckman, 2014; Levy, 2013; Toman, 2002), and two from specialist ED services comprising in- and outpatient care. Four studies used convenience sampling using voluntary expression of interest (Bowlby, 2007; Puhl et al., 2013a; Shisslak et al., 1989; Walker & Lloyd, 2011), two used random sampling of conference attendees and members of a special interest group (Gorman-Ezell, 2009; Warren et al., 2008), six used purposive sampling, where participants were approached because of their characteristics (Ali, 2022; Levas-Luckman, 2014; Levy, 2013; Loewy, 1994; Palmer, 2015; Toman, 2002).

Quality Appraisal

Two of the seven qualitative papers received a high rating using the Babb et al. (2022) system (Ali, 2022; Levas-Luckman, 2014). Five were rated as moderate quality (Bowlby, 2007; Levy, 2013; Palmer, 2015; Rance et al., 2010; Walker & Lloyd, 2011). Of the five quantitative studies, three were given a high-quality rating (Gorman-Ezell, 2009; Loewy, 1994; Puhl et al., 2013a), one was given a moderate-quality rating (Toman, 2002), and one was given a low-quality rating. Specifically, Shisslak (1989) failed to define the inclusion criteria; the study subjects were not described in detail (e.g. the author states that 59% work in a hospital but does not describe the other 41%). They did not use validated measures or report on the confounding variables. The one mixed-method study was rated as low quality (Warren et al., 2008). Guidance for reporting the MMAT (Hong, 2020) states that the overall quality of a study cannot exceed the quality of the weakest component, so although the qualitative component was rated as good, the mixed methods section was rated as poor. Specifically, there was no rationale for conducting a mixed-methods study, the discussion was mainly descriptive, and the findings were not adequately interpreted or explained. Quality appraisal and associated grades are shown for the CASP, JBI Cross-Sectional Analytic and MMAT in *tables 2, 3 and 4*, respectively.

Table 1 Summary of studies

Author(s)	Study design	Study aims	Study population and location	Number of participants	Participant characteristics	Main findings
Ali (2022)	Qualitative	To explore BI concerns of counsellors working with ED clients,	Qualified counsellors working with clients with ED with lived experiences of ED. Counsellors worked in inpatient unites, private practice, mental health agencies. USA	11	All aged between 30-48. 100% female; 45% white, 27% Black; 9% middle Eastern, 18% mixed race. Between 2-8 years of experience	Three themes captured clinicians' experience: 1. Seeking congruence, 2. Lack of formal training and 3. Counsellors' self-awareness
Bowlby (2007)	Qualitative	To explore the lived experience of recovered professionals in the field of ED: the various challenges and benefits of working in the therapeutic process,	Clinicians working with ED who had recovered from ED. Most worked in private practice the others worked in inpatient. USA	8	Psychologists, psychotherapists, counsellors and one social worker. 100% white women. Mean years of experience in ED 12.3 years (Range 6-22 years)	Seven themes captured clinicians' experience: 1. View of ED. 2. View of recovery 3. Change factors for recovery. 4. View of occupation 5. View of their role in the treatment process. 6. Views of challenges in treatment 7. View of self-disclosure
Gorman-Ezell (2010)	Quantitative	To study the degree to which countertransference exists among therapists who treat clients suffering from ED	ED professionals (Members of the American Academy of ED). USA	84	86% female, 90% Caucasian, multidisciplinary, most were psychologists (54%)	Mean scores on the Countertransference questionnaire indicated that ED clinicians experience mild feelings of countertransference. High self-esteem, as measured by the Rosenberg Self-Esteem scale was found to be correlated with counter transference feelings of being parental and protective ($\beta = -0.053$; $p<0.05$), helpless and inadequate ($\beta = -0.048$; $p<0.001$) and overwhelmed and disorganised ($\beta = -0.013$; $p<0.05$).

Levas-Luckman (2014)	Qualitative	to explore the experiences of nurses treating patients diagnosed with EDs.	Nurses working on 2 separate inpatient units within an ED hospital. USA	12	Qualified nurses aged from 20s-50s. 2-35 years of experience. 83% White, 8% mixed race and 8% Hispanic. 58% worked with adults and 42% worked with adolescents. 100% female	Three themes captured clinicians' experience of working with ED from the semi-structured interview: 1. Initial attitudes. 2. Conditions of treatment. 3. Emotional awareness and outcomes. Two themes arose from participants bringing an artefact representing their experience of working in ED: 1. Stability and grounding, 2. Hope
Levy (2013)	Qualitative	To explore the experience of female direct care staff members who have worked in residential treatment programs for ED.	Female Clinicians working in ED residential setting as carers/ in a direct care provision. USA	10	100% female. Aged from 24-37. 40% mental health counsellors, 40% trainee social workers, 10% ABA trainee and 10% trained in business management. Employed for 5-24 months within that setting. Racial background of participants not reported.	Seven themes captured the clinicians' experience of working in ED: 1. Overall experience, 2. Challenges, 3. Relationships with clients, 4. Body satisfaction, 5. Social comparison, 6. Thin ideal, 7. Awareness, 8. The experience of co-workers
Loewy (1994)	Quantitative	To see if therapists hold stereotyped views differently depending on their specialism	Mental Health professionals (one group generalist, one group ED professional). USA	52	25 working in ED; 27 working in general mental health. In the ED specialist sample: 76% women and 24% men, 88% white, 50% had been obese, and some had relatives with obesity. ED specialists had on average 3.7 weight loss attempts and generalists had on average 1.2. The average amount of experience was 11 years, with a range of 2-30.	Professional's ability to retain information about people of different sexes and sizes was related to the target's characteristics rather than the presence of stereotype in/congruent information. Processing ability using the illusory correlation paradigm was only significantly different between thin women and fat men. ED Specialists made fewer errors than generalists. Professionals made fewer

						processing errors on the illusory correlation paradigm when presented with a thin person in comparison to a fat person
Palmer (2015)	Qualitative	To find the experience of dance movement therapists working with ED.	Dance therapists working with in community and inpatient ED services. USA	5	100% female, Range of 1-40 years' experience.	Five themes were described dance therapists' experiences of working in ED: 1. Kinaesthetic awareness, 2. Countertransference, 3. somatic countertransference, 4. boundaries 5. therapists body image
Puhl et al. (2014)	Quantitative	To assess weight bias among professionals who specialize in treating ED and identify to what extent their weight biases are associated with attitudes about treating patients with obesity	Clinicians working in specialist ED services USA	329	92% women, 8% men, 95% were white, average age of 45.55, mean BMI was 24. 27% psychologists, 25% therapists, 14% dieticians, 13% social workers and the rest were psychiatrist, nurses, nutritionists, paediatricians, and professors. Average time working in their job was 16 years, 38% had previously experienced an ED, 23% were trying to lose weight, 42% had been teased about their weight, 20% had been treated unfairly due to weight and 14% had been discriminated against because of their weight.	Weight bias scores among ED clinicians, measured using the Fat Phobia Scale (3.16, SD= 0.47) indicated some anti-fat bias among ED professionals. 88% of participants felt confident to treat patients with obesity, but 56% of participants had observed colleagues making negative comments about patients with obesity. Compared with professionals with less weight bias, professionals with higher weight bias were more likely to attribute obesity to behavioural causes, have negative attitudes towards treating patients with obesity and perceived poorer treatment outcomes for these patients.

Rance, Moller & Douglas (2010)	Quantitative	Exploring recovered practitioners' experiences of working with ED	Counsellors with ED history working in ED services in the UK	7	100% female counsellors. ED work experience ranged from 2-17 years.	Three themes captured practitioners' experiences of working with ED: 1. Double-edged history, 2. Emphasis on normality and Selective attention
Shisslak (1988)	Quantitative	To explore the impacts of working in ED	Clinicians specialised in ED treatment. USA.	71	25% Psychologists, 3% psychiatrists, 4% physicians, 35% mental health nurses, 8% counsellors, 7% social workers, 10% nutritionists and 8% other. 82% women, 18% men. 84% white, 51% married 59% worked in a hospital. Average time working in ED was 3.06 years.	In a survey developed by the researchers, 28% of participants perceived themselves to be affected by their work with ED patients. In response to a questionnaire describing ED symptoms, 39% of the sample were categorised as binge eaters, 40% of the sample were categorised as "normal" eaters and 21% of participants had experienced bingeing, purging or anorectic symptoms during their lives. Participants across all three groups of eating style were impacted by their work. Participants who were impacted by their work noted increased awareness of their body and food, improved body image, and increased intake of "healthy" foods.
Toman (2002)	Quantitative	To explore the interaction between the client's BMI and the therapist's	Therapists (trainee clinical psychologists and medical doctors) working with ED in an inpatient unit	6	100% women, 3 trainee clinical psychologist and 3 medical doctors. Aged 24-34 years. Ethnicity not reported	Factor analysis was carried out on semi-structured interviews with clinicians discussing their relationship with a particular client. Subsequent ANOVA found

		countertransference reactions to them.				that relationships with higher weight clients were significantly more likely to be 'distant-confrontative' than lower-weight clients and. Relationships with lower-weight clients were significantly more 'close protective' than higher weight clients.
Walker & Lloyd (2011)	Qualitative	To explore the attitudes of health professionals towards treating clients with ED	Mental health professionals working in a mental health clinic in Australia	15	67% female and 33% males. 20% Psychologists, 13% medical registrars, 20% social workers, 27% mental health nurses.	Three themes captured clinicians' attitudes towards working in ED: 1. Attitudes of healthcare professionals, 2. Countertransference, 3. Barriers to providing treatment
Warren (2008)	Mixed Methods	To explore the experiences of ED clinicians' experiences of working with ED	Clinicians attending the multi-service ED association annual meeting in the USA	43	Experience of working with ED range 6 months - 31 years. 30% had more than 15 years of experiences. 50% of their current patients had an ED. 73% worked in private practise and 37% worked in hospitals, clinics, and educational settings. 9% men and 91% women, 95% White, 30% social workers, 18% counselling doctorate, 16% mental health counsellors, 9% psychologists, 9% nurses, 7% dieticians, 5% medical doctors, 6% other. Mean	Participants completed a questionnaire designed by the authors, measuring their experiences of treating ED. In the quantitative part of the analysis, 25% of participants had received comments from patients about their appearance, 46% of participants reported that comments occurred frequently or sometimes. Qualitative analysis of the surveys explored two superordinate themes: 1. effects on treatment providers and 2. Recommendations for trainees and other treatment providers

Table 2 quality appraisal of qualitative studies using the CASP Qualitative Checklist.

CASP Item	Ali (2022)	Bowlby (2007)	Levas-Luckman (2014)	Levy (2013)	Palmer (2015)	Rance (2010)	Walker & Lloyd (2011)
Clear statement of the aims of research?	Y[3]	Y	Y	Y	Y	Y	Y
Is a qualitative methodology appropriate?	Y	Y	Y	Y	Y	Y	Y
Was the research design appropriate?	Y	Y	Y	P	P	Y	P
Was the recruitment design appropriate?	Y	Y	Y	P	Y	P	P
Was the data collected in a way that addressed the research issue?	Y	P	Y	P	P	Y	Y
Has the relationship between researcher and participants been adequately considered	P	N	Y	N	P	P	N
Have ethical issues been taken into consideration	Y	P	Y	Y	N	P	Y
Was the data analysis sufficiently rigorous	P	P	P	P	Y	P	P
Is there a clear statement of findings	Y	P	P	P	P	P	P
Global rating	High	Moderate	High	Moderate	Moderate	Moderate	Moderate

[3] Key for interpreting table 2: Y: most or all of prompts met, P: prompts partially met, N: prompts not met

Table 3 quality appraisal of quantitative studies using JBI Checklist for Analytical Cross-Sectional Studies

JBI Item	Gorman-Ezell (2010)	Loewy (1994)	Puhl et al. (2014)	Shisslak (1988)	Toman (2002)
Were the criteria for inclusion in the sample clearly defined?	Y[4]	Y	N	N	N
Were the study subjects and the setting described in detail?	Y	Y	Y	N	Y
Was the exposure measured in a valid and reliable way?	Y	U	Y	N	Y
Were objective, standard criteria used for measurement of the condition?	N/A	Y	Y	N/A	Y
Were confounding factors identified?	Y	Y	Y	N	N
Were strategies to deal with confounding factors stated?	N	N	N	N	N
Were the outcomes measured in a valid and reliable way?	Y	N/A	Y	N	U
Was appropriate statistical analysis used?	U	Y	Y	U	Y
Global rating	High	Moderate	High	Low	Moderate

Table 4 Quality appraisal of mixed methods study using the Mixed Methods Appraisal Tool

Study	Criteria from the Mixed Methods Appraisal Tool[5]															
	1.1	1.2	1.3	1.4	1.5	4.1	4.2	4.3	4.4	4.5	5.1	5.2	5.3	5.4	5.5	Score
Warren et al. (2008)	Y	Y	Y	Y	Y	Y	Y	C	N	Y	N	Y	N	C	N	Low

[4] Key for interpreting table 3: Y= Yes, N= No, U= Unclear, N/A = not applicable

[5] Key for interpreting table 4: What each number corresponds to: 1·1, is the qualitative approach appropriate to answer the research question? 1·2, are the qualitative data collection methods adequate to address the research question? 1·3, are the findings adequately derived from the data? 1·4, is the interpretation of results sufficiently substantiated by data? 1·5, is there coherence between qualitative data sources, collection, analysis, and interpretation? 4·1, is the sampling strategy relevant to address the research question? 4·2, is the sample representative of the target population? 4·3, are the measurements appropriate? 4·4, is the risk of non-response bias low? 4·5, is the statistical analysis appropriate to answer the research question? 5·1, is there an adequate rationale for using a mixed methods design to address the research question? 5·2, are the different components of the study effectively integrated to answer the research question? 5·3, are the outputs of the integration of qualitative and quantitative components adequately interpreted? 5·4, are divergences and inconsistencies between quantitative and qualitative results adequately addressed? 5·5, do the different components of the study adhere to the quality criteria of each tradition of the methods involved? Y=yes. N=no. C=cannot tell.

Thematic synthesis

The thematic synthesis yielded four themes: 'A spectrum of attitudes, 'A change in perspective,' 'Unresolved issues and working in ED' and 'Navigating the body.' These analytical themes are further divided into descriptive themes, which are discussed in turn.

A spectrum of attitudes

Participants noted experiences of societal, peer and family messages influencing their attitudes to weight and shape, particularly body image. *E.g. "There is such an emphasis on being thin. The media plays a huge role in people's perception of body image. In magazines and on TV, everybody is very skinny.,"* (Bowlby, 2007, P. 59). Some clinicians found it difficult to move on from these influences, and some internalised them to varying degrees. For example, one study found that, on average, clinicians' desired body weight was lower than their actual weight (Gorman-Ezell, 2009) and ED clinicians had more weight loss attempts than their counterparts in other settings (Loewy, 1993). The internalisation of the thin ideal contributed to body image dissatisfaction and dieting behaviours. E.g. *"The media plays a big role, I think, but also, growing up, I was constantly told I was overweight and stuff like that, so it was ingrained in me that people must be thin."* (Levy, 2013, p. 60).

Clinicians felt that it was normal to have body image concerns: E.g. *"I think I feel the way that any person in the world would feel about their body - it is impossible to love your body*

*100% of the time" (*Levy, 2013, p. 54) and that it was ordinary to scrutinise and compare your body*, E.g. "We scrutinize and examine our own bodies, we scrutinize and examine, other women's bodies whether we like to admit it or not"* (Rance et al., 2010, p. 388). This dissatisfaction was often placed within the context of societal pressures to attain appearance ideals and the level of endorsement of diets. However, there was also a sense that body dissatisfaction exists on a spectrum of normal to pathological.

Other clinicians felt that they had healthy relationships with food, fewer body image concerns, and their weight and shape was not fundamental to their self-esteem: *E.g. "I enjoy eating and exercise, and I think I've always had a pretty healthy relationship with my body image and self-esteem."* (Levy, 2013, p. 53). Some clinicians had lived experience of EDs, and their attitudes had shifted towards weight inclusivity and body acceptance. For example, *"…recovery entails not taking that as who I am. A wrinkle is not me. A pound is not me. I am more than that"* (Bowlby, 2007, p. 69). Some participants were found to have disordered eating; for example, in Shisslak (1988), 49% of their participants were categorised as "binge eaters". Interestingly, Gorman-Ezell (2009) found that the clinicians in their sample had mild body image disturbance and low levels of disordered eating, indicating that the level of disturbance may vary from clinician to clinician.

Studies found professional weight bias. Puhl et al. (2014) and Loewy (1993) found that weight bias, although lower than that of professionals working in other settings, was present among ED clinicians. In Puhl et al. (2014), increasing weight bias was found to be associated with negative beliefs about treating obese people, increased attribution of obesity to behavioural causes and increased pessimism towards treatment outcomes

when working with people with obesity. In general, clinicians with lower BMIs (Body Mass Index) held more substantial weight bias than those with higher BMIs. However, clinicians who were trying to lose weight (who, on average, had BMIs of 27) also held more weight bias and stigmatising attitudes to obesity; this was explained by other studies showing that individuals with greater fear of fat show stronger weight bias (Swami et al., 2010).

Interestingly, Loewy (1993), using the Illusory Correlation Paradigm, found that although there were some biases when processing information about people with larger bodies, this was not related to the activation of stereotypes. In contrast with Puhl's (2013) findings, Loewy (1993) explained the lack of activation of stereotypes about larger people by the fact that many of their participants had been obese at specific points in their lives and hypothesised that stereotypes would have less impact on people with lived experience of obesity. Studies also showed clinicians endorsing weight-inclusive attitudes*, e.g. "Everyone's body is different; what we see in the media isn't normal" (*Levy, 2013, p. 59) and Puhl et al. (2013), most participants endorsed providing good-quality care to people with obesity and treating them with respect, despite the opposing views found among the same sample in this study. Despite these conflicting accounts, none of the studies directly measured whether clinician attitudes would impact therapeutic outcomes.

A Change in Perspective

Clinicians noted that working in ED had changed their attitudes to weight and shape. However, the quality of this change varied from study to study and within samples. In

quantitative studies, clinicians noted that they had taken a more weight-inclusive approach and begun to feel more confident in their bodies. Clinicians with more experience in EDs were also found to hold less weight stigma. E.g. *"I think being with the girls made me realize I'm happy that body image isn't an issue for me. I have my bad days, but it could be so much worse"* (Levy, 2013, p. 55). Clinicians also began to take a more critical view of dominant discourses in society because of their professional experience. Health at Every Size was a framework which clinicians adopted because of their professional work, *e.g. "Diet culture very much typically aligns with, "Oh, if somebody is in a smaller body, then they're automatically healthy, and if somebody is in a larger body, then they're automatically unhealthy," where the research behind Health at Every Size really disproves that"* (Ali, 2022, pp. 72-73). This demonstrates a change in individual beliefs and how shared cultural beliefs are shaped by working in an ED setting.

Clinicians with lived experience of EDs also noted new perspectives towards their ED because of their professional experience: E.g. "*I think my recovery has gotten stronger since working around eating disorders so much. I get it now; eating disorders are not glamorous or something to idealize. Life is not about weight."* (Bowlby, 2007, p. 58). However, some clinicians have noted that their body image was worse because of working in EDs. E.g. "One participant reported *feeling "huge and big' as service users were 'such small, tiny delicate things."* (Walker & Lloyd, 2011, P.387).

Clinicians became more aware of their own eating patterns and body image because of working in ED (Levas-Luckman, 2014; Levy, 2013; Rance et al., 2010; Shisslak et al., 1989; Walker & Lloyd, 2011; Warren et al., 2008). *E.g. "I've gained insight into my own issues*

with food through working in this field, and I have a healthier relationship with food as a result." (Warren et al., 2008, p. 37). Clinicians noted that their eating behaviours had changed since working in ED (Shisslak et al., 1989; Warren et al., 2008), with some clinicians intensely rejecting diets, e.g. *"I'll also go to an extreme of thinking it's not okay to eat healthy and eat more junk food in an effort to practice what I preach to clients about all food being okay. I lose sight of moderation and go to an extreme…"* (Warren et al., 2008, p. 37). Others made more intentional food choices based on nutritional knowledge (Levy, 2013; Warren et al., 2008), and a small minority (8%) experienced more disordered eating (Warren et al., 2008). Some clinicians compared their dietary intake to clients and experienced negative emotions if they perceived that they ate more than clients (Levy, 2013). E.g. *"If they were trying to gain weight while in the program, but I was eating more than them and trying to lose weight, what that meant about me."* (Levy, 2013; p 56).

Increased awareness of body image comprised greater awareness of food, more aware of their physical condition, more aware of their weight, more aware of feelings about their body and more aware of clothes and appearance (Shisslak, 1988) and more aware of other people's bodies (Warren et al., 2008), this was attributed to the focus of their work, e.g. *"The environment of an inpatient ED hospital naturally revolved around discussions of food and weight. Subsequently, this becomes a focus not just of patients but of staff."* (Levas-Luckman, 2014, p. 160). Clinicians' concerns about their appearances were often linked to concerns about their patients' opinions of them. Clinicians were particularly concerned about being perceived as larger-bodied. For example, *"Wow, what do they think of me? Are they thinking anything negative about how I look?"* (Levy, 2013, p. 56). Appearance concerns were also related to not wanting to impact patients negatively*: E.g.*

"Given her thin frame, fast metabolism, and small bladder (frequently having to use the restroom), Emily worried that other staff and patients might think she had an ED herself." (Levas Luckman, 2014 p. 139). Indeed, clinicians also expressed feeling watched by clients (Warren et al., 2008), which may have contributed to this heightened awareness.

Despite this, some clinicians with lived experience of ED noted that their attitudes to weight and shape had not been impacted by their professional experiences. Although there were few males in the studies' samples, one study found that men did not notice changes to their awareness of their body image following on from working in ED in comparison with female colleagues, which was attributed to body image concerns being more relevant to women due to societal pressures (Walker & Lloyd, 2011).

<u>Unresolved issues and working in ED</u>

Participants' pre-existing body satisfaction played a role in how their current body satisfaction was impacted by working in an ED (Levy, 2013; Rance et al., 2010; Shisslak et al., 1989), but there were mixed findings. Some studies found that clinicians with pre-existing concerns were less impacted (Rance et al., 2010; Warren et al., 2008), and other studies found the opposite (Levy, 2013; Shisslak et al., 1989).

Levy (2018) and Shisslak (1988) reported that higher levels of thin-ideal internalisation lived experience of an ED and history of dieting were predictive of being negatively impacted by work, *e.g. "the degree to which the concept of the thin ideal was internalized by participants was also a factor in how body satisfaction was affected." (*Levy, 20130, P.

73). On the other hand, other studies found that the clinicians were less aware of their bodies after working in ED and felt struck by how little they had been impacted (Rance et al., 2010; Warren et al., 2008). *e.g. I don't think it's [body image] altered … no, it [relationship with food] hasn't changed … my appetite hasn't changed"* (Rance, 2010, p. 385). This was interpreted in two ways: clinicians working through their body image concerns and professional knowledge bringing perspective or as clinicians in recovery claiming being "absolutely recovered" due to fears about being viewed as unfit to practice if they admitted to being impacted by the work, e.g. *"Thus, by emphasising just how little the work impacted them in terms of their own body image, weight and relationship with food, they were able to make a pre-emptive strike against any questioning of their fitness to practise."* (Rance, 2010, P.388)

Indeed, there was a narrative present within the reviewed studies that it is paramount to accept your body, work through your body image concerns and have food freedom to be an effective clinician and model 'good behaviour' to clients (Ali, 2022; Bowlby, 2007; Levy, 2013; Palmer, 2015; Walker & Lloyd, 2011). Poor clinician body image was seen to impact the therapeutic relationship, E.g. *"As a therapist, you are also a role model. How comfortable you are in your body…at least nonverbally, impacts your client." (Palmer, 2015, p.127)*. Clinicians were also mindful of 'practising what they preach,' and having unresolved body issues or disordered eating was seen as either irresponsible (Rance, 2010) or harmful to the therapist (Warren et al., 2008). Clinicians were aware of this narrative, but it felt unhelpful and unrealistic (Ali, 2022; Levy, 2013), *e.g. "Rose wanted to be "able to talk about it without feeling like I'm a bad therapist because…I think that [this is a] really unhealthy narrative."* (Ali, 2022, p. 74)

Navigating the body

Clinicians reflected on how they navigate their attitudes to weight and shape within clinical practice. For example, clinicians felt that their experiences of living in a society which highly values appearance and lived experiences of body image concerns or EDs helped them to feel a greater sense of empathy and understanding for their clients (Ali, 2022; Bowlby, 2007; Levas-Luckman, 2014). E.g. *"I get it from all angles. Eating disorders are just hell. It is going through hell and recovery is coming out to the other side."* (Bowlby, 2007, p. 57).

Clinicians noted how their bodies and their attitudes to bodies interacted with the therapeutic relationship (Palmer, 2015) and how their attitudes to weight, shape and eating emerged during therapy sessions (Ali, 2022; Bowlby, 2007; Levy, 2013; Walker & Lloyd, 2011), e.g. *"This sounds so terrible, but in a sense, I wish that I had the control that some of the girls with anorexia had"* (Levy, 2013, p. 52). Clinicians who experienced this endorsed reflecting on their attitudes after the session, e.g. *"If a client expressed feeling "gross, inadequate, or ugly and they were a similar shape as me, I would have to consciously bracket and process that later."* (Ali, 2022, p. 88). Furthermore, Toman (2002) found that countertransference reactions were related to the client's BMI. For example, clinicians were found to rate their relationships with low BMI clients as closer than high BMI clients. Low BMI clients elicited more anxious and caring reactions, whereas higher BMI clients elicited more hostility, aggression, and higher expectations. Clinicians working with higher-weight patients reported images of being crushed by their patients.

These all demonstrate the complex emotional responses clinicians experience in sessions related to the client's body size.

Specialist supervision, reflective practice, and training to address clinician weight and shape attitudes were felt to be necessary to avoid inadvertent harm to the patient and to help the clinician increase their awareness of dominant discourses about weight and shape (Ali, 2022; Bowlby, 2007; Levas-Luckman, 2014; Walker & Lloyd, 2011). Clinicians reflected on the dearth of training on this topic and the negative impact this may have on therapist skills and confidence. *"We do not give the clients adequate service not because we don't want to—we just don't have the training … we simply don't know what to do, "(*Walker & Lloyd, 2011, p. 387). In addition, clinicians reflected on how processing their weight and shape attitudes through supervision or training would help them to be more effective therapists (Ali, 2022; Bowlby, 2007; Levy, 2013). For example, bringing their bodies into the room was felt to be a valuable tool to acknowledge differences in bodies, experiences, and lifestyles, e.g. *"I'm somebody in a smaller body, and if I'm working with a client who's in a larger body, I want to make sure that the difference in our life experiences is being acknowledged and discussed." (*Ali, 2022) p. 76. Although other clinicians did not think discussing their own body or body image with a client was relevant, e.g. *"I've never been in the position to disclose, erm, and I don't know if I would or why I would."* (Rance et al., 2010, p. 386).

Several studies explored the relationship between weight and health (Ali, 2022; Levas-Luckman, 2014; Levy, 2013). Participants noted that their clients' external appearances met the societal standard of what a healthy body should look like despite being very

unwell. E.g. *"With some of the girls that didn't look very sick and who were my height, I found myself thinking, they don't look sick, they actually look good"* (Levy, 2013, p. 58). This potentially demonstrates the internalisation of narratives around healthy and slim (but not emaciated) bodies and health. Despite this, clinicians also endorsed messages from the Health at Every Size movement, showing that a clinician's therapeutic stance may be at odds with the dominant discourse about health and weight: e.g. *"Basically, somebody's body size, their weight, the type of body that they have does not determine health."* (Ali, 2022, p. 72).

Discussion

This review aimed to synthesise the current literature's findings on ED clinicians' attitudes to weight and shape and examine the quality of these studies. The review identified 13 studies that met the inclusion criteria. Research on this topic is scarce, comprising unpublished theses or broader clinician experience studies that incidentally delve into attitudes toward weight and shape. These studies reveal that individual experiences and professional contexts influence clinician attitudes toward weight and shape. They underscore the need for enhanced training and supervision to navigate better and address these attitudes.

Main findings

ED clinicians' attitudes to weight and shape

Clinicians in the included reviews noted being influenced by societal appearance ideals, with lived experiences of thin ideal media promotion and receiving comments from peers and family members (Ali, 2022; Levy, 2013). Clinicians had differing experiences of internalising the thin ideal and experiencing body ideals; in line with non-clinician samples, these areas caused more distress for some and were less important for others. Some of the studies' participants were clinicians with lived experience of EDs (Bowlby, 2007; Rance et al., 2010). The clinicians felt that it was normal to experience body image concerns given societal pressures and that these concerns can exist on a spectrum of normal to pathological (Levy, 2013; Palmer, 2015; Rance et al., 2010). Studies examined

clinicians' attitudes to weight, shape, and eating behaviours, with mixed findings. Some studies found clinicians had worked to challenge unhelpful attitudes to weight and shape and had improved their body image before starting work as an ED clinician, either through accessing support for an ED or other means of personal development (Bowlby, 2007; Rance et al., 2010). Other studies found that clinicians vary in their level of distortion, with eating and body image disturbance ranging from mild (Gorman-Ezell, 2009) to more pathological (Shisslak et al., 1989).

Quantitative studies found that weight bias does exist within ED clinicians but at a lower level than mental health professionals in other settings (Loewy, 1994; Puhl et al., 2013a). In Puhl et al. (2013a), increased weight bias was associated with more pessimism about treatment outcomes and attributing behavioural causes to obesity. However, in Loewy (1993), cognitive processing deficits about fat people did not relate to the activation of stereotypes. These findings were also further complicated by clinicians simultaneously endorsing weight-inclusive views; for example, in Puhl et al. (2013a), clinicians endorsed the belief that obese people deserve to be treated with respect and the knowledge that all bodies are different. This demonstrates a difference between implicit and explicit bias; when clinicians are required to connect with their values, they take a different stance.

The included studies also reported how working in ED changed clinicians' attitudes to weight and shape. Most of the participants across studies had used their learning to take a more critical view towards dominant discourses about bodies, improve their body image and become more intentional with their food choices (Ali, 2022; Bowlby, 2007; Levas-Luckman, 2014; Levy, 2013; Palmer, 2015; Rance et al., 2010; Shisslak et al., 1989;

Warren et al., 2008). However, a significant minority of clinicians had noticed worsened body image and more disordered eating (Shisslak et al., 1989; Warren et al., 2008). In addition, some clinicians reported increased awareness of their physical bodies and thoughts about their bodies, although the valence of impact depended on the clinician. The studies found conflicting results on what might predict how that work impacts clinicians. Some studies found that clinicians with pre-existing concerns were less impacted (Warren et al., 2008), and others found the opposite (Levy, 2013; Shisslak et al., 1989). This could be explained in several ways; some clinicians may have engaged in personal therapy and self-reflection about their body image, which may have helped them feel more secure in their bodies; others may not have processed these issues yet and so found themselves impacted by their work. Another interpretation may be that, given the narrative that one must feel secure in one's body to work in ED (Ali, 2022; Bowlby, 2007; Levy, 2013; Palmer, 2015; Walker & Lloyd, 2011), clinicians may have felt pressured not to admit to residual body concerns out of fear that their fitness to practice is questioned (Rance et al., 2010). Clinicians were aware of this narrative, felt that it was unhelpful (Ali, 2022; Levy, 2013), and expressed that there is a lack of opportunities for them to process their own weight and shape beliefs within their clinical practice (Ali, 2022; Bowlby, 2007; Levas-Luckman, 2014; Levy, 2013; Walker & Lloyd, 2011).

Clinicians were aware of their weight and shape attitudes emerging within direct work with clients; for example, they sometimes felt envy towards the client and were conscious of their bodies because of session content (Ali, 2022; Bowlby, 2007; Levy, 2013; Palmer, 2015; Warren et al., 2008). Toman (2002) also found that lower-weight patients elicited a more anxious, caring reaction from clinicians, while higher-weight

clients elicited more distant, confrontative countertransference reactions. Supervision was felt to be a helpful avenue to explore these thoughts and feelings, and clinicians were mindful of the potential for harm to the client if their countertransference remained unchecked (Ali, 2022; Bowlby, 2007; Levas-Luckman, 2014; Walker & Lloyd, 2011).

Narratives around health and size emerged through the synthesis of studies. For example, clinicians had internalised the belief that a slim body would be a healthy body, and this expectation was often violated when seeing ED patients in the healthy BMI range who may have a conventionally attractive body (Ali, 2022; Levas-Luckman, 2014; Levy, 2013). Clinicians also reflected on how size does not necessarily correlate with health; this pertained to challenging the standard narrative that people with obesity are inherently "unhealthy" because of their size (Ali, 2022; Levy, 2013) and also reflecting on how slimmer people may be assumed to be healthy given their external appearance, but in reality, they may be engaged in dangerous behaviours, such as purging and restricting or have other health complications related to their ED (Levas-Luckman, 2014; Levy, 2013).

Methodological issues of included studies

Most studies in this review were of poor to moderate quality, although the evidence from five was deemed high quality. A key contributing factor was not acknowledging and not reporting on strategies used to manage confounding variables in quantitative studies, which increases the risk of drawing incorrect conclusions about the relationships between variables. For example, Toman (2002) and Shisslak (1988) did not discuss confounding variables during their analysis. Gorman-Ezell (2009) raised issues with

participants being unclear on how to respond to a questionnaire and thus a possibility that there was variability in how the measure was completed amongst participants. Puhl et al. (2013) discuss attrition rate, and Loewy (1993) raises therapist's education level and socioeconomic status as confounding variables. However, none of these papers discuss measures used to manage these. This means that inferences made from the results of these studies must be taken cautiously. Whereas among qualitative studies, the most common issue was reflection on the researcher's position. In three of the studies, this was not mentioned (Bowlby, 2007; Levy, 2013; Walker & Lloyd, 2011). Ali (2022), Palmer (2015) and Rance (2010) briefly discuss using various techniques, such as reflexive journals, bracketing and epoché, but do not disclose what arose from these reflections or how they may have been biased or influenced the research process. Thus, there is a possibility that the credibility, dependability, and transferability of the findings may have been jeopardised.

Despite recruiting suitable samples for the research question regarding participant profession, most study participants were White, female and from the USA. Therefore, findings may not be entirely generalisable and suggest that recruitment should include broader outreach. It was unclear how articles dealt with social desirability; this may have important implications given the topic's sensitivity. For example, respondents may not have been entirely candid in their responses in interviews and surveys. Studies also did not distinguish between implicit and explicit bias. It makes sense that, on a conscious level, clinicians would endorse weight-inclusive views and be critical of a dominant discourse given the values underpinning healthcare professions. However, this does not account for automatic judgments often made at the pre-conscious level.

The quantitative studies included in this paper were all cross-sectional analytic designs, and there were no studies with experimental designs. While cross-sectional analytic studies have strengths, they come with limitations compared to experimental designs. For example, it is only possible to establish causality with randomisation, it is difficult to control for confounding or extraneous variables, and the findings are limited in generalisability to other populations or contexts.

Many studies implied that unchecked weight and shape attitudes (weight bias or clinician body image concerns) may impact treatment outcomes; however, none of the studies tested for this. Anti-fat bias has been found in the literature to negatively impact mental health outcomes (Pearl & Puhl, 2018). In the racial equality literature, reducing implicit bias has been found to influence non-verbal communication and increase patient satisfaction (Dovidio et al., 1997; Penner et al., 2010). Thus, it would follow that the same would apply to anti-fat bias. However, the researcher is unaware of any studies that have tested how clinician body image impacts therapeutic outcomes. Although evidence from the patient's perspective shows that staff with unchecked beliefs can behave in a way that causes distress to the patient (Moore, 2022), there is a lack of research showing a statistical relationship between weight bias or clinician body disturbance and poor outcomes. Given the narrative regarding staff needing to resolve their concerns to work in ED and the pressure this puts on clinicians may impair their ability to reflect honestly about their beliefs, it is essential to examine this. This demonstrates a need for more robust study designs in this area to supplement and draw more definitive conclusions from the existing findings.

Strengths and limitations of review

This review has contributed to understanding ED clinicians' attitudes to weight and shape. The inclusion criteria were broad and permitted studies of any design which studied or reported on ED clinicians' attitudes to weight and shape. This included unpublished theses, which enabled a wide range of results to be considered and reduced the risks of the results having a positive data skew or confirmatory narratives in qualitative research, given publication bias. The databases used in the search were highly relevant to the review topic, thus increasing the likelihood of capturing relevant studies. Using a secondary reviewer to screen a percentage of papers and review the methodological quality enhanced the reliability of the review, and the high inter-rater reliability attained signifies the feasibility of replication.

A limitation of this review is that just over half of the inferences are drawn from poor—to moderate-quality papers and qualitative studies with small sample sizes, therefore the recommendations from this review should be taken with caution as findings may have been different if the studies were of higher quality. The reviewer recommends that the findings from this review are backed up with more rigorous research using experimental designs and larger sample sizes. Approximately half of the papers included in this review were unpublished theses. Although these papers were deemed moderate to high quality, this demonstrates a lack of studies investigating ED clinicians' attitudes to weight and shape within the peer-reviewed literature. Furthermore, only two of the studies (Ali, 2022; Levas-Luckman, 2014) were released in the past ten years, so there is a possibility that this review may not represent current views amongst ED professionals. The reviewer

opted to search only two databases due to the number of results generated from two searches and the scope of the review. However, there is a possibility that, by limiting the search to two databases, relevant papers were not included. In addition to this, although it is a strength that PsychInfo included grey literature in the search, no specific grey literature search was carried out by the reviewer. This is a limitation to the review as, given most of the sample counted as grey literature, not doing a specific grey literature search may have caused relevant papers to be missed.

Clinical implications

The findings from this review provide insight into ED clinicians' attitudes to weight and shape. However, clinical implications must be viewed considering these limitations. This review was unique in that it examined ED clinicians' attitudes to weight and shape more generally rather than examining weight stigma specifically, which has been the case in other reviews (Panza et al., 2018). This review has found that clinicians have varied and complex beliefs regarding weight and shape, further impacted by ED work. Findings regarding the lack of training on navigating weight and shape attitudes and narratives that clinicians must resolve all their weight and shape concerns before starting work in ED demonstrate the need for this topic to be included in training, supervision, and reflective practice.

Future research

This review recommends replicating existing studies with underrepresented participants, such as people from the Global Majority and men. Given recent efforts to widen access to clinical training courses and to diversify the clinical workforces and the differing beauty standards for men and people from the Global Majority, it is crucial to understand any differing views which may arise from staff coming from a diverse cultural viewpoint.

Given the findings in this review around how working in a particular setting shape pre-existing cultural and individual beliefs about weight and shape, this review also recommends future research investigating how this intersection between cultural beliefs about weight and shape and working in ED plays out within a therapeutic setting. Particularly how clinicians experience this and how clinicians make sense of it. Furthermore, future research investigating the impact of confounding variables found within the papers in this review is recommended. Rigorous, experimental studies should be undertaken to determine the factors that may impact how clinicians are impacted by their work, such as pre-existing attitudes to weight and shape. In addition, paradigms that may reduce the impact of social desirability, such as the Implicit Association Test, should be used to determine what potential unconscious and unconditioned attitudes may exist within ED clinicians.

Conclusions

This review synthesised the available empirical research evaluating ED clinicians' attitudes to weight and shape. The evidence base regarding this topic is limited, with many of the relevant articles being unpublished theses or studies exploring clinician experience more generally but discovering weight and shape attitudes as part of the analysis. The findings suggest that clinicians bring a variety of attitudes to weight and shape depending on their unique experiences as individuals and are also impacted by their work to varying degrees. There is a need for more training and supervision on making sense of weight and shaping attitudes. More rigorous research is needed to explore the factors that may increase the risk of harm to clinicians and patients and the actual impact on outcomes of said attitudes.

Chapter 2: Empirical Paper

How do weight and shape attitudes emerge in therapy? Clinician reflections from eating disorder treatment

Abstract

The thin ideal, diet culture and weight bias are highly normalised within society, which can lead people to experience body image concerns or make assumptions about others based on their body size. As treatment providers in Western cultures receive the same messages around thinness and beauty, therapists bring their beliefs and subjective experiences of weight and shape concerns to the therapy room (Warren et al., 2008). This may affect the therapist or the dynamic within the therapeutic relationship. The phenomenological element of how therapists bring and experience societal narratives regarding body size remains unexamined. Understanding the therapist's experience in greater detail will add to the knowledge about how clinician attitudes to weight and shape impact the therapeutic relationship.

To explore this, semi-structured interviews were conducted with eight clinicians providing psychological interventions within ED services. The interviews were analysed using Interpretative Phenomenological Analysis (IPA). Four superordinate themes were identified: 'Clinician understanding of diet culture and appearance ideals,' 'Therapist experience of the narratives, 'The impact of working in an ED service', and 'Clinician experience of delivering ED therapy.' The clinicians discussed their experiences of internalising the thin ideal during their lives while simultaneously endorsing weight-inclusive attitudes. This was understood to help clinicians empathise with their patients but also created an urge to do more for them. Clinicians were self-aware that they may hold some explicit bias and endeavoured to check their countertransference reactions. However, clinicians discussed the lack of opportunities to reflect on weight and shape

within their clinical practice. These findings are explored in relation to the existing literature and the implications for policy and practice within ED settings.

Introduction

Eating disorders (EDs) are complex mental health difficulties characterised by a preoccupation with food, weight, and shape and one or more disordered eating behaviours (e.g., restricted eating, binge eating, self-induced vomiting). The treatment of ED is complex and typically requires a multidisciplinary approach (NICE, 2019). Treatment efficacy is modest, with remission between 40-60% (Monteleone et al., 2022). The therapeutic alliance is associated with favourable outcomes in the treatment of EDs (Graves et al., 2017). Clinicians can perceive EDs to be 'difficult to work with' (Warren et al., 2013), and there is a high dropout rate from treatment, with up to 50% of patients discontinuing therapy early. This is partially due to the patient's ability to engage with treatment but may also be related to clinician behaviour (Masson & Sheeshka, 2009). Little is known about facilitators and obstacles to the therapeutic process (Sibeoni et al., 2020); however, given the overvaluation of weight and shape within EDs, appearance ideals may intersect with the therapeutic process.

Appearance ideals, weight stigma and diet culture

Appearance ideals are defined as a socially constructed set of standards which define beauty (Stice et al., 1994). In Western culture, appearance is highly valued, and the most attractive characteristics are often portrayed in the media and perpetuated via other methods of socialisation, such as via families and peer interactions (Thompson et al., 1999). This means the appearance ideal becomes a cultural norm (Buote, 2011). Several characteristics comprise the beauty ideal, and the focus here will be body size. The

appearance ideal regarding body size has changed over time; however, for women, thin bodies are deemed ideal, and for men, the lean muscular appearance is ideal. For both genders, larger, softer bodies are denigrated (Hoff & Hancock, 2022). This denigration of larger bodies can lead to weight stigma, specifically fatphobia, which comprises stereotypes that larger-bodied people are lazy, unattractive and lack motivation (Puhl & Suh, 2015). Fatphobia results in marginalisation and systemic inequalities, which have negative implications for financial attainment and physical and psychological health (Fikkan & Rothblum, 2011). Diet culture is seen to be a consequence of the thin ideal and associated weight stigma (Puhl & Suh, 2015). It describes the cultural practice of weight loss dieting, specifically calorie restriction to induce weight loss and the attribution of moral qualifiers to food and body characteristics (e.g. low calorie= good; high calorie=bad) (Jovanovski & Jaeger, 2022). A more in-depth review of this topic can be found on pages 14-17 of this thesis.

Several psychological frameworks can be applied to explain how body image disturbance and ED behaviours may emerge because of socialisation. Here, the Tripartite Influence Model (Thompson et al., 1999) will account for how the thin ideal is perpetuated throughout society. Objectification theory (Fredrickson & Roberts, 1997) will account for the psychological mechanisms through which external influences manifest in individuals' thoughts, feelings, and behaviours regarding their bodies.

According to the Tripartite Influence Model (Thompson et al., 1999), society and culture dominate people's attitudes and beliefs, specifically around the importance of appearance. Socio-cultural pressure from the media, peers, and family will cause

individuals to compare themselves and others against the ideal. Society's denigration of overweight people may contribute to anti-fat attitudes or unfavourable self-comparisons against the thin ideal, which may lead to experiencing weight and shape concerns or engaging in disordered eating. This theory differentiates between the impacts of awareness of the ideal and internalisation of the thin ideal (i.e. personal acceptance of it), with the internalisation of the thin ideal being more predictive of weight stigma and disordered eating behaviour than awareness alone, regardless of body mass index (BMI) (Vartanian et al., 2007). This demonstrates that individuals across the weight spectrum are vulnerable to being impacted by society's attitudes to weight and shape. However, it also helps to account for the fact that not all people develop EDs following media exposure.

According to Objectification theory (Fredrickson & Roberts, 1997), experiences of comments about one's appearance or media exposure can lead individuals to view themselves as objects to be evaluated based on appearance, otherwise known as self-objectification. Specifically, people take a third-person view of themselves and place more value on how they look to others rather than how they feel. This is due to an internalised belief that their worth depends on how closely their body fits the ideal. This then leads to chronic body self-surveillance in anticipation of being objectified by others, which in turn results in body shame and identity and interoceptive deficits. Such experiences can contribute to poor psychological well-being, depression, anxiety and EDs. This approach moves past the simple internalisation of the thin ideal. It describes EDs as a response to people's feelings of powerlessness to control the systematic objectification of their bodies (Calogero, 2012).

Studies have found self-objectification to be linked to body dissatisfaction, dietary restraint and binge eating (Dakanalis et al., 2014). Exposure to media, peer and family influences has also been found to drive appearance comparisons, pursuit of thinness and ED behaviours (Rodgers et al., 2011). Objectification Theory and Tripartite Influence Model of EDs were initially focused on describing women's experiences, and most studies have tested them using female samples. However, studies have found that they can be adapted and applied to explain how people of all genders, including men, gender non-conforming and transgender people, experience appearance ideals and how this can relate to EDs (Schaefer & Thompson, 2018; Strübel et al., 2020).

As treatment providers in Western cultures receive the same messages around thinness and beauty, therapists bring their beliefs and personal experiences of weight and shape concerns to the therapy room (Warren et al., 2008). ED clinicians exist in a unique position where bodies are the focus of their work environment. Patients' bodies are monitored when treating EDs (e.g., weighing during appointments and weight restoration). However, clinicians also report receiving patient comments regarding their body size (Warren et al., 2008). This indicates that the focus on body size and weight may foster a milieu where both patient and clinician feel “looked at”, potentially resulting in self-objectification. However, many ED treatment targets are at odds with the dominant discourses that regulate bodies and identities within society, such as body image and self-evaluation work in CBT for EDs (Fairburn, 2008). Therapists may be helping people to question or reject the thin ideal in their professional work with EDs, but this sits alongside their own exposure to societal beauty standards and possible internalisation of these. This may affect the therapist or the dynamic within the therapeutic relationship.

Countertransference and the Therapeutic Relationship

The therapeutic relationship comprises the co-constructed interactional sequences between therapist and client (Leahy, 2007), their reactions to one another and information about how past relationships influence the current problem (Leahy, 2008). The client's reaction to the therapist is commonly known as transference (Cartwright, 2011). Transference is conceptualised in several ways; most models of transference agree that they encompass the client projecting beliefs developed from past experiences and relationships onto the therapist; this reaction has emotional, behavioural, and motivational components which play out in the therapy room (Cartwright, 2011). The therapist's reaction to the client is commonly defined as countertransference. Much like transference, countertransference has been conceptualised from multiple perspectives. In general, it is seen to be the therapist's thoughts and feelings about the client, reactions stemming from the client, and the clinician's own experiences and beliefs about themselves and others (Cartwright, 2011).

Therapists working with EDs have complex reactions towards their patients based on a variety of clinician and patient factors, such as gender, patient functioning, personality styles and attitudes towards EDs (Satir et al., 2009). For example, therapists can hold negative stereotypes of ED patients, such as the belief that they are vain and manipulative (Reas, 2017). The elevated levels of physical and suicide risk within this population can result in clinician anxiety, and the workload associated with monitoring said risk can contribute to feelings of exhaustion (Warren et al., 2008). In addition, many patients highly value elements of their ED, and recovery can prove elusive, which can

impact patient engagement, further eliciting feelings of frustration, anger, and hopelessness within ED clinicians (Graham et al., 2016).

It is also possible that clinicians have countertransference reactions to ED clients related to their own beliefs about weight and shape. Psychodynamic thinking posits that the body has a representative function in therapy and that we form assumptions about others based on our bodily history and narratives (Erb, 2020). Thus, it follows that clinicians' socialisation experiences with appearance ideals could play some part in their reaction to the client and the client's body. How the therapist makes sense of that will be determined by their socialisation experiences relating to bodies. Cultural countertransference (Foster, 1998), originally used to describe cross-cultural therapeutic dyads, can provide a framework to understand how clinicians may experience the above social narratives around weight and shape in therapy. According to this framework, cultural countertransference comprises cultural values, academically informed theoretical beliefs, personally driven idealisations about groups and biases about the self.

Cultural values involve understanding oneself and one's place in the world, informing how clinicians define pathology and functioning. This can be linked to the awareness and internalisation of the thin ideal, as stated in the Tripartite Influence Model (Thompson et al., 1999) and Objectification Theory (Fredrickson & Roberts, 1997). Academically informed theoretical beliefs demonstrate how broader cultural values influence the educational and academic setting. For example, psychology textbooks often portray the 'obesity as a disease' point of view and do not consistently acknowledge research

demonstrating the ineffective nature of dieting (McHugh & Kasardo, 2012). This illustrates how broader cultural values influence the educational and academic setting.

Idealisations about other groups may comprise the assumptions people make about others depending on body size, such as weight-based stereotypes (e.g. people with obesity are lazy). Finally, the biases about the self may comprise the countertransference reactions arising from the therapist's identity being denigrated, e.g., their own actual or perceived deviation from the beauty standard. Disciplines such as psychology and clinical settings are key settings where dominant discourses can be perpetuated (Foucault, 1973). Furthermore, research has found that countertransference reactions in ED treatment working in a culture which endorses dietary restriction has been described as challenging and is thought to contribute to clinician burnout (Warren et al., 2012). As clinician burnout has been found to be detrimental to clinical outcomes (Maslach & Leiter, 1996), it is essential to investigate how these narratives play out in a therapeutic setting.

Clinicians having anti-fat biases can adversely affect the quality of care (Puhl & Suh, 2015) and research has already demonstrated that clinicians' weight, shape and eating beliefs impact clinical decision-making (Phelan et al., 201b). Medical professionals are more likely to forego medical testing and attribute health problems to body size if their patient is obese (Drury & Louis, 2002). In other studies, patients with a "healthy BMI" were deemed as being 'less sick' (Levy, 2013) despite findings that ED patients who are not underweight can experience similar life-threatening complications as underweight patients (Veillette et al., 2018). This demonstrates that clinicians are vulnerable to

making erroneous decisions on health based on an internalisation of overly simplistic cultural narratives about body size, which may have implications for clinical outcomes and patient safety.

Some clinicians working with EDs have lived experience of body image disturbance or an ED. Evidence shows that clinicians bring this experience with them, and it can play out in therapy in different ways and can impact the outcomes. In one study, it was suggested that distorted attitudes towards eating, weight and shape might indirectly contribute to feelings of hopelessness towards ED clients (Gorman-Ezell, 2009). Research has shown that hope is essential to good treatment outcomes in ED (Fogerty & Ramjan 2016). Therefore, clinicians' distorted beliefs may be detrimental to their ability to engender hope within their treatment, which may render the treatment less effective. Other studies reported that clinicians with lived experience of ED had elevated levels of empathy towards their clients due to their insight into their patients' difficulties (Rance et al., 2010). Clinicians also reported wanting to model healthier attitudes towards weight and shape. This encouraged them to be mindful of their unhelpful cognitions and to reject ideas from the diet culture narrative which had perpetuated their disorders (Ali, 2022). This demonstrates that clinicians can be aware of the ideal but may not wholly internalise it or may be able to resist it, thanks to the knowledge gained from working with this population. Therefore, critical awareness of beliefs can help clinicians make more helpful choices, whereas a lack of awareness that your beliefs are distorted may create a sense of hopelessness which may be detrimental to treatment.

Unexamined countertransference may harm the client, although little is known about how and when countertransference occurs with ED patients (Moore, 2022). For example, unchecked countertransference may rupture the therapeutic relationship by hurting the client or may trigger negative self-schema within the therapist, contributing to burnout (Cartwright, 2011). Furthermore, therapists can use compensatory and avoidant strategies to respond to countertransference (Leahy, 2008) and overidentification with clients may make it difficult for therapists to challenge clients' unhelpful beliefs (DeLucia-Waack, 1999). Indeed, countertransference reactions, particularly a heightened sense of responsibility for the patient has been found to contribute to therapist burnout (Warren, 2013). This demonstrates that clinician beliefs playing out in the therapy room may negatively impact the patient and the clinician, highlighting the importance of investigating this topic.

Implicit weight bias has been found to significantly impact patient-provider outcomes (Hall et al., 2016) and is associated with 19% higher risk of patient non-adherence to their treatment and higher feelings of mistrust towards clinicians (Phelan et al., 2015b). ED patients of all sizes experience discrimination and micro-aggressions within the therapeutic space. For example, higher-weight women have reported that clinicians wrongly attributed their psychological distress to large body size and being prescribed weight loss as a means of 'fixing' their mental health difficulty (Moore, 2022). Adolescents receiving inpatient care for anorexia nervosa have also reported feeling as though clinicians viewed the patients as 'all the same' and having their behaviours described in terms of anorexia only, with little attention being paid to their unique experiences as people (Sibeoni et al., 2020). This demonstrates not only the internalisation of the diet

culture narrative but also the objectification of both obese and very underweight clients on the part of the clinician. Furthermore, these experiences may have caused a rupture in the relationship, potentially engendering a feeling of mistrust or psychological distress.

Despite the complex emotions that clinicians experience when working with EDs, clients with EDs experience the therapeutic relationship as playing a significant role in their recovery (Zaitsoff et al., 2015). The lack of compelling evidence for any therapy over another in treating EDs (Monteleone et al., 2022) indicates that the therapeutic relationship is the default active ingredient in the treatment of ED. More generally, the therapeutic alliance has been found to mediate therapeutic outcomes in 70.3% of cases, regardless of the modality used, further highlighting the therapeutic alliance's importance (Baier et al., 2020). Despite this, evidence suggests that unhelpful therapist about weight and shape beliefs may be detrimental to the therapeutic relationship.

Indeed, qualitative research has found that BMI can predict clinician's countertransference reactions. For example, Toman (2002) found that clinicians felt more anxiety, more closeness and more caring towards lower BMI patients and felt more fear of the patient, more distance, more aggression and higher expectations with higher BMI patients. Studies have also found that clinicians can experience complex reactions when working with very thin clients, such as experiencing body image concerns themselves (Warren et al., 2008). Some clinicians may also identify with or admire the 'self-control' associated with dietary restriction in patients with anorexia nervosa (Levy, 2013) or may feel envy towards the patient's body (Bowlby, 2007). These findings may demonstrate how cultural beliefs may play out within the therapy room and impact the

therapist's wellbeng. Both of these things may then impact the therapist's behaviour towards the client, the quality of the therapeutic relationship and ultimately the treatment's efficacy.

The phenomenological element of how therapists bring and experience societal narratives regarding body size while treating people with EDs remains unexamined. Understanding the therapist's experiences in greater detail will add to the knowledge about how clinician attitudes to weight and shape impact the therapeutic relationship and clinicians' well-being. Everyday societal discourse may influence their emotional and cognitive reactions to patients. This idea is supported by the finding that clinician responses to clients vary systematically and predictably based on the client group (Cartwright, 2011).

Aim

The current project aims to explore how clinicians' beliefs about weight and shape are present in the therapeutic relationship during ED treatment. NHS Clinicians providing psychological interventions to people experiencing EDs will be interviewed on the above topic to establish common themes relating to their experiences. The transcripts will be analysed using Interpretative Phenomenological Analysis (IPA).

Research Questions

1. How do clinicians' attitudes towards weight and shape emerge during therapy sessions, and what impact does this have on the therapeutic relationship
2. How do clinicians working with people experiencing EDs make sense of socially constructed narratives about eating, weight, and shape?

Method

Design

A qualitative methodology was used, with a semi-structured interview to help explore participants' experiences and IPA to interpret the qualitative data.

Ethics

The research was granted ethical approval by the Royal Holloway University of London Ethics Committee (REC Project ID 3826) on 14th August 2023 (see Appendix A). Although the participants were NHS staff, further approval from the Health and Research Authority within the NHS was not required because NHS staff were recruited due to their professional role, no sensitive or patient information was collected, and no NHS resources were used (see Appendix A). The Trusts' R&D departments reviewed the research and provided consent for the researcher to recruit staff members. Email or verbal confirmation of approval from each participating site was received between March and October 2023 (see Appendix B). For participating in the study, the participants were entered into a £100 prize draw. Given that the participants were recruited from busy NHS services, and the ask of completing reflective logs and attending an interview where the topic was personal was felt to be high, it was felt that recruitment may be challenging without a financial incentive. As the amount on offer was felt to be relatively low and the researcher also worked as a clinician in the NHS, the risk of coercion or an untoward power dynamic commonly associated with paying participants was felt to be low.

Recruitment

Participants were recruited from two specialist ED services and one IAPT ED treatment pathway based in Greater London. These sites were chosen as they were known to the researcher. Multiple sites were approached to maximise recruitment potential; due to the length of the interview and the personal nature of the topic, it was felt that some clinicians might be reluctant to take part. Purposive sampling was used, whereby the recruitment poster (Appendix C) and a participant information sheet (Appendix D) were presented in relevant team meetings and displayed in common areas to generate expressions of interest. The inclusion criterion was any clinician providing psychological interventions to people with ED, regardless of banding, including trainee psychologists/psychotherapists. Clinicians not providing psychological interventions were excluded from the study, as were peer support workers. The sample was limited to clinicians providing psychological interventions for three main reasons. First, much of the prior research was carried out with clinicians from multiple disciplines, with fewer studies examining the perspective of psychological therapists. Second, psychological therapists are trained in ED therapies and processes around the therapeutic alliance/transference in a way that other professional groups may not (e.g., peer support workers). Thirdly, IPA is best carried out with a homogenous sample; thus, including staff members who do not provide psychological interventions may have provided a distinct perspective, which would not have suited this analysis. Furthermore, as the researcher had previously worked in one of the IAPT services and was currently on placement in one of the specialist services, any potential participants with a close personal relationship to the researcher were excluded to minimise conflict of interest.

Procedure

Once the recruitment poster and information sheet had been disseminated to the identified teams, potential participants were asked to contact the researcher directly via email to express interest in participating. Informed consent was obtained by the participants reading the participant information form, reviewing, signing, and returning the consent form. The participant information and consent forms included detailed information regarding what the study would involve, confidentiality and anonymity, the data storage plan and participants' ability to withdraw (see Appendices D and E). Participants chose whether to meet remotely via Microsoft Teams or in person on Royal Holloway's Campus in Egham. All participants opted to interview Microsoft Teams. All eight interviews took place between November 2023 and January 2024. Interviews were audio recorded via Microsoft Teams and transcribed by the researcher. To ensure anonymity, interviews were only accessible to the researcher and stored separately to consent and demographic forms (Appendix F).

Demographic forms were emailed to participants before the interview. The researcher checked informed consent before the interview, checking the participants' understanding of the study and providing another opportunity to ask questions. The researcher reiterated the limits of confidentiality regarding risk and safeguarding.

Interviews were anticipated to last between 45 and 60 minutes, but two took longer than this, with the total time range being between 43 minutes and two hours and seventeen minutes. The longest interview took place in two sittings due to time constraints. In one

interview, the researcher and participant experienced poor internet connection, meaning both parties were ejected from the call or experienced poor sound. This was managed by both parties turning off their camera and repeating what they had most recently said to minimise data loss. Some interview recordings included moments where the sound was unclear or dropped; this was noted in the transcription.

For participating in the study, the participants were entered into a prize draw for a £100 voucher. A debrief information sheet (see Appendix G) was emailed to participants post-interview, providing another summary of the research, contact details, and a list of website links and resources to support clinicians.

Materials

A semi-structured interview schedule was created by reviewing the existing literature and through discussion between the researcher and supervisors. Smith et al. (2009) was used to guide the development of the questions so that they were appropriate for IPA. Given the interest in societal narratives, socialisation and internal phenomenon, Tripartite Influence Model (Thompson et al., 1999) and Objectification Theory (Fredrickson & Roberts, 1997) were used to inform the interview's direction and question themes. A template for an optional reflective log was also developed for participants to document in real time the thoughts, images, and emotions they experienced during therapy sessions leading up to the interview. This form was optional so as not to overburden the participants, so the researcher did not collect it for analysis. During the draft phase, one psychologist working in an ED service and two former service users of

the same service were consulted on the interview schedule and the reflective log. They were asked to advise on their understanding of the questions, views on the format, wording and depth and breadth of questions. The feedback was then discussed between the researcher and supervisors, resulting in the addition of some prompts to consider intersectionality, removal of jargon or confusing terms and changing the order of some of the questions. The service users were reimbursed for their contribution (see Appendix L).

The final interview schedule (see Appendix H) was designed to be open-ended. The interview consisted of ten questions exploring the clinicians' relationships to their bodies, their experiences of societal narratives around shape and weight, how these are present in therapy, and finally, their experience of the therapeutic relationship with working with ED. A demographic questionnaire about age, gender, ethnicity, and professional experience was also developed to describe the sample; this information was not used quantitatively.

Sample

The sample consisted of eight clinicians working within two specialist ED services. The researcher received no volunteers from the IAPT ED treatment pathway. In total, 12 people volunteered to participate, 10 of whom were eligible. Eight participants were selected on a first-come, first-served basis, with the additional two volunteers waitlisted in case of dropout. The two individuals who were not eligible were excluded because they did not provide psychological interventions to people with ED. No participants dropped out of the study after volunteering to participate.

A sample size of eight was selected in line with the study's aim and the IPA analysis method to provide an in-depth case-by-case analysis of individual experience and investigate the similarities and differences within a group (Pietkiewicz et al., 2014). IPA studies can be published with various sample sizes, but clinical psychology doctoral programmes in Britain recommend a sample size of between four and ten (Turpin et al., 1997). Many qualitative studies use data saturation to characterise sample size sufficiency (Vasileiou et al., 2018). However, it is not typically a process used in IPA data collection (Brocki & Wearden, 2006); therefore, this as a metric was not used for deciding on sample size.

To contextualise the sample and facilitate consideration of the transferability of findings, participant demographic information is provided in Table 5. All the participants were White, four were White British, two were White Irish, and two were of mainland European origin. Age was collected via age brackets rather than specific age; six participants were between 25 and 34, and two were between 35 and 44. The mean length of time working with ED was 2.45 years. The CBT therapists, trainee clinical psychologists and counselling psychologists practised Cognitive Behavioural Therapy for Eating Disorders (CBT-E) and the briefer 10-session CBT for EDs (CBT-T). The psychology practitioners and assistant psychologists practised CBT-T and Guided Self-Help—seven participants identified as female; one participant identified as male. The participants have been given a pseudonym to ensure confidentiality.

Table 5

Participant	Age	Ethnicity	Gender	Profession	Length of time working with ED
Alice	25-34	White Irish	Female	Psychology Practitioner	1 year
Beatrice	35-44	White Irish	Female	CBT Therapist	15 months
Carolina	35-44	White European	Female	CBT Therapist	3 years
Diana	25-34	White British	Female	Psychology Practitioner	2 years
Emilia	25-34	White British	Female	Psychology Practitioner	3 years
Francesca	25-34	White European	Female	Counselling Psychologist	5 years
Grace	25-34	White British	Female	Trainee Clinical Psychologist	5 months
Harry	25-34	White British	Male	Assistant Psychologist	4 years

Analytic Approach

The study aimed to capture a rich reflection on clinician experiences of the therapeutic relationship, including cognitions, biases, and visceral reactions to clients, which quantitative data collection would not capture. Furthermore, the study did not aim to establish a causal relationship between clinician's attitudes to weight and shape and therapy outcomes. Therefore, a qualitative approach was indicated. IPA was considered the most appropriate qualitative approach given the research question's emphasis on personal, lived, and embodied experience and the participants' interpretation.

Although other qualitative approaches were considered, IPA was preferred because its hermeneutic phenomenological epistemology matched the study's theoretical underpinnings well. The investigation concerns itself with the therapist's experience. Namely, experiences of societal narratives, socialisation, and countertransference occur within a therapeutic relationship related to said socialisation. This phenomenon

comprises the therapist's internal state, such as thoughts, emotional reactions, and physical sensations. IPA is recommended for questions about *how* things are experienced and the meanings attributed to the experience (Pietkiewicz et al., 2014). So, IPA was deemed the best fit.

Qualitative approaches taking realist epistemological assumptions were considered inappropriate because they assume that a participant's perspective directly reflects reality; however, according to Leahy (2008), therapists may hold dysfunctional schema (i.e., inaccurate beliefs), which can impact their reaction to a client. Relativist approaches were considered due to the relevance of culture and language and the shared belief in appearance ideals, diet culture, and weight stigma. However, this approach was also disregarded, given the study's focus on clinicians' thoughts and emotional reactions. Given that an existing model of countertransference guides this piece of work, grounded theory would also not be appropriate because this form of analysis generates a theory after the analysis has taken place. Thematic analysis was also considered because this approach can be used with a phenomenological framework. However, it was felt that IPA would produce a richer data account due to the subsequent interpretative analytic phase of themes. This would place the clinician's perspective within the social context of a society that highly values thinness.

IPA has some critiques, of which the researcher was mindful. Firstly, due to its ideographic approach, IPA may be limited in terms of the generalisability of the findings. IPA can provide deep knowledge that can be generalised to the target setting (Brocki & Wearden, 2014) and align with the project's aims. IPA may contribute to more general

claims by gradually accumulating similar studies (Noon, 2018). Any limitations to the scope of the conclusions drawn and the limitations to how they can be applied to other groups will be considered on page 134.

The researcher followed the steps outlined in Smith et al. (2009) to analyse the data. This involved reading and re-reading each transcript and creating detailed notes regarding the content, linguistic elements, and conceptual interpretations. Following this, emergent themes were created using the initial detailed notes. The researcher then looked for relationships between emergent themes by clustering them based on their similarities. Thematic tables were made for each participant. These steps were followed for each participant sequentially. Once each case had been analysed to this stage, each case's emergent themes were compared to find patterns across cases and develop the final superordinate and subordinate themes. To enhance the credibility and reliability of the analysis, each participant reviewed their respective transcript and list of emergent themes to give feedback on how well the researcher had captured their intended meaning.

Reflexivity

Data analysis using IPA involved the researcher trying to make sense of the participants making sense of their own experiences, described by Smith (2009) as a double hermeneutic. Considering this, it is essential to acknowledge the researcher's pre-conceptions and position and the impact that may have on the research (Biggerstaff & Thomson, 2008). In this vein, the researcher's thoughts and feelings are acknowledged;

the extent to which they converge and diverge from the data is examined. Therefore, a reflexive journal was kept reflecting on how the researcher's identities and experiences informed their assumptions, questions, and relationship to the participants and data. Any issues that arose were explored in supervision to allow the researcher to bracket their biases.

The researcher is a white British, middle-class, able-bodied, cis-gendered, heterosexual woman who is employed as a Trainee Clinical Psychologist. The researcher has previously worked in an ED treatment pathway within IAPT and completed a year-long placement within a specialist ED service during the research process. The researcher has lived experience of an ED and experienced the problem being poorly explored and eventually dismissed by medical professionals purely due to their body size. The researcher's position as an ED clinician with lived experience of the disorder has undoubtedly contributed to their interest in this topic. The researcher's experiences have shaped the researcher's assumptions that clinicians working with ED may make unhelpful judgements about their patients based on their bodies.

Furthermore, this may have caused the researcher to unfairly assume that most people, including ED clinicians, internalise the thin ideal. The researcher's position as a White, British woman may cause them to privilege narratives about Western women's beauty ideals and feminist perspectives regarding the objectification of women's bodies over the perspective of global majority cultures or the experiences of people who do not identify as women. To avoid the research being unduly influenced by these biases and assumptions, the researcher endeavoured to frame the questions from a neutral stance

to not lead participants into discussing weight stigma and to allow for exploring positive or neutral experiences. Furthermore, the researcher added prompts to discuss cultural and gender diversity to ensure that the White feminist perspective was not excessively centred.

Quality Assurance

Elliot et al.'s (1999) guidelines for quality standards for qualitative research were adhered to throughout the research process. The researcher's perspective was owned from the outset. The bracketing interview and reflective journal enabled the researcher to name, acknowledge and put aside their assumptions throughout the study. The sample was situationed by reporting on the participant characteristics to contextualise the findings. The themes were grounded in examples by providing quotes from the data to illustrate the analytic procedures used, to allow the reader to appraise the fit between the data and the researcher's knowledge of it and to enable readers to conceptualise alternative meanings. Credibility was checked by the researcher's supervisors reviewing theme development. Participants were also invited back to check that the researcher's themes accurately reflected their statements. Coherence was ensured by using a visual map to show the relationships between themes arising in the data and the researcher's reflections, which were accompanied by verbal reflections. Elliot et al.'s (1999) guidelines advise that the researcher is clear on whether they aim to gather a general understanding of a phenomenon or an understanding of a specific instance. Given that the aim was a general understanding of a phenomenon, this standard was upheld by carefully considering the sample size, stating the study's limitations and the scope for

generalising the findings to other contexts. Finally, the researcher endeavoured to resonate with readers by accurately capturing the experience of the phenomena and establishing a language for experiences that are difficult to express.

Results

Master list of themes

IPA revealed 13 subordinate themes grouped into four superordinate themes, as represented in *Table 6*. The nature of each superordinate theme is summarised by its subthemes. A more comprehensive summary table of themes with additional supportive extracts from participants is provided in Appendix I.

The themes and their data are presented as a narrative account, following the approach outlined by Smith (2009). This involved case-by-case analysis of the transcripts and comparisons across cases to find the patterns across all the interviews. The final themes were chosen because they were representative of most of the interview transcripts. However, variations of opinions about these themes are captured within the breakdown of each theme and subtheme to highlight individual differences. Examples of the process are given in Appendices J and K. Interpretation of these themes will be included within this chapter, followed by deeper interpretation through the lens of the study's theoretical grounding in the Discussion. This narrative is enriched by characterisations of participants' experiences and analytical interpretations, supported by quotes selected to represent each theme. After reviewing the transcripts, the participants confirmed that they agreed with the chosen themes and provided some additional context to their answers, which is discussed in the analysis below.

The themes and subthemes were understood in relationship to the multiple levels of systems which impact the clinician's beliefs and reactions to the therapeutic process.

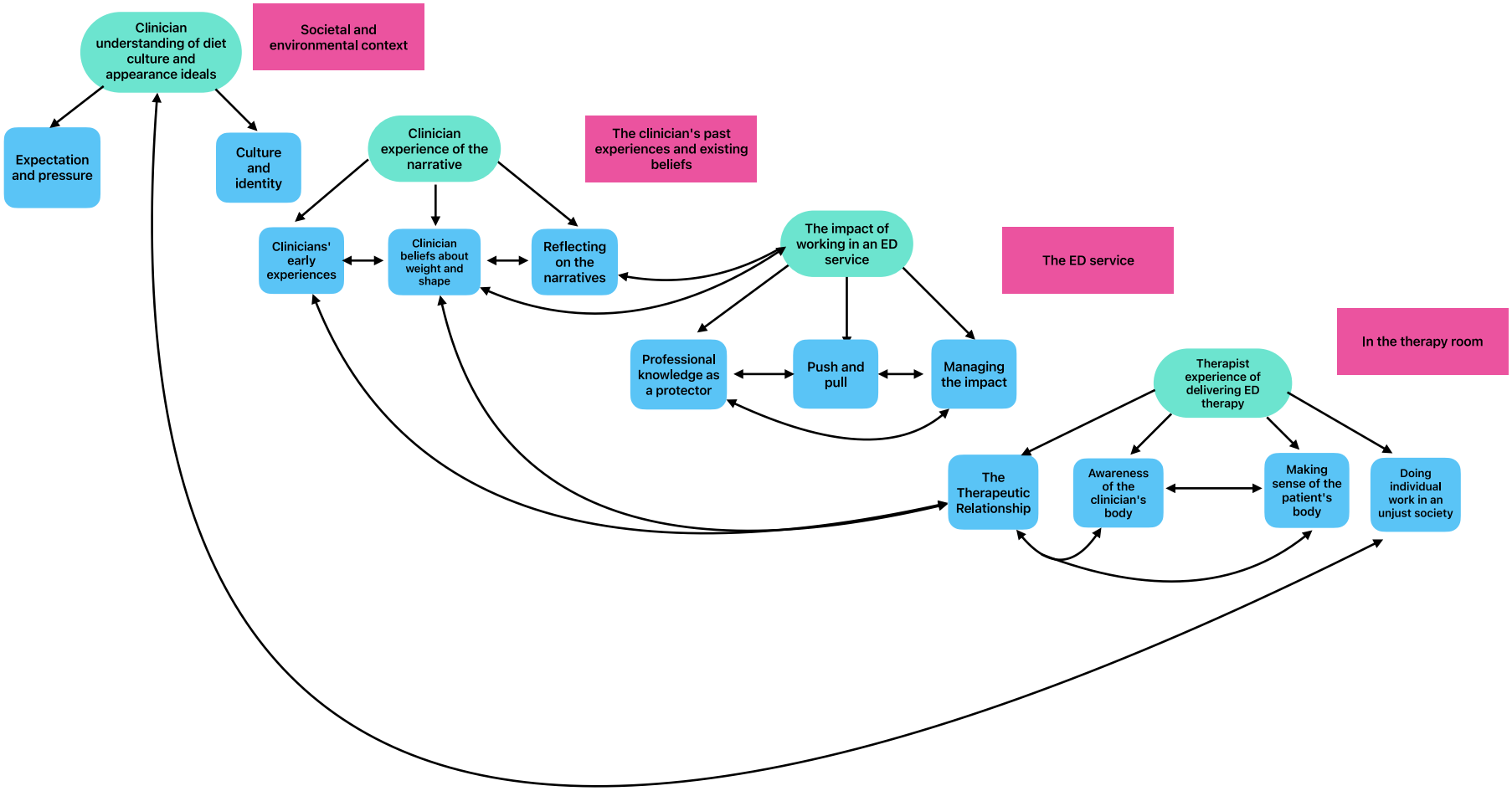
For example, the influence of the clinician's cultural context and early experiences on the development of their beliefs about weight and shape; the interaction between the belief systems in an ED service, the clinicians' existing beliefs and dominant discourse within society; and finally, the moment-to-moment thoughts and feelings emerging within the therapeutic space. A thematic map demonstrating the relationships between each superordinate theme and subtheme can be found in *Figure 1*.

Some quotes have been edited to ensure confidentiality and to maintain clarity. Less relevant information and some linguistic fillers have been omitted, as indicated by '[...].' Explanatory material added by the researcher is noted as [text].

Table 6. Master Table of Themes

Superordinate theme	Subordinate theme	Number of transcripts contributing to the theme
1. Clinician understanding of diet culture and appearance ideals	1.1 Expectation and pressure	8
	1.2 Culture and identity	8
2. Clinician experience of the narratives	2.1 Early experiences	8
	2.2 Reflecting on the narratives	8
	2.3 Clinician beliefs about weight and shape	8
3. The impact of working in an ED service	3.1 Professional knowledge as a protector	7
	3.2 Push and Pull	7
	3.3 Managing the impact	8
4. Clinician experiences of delivering ED Therapy	4.1 The Therapeutic Relationship	7
	4.2 Awareness of the clinician's body	6
	4.3 Making sense of the patient's body	5
	4.4 Doing individual work in an unjust society	7

Figure 1: Thematic map



Superordinate theme 1: Clinician understanding of diet culture and appearance ideals

This superordinate theme comprised two subordinate themes: 1.1. "The expectation and pressure to meet the ideal" and 1.2 "The relationship to culture and identity." Before these are elaborated, clinicians' definitions of diet culture and appearance ideals will be defined.

All participants described appearance ideals as culturally defined standards of appearance.

"Appearance ideals [...] my understanding of that would be [...] what is deemed [...] conventionally attractive at a given time in society" - Alice

Appearance ideals were deemed to have many components, such as "l*ooking youthful and things like that [...] it could also [relate] to like facial things as well, not just specifically body"- (Alice),* but most clinicians focused on body size due to the study's framing and the focus of the interview questions.

"...that involves being quite slim as kind of an ideal to strive for [...] having a certain type of proportion build with... If you do have curves only in certain areas and not others" - Alice

Diet culture was understood to be related to appearance ideals, as a set of standards *"that's [...] been introduced in our society, where it's always striving to lose weight or be a certain body type" – Emilia*

Participants tended to use umbrella terms (e.g. "certain way") rather than definite descriptive terms ("fat," "thin"). Following the initial analysis, the participants were asked why they thought they had used "certain way" over a specific descriptor. Clinicians who responded confirmed that they chose fewer specific terms to account for multiple appearance standards, they had assumed the researcher would understand her meaning due to the normalisation of the thin and lean muscular ideals and one person used "certain way" to avoid using offensive terms or body shaming.

Expectation and Pressure

Clinicians understood appearance ideals to be "*pushed....the narrative it's pushed" - Harry*. Most clinicians discussed the prevalence of messages about appearance ideals and diet culture in traditional and social media.

"... The kind of thing that you see on social media and airbrushed all of the time, [in] magazines " – Harry

"...And now we've got social media as well, which, ummm...you know, I think exacerbates pressure on young people and on people, maybe not just young people... people to adhere to, you know, a healthy diet or a diet that would keep their weight low." – Beatrice.

Clinicians discussed how diet culture and appearance ideals related to capitalism and reflected on the methods used by companies to market products related to diet culture. The prevalence of messages, level of endorsement and marketing strategies created pressure to meet the ideal.

"Buying into any like products they're selling or whatever, umm…so I think yeah, it made me feel terms of societal appearance… Yeah, made me feel like I need to look like that." – *Diana*

"[You get] doctors as well on TV sometimes saying things around, it's fine to eat only 800 calories, and you're like you're a doctor, like, so kind of then it's hard to know what's right". *- Carolina*

Clinicians related appearance ideals and diet culture to weight stigma. They reflected on various means of discrimination towards people who do not meet the ideal.

"It's about, yeah, being very skinny, and that's being valued versus people who are overweight or obese. There's a lot of stigma around that" – Carolina.

"There are studies that kind of show that […] for a woman in, like the workplace […] she will be taking more seriously [if she is] a lower weight, or if she were to lose some weight if she is […] overweight" – Alice

Clinicians' understanding of appearance ideals and diet culture demonstrates these phenomena' pervasive nature and normalisation and how the values ascribed to meeting the ideal relate to Western individualism and capitalism. The pressure to look *"a certain way"* extends beyond appearing attractive to others and has direct implications for one's value within society.

Culture and identity

Clinicians noted that diet culture and appearance ideals messages were often trend-based and evolving.

"Body ideals have changed throughout the years I've been alive, and I guess in my mind because I've grown up in the 90s and noughties, diet culture means eating less in order to have a very skinny body, whereas now I appreciate having a big bum and big breasts and a lot of curves [...] So maybe diet culture is more [...] focused around exercise" – Francesca

Expectations around appearance ideals were also deemed to be culturally bound.

"East Asian cultures and someone that I was working with who was actually from a like Chinese... heritage said like just generally East Asian [...] celebrities that she follows, and stuff are very, very underweight." -Diana

Clinicians related interpretations of appearance ideals to Social Graces (Burnham, 2018). Most participants noted the specific pressures on women, reflecting how feminine appearance ideals seemed more specific and rigid. Participants acknowledged that people of all genders experience appearance ideals in diverse ways, reflecting on the experiences of men, trans, and gender non-conforming people.

"Because you know, from a male perspective, the ideal is ripped and six pack and muscly.....and I guess also generally feels like there's a...higher standard for women than there is for men" – Harry.

"I'm working with a [...] trans woman [...] really, really tricky eating difficulties a-around the [...] wanting to look a certain way as a female [...] trying to not have the male aspects anymore." - Diana

Participants also reflected on the intersection of identities (e.g. racial identity) and appearance concerns.

"I think there is particularly one patient I've worked with who spoke about kind of like worrying about meeting this stereotype of being like a big, big Black woman and [...] not wanting to kind of fall into that category "- Emilia

Clinicians reflected on other cultural elements underlying diet culture, such as the value on achievement and the male gaze.

“I guess it's also interesting in that sense of like. The this, this societal ideal …Is, I guess, designed, or created from a male gaze – Harry

“I read an article a couple of months ago really about how successful people, a lot of successful people, equate thinness with success” – Beatrice

Thus, appearance ideals and diet culture interact and are related to the systems of power and oppression within a given socio-political context. Namely, weight stigma acts within the context of White supremacy, patriarchy, and individualism.

Superordinate Theme 2: Clinician experience of the narrative

This superordinate theme comprises three subordinate themes: 2.1 ‘early experiences’, 2.2 ‘clinician attitudes to weight and shape,’ and 2.3 ‘reflecting on the narrative.’ These subthemes explore clinicians' experiences of living within a society that values thinness, key memories defining their attitudes to weight and shape, and reflection on these experiences. The subthemes were understood to interact with one another, with clinician experiences contributing to developing their attitudes to weight and shape, specifically the internalisation of the ideal. Clinicians’ current reflection on the ideal, impacted by their experiences of working in an ED service (to be discussed in greater detail in Super-ordinate theme 3: “The impact of working in an ED service”) were felt to interact with their pre-existing attitudes.

Early experiences

Participants described how their early experiences influenced their food, weight, and shape attitudes.

"So, my family are of like a very healthy household, and my mum was always like cooking things from scratch and very conscious about, like, not having processed food." – Grace.

"The first point around kind of family, [...]. Me and my sister, I think both... well, I felt like quite like validated if I was [thinner]." – Diana.

Clinicians reflected on their experiences of appearance ideals and diet culture narratives. For example, diet talk among their families and peers and receiving comments from others.

"...There's a lot of that kind of pressure just from, like, [...] friends always talking about, like, dieting and exercising, and I used to go to the gym a lot and stuff like that." – Emilia.

"And I wouldn't say I was ever really like actively, like, bullied for it. But if anyone was gonna say anything mean to me, it would be around weight" – Harry.

Clinicians also described being influenced by portrayals of diets in the media.

“I remember being like a child and maybe being like ten and on TV at the time, there was all those kind of really intense dieting shows […] I remember watching those with a friend […] and we decided that we needed to go on a diet also – Alice

The lack of representation of their body type in the media was a challenging experience that impacted the clinicians’ body image.

[When talking about fitness influencers] “*The ideal was like […] petite, but strong […]. But no one has big boobs […] I've got big boobs, and I don't look good in like a nice little sports bra. […] I used to hate that […] so yeah, it's affected […] my thinking about like body parts.” – Diana*

It is evident that thinness and restrictive diets were rewarded in the clinicians’ experiences. Fatness, having different proportions to the ideal and eating what is considered “bad” food were denigrated. The impact of these messages on behaviour and self-image demonstrates the power and authoritative nature of the diet culture message. However, it is essential to note that there may have been factors within the clinicians' pasts that protected them from developing appearance concerns. When validating the themes, one participant clarified that her parents frequently complimented her appearance during her childhood, which she thinks helped to instil self-confidence in her appearance.

Clinician attitudes to weight and shape

All clinicians were aware of appearance ideals and diet culture narratives and acknowledged that they internalised these beliefs to differing degrees. Most clinicians felt that they had internalised diet culture narratives to a greater extent in the past.

"I had an eating disorder before, umm... So yes, like I was called names in school, and I was a primary school...Like a lot of people do, and for being chubby and so that would have [...] impacted on me" – Beatrice

Clinicians discussed lived experiences of appearance concerns, dieting to lose weight, disordered eating, anorexia, and overexercise, all related to feeling under pressure to conform to the ideal. However, some felt this more than others.

"I was like quite overweight and I... was like, I'm really unhappy with the way I look, just like, OK, I wanna lose some weight" – Harry.

"I [...] really struggled with sleep at uni and I was trying to like tire myself out. So [I went] to the gym quite a lot to get tired [...] then I realized it could help with how I look a certain way and then it got a bit like... obsessive" - Diana

Clinicians also expressed current pro-thin attitudes and entrenched fear of weight gain.

"...I don't like to be overweight. So, if I went on holidays like I did in the summer and put on, put on half a stone, I don't feel comfortable [...] if I've done that. [...] I like to be... I like to be slim because I think that helps you to look better" – Beatrice.

"I definitely have been influenced by [...] the ideal narratives around weight and shape. And so, while I would be quite accepting of other people at all different shapes and sizes, I think for me specifically I probably it would take a while to work on that acceptance, if I did have any major changes" - Alice

Clinicians simultaneously endorsed inclusive attitudes about body size, and all believed in the importance of regular eating, a balanced diet and flexibility. As clinicians have been influenced by their work, this theme relates to subtheme 4.1, "Professional knowledge as a protector." Clinician reflection on simultaneously holding two beliefs is further explored in subtheme 3.4, 'untangling two conflicting beliefs.

"I will be the first one to preach to everyone I know about [...] regular eating and balance and having space for the nice foods [...] I try and kind of stick to that myself as well now" – Emilia.

"I definitely do think that you know people of all shapes and sizes are [...] equally deserving of you know respect, opportunities, kindness, everything" – Alice

The clinicians had all experienced a drive to meet the thin/ lean ideal at some point in their lives. Living in a larger body was associated with feelings of discomfort and sadness;

the clinicians reject a larger body for themselves, but the same is seen as acceptable for other people. This exists within the knowledge that fat bodies are discriminated against within society.

Reflecting on the narrative

Clinicians expressed frustration with societal messages about appearance and diet. They found many of the messages to be inaccurate (E.g. "*if diets worked, there'd be one diet everyone would follow" - Harry)* and felt that society places too much value on appearance.

"The way that you'll look should be on… a lower step of the hierarchy of importance than how you feel, for example, or how good your relationships are, or how good you feel about yourself" – Francesca.

Clinicians reflected on how diet talk is often at odds with dietetic advice despite masquerading as "science."

[When talking about weight loss apps*] "It's like, here's the here's the science […] you need to wear a wearable device on your arm. You need to send us all your faeces…." – Harry*

"But at the same time, eating healthy, from a dietetic point of view, would be, you know, you can eat everything, but you know…eating healthy in society is like "don't eat fat, don't eat sugar, don't eat carbs…" – Carolina

As Clinicians working with ED often give psychoeducation about nutrition and weight to support patients to challenge maladaptive beliefs, the clinicians taking a critical stance towards diet culture and dominant discourse about bodies can be understood within the context of their experience of working in an ED service. Scientific knowledge counteracts the myths that exist within society about food, weight, and shape. This concept will be explored further in the next superordinate theme.

Despite this, Grace and Francesca reflected that diet culture narratives contained some truth, such as the usefulness of monitoring one's dietary intake to ensure a nutritionally balanced diet.

"So, there is, there is some truth in the diet culture that you know it's good to eat… umm… more frequently, but less or whatever or don't have only carbs all the time, that's bad." – *Francesca*.

"There's still like an element of like us having to moderate our intake […] Because if I had like no rules around food, I'd just probably eat like chocolate all day long [laughter]" - Grace

Clinicians noted a shift in the cultural landscape, (E.g. "*that celebrities are coming more out with a more […] curvy figures and things, […] that can help change things…" – Beatrice)*. This demonstrates the clinicians' understanding of the influence of societal context on people's beliefs, self-image, and expectations for themselves. If there is more representation of diverse bodies, perhaps the expectation to be thin or lean will be less.

Clinicians described making an active choice to reject appearance ideals and diet culture beliefs, but they said it felt hard to let go of them completely. Most clinicians experienced this as still having automatic thoughts but not acting on them or actively challenging them.

"I don't want to be stressed about how many times I'm gonna eat in a day, so I'm not going to let these messages I received from the outside world dictate that to me." – Francesca.

This demonstrates the tension within many clinicians between the implicit attitudes internalised by society and the explicit attitudes informed by the clinicians' values and training. The experience will be explored in greater detail in theme 3.2, "Push and Pull."

Many clinicians who reflected on their position in the narrative were aware of their relative privilege as living in a thin to average-sized body and having a naturally lower weight. They reflected how their level of thin-ideal internalisation and distress related to this may be different if they were larger-bodied.

"I think I've always had quite a standard body type anyway, so it's not like for me personally I've ever had to kind of fight too much to fit into body standards because my body is quite, like, naturally quite slim and stuff like that" – Emilia.

"I'm not overweight, so I don't need to be on like a constant like… not diet but like constant like thoughts around making sure I eat this or, don't eat that," Diana

The researcher notes the use of language in the above two quotes, "I've never *had* to fight" and "I don't *need* to be on a diet," demonstrates the societal expectation that people who do not meet the ideal are expected to change themselves to attain the ideal. Despite clinicians consciously rejecting diet culture narratives, the unconscious internalisation of these beliefs is seen through linguistic elements.

Superordinate theme 3: The impact of working in an ED service

This superordinate theme comprises three subthemes: 3.1 'professional knowledge as a protector,' 3.2 'push and pull' and 3.3 'managing the impact.

The section describes how clinicians' general beliefs towards weight and shape have changed since working in an ED service. Clinicians discuss the complex effects of their work: the tension between internalising diet culture narratives and simultaneously rejecting these as part of their role and the experience of heightened attentional focus on their body while simultaneously accepting their shape. It was felt that clinicians manage this conflict by using their professional knowledge; hence, the subthemes 3.1 and 3.2 are seen to be related. Finally, the clinicians discussed how they manage the challenges of their work and how they think services can best support them. The impacts on their weight and shape attitudes will be discussed in more detail below. However, it is important to acknowledge that clinicians also described more general effects, such as struggling with a high workload; this will not be explored due to it falling outside the focus of the study. The subtheme 3.3.'Managing the impact' relates to 3.2 'Push and pull', the

sense that external support was felt to be needed to manage the emotional impact of the internal tension they experience.

Professional knowledge as a protector

Most participants thought that they had learned much from working in an ED service and had internalised the messages from their treatment protocols. The dietetic advice given as part of the treatment was seen as helpful in dispelling food myths they had internalised and helping them to create more realistic cognitive links between dietary intake and weight.

"Since working here [...] I feel like I've sort of got rid of like any, any rules around food in a way that I feel [...] actually it's OK to have a snack or it's fine to have some sugar, that's not gonna like damage your health or change anything drastically and it's actually worse to like, restrict yourself" – Grace

Professional awareness also contributed to a pressure to "practice what you preach."

"But then I also feel like there's a real pressure from myself to like, eat consistently and allow myself to have nice foods... Like not giving in to these ideas around like weight loss or trying to change what you do to do with your weight and shape ...." – Emilia

Thus, at the same time as feeling liberated by their knowledge, clinicians also felt responsible and accountable to live in accordance with the messages they gave to

patients. The sense of not wanting to "give in" to external messages further demonstrates the power of dominant discourses about eating, weight, and shape, but also the choice to reject them.

"As long as you're feeling happy with the way you're having your food and feeling kind of content with you know your health, then I think do whatever makes you feel relaxed and comfortable and happy" – Diana

Because of their work, the clinicians had become more accepting of diverse sizes and diets. They had come to appreciate the value of nutrition and general health when considering their food intake. They had gone beyond the binary often presented with diet culture narrative (e.g. good food vs bad food) to taking a nuanced view accounting for self-care, genetics, and emotional well-being, rather than the focus being entirely on one's appearance.

<u>Push and pull</u>

Despite the overall positive impact of working with ED on clinicians' body acceptance, clinicians also observed a cognitive dissonance related to still internalising diet culture to some extent but consciously rejecting it. It felt challenging to untangle these two conflicting beliefs as the bias often operated on an unconscious level.

I think it would be very difficult to grow up in kind of society that that I grew up in and not absorb some of these ideas. Umm [pause] But yeah, I think it's uncomfortable to think

about [...] it's like ...a bit tiring... like it's not, it's kind of like I feel like I need to have like some brain power [...] when I'm trying to think about it and trying to kind of untangle things – Alice

Automatic thoughts were deemed to be a product of society's messages, and when they came into consciousness, they were actively challenged.

"You are not your automatic thoughts; they are the societal constructs and [...] you know, it's how you respond to that thought that is more important; that's you. [...] Correct it and come back [...] to what I believe in, like, morally." -Harry

"I have to consciously come in and say it's- set a boundary and say, "OK, I'm not gonna think about this anymore" because I can see how if I don't, I can end up getting obsessed around food or snacks" - Francesca

Thin ideal internalisation was experienced via implicit bias, which often came into consciousness through automatic thoughts. Simultaneously, the clinicians looked at dominant discourse through a critical lens. Their moral beliefs, values, and theoretical knowledge from their work and training told them that the narrative was unfair, which enabled them to check their automatic responses.

As bodies, weight, and diet were all a focus of the participants' work, they had either noticed increased thoughts about bodies, food, weight, and shape or higher awareness of previously unnoticed thoughts about the same.

“Through working in this role. I think I will probably notice like umm, certain areas more like…I feel like I probably notice my stomach more and kind of like probably have more thoughts of kind of being like, have I gained weight or things like that” - Alice

Clinicians also noted heightened awareness of their dietary intake.

It got to the point that I would feel a little bit bad when I don't [follow three meals and three snacks a day] […] is this good advice for anyone or is this good advice for people with eating disorders and where do I draw the line for myself?” - Francesca

Despite this, clinicians felt more body acceptance overall, thanks to internalising their treatments’ messages about body acceptance and the knowledge gained from the treatment protocol, which enabled them to question dominant discourse.

“Sometimes I’ve experienced those like strong and thoughts of like, dislike towards my body or like noticing my body much more than I would before. Umm but that's really like only at specific times. I think overall it's made me just like, really accept my body much more” – Grace

This dichotomy felt complex. On one hand, professional knowledge had helped them to challenge their own appearance concerns, but on the other hand, it felt confusing.

“It's quite draining. I always miss [...] like not having that awareness sometimes because it was like less to think about almost umm...but then also [...] I know that I have like a much better relationship with like food. – Emilia

Participants also noted hyperawareness of doing common behaviours that could be construed as ED behaviours, demonstrating the stark difference between the accepted narratives at play within ED services and elsewhere. Engaging in weight loss behaviours as a clinician was interpreted to feel quite taboo.

“...it always feels weird to tell people because of the service I work in, probably in about a year I think I lost about 20 kilos. Which I know if I heard that about a patient and I'd be really concerned....” - Harry

[When talking about the urge to skip dinner to avoid bloating] *“I’m like actually I cannot do that when I work with patients and I'm getting this message across...”- Diana*

This sometimes-elicited worries about *“getting caught up” (Alice)* in something more pathological, perhaps eliciting concerns about a slippery slope to ED

[When talking about weighing himself] *“I think it's the panic of “Crap, am I doing what my patients do?” - Harry*

This relates back to the pressure to “practice what you preach” which emerged in subtheme 3.2 but goes further than the liberation felt from dismissing their own food

rules with their professional knowledge. In this case, experiencing any pathological thoughts or behaviours is felt to be prohibited given the person's identity as an ED clinician. This will be explored further in subtheme 4.1, "The therapeutic relationship."

Managing the impact

Reflective practice was deemed to be the most important way of managing the impact of their work.

"I think I try to like talk to myself and like when I'm anxious, I try to respond to myself in a way that's like reassuring or like to calm myself down." - Grace

I guess afterwards is trying to be "that's her [patient's] thing," but I mean, I go to the formulation sometime as well.... I think it helps me. – Carolina

Supervision and reflective practice were thought to be useful avenues for discussing attitudes to weight and shape. However, some clinicians had not yet used supervision to explore this or felt that having this as an agenda item would be too intrusive. Others had sought support after personal vulnerabilities were activated within a therapy session.

'Because I guess you have a general, have a general well-being question, but you don't get [...] "how's your relationship with your body at the moment?" which is a really probably really triggering question to ask and clinician.." - Harry

I think I talked to [senior colleague] […] And so, it was just helpful to talk it through. I think I'm just gonna be open sometimes because […], if I feel a certain way, it could then influence how you are with your patients or the questions you ask. - Carolina

Clinicians felt that having a dedicated reflective practice space to discuss their weight and shape attitudes would be useful, but there was also anxiety about this being too exposing and a sense that clinicians would not use the space for fear of scrutiny.

I think as well in bigger groups, people try and keep their professional hat on, don't they? So, people don't want to […] share their own kind of personal things as much as, say, like a smaller group or an individual conversation. – Emilia

Participants also named peer support from colleagues, emotional support outside of work, having a work/life balance and training as useful ways to minimise the impact of work.

I've got really good colleagues that I can just rant to if I want to or say things or reflect on things or advice from them - Diana

Superordinate theme 4: Clinician experiences of delivering ED treatment

This superordinate theme comprises four subordinate themes: 4.1 'The therapeutic relationship,' 4.2 'Awareness of the clinician's body,' 4.3 'Making sense of the patient's body,' and 4.4 ' The tension of doing individual work in an unjust society.' Superordinate

theme 4 differs from Superordinate theme 3: ‘The impact of working in an ED service’ as it relates solely to the phenomenological experience of being in the therapy room with their patients, whereas Superordinate theme 3 focuses on the clinician’s wider experience of working in an ED service. Subthemes 4.1, 4.2 and 4.3 all relate back to superordinate theme 2: ‘Clinician experience of the narrative’, specifically that clinician’s lived experiences, internalised biases and beliefs about weight and shape present within the therapy room. This had implications on how the clinician made sense of their own and the patient’s bodies within the space and how the therapeutic relationship played out. Finally, 4.4 ‘The tension of doing individual work in an unjust society’ was related to Superordinate theme 1: “Clinician Understanding of appearance ideals and diet culture”, as the participants reflected on their role as clinicians in Western society.

<u>The Therapeutic Relationship</u>

Overall, clinicians felt that they had good therapeutic relationships with their patients, which was thought to have important implications for outcomes.

“You're asking people to make any significant changes […] And I think that the main thing that kind of allows that to happen, […] is the therapeutic relationship” – Alice

Clinicians reflected on the other complex dynamics between themselves and their patients, apart from their knowledge and experience of diet culture. For example, the collisions of clinicians' and patients' individual vulnerabilities impacted the therapeutic process and relationship. These will not be explored in detail here as they fall outside the

study's scope. However, relevant quotes are included in Appendix I to illustrate the breadth of the discussion.

Clinicians thought that their experiences of thin-ideal internalisation helped the therapeutic relationship by enabling them to empathise with their patients (e.g. *"I can relate [...] they make me think of me." – Carolina)*

Passion and interest in the area also motivated clinicians to advocate for their patients, which felt highly motivating; sometimes, this took an emotional toll.

I'm aware [they need] to do the work [...] like nobody can do that for them, but I maybe have a sense of really wanting to put more into [the] work [because of the similarities of their experience] and take more responsibility which may not be sometimes... helpful...."
- Carolina

Some clinicians felt that appropriate self-disclosure was a helpful therapeutic tool; others felt unsure about how much of themselves to bring.

"I would never kind of say too much about my own personal life, but I [...] resonate with the pressure that they might feel to look a certain way, [...] I think sometimes that's quite really quite helpful for them to hear that – Diana

[When asked about her attitudes weight and shape by a patient] "I think I was a little [...] caught off guard. [...] So, I'm like, oh, how do I answer this? [...] I guess it's kind of difficult to know [...] how much do you kind of bring about yourself?" - Emilia

Carolina also acknowledged working as a clinician with lived experience of an ED elicited complex feelings towards herself and her patients.

Maybe if I have a bad day thinking, having a sense of "oh, I'm a bit jealous, they can restrict their food [...] part of me is like "ohh, that'd be nice just to lose weight..." [...] I remember thinking, "oh, it was so much better." The reality? It's not. It's just the burst when you weigh yourself, you went down, you feel good, but then your day is horrible because you have to maintain that and it's such hard work. – Carolina

The lived experience of internalising the thin ideal and then choosing to move on from it also enabled clinicians to take a position of hope for the patient.

"I look at [patients] with a lot of empathy and compassion in the sense that, "you are in the grips of an eating disorder, and you are probably not aware of how much is coming from outside [...]. So, I want to help you see it. I want to help you figure it out," – Francesca

This feeling of enhanced empathy and closeness to the patients can be contrasted with the narrative in Subtheme 3.2, 'Push and pull,' that clinicians felt under pressure not to engage in any dysfunctional behaviours. On one hand, clinicians think their similarities

to their patients aid them; on the other hand, clinicians are keen to distance themselves from behaviours that might be perceived as pathological.

Clinicians also explored other ways that the patient's weight can impact the therapeutic relationship. For example, the cognitive deficits associated with extremely low body weight were felt to hinder patient's ability to make effective use of therapy. In contrast, clinicians observed how average to higher-weight patients were more cognitively intact, more motivated to change and had more appropriate emotional expression. Extremely low body weight and associated risk of death also increased clinician anxiety, which was seen to impact their behaviour.

"The ones that are low weight, the cognitions are so different and they're so rigid. [...]. I mean, it's gonna affect their emotions, everything, and they're a bit more like... hostile sometimes [...] – Diana

"I think the ones on the ward probably take more of a toll on me [...]. In like, I put so much in myself into this person that I find that I probably do that less in outpatients, you know because they're not at risk of death immediately [...] the relationship is more intense on the ward" – Harry

The clinicians did not think that their attitudes to weight and shape significantly impacted the therapeutic relationship. However, they hypothesised that this may be the case for other clinicians, such as clinicians with more tenuous relationships with their bodies or clinicians with unchecked weight bias.

“If there's a kind of comparison going on, I haven't noticed it with myself. It doesn't mean it's not happening, but it could be, but not very obviously. Umm, but that could in interfere a little bit” – Beatrice

Other clinicians were mindful of their own vulnerabilities and later in the interview, hypothesised about how this may cause them to behave differently in the therapeutic space.

“I think it's harder when we talked about body image versus this other thing. I find it easier, but when we talked about body image, I can feel a bit like ohh it’s uncomfortable [laughter]" - Carolina

[When asked how unchecked countertransference may impact her during a session] *I might be [...] worried of being triggered in that sense, I think and because maybe you're worried, or if you have bias of views, you may not ask certain good question or learn about the patient” – Carolina*

Again, the assertion that other clinicians may be more impacted than them may have been due to a concern about being badly perceived, or it may have been related to such biases and attitudes operating on an unconscious level. The researcher also notes Carolina moving from the first to the second person “*I* might be triggered…. if *you* have a bias of views, *you* may not ask certain good question….” This may be perceived as wanting to distance herself from therapist behaviours, which can be considered unhelpful or could represent speaking more generally due to speaking hypothetically.

Awareness of the clinician's body

Clinicians described varying experiences of becoming aware of their bodies within the room. Reflecting on how the clinician's and patients' bodies related to appearance ideals felt less threatening if the clinician lived in a slimmer body and hence came from a relative position of privilege.

"Even the men I've worked with in outpatients specifically…have all been overweight. I'm the slimmer person in the room. […] [But] If I was working with, you know, […] men who were who looked like [the muscular ideal], I think I'd struggle more […] I'd be more aware of my body" – Harry

Conversely, some clinicians felt self-conscious of how the treatment messages would be perceived when working with higher-weight patients due to their thin privilege.

"…talking about the body image things and kind of promoting this acceptance and neutrality. I sometimes feel like it's like easier for me to say this because my own….ummm body that maybe fits like certain ideals better." - Alice

This was also explored from the context of gender.

"I've become very aware of the fact that I'm a man advising or telling anyone on what to do with their body when already the ideals of society are from a male perspective and a male gaze" – Harry

This demonstrates that the clinician's body is not neutral in the therapeutic space. Bodies can represent systems of power (e.g., the thin body, the male body), which the patient will perceive, and which may interact with the therapeutic dynamic.

Clinicians also noted concerns about their own bodies or eating behaviour arising from therapeutic conversations.

"I think it can be like all "ohh... you're like a good weight and a good size.... like...why??" Obviously, I'd never say that! [...] I think sometimes it can make you think "ufff...if they're feeling bad about themselves, [laughing] maybe I should be feeling a bit more" ...like..ha ha...'cos they're like thinner than...this is definitely more like an unconscious thing..." - Diana

This demonstrates that the clinician's internalisation of the thin ideal and diet culture narratives emerges because of therapeutic content; yet again, the protective and resilient parts of the clinicians activate and challenge the narratives.

<u>Making sense of the patient's body</u>

Clinicians described the complex nature of making sense of the patient's body. They acknowledged that they were aware of the patient's body but that their conscious thoughts were also focused on the therapeutic process and protocol.

My focus is more I see the clients as being ill and I see them as [...] we need to fight the illness and we need to be able to...like find a way to live so that the illness isn't dominating. I don't consciously at least think about their appearance, I don't think I made any judgements - Francesca

Sometimes, clinicians were shocked by the extreme nature of some patients' appearances.

"The extremes of both ends of the spectrum, I would notice more and maybe judge more...um... you know someone comes into the ward, with a BMI of 11... But am I judging on societal constructs, or am I just like you're... You look like death. You're about to die. I'm concerned for your wellbeing [...] To get there, you're clearly very unwell mentally, maybe physically as well." - Harry

Clinicians made assessments based on body size that were relevant to risk management and assessing the level of cognitive distortion.

"When I think of appearance of our clients [...] there is a part of me that...almost assesses how...how... realistic their views are ... to give me an indication of how well or unwell they are [...] Objectively assessing how they look is also an important factor to consider for risk." – Francesca

The narrative about the health implications of being an "overweight" BMI caused some clinicians to expect patients with a BMI over 25 to "appear unhealthy" but found that this was not always the case.

"...the BMI spectrum [is] saying that they are overweight, and you look at them and think you don't look overweight. You know, [...], you look perfectly healthy. [...]. So yeah, I think there is almost like this expectation to me that people who are overweight or unhealthy should look unhealthy' – Emilia

Thus, the relationship between health and appearance endorsed by society becomes apparent here. The clinicians' expectations of the patient are influenced by their preconceived ideas.

<u>The tension of doing individual work in an unjust society</u>

Most clinicians found it relevant to acknowledge societal narratives within their sessions and would do so by naming the stigma and having open conversations about it.

"It like it can be more difficult for people to exist in these bigger bodies and I think not acknowledging that...kind of pretending that's not the case isn't helpful for people" - Alice

Despite this, acknowledging systemic influences created a sense of hopelessness. Some clinicians even expressed doubt about whether psychotherapy would be enough to bolster patients against societal beliefs.

“How are we ever meant to work with these people with the [...] society that we [...] work in that [...] does promote that [...] the thinner, you are, the more likely you are to find [a romantic partner][...] ohh my God, how it's we're literally fighting the biggest uphill battle ever?”. - Diana

Clinicians managed this by clearly setting the remit of therapy, acknowledging that the narratives will still exist but that they will help the patient to navigate society without relapsing into their ED.

“How do we get to a place that you can have... have this pressure, that pressure is not gonna go away. It's gonna be there if you're on social media, but how do you then not let it affect your [...] symptoms?” - Diana

“I guess just trying to be validating of people, but while still moving in the right direction, which I think is a really difficult balance to strike.” – Alice.

Clinicians’ holding their knowledge and reflections on societal narratives in mind during therapy is apparent here. However, it is essential to note here that the clinicians varied in how much relative importance they placed on societal narratives in the development of ED. Some clinicians formulated from an intra-psychic point of view, which meant that they were more concerned with personality factors which may drive the ED. Other clinicians who took a social justice stance were mindful of societal narratives, reflected on them often, and actively brought discussions about the narratives into the therapeutic space. Thus, it appears that clinicians' attitudes to weight and shape interact with the

therapeutic relationship, and their stance and values impact what they privilege in therapy.

Discussion

This study explored ED clinicians' experience of societal ideals and narratives around weight and shape both generally and during therapy with ED clients. This project explored how clinicians' beliefs towards weight and shape are present within the therapeutic relationship during ED treatment. Four superordinate themes were developed concerning the interviews: 'Clinician understanding of diet culture and appearance ideals,' 'Therapist experiences of the narrative,' 'Clinician experience of delivering ED therapy,' and 'The impact of working in an ED service.' The results are discussed regarding the research questions and previous work in this area.

RQ 1: How do clinicians' attitudes towards weight and shape emerge during therapy sessions, and what impact does this have on the therapeutic relationship

This is most appropriately considered concerning the two themes: 'Clinician experience of therapy' and 'The impact of working in an ED service.'

Clinicians acknowledged the role of diet culture narratives in shaping their weight and shape attitudes, bringing examples of key memories of these constructs, in line with Objectification Theory (Fredrickson & Roberts, 1997) and the Tripartite Influence Model (Thompson et al., 1999). Clinicians had experienced societal messages transmitted through media, peer and family relationships, and experiences of being objectified through comments. All described how this had caused them to compare themselves to the ideal. The level of distress this caused depended on perceived deviation from the

ideal. Some clinicians felt their bodies were close to the ideal and felt less motivated to change their diets. Other clinicians who had felt vastly different to the ideal did report engaging in dieting behaviours. This reflects existing literature showing that weight perception (e.g. how satisfied someone is with their body) is an essential predictor of body dissatisfaction and dieting behaviour (Papp et al., 2013).

All clinicians acknowledged that they still internalised the thin ideal, but their experiences of working in ED had shaped their relationship to these cultural narratives. This created a pattern of conscious rejecting of automatic thoughts and assumptions thought to be internalisations of societal narratives. This is consistent with the Tripartite Influence Model (Thompson et al., 1999), given that people internalise the thin ideal based on being exposed to messages within society; the converse may happen if people are exposed to evidence that discredits said messages. Indeed, education on factors impacting weight, self-reflection, empathy-building experiences, and exposure to positive narratives about obese people have all been shown to reduce weight bias (Moore et al., 2022). Given that therapists routinely give patients education about non-modifiable impacts on weight and are encouraged to be self-reflexive and empathetic by virtue of their job roles, their work experience may have contributed to them becoming questioning of societal narratives about weight and shape.

Furthermore, the cultural countertransference model can provide a valuable framework to account for clinicians stepping back from the dominant discourse. According to Foster (1998), clinicians bring cultural and academic theoretical beliefs to therapy. Despite general psychology courses and textbooks taking an ‘obesity as a disease’ approach

(McHugh & Kasardo, 2012), ED treatment protocols, such as CBT-E and CBT-T (Fairburn, 2008; Waller et al., 2019), give information about the genetic factors which may determine one's weight and shape above their diet and exercise regimens. So, in this case, the ED therapist's cultural beliefs may be at odds with theoretical academic beliefs.

This pattern of automatic internalising and conscious rejecting created complex and unique reactions. Clinicians noticed varying levels of awareness of the client's body during sessions. Sometimes, this comprised automatic, uncondoned judgements about the client, their body and their difficulty aligned with dominant discourse about bodies and diet (e.g. 'they are thin, they do not need to diet'), being shocked by the client's bodies, comparing the client to the ideal and comparing themselves to the clients. This reflects existing findings in the literature, which have demonstrated that clinicians working in ED envy the patient's body (Bowlby, 2007) and the self-control associated with dietary restraint (Levy, 2013) and that they can feel shocked by seriously underweight patients' bodies (Seah et al., 2017). Clinicians disapproved of their own thoughts, stating that these often happened automatically or were challenged, so they were not deemed to impact the therapeutic alliance. Clinicians' judgments about the client's body also pertained to their formulation of the client (level of cognitive distortion) and risk management (when working with very underweight clients) and were deemed helpful. Given the participants' work setting, clinical responsibility, and physical risks to clients experiencing ED, it makes sense that clinicians may appraise the client's appearance as a risk-management exercise.

The clinicians advocated for a weight-inclusive stance and passionately endorsed messages given in treatment about food freedom and the importance of overall health. This aligns with the literature, with clinicians working in ED wanting to model healthier attitudes to weight and shape to their clients. This may encourage them to be mindful of their cognitions and reject diet culture narratives (Ali, 2022). This also contributed to clinicians feeling protective towards their clients; they had the urge to advocate and an ardent desire to support the clients in taking a different view. The researcher sensed that the clinicians interviewed in this study took an enthusiastic and encouraging stance within the therapeutic relationship.

Furthermore, clinicians reported that their past experiences of thin-ideal internalisation, diet-related behaviours, cognitions, and (for some) lived experience of ED enabled them to empathise with their clients and have a sophisticated understanding of the client's difficulties. This was felt to aid the therapeutic relationship and can be understood in relationship to Tripartite Influence Model (Thompson et al., 1999), which states that internalisation of the ideal is a crucial driver for psychological distress. Although not all participants in this study had experienced an ED in the past, all were able to relate feelings of body dissatisfaction due to their past experiences, which is aligned with findings in other studies (e.g. Ali, 2022). An emotional bond made up of reciprocal positive feelings is an essential element of the therapeutic relationship, which helps the patient accept, follow, and believe in the treatment (Bordin, 1979). The clinicians interviewed within this study echoed this framework, expressing that they kept their lived experiences in mind during sessions to some degree, and a strong relationship helped their patients feel brave enough to make changes.

In addition, shared experiences (such as thin-ideal internalisation) were found to elicit varying countertransference reactions from the clinicians. Namely, the 'urge to do more' was a recurring theme. While this can relate to clinician's enthusiasm for their roles, clinicians also noted how this tendency may not always be helpful. It was often associated with anxiety about the patient deteriorating, disengaging, or not recovering. This contributed to a feeling of stuckness and emotional fatigue. Overidentification with a client is known to make therapists vulnerable to overdoing in therapy (Leahy, 2007); thus is, it possible that, although relating to your clients can improve empathy, it may also activate therapists' vulnerabilities.

Clinicians also noted becoming aware of their own bodies within the therapeutic space, comprising comparisons to the client, concerns about their own bodies and eating behaviours. This replicates existing findings in the literature; for example, Levas-Luckman (2014) also reported that ED clinicians become aware of their bodies and worry about what the patient thinks of their size. In the present study, the client living in a thinner body was deemed to be more threatening than the client living in a larger body; this was the case with clinicians working with both underweight and non-underweight presentations.

Other clinicians acknowledged that they felt uncomfortable discussing body image with patients due to their own body image concerns and hypothesised that they might avoid this if they allowed their countertransference to remain unchecked. This relates to

Objectification Theory (Fredrickson & Roberts, 1997). For example, in Objectification Theory (Fredrickson & Roberts, 1997), people habitually monitor their own bodies in anticipation of receiving comments or feeling looked at. Thus, it follows that ED clinicians experience fears about what the patient thinks about them, given that bodies are the focus of the topic of conversations, patients are pre-occupied with shape and receiving comments from patients about their size is known to happen within ED treatment (Warren et al., 2008).

It is also possible that thinner clients may be closer to the clinician's perception of the ideal, so clinicians experience an unfavourable upward comparison to the patient as per the Tripartite Influence Model (Thompson et al., 1999). Indeed, one participant experienced worse unfavourable comparisons to the client with underweight clients than clients who were closer to her size (this was also related to her fears around their judgement). However, another participant working with severe anorexia nervosa presentations found it challenging to compare himself to them, given the extreme nature of their appearance. It is worth noting that this participant was male, and his ideal body was the lean, muscular ideal, which he had not observed in his work experience.

Clinicians were skilled in building therapeutic relationships and had good relationships with most clients. Most felt they did not hold negative attitudes towards clients because of their size. In addition, clinicians showed self-awareness and reflexivity about their countertransference reactions, which enabled them to keep them in check and avoid harm to the therapeutic relationship. That said, some unconscious bias was at play,

which was evident through the therapist's use of language at times. For example, therapists living within thin bodies reported having "standard" bodies and not "having to" fight to meet the ideal. This demonstrates the normalisation of thinness within society (i.e. thinness is "the standard body" despite evidence that the average BMI in the UK is 27.2 (Public Health Analysis Directorate, 2021), which sits within the 'overweight' range on the BMI scale. It also demonstrates the implicit attitude that people who do not live in thin bodies are *expected* to make efforts to meet the ideal. As the conscious desire to move towards an inclusive stance does not necessarily defuse complex emotional reactions, which often happen at a pre-conscious stage (Foster, 1998), we can see how cultural values may be brought unconsciously into therapy despite therapists' best efforts to be self-aware.

RQ 2: How do clinicians working with people experiencing EDs make sense of socially constructed narratives about eating, weight, and shape?

This is most appropriately considered concerning the themes 'Clinician understanding of diet culture and appearance ideals' and 'Therapist experience of the narrative', as well as the subthemes 'Untangling two conflicting beliefs' and 'Managing the impact'.

The clinicians agreed that socially constructed narratives about weight and shape were highly prevalent and endorsed but equally unfair and failed to consider non-modifiable factors impacting a person's weight. Findings in the literature support clinicians' views.

Studies have shown that individuals can have diverse body sizes despite comparable exercise and diet regimens (Komaroff & Twain, 2016). Clinicians felt that, due to the prevalence of such messages, it was understandable that these beliefs are widely internalised and endorsed. Clinicians felt that professional knowledge learned through their work In ED had helped them "overcome" unhelpful messages peddled by society and the media. This aligns with existing findings in the literature that clinicians who were educated on the non-modifiable determinants of weight were found to show significantly less anti-fat bias than before the education (Puhl et al., 2005)

Clinicians reflected on simultaneously internalising and rejecting the ideal. This created a complex inner tension, with clinicians reporting discomfort and "needing brain power" to consider these opposing views. This may speak to the difference between implicit and explicit bias. Implicit bias describes the unconscious preference for thin people over fat people, and explicit bias accounts for the conscious bias of thin over fat people (Phelan et al., 2013). In this case, clinicians may consciously endorse one point of view while implicitly holding another. This dichotomy is presented as being accepting of other people regardless of their size but simultaneously finding it difficult to accept their bodies in situations where they did not meet the ideal. Objectification theory (Fredrickson & Roberts, 1997) could explain the above points: suppose individuals view themselves from a third-person perspective to anticipate judgements from others; judging themselves very harshly may serve a more protective function by enabling the individual to be overly cautious.

Interestingly, most clinicians identified as having slim to average-sized bodies and acknowledged that their relationships with said narratives were less fraught, giving them relative privilege. This relates to the Tri-partite Influence Model (Thompson et al., 1999), in that appearance comparison leads to shame if the person does not perceive themselves to meet the ideal. In this case, clinicians felt they were close to the ideal, which explains why the emotional reaction was less intense. Relationships to the ideal were expected to be "more difficult" for people living in bigger bodies, attributed to a real risk of discrimination. This is an understandable belief, given the prevalence of negative attitudes towards people with larger bodies (Puhl & Heuer, 2010). However, weight *perception* rather than actual BMI has been found to have more of an impact on body shame (Papp et al., 2013). This may have important implications for the assumptions that clinicians make regarding the intensity of body shame depending on a client's size.

Clinicians endorsed reflective practice through peer conversations, supervision, and individual reflection. They felt that talking about this topic would help them to build self-awareness and potentially unlearn these attitudes. This aligns with literature recommending reflective practice for clinicians to critically appraise their weight and shape attitudes (Kinavey & Cool, 2019). However, while some clinicians reflected on these attitudes in personal therapy and supervision, others did not. Some felt this would be beneficial, while others felt this would be too intrusive or exposing. There was also a lack of opportunity to reflect on weight and shape attitudes due to time constraints in supervision, case management taking priority and the relative lack of opportunity for group reflective practice spaces. The Equality, diversity, and Inclusion (EDI) literature states that reflective practice spaces help clinicians build awareness of EDI issues

(Bolster & Jameel, 2024) and that engaging in EDI reflective practice helps clinicians feel more confident in exploring issues concerning race (Holdren et al., 2023). Therefore, the same may be true for clinicians working in ED (and other services where weight is a pertinent issue, such as bariatric services), reflecting on their attitudes to weight and shape. However, it is essential to acknowledge that discussing weight and shape attitudes will elicit differing emotional reactions to other EDI topics, such as racism, so the comparison may not be exact; however, similar processes may still apply.

This reluctance was also somewhat apparent in the clinician's use of language, with most clinicians avoiding using descriptive terms such as "fat" and "thin" and opting for vague descriptors such as "look a certain way" or "having a different body." Clinicians were asked to clarify why they chose to say "certain way" instead of using a specific adjective. Reasons given were that they were anxious about using terms which could be perceived as body shaming and so stuck to ambiguous terms to stay neutral, but also that they were trying to account for multiple possibilities due to the speed at which body image changes and individuals having different body ideals and not wanting to assume. This could have implications for the therapeutic relationship, with service users noting that clinicians miss opportunities for helpful discussions about societal fat phobia and this feeling harmful (Harrop, 2019). The same could be valid for avoidance of naming specific body types, with clients feeling marginalised or "othered."

Clinical implications

The results highlight several clinical implications for ED services. The findings demonstrate that clinicians have complex relationships with societal narratives about weight and shape. This comprised feeling torn between internalising the thin ideal and rejecting it. Therapists named a need for specialist supervision on this topic, but there was a lack of opportunity or encouragement to do so. This makes sense, given the lack of training in this area and the fact that anti-fat bias is often not considered within unconscious bias training and diversity reflective practice (Mchugh & Kasardo, 2017). Despite this, ED clinicians should reflect on weight and shape attitudes (DeLucia-Waack, 1999; Kinavey & Cool, 2019) and reflective practice is known to reduce bias concerning fatphobia (Powers, 2019). Despite explicit anti-fat bias not being evident within this sample, reflective practice and specialist supervision regarding weight and shape attitude could help clinicians to bring any implicit biases to their awareness, support them in checking countertransference reactions in a safe environment and normalise clinicians' experiences of feeling 'torn.'

This study highlights the need for clinical training programmes and services to consider how to support clinicians in reflecting on weight and shape attitudes. Training programmes for ED clinicians could add anti-fat bias and weight and shape attitudes as a curriculum item. One primary consideration is the need for specific guidance regarding supervising and training ED clinicians and supporting them to reflect on their attitudes to weight and shape. Therapeutic manuals lack guidance on this, and in some modalities, therapists' weight and shape attitudes are deemed to be of minor importance (e.g.

Fairburn et al., 2008). This study's findings indicate that this may not be the case and suggest that clinicians' attitudes to weight and shape are integral to the therapeutic picture.

Strengths and limitations

This is the first study to explore the interaction between clinicians' weight and shape attitudes and the therapeutic relationship. It builds on existing research on how clinicians make sense of societal narratives about weight and shape and provides valuable insight into the lived experience of ED clinicians. To avoid undue influence of the researcher's biases and assumptions on the study's design and analysis, external stakeholders, namely service users and ED clinicians, were consulted regarding the interview schedule and the analysis. Member checking of the analysis gave a helpful external perspective regarding the interpretation of the interview transcripts, which helped to enrich the findings. The researcher also kept a reflexive journal to note their reactions to the interviews, which was reflected in supervision.

Multiple ED teams were contacted and requested to participate in this study; two were specialist ED services working with the full range of ED presentations, and two were IAPT services with treatment pathways for 'mild to moderate' EDs. However, only staff members from the specialist services volunteered. Given that volunteers came from specialist services, the findings may only be partially generalisable to clinicians working in non-specialist ED teams. Given the lack of cultural and gender diversity within the sample, results also reflect a narrow demographic group of clinicians. Furthermore, As

the sample size was small, the likelihood of each participant winning the £100 voucher was relatively high. There are potential limitations associated with this, namely that the prize may have attracted individuals who were motivated by the financial incentive, which may have caused selection bias and there is a possibility that the sample was non-representative of the wider population as a whole. However, generalisability is not necessarily a goal of IPA (Brocki & Wearden, 2006), and the diversity of the sample is broadly like the average demographic profiles of ED clinicians found elsewhere (Jennings Mathis et al., 2021). Despite this, it is vital to consider this while interpreting the results.

Although none of the participants had a close, personal relationship with the researcher (in line with the study's exclusion criteria), some were the researcher's colleagues. This may have impacted how candid participants were in the interview due to social desirability. However, given the sensitive and personal nature of discussing weight and shape attitudes, social desirability may have impacted all participants, regardless of whether they worked alongside the researcher. In addition, Foster (1998) describes that many cultural countertransference reactions may occur outside of conscious awareness, meaning that a semi-structured interview may not capture the full extent of reactions. To capture as complete an account as possible, the participants were given an optional reflective form to log thoughts, feelings, images, and fantasies following appointments in the lead-up to their interview. As this was optional and not collected by the researcher, there were inconsistencies in how the participants used them. Making the forms compulsory may have rendered richer interview data, particularly regarding unconditioned automatic thoughts and emotional reactions, but may also have impacted willingness to participate.

Future research

It is recommended that future research focuses on developing guidance to support ED clinicians in reflecting on their weight and shape attitudes. None of the participants in the research were supervisors, so the perspective of how supervisors may feel about encouraging their supervisees to reflect on weight and shape attitudes was not obtained; this would be useful to investigate in the future. Further research could examine existing practices, such as what services are already doing to support ED clinicians in reflecting on weight and shape attitudes and barriers and facilitators to achieving this. If this research is used to generate reflective practice guidelines for ED clinicians, future research would also be warranted to test these guidelines' feasibility, acceptability, and effectiveness in improving therapeutic relationships, clinical outcomes, and clinician well-being.

Conclusions

This study found that internalising the thin ideal at some point in life helped clinicians feel closer and more understanding of their patients with EDs. Sometimes, this pressured clinicians to try and know everything and do everything for their clients. Clinicians simultaneously endorsed anti-diet and weight-inclusive attitudes. Clinicians knew they held some implicit bias but tried their best to challenge their thoughts. Clinicians had not reflected much on their attitudes about weight and shape, and there were mixed feelings about how it would feel to do this. Due to the cognitive dissonance clinicians felt about simultaneously holding two opposing attitudes, it was felt that

specialist supervision and support about making sense of their weight and shape attitudes would be beneficial. The clinical implications of this study will hopefully result in increased training and reflection for ED clinicians regarding their weight and shape attitudes and the development of guidance on how best to do this. This could be informed by future research investigating existing practice, supervisors' perspectives and the acceptability, feasibility, and efficacy of said guidance.

Chapter 3: Integration, Impact and Dissemination

Integration

The overall aim of this paper was to explore how societal narratives about weight and shape are experienced and emerge within therapeutic interventions for people experiencing eating disorders (ED). It sought to gain insight into how clinicians reflect on and manage dominant discourses, which are often at odds with their aims for treatment, and to develop recommendations on how to support staff working within this setting.

The systematic and empirical papers had similar objectives, with some differences. Both focused on establishing clinicians' attitudes to weight and shape. The systematic review examined the diverse types of attitudes to weight and shape, such as body image and weight bias. The empirical study built on this by looking more specifically at situating clinicians' attitudes to weight and shape within the context of society's values, past experiences, and therapeutic relationships. Where the systematic review synthesised studies including ED clinicians of any discipline, the empirical study focused on the experiences of therapists delivering psychological interventions to provide a more nuanced perspective specific to psychological therapists. The systematic review synthesises findings from differing viewpoints, such as quantitative and qualitative studies, from various theoretical perspectives. The empirical paper builds on the findings from the systematic review, which discusses how societal narratives emerge during ED therapy and makes this the focus, taking a social constructionist, feminist, and phenomenological stance.

The findings across both papers are related and can be well integrated. For example, findings from both the systematic review and the empirical study show that therapists all bring lived experiences of receiving messages from society that thinner is better; this may result in body dissatisfaction, self-conscious feelings, or dieting behaviours. Furthermore, it is evident that society's influence contributes to the othering of fat bodies and the normalisation of thin bodies. This may result in implicit and explicit anti-fat bias, which was more evident in quantitative studies. In qualitative studies, although clinicians discussed feeling influenced by societal narratives, they expressed negative attitudes towards their bodies but did not discuss negative attitudes towards other people's bodies. This may have been due to social desirability, it may have been due to this bias happening on the subconscious level, or it may have been due to the clinicians' mindset in the context of treatment, e.g. it is not appropriate to judge someone's body outside of clinical decision making. Clinicians across the systematic review and empirical study also discussed finding that their attitudes to weight and shape had been impacted by their work in ED, with them gaining knowledge about nutrition and non-modifiable determinants of weight and taking a more critical stance towards societal weight and shape narratives.

On the other hand, clinicians noted that they were now more aware of their thoughts about weight, shape, and their bodies. The valence of this difference varied from study to study; in the empirical study, the participants felt a tension between the benefits and drawbacks of this. Overall, it was felt to be a complex and confusing experience, although people overall thought that the benefits of working in ED outweighed the negatives. Across the systematic review and the empirical study, lived experience of thin-

ideal internalisation was felt to enhance the therapist's understanding of the patient and give a therapeutic 'edge.' However, there was a narrative present that therapists should resolve their existing concerns about eating, shape, and weight to work in ED, with concerns about potential harm to the patient or the therapist if this were not the case. However, this prediction has not been tested empirically, so it is difficult to ascertain whether this is true.

The empirical study aimed to build on some of the findings from the systematic review. The participants were asked how their attitudes to weight and shape might impact the therapeutic relationship. Clinicians had complex reactions to clients based on many factors, and clinicians were mindful of the unique dynamics between each client/therapist dyad. In general, clinicians felt anxiety when faced with underweight clients, which was related to physical risk concerns. This, coupled with the clinician's empathy towards the client due to their lived experience of thin-ideal internalisation, alongside the experience of feeling liberated from the ideal, could cause pressure to know and do everything for their client. At times, this was seen to take responsibility away from the patient and contribute to therapeutic "stuckness." This was perceived to disadvantage the patient in the sense that they took less of an active role in their treatment, which was felt to stall their progress. This contributed to feelings of exhaustion and burnout among the therapists.

Participant and researcher reflexivity

Participant reflexivity

The participants were given optional reflective forms within the empirical study to assist them with the interview. These forms were provided to capture fleeting emotions, images, or fantasies during therapy sessions in the weeks leading up to the interview in real time. This was intended to capture the differing reflections that may come up during reflection-in-action instead of reflection-on-action (Schön, 1983). A retrospective interview alone may limit clinicians' ability to access their reflections (Carmichael et al., 2020). However, these forms were not made compulsory due to concerns about the feasibility of asking clinicians to complete forms with high workloads. As they were optional and were not intended to be part of the analysis, I did not collect them. Although I did not explicitly ask whether the participants had completed the log, I observed that about half referred to them; two people admitted that they had not completed them, and the other two did not mention them.

The British Psychological Society (BPS) and Health and Care Professions Council (HCPC) recognise the reflective practice as a core competence (BPS, 2017; HCPC, 2015), and this has gained traction in clinical psychology to help answer the questions that scientific data cannot answer, such as how to interpret resistance and how to react to client questions (Lilienfeld & Basterfield, 2020). According to (Meehl, 1957), when we have no specific guidance to guide clinical decision-making, we need to use our heads. This involves reflecting on the present clinical situation and considering our past experiences,

colleagues' experiences, psychological theory, and wisdom. Reflective practice can occur in multiple ways, such as thinking, supervision, peer discussion, and writing (Lilienfeld & Basterfield, 2020). Psychology training programmes commonly recommend completing logbooks, personal journals, or diaries to help therapists reflect on their cognitive and reflective reactions to patients, to consider why they made certain clinical decisions, what the alternative course of action might have been, and to evaluate what went well and what could have been improved (Cooper & Wieckowski, 2017). This is believed to lead to greater self-awareness to facilitate growth (Osterman, 1990) and to lower susceptibility to cognitive biases (Toplak et al., 2011).

Time and motivation are two critical barriers to reflective practice identified in the literature (Gathu, 2022; Gilheaney & Quigley, 2022). Interestingly, reflexivity is an integral part of the role of a psychologist. However, there was a concern that asking the participants to complete a reflexive log was considered too much of a burden on them. The lack of time and opportunity for reflective practice was also commented on within the interviews:

E.g. "*But obviously because I have so much to bring to supervision, it can often be anything that I might just want to reflect on rather than have any questions about might be I might choose to leave that to the end"* – Diana.

E.g. [When discussing reflective practice spaces focused on weight and shape attitudes and clinicians struggling with body image] ...L*ike it's never actually said, and it might be*

that they're having, like, individual conversations or whatever, but there isn't like anything overtly made available for [that] – Emilia

This demonstrates the delicate balance that one must achieve when designing a research study, to balance in-depth, detailed data analysis alongside not adding undue burden to your participants and risk dropping out. The participants themselves report the need for more time and opportunity for reflection, so making the reflective log compulsory may have been overwhelming. If participants had not completed the log, I may have had to exclude them from the study and would not have been able to gather the exciting data they brought.

In the initial stages of designing this study, I assumed that eliciting reflective diaries could serve as a means of 'tapping into' private data, which may have been rawer and less constructed than an interview account. However, it is essential to acknowledge that participants are constantly engaged in a self-editing process (Bell, 2010), and there is no guarantee that the data gathered from reflective logs would be richer than what emerged during the interviews. However, other studies have found that diaries provided a tool for participant self-analysis and enabled discussion about participants' contradictions within the interviews via the facilitation of reflexivity on the part of both participant and researcher (Harvey, 2011). With that in mind, I would also be interested to know if the results would have been different if the logs had been a compulsory element of participation and a part of the analysis. Furthermore, given that participants were not used to discussing their attitudes to weight and shape, keeping a log beforehand may have helped them to access more of their thoughts and awareness.

Personal reflections

I developed most of the research design and interview schedule before beginning my placement within an ED service. Much of the literature I had read to prepare the study's design focused on weight stigma and clinician body image. Although I did not set out to test a specific hypothesis due to the study's idiographic approach, the literature I had read in developing the study had caused me to expect findings relating to clinician body image and weight stigma. However, working in an ED service gave me some fascinating insight into the working culture of ED professionals, which I held in mind while analysing the interview transcripts. I was struck by not hearing any "diet talk" in the break room, which, in my experience, is commonplace in other settings. This, alongside getting the sense that my colleagues were quite liberated from diet culture and instead focused on nurturing themselves, caused me to change my expectations of what participants would discuss during the interview.

In addition, just before I began the interviews, I gained the experience of delivering ED therapy. I felt anticipation towards this given my firsthand experiences of an ED and with regards to my interview questions and wondering how *I* would answer the questions as someone in a comparable situation. Before interviewing my first participant, I answered my interview questions as part of my bracketing process. It was helpful to examine the impact of my early experiences and my family's attitude to weight, shape, and eating, become aware of my pre-conceived ideas and reflect on how this plays out in the therapy room. My personal experience is that this is a complex phenomenon; it is often challenging to be aware of your automatic thoughts and attitudes to weight and shape as

the focus is often on the patient's beliefs. It can be challenging to untangle the patient's beliefs and feelings and what they are my own. Thus, I realised that many interview questions were complicated and required much reflection.

Smith et al. (2009) discuss how IPA sits within the hermeneutics of empathy and the hermeneutics of suspicion. The hermeneutic of empathy comprises understanding and interpreting texts or accounts by empathising with the perspective and intentions of the author by placing oneself in their shoes. The hermeneutic of suspicion involves critical examination and scepticism towards texts or accounts, questioning the surface meanings and looking for underlying ideologies or unconscious drives, according to Smith et al. (2009). IPA should sit in the middle of these two positions, combining both empathy and suspicion. That is, to move between standing in their shoes and empathising with their experience and then taking a step back and critically reflecting on how they construct their account and the potential cultural influences on this.

Regarding my process, I initially approached the study from the hermeneutic of suspicion. I was mindful of the societal narratives of weight and shape and expected to uncover their insidious influence on people during my interviews with the participants. I should also be transparent in stating that I have a strong dislike towards diet culture narratives due to my lived experience, feminist stance, and general scepticism towards the status quo. Therefore, it might be fair to say that I was "out to get" diet culture and expose its nefarious activity amongst ED clinicians. However, as I gained experience as an ED clinician and came to understand the challenges associated with working in an ED service, I took a more nuanced approach to my colleagues' attitudes, and I shifted more

towards the hermeneutic of empathy. I felt anxious about reaching too far and making an unfair interpretation. I wanted to portray my participants in a good light. This is influenced by some of my participants being my colleagues, my enjoyment of carrying out the interviews and liking all my participants. It felt refreshing to discuss this topic with like-minded people. However, with this frame of mind, I risked not adequately answering my research question, so I needed to review my analysis several times from both perspectives, finally settling on a place which felt adequately empathetic and questioning.

I was nervous about sending my annotated transcripts to my participants and them seeing some of my 'suspicious questioning' in the margins. For example, when I noted that they had started to minimise or had contradicted themselves, as a defence. I steeled myself to have awkward conversations after offending one of my participants. Member checking is commonly used in IPA research but also has its critiques (Mcgaha & D'urso, 2019), namely, that member checking creates a reversal of the power dynamic between the researcher and the participant, the participant may choose to change their story, or the researcher may overly romanticise the participant's account (Varpio et al., 2016). I experienced a temptation to mask some of my more 'suspicious' interpretations for this reason. However, I was pleasantly surprised that my participants gave insightful comments, which added value to my analysis. For example, a participant who had not struggled with body image added helpful context to her account by explaining that her parents had consistently been very complimentary towards her appearance, which had helped her to feel confident and worthy. This helped to check my biases and assumptions; it became clear that I was expecting to hear about unhelpful comments

resulting in poor body image, so it was beneficial to consider an alternative perspective. Despite concerns within the IPA literature that member checking may give 'too much power' to the participant and detract from the interpretative nature of this analysis, my experience is that it can also help to bracket some of the researcher's unhelpful biases by adding more context to the account.

Impact

The empirical paper and systematic review have significantly contributed to the ED literature and have important clinical implications. The findings provide valuable insight into reflective practice and unconscious bias within this population. The findings can significantly impact various stakeholders, including clinicians delivering therapeutic interventions to people with ED, service managers within ED services, training providers, researchers developing guidance for therapists and therapy manuals, and third-sector organisations supporting people with EDs.

In terms of clinical impact, this research may normalise ED clinicians' experiences and provide a language for their experience. It may encourage them to reflect on their attitudes to weight and shape independently, with their peers or in supervision. For service managers, this research may encourage them to set up reflective practice spaces to discuss weight and shape attitudes, to provide in-house training to colleagues about reflecting on their attitudes to weight and shape and to support their supervising clinicians to facilitate conversations about weight and shape attitudes with supervisees. People developing training programmes on clinical training courses for continued

professional development may also set up training for ED clinicians to reflect on their attitudes to weight and shape. Overall, I hope these initiatives will result in increased self-awareness, more normalised discussions about weight and shape, and an opportunity for increased emotional and practical support for clinicians.

There is a potential for service users accessing ED treatment to benefit if ED clinicians are more able to reflect on their attitudes to weight and shape. Evidence suggests that reflective practice can assist in reducing explicit and implicit bias, improving treatment outcomes (Dovidio et al., 1997). Furthermore, this research may be used to add weight and shape attitudes or weight bias to Equality, Diversity, and Inclusion training, thus providing another avenue for clinicians in training to consider their attitudes to weight and shape. This may reduce unhelpful countertransference reactions and aid in improving the therapeutic relationship and, in turn, improve outcomes.

In terms of academic impact, research may generate more studies which will aid in developing the best practice guide to reflect on their attitudes to weight and shape. I hope that other researchers in the field will take this research forward, by generating studies suggested in “Future Research” on page 135. There is a need to understand the barriers and facilitators to reflecting on weight and shape attitudes and the actual impact this will have on outcomes.

Dissemination

To maximise the research's impact, the study's findings will be disseminated to each relevant stakeholder, as mentioned above. The research has already been presented to Trainee Clinical Psychologists and staff at Royal Holloway. It is hoped that the findings may inspire future research projects and that the attendees gained insight into some of the ways the clinicians' attitudes to weight and shape emerge during therapy with ED clients. The research was also presented at a specialist ED service in London, and the researcher facilitated reflective practice afterwards. Feedback was collected to evidence the impact of this presentation. Attendees stated that the presentation had named a shared experience that was not widely spoken about among clinicians. Clinicians in attendance reported that they were keen to reflect more specifically on their attitudes to weight and shape. The impact of the presentation can further be evidenced by following up with the attendees, collecting information about their experience of reflecting on their weight and shape attitudes.

To further maximise the clinical and academic impact of the findings to a wide audience, the systematic review and empirical study will be submitted to peer-reviewed academic journals. The submission of two separate papers will maximise the dissemination to the academic and clinical community. Impact and journal relevance will be considered when picking journals to submit the papers to, as those with more citations will reach a larger audience. Therefore, the subsequent journals will be approached for publication: The European ED Review, Eating and Weight Disorders, International Journal of Eating Disorders, Journal of Eating Disorders, Body Image and Feminism and Psychology. This

impact will be evidenced by tracking the study's citation count and documenting alternative metrics and media mentions, such as views, social media mentions, and media coverage.

Furthermore, promoting the study via social media will enable the researcher to create relationships with other relevant stakeholders, such as ED researchers and those involved in developing treatment protocols and best practice guidelines. Presenting the findings at conferences will further enable networking with relevant stakeholders and increase the possibility that others may take this research forward or create opportunities for collaboration. Given the campaign work done within the third sector, which directly impacts ED treatment and research from a policy level, the researcher will approach third-sector organisations such as BEAT to broaden the dissemination of findings. This impact will be evidenced by maintaining engagement with stakeholders and potential future collaborators whom I encountered over social media, at conferences or via relevant third-sector organisations, by organising follow-up engagements with said stakeholders to explore further possibilities for future research and collaboration and by tracking subsequent publications.

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Appendices

Appendix A - *Ethical Approval*

Result of your application to the Research Ethics Committee (application ID 3826)

EA **Ethics Application System <ethics@rhul.ac.uk>**
To: NKJT013@live.rhul.ac.uk; elizabeth.harding@rhul.ac.uk; ethics@rhul.ac.uk

Monday 14 August 2023 at 09:25

PI: Elizabeth Harding
Project title: Clinician perspectives on how their attitudes to weight and shape impact the therapeutic relationship when working with eating disorders.

REC ProjectID: 3826

Your application has been approved by the Research Ethics Committee.
Please report any subsequent changes that affect the ethics of the project to the University Research Ethics Committee ethics@rhul.ac.uk

This email, its contents and any attachments are intended solely for the addressee and may contain confidential information. In certain circumstances, it may also be subject to legal privilege. Any unauthorised use, disclosure, or copying is not permitted. If you have received this email in error, please notify us and immediately and permanently delete it. Any views or opinions expressed in personal emails are solely those of the author and do not necessarily represent those of Royal Holloway, University of London. It is your responsibility to ensure that this email and any attachments are virus free.

From: [redacted]
Sent: Monday, June 26, 2023 2:58 PM
To: Dyer, Catherine (2021) <Catherine.Dyer.2021@live.rhul.ac.uk>
Cc: Harding, Elizabeth <Elizabeth.Harding@rhul.ac.uk>; Allen, Karina <karina.Allen@slam.nhs.uk>
Subject: RE: [EXT] IRAS 326421: Request for information

Hi Kate,

I've re-reviewed your application and if all that you are doing is asking for posters to be added for staff to opt-in, then this is not PIC activ other aspects which would warrant HRA/HCRW approval, and you only have clinicians, so no REC required.

I am only able to advise what approvals you may or may not need for your application. Ultimately it is the Sponsor's responsibility to ensi appropriate submissions are made. I am happy to withhold withdrawal if you wish to get further confirmation.

Please let me know how you would like to proceed.

[redacted]
Approv Specialist
Health earch Authority
T.
W. www.hra.nhs.uk

Appendix B – Example of local R&D/ Trust approval to recruit

[EXT] FW: Research project - query

AC

To: Dyer, Catherine (2021); Cc:

Wednesd

Dear Catherine,

Thank you for gettin k to me. We have decided your study does not require R&D review because it is a:

1. Staff only stu herefore n/a to CAG monitoring)
2. You wish to c inate posters electronically to staff mailing lists in eating disorders services (no patient involvement).
3. HRA and REC pt (University ethics and protocol has been provided and reviewed)

We have c g disorder service who you may contact to see if they have capacity to supp

Kind regar

Senior R& nance Facilitator, Joint R&D Office

Upcoming Wednesday 25th - Mon 30th October (returning Tue 31st October).

Appendix C - *Poster*

How clinicians' attitudes to weight and shape impact the therapeutic relationship when working with eating disorders

ROYAL HOLLOWAY UNIVERSITY OF LONDON

V2.0 23/10/2023
Project ID: 3826

I'm looking to explore how therapists working with eating disorders experience and make sense of their own attitudes towards weight and shape in their clinical practice. I hope this project will aid in understanding how to support clinicians working with this population, by improving reflective practice, supervision and training.

This research will form part of my thesis for the Doctorate in Clinical Psychology at Royal Holloway University of London.

Who can take part?

Any clinician (trainee or qualified) working within an NHS eating disorder service/ treatment pathway who is currently providing psychological interventions to people experiencing eating disorders and is able to reflect on the therapeutic relationship with this client group is eligible to participate.

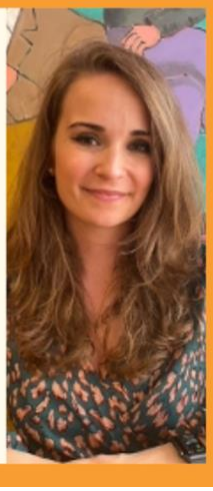
What would it involve?

- Taking part in a one-hour interview via Microsoft Teams
- An optional reflective log

Each participant will be entered into a £100 voucher prize draw.

For more details and an information sheet, please contact Kate Dyer, Trainee Clinical Psychologist via

Catherine.dyer.2021@live.rhul.ac.uk



Appendix D - *The participant information form*

Version 1.0
Date: 22/06/2023

Prospective Research Participant Information Sheet
Department of Psychology
Royal Holloway, University of London

Project Title: Clinician perspectives on how their attitudes to weight and shape impact the therapeutic relationship when working with eating disorders.

Chief Investigator's names and email addresses: Elizabeth Harding; Elizabeth.harding@rhul.ac.uk and Karina Allen; karina.allen@slam.nhs.uk

Primary Researcher: Kate Dyer; Catherine.dyer.2021@live.rhul.ac.uk

Introductory paragraph

You are invited to take part in a research project. Before you decide to consent to take part, you need to understand why the research is taking place and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Please consider carefully whether you wish to consent to take part.

Why is this research being conducted?

In Western culture, thin bodies are deemed ideal, which can lead to stigma and prejudice towards those living in larger bodies. Therapists also exist within a society that promotes the thin ideal, which may impact their beliefs towards weight, shape and eating. Past research shows that working with eating disorder clients can make therapists conscious of their bodies, causing anxiety. Studies have shown that a client's body size can impact the therapeutic relationship. I expect to learn more about how these issues might affect therapists' well-being and their relationship with their clients. I hope that once this is better understood, NHS services will be able to find ways to support therapists with their well-being and ensure that clients are receiving good quality care.

Why have I been invited to take part?

You have been identified as a participant because you are a clinician providing psychological interventions to people experiencing eating disorders. Clinicians with a personal relationship with the researcher will not be invited to participate to minimise conflict of interest. A total of 8 participants will take part in the study.

Do I have to take part?

No. It is up to you to decide whether you wish to participate. You can withdraw from the study at any time, without any consequences and without needing to give a reason, and you can withdraw your data until 1 April 2024 by contacting the primary researcher. After this date,

the research will be submitted as a thesis for assessment and withdrawing your data will no longer be possible.

What will my participation involve?

In this study, you will be invited to an interview where we will discuss experiences of working with clients with eating disorders, the therapeutic relationship, your experiences of societal narratives towards weight and shape and how this has impacted your attitudes to weight and shape. The interview is anticipated to last for one hour and will take place remotely via Microsoft Teams, or in person on the Royal Holloway Campus in Egham. With your consent, I would like to record your interview so that I can transcribe the interview and will use the transcript to analyse themes in your account. You are welcome to pause or take a break in the interview anytime. The recordings will be destroyed once transcribed.

You will consent to participate in the interview by signing a consent form.

Before the interview, you will be invited to keep an optional reflective form to capture your experiences of working with clients as they happen in the two weeks leading up to the interview. The form is optional and is intended purely as a reflective prompt to assist you in the discussion. It is up to you whether you wish to use the log, and you can record as much or as little information as you want. The form will be private; you do not have to hand it to the researcher. I will then analyse the interviews to find common themes in therapists' experiences.

What are the possible disadvantages and risks of participating, and how might these be mitigated?

The content of the interviews may be upsetting or uncomfortable to discuss. If this is the case for you, you can take a break at any point in the interview. You can drop out of the study at any time, but the research team will keep the research data about you that they already have. This is to protect the validity of the research and is permissible as an exemption to data subject rights under GDPR.

The data collection method (optional reflective form and interview) may create a time burden for clinicians working in an NHS service. To minimise this burden, the reflective forms will be optional. Clinicians can add as much or as little information as they feel helpful when completing them to prevent causing unnecessary stress by adding to an already busy workload. In addition, the interviews may take some time (up to an hour), which may be difficult if clinicians are already pushed for time. To counter this, interviews will occur remotely to eliminate the need to travel to interviews, thus reducing the time burden. In addition, the interviewer will be offered flexible time slots, with the option to be interviewed outside of typical working hours. Participation in the study is also voluntary, and participants can withdraw if they do not have enough time for the interview.

Measures will be implemented to protect your data (including special category data on ethnicity), with data being anonymised where possible and kept securely. Despite this, there is a small risk that these measures may be circumvented, although this is extremely rare.

Are there any benefits to taking part?

Participants may find that the interview provides a valuable opportunity for reflective practice along the themes of appearance ideals, the therapeutic relationship and their beliefs.

Payments

Each participant will have the option to be entered into a £100 voucher prize draw.

What information about me will be collected?

We will need to use information from you for this research project.

This information will include your name and contact details. People will use this information to do the research or to check your records to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?'

You can find out more about how we use your information

- by asking one of the research team

- by sending an email to dataprotection@royalholloway.ac.uk
- by ringing us on 01784 917157.

Contact after the study has finished.

I would like your permission to contact you after the study has concluded to check my interpretation of the interview data to ensure the validity of the findings. You may also opt-in to receive a report about the study findings once it is complete. In addition, if you want to enter the £100 voucher prize draw, you must consent to be contacted after the study so that the voucher can be sent to you if you win.

How will the results of my participation be used? Will the research be published? Could I be identified from any publications or other research outputs?

This research will be used to produce a thesis as part of the Doctorate in Clinical Psychology, which will be deposited in Pure, Royal Holloway's research information system, and with the British Library to be made available via the EThOS electronic thesis. The findings from the research may be written up in academic publications, conference presentations, a report commissioned by an external organisation, websites, videos etc. Participants will not be identifiable from the outputs.

I would like your permission to use direct quotations without identifying you in the research outputs.

Who do I contact if I have a concern about the research or wish to complain?
If you have a concern about any aspect of this study, please contact either the primary researcher, via Catherine.dyer.2021@live.rhul.ac.uk, or the principal investigators Elizabeth Harding via Elizabeth.harding@rhul.ac.uk or Karina Allen via *karina.allen@slam.nhs.uk*, or Royal Holloway's Research Ethics Committee via ethics@rhul.ac.uk. If you wish to make a formal complaint, please email integrity@rhul.ac.uk.

Ethical Approval

This study has received ethics approval from Royal Holloway, University of London's Research Ethics Committee, with the approval ID of 3826.

Safeguarding and when confidentiality may need to be breached.

Confidentiality might need to be breached due to safeguarding or legal reasons. If the primary researcher is concerned about unsafe practice, harm to clients or fitness to practice, this will be flagged to your local safeguarding officer or the service lead via PALs.

Data protection

This research commits to abide by the Data Protection Act (2018). For detailed information about what this means for research participants, please visit the Research Participant Privacy Notice: *https://intranet.royalholloway.ac.uk/research/documents/researchpdf/new-intranets/research-participant-privacy-notice.pdf*

General Data Protection Regulation Statement

Important General Data Protection Regulation Information (GDPR). Royal Holloway, University of London, is the sponsor for this study and is based in the UK. We will be using information from you to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Any data you provide during the completion of the study will be stored securely on hosted servers within the European Economic Area. Royal Holloway is designated as a public authority, and in accordance with the Royal Holloway and Bedford New College Act 1985 and the Statutes which govern the College, we conduct research for the public benefit and in the public interest. Royal Holloway has put in place appropriate technical and organisational security measures to prevent your data from being accidentally lost, used or accessed in any unauthorised way or altered or disclosed. Royal Holloway has also put in place procedures to deal with any suspected personal data security breach and will notify you and any applicable regulator of a suspected breach where legally required to do so. To safeguard your rights, we will use the minimum personally-identifiable information (i.e., the email address you provide). The lead researcher will keep your contact details confidential and will use this information only as required (i.e., to give a summary of the study results if requested and for the prize draw). The lead researcher will keep information about you and data gathered from the study, depending on the study's duration. Certain individuals from RHUL may look at your research records to check the accuracy of the research study. If the study is published in a relevant peer-reviewed journal, the anonymised data may be made available to third parties. The people who analyse the information will not be able to identify you. You can find out more about your rights under the GDPR and Data Protection Act 2018 by visiting https://www.royalholloway.ac.uk/about-us/more/governance-and-strategy/data-protection/ and if you wish to exercise your rights, please contact dataprotection@royalholloway.ac.uk

NB: You may retain this information sheet for reference and contact us with any queries.

Appendix E - *Consent form*

Version 1.0
Date: 22/06/2023

Research Participant Consent Form

Name of study: How clinicians' attitudes to weight and shape impact the therapeutic relationship when working with eating disorders.

Name and email address of researcher: Catherine Dyer, Catherine.dyer.2021@live.rhul.ac.uk

Name and email addresses of supervisors: Elizabeth Harding, Elizabeth.harding@rhul.ac.uk and Karina Allen, karina.allen@slam.nhs.uk

Research Participant - please read the following statements and indicate your consent by adding your initials in the right-hand column.

I confirm that have read and understood the information sheet V1.0 Dated 22/06/23	
I agree to participate in this study	
I have had the opportunity to ask questions about this study	
I have received satisfactory answers to my questions about this study	
I understand my participation in this study is voluntary	
I understand that I am free to withdraw from the study/research project at any time until 1 April 2024, without giving a reason and without detriment to myself	
I understand that my interview recording, and transcripts will be stored securely on a password protected device. Identifiable data (contact details and demographic information) will be kept separately on a password protected device to ensure anonymity. Interview recordings will be destroyed as soon as they are transcribed. I understand that a pseudonym will be used when presenting excerpts of the interviews. All data will be backed up on Dropbox for business. This data will be kept by the researcher until the study ends. Consent forms will be kept by the thesis supervisor for up to two years after the study ends in a secure location. After the study ends, the data will be kept in a research depository for up to 10 years.	
I agree to be video or audio recorded for the interview. I will be given a choice at the beginning of the interview.	
I agree that anonymized excerpts of my interview may be included in the write up of the project under a pseudonym.	
I agree that direct quotations of my interview may be included in the final write up of the project under a pseudonym	
I understand that confidentiality may be breached in circumstances as detailed in the information sheet.	

Optional clauses – you can participate in the research if you do not consent to these elements of the study

I agree to complete the optional reflective log in advance of the interview	
I agree to provide my contact details and to be contacted after the study has finished to be entered into the £100 voucher prize draw.	
I agree to be contacted after the study has finished to validate interpretation of the interviews.	
I agree to receive a report on the study's findings via email after the study has finished	

Participant signature..... Participant Name .....

Date .....

Researcher signature ..... Researcher Name .....

Date .....

Please note that this Consent form will be stored separately from the responses you provide. One copy of the consent form will be given to the participant and one copy will be kept in the research file.

If you have any concerns about this research, please email ethics@rhul.ac.uk.

Appendix F - *Demographic form*

Demographic form

What is your age?

18-24			
25-34		55-64	
35-44		65-74	
45-54		75 or above	

What is your ethnic group?
(Please choose one option that best describes your ethnic group or background)

Asian/ Asian British	**Tick**	**Other Ethnic Group**	**Tick**
1. Indian 2. Pakistani 3. Bangladeshi 4. Chinese 5. Any other Asian Background, please describe: _____		1. Arab 2. Any other ethnic group, please describe: _____	
Black / African/ Caribbean/ Black British	**Tick**	**White**	**Tick**
1. African 2. Caribbean 3. Any other Black background, please describe: _____		1. English/Welsh/ Scottish/ Northern Irish/ British 2. Irish 3. Gypsy or Irish Traveller 4. Any other White background, please describe: _____	

What gender do you identify as?

Female (including trans woman)		Prefer not to answer	
Male (including trans man)		Other _____	
Non-binary			

Profession

Please state your profession (e.g. Clinical Psychologist, Counselling Psychologist, CBT therapist etc.) **:** _____

How long have you worked with clients experiencing eating disorders?

Please state in years: _____

Appendix G - *Debrief form*

Study Debriefing

This study concerns how clinicians make sense of their beliefs towards weight and shape while working with patients experiencing eating disorders.

How was this tested?
You were invited to a semi-structured interview and asked to reflect on your experiences of societal narratives around weight and shape, your beliefs around weight and shape, how (if at all) they presented while working with patients with EDs and how you make sense of this. You were also given an optional reflective form to be a reflective prompt during the interview. The form was designed so that you could capture your experiences of therapeutic sessions as they happen. The interviews will now be transcribed and then analyzed using interpretative phenomenological analysis.

Hypotheses and main questions:
We are interested in investigating how therapists working with eating disorders relate to societal attitudes towards weight and shape. We are interested in how clinicians' beliefs about weight, shape and eating impact the therapeutic relationship with ED patients and how working with this population affects a clinician's attitude towards weight and shape. We do not have any expected findings and are open to discovering a variety of accounts.

What if I want to know more?
If you have concerns about your rights as a participant in this experiment, please contact ethics@rhul.ac.uk. If you wish to make a formal complaint, please email integrity@rhul.ac.uk. If you wish to contact the research team, please email Kate Dyer at Catherine.Dyer.2021@live.rhul.ac.uk, Liz Harding at Elizabeth.Harding@rhul.ac.uk or Karina Allen at Karina.Allen@slam.nhs.uk.

What will happen with my data?
The recordings of your interview and transcripts will be saved on a password-protected laptop using a number rather than your name to maintain anonymity. The interview recording will be destroyed once it has been transcribed. The consent forms, demographic forms, and interview transcripts will be stored on a password-protected device and backed up using Dropbox for business until May 2024. The research data will be held for ten years after the publication or public release of the research work. Separately, we will record participants' names and email addresses corresponding to those numbers. This will be stored as an Excel spreadsheet on a password protected device. The internal supervisor from Royal Holloway will keep signed consent forms in a locked cabinet for five years before they can be destroyed for audit purposes.

Contact after the study
If you have consented to be contacted after the study, you may be invited to provide feedback on my analysis of the interviews. In addition, you will be emailed a report of the study once it is finished and you will be informed if you are the winner of the £100 voucher prize draw.

Accessing Support
If you feel upset after completing the study or find that some questions or aspects of the study were distressing, talking with a qualified clinician or counsellor may help. If you feel you would like assistance, you can contact the BEAT helpline on 0808 801 0677. Alternatively, you can book an appointment with your GP or call the Samaritans on 116123.

Thank you again for your participation.

Appendix H - *Interview schedule*

Interview schedule

1. Can you describe your understanding of the terms diet culture and appearance ideals?

2. Can you describe any key experiences or memories that have shaped your relationship to food, eating, weight & shape?

(Examples if needed: seeing predominantly thin people in the media, cultural eating/feeding practices)

Prompts: How have these experiences affected you (how you see yourself, your values, stance as a therapist)? How did you interpret those experiences? Why do you think that experience happened? What was going on in your mind then? Thought/ associations/ images?

3. Can you describe how working with eating disorders makes you feel about your body?

Prompts: What kinds of reactions do you have? Why? What thoughts run through your mind? What did you make of those thoughts? Why do you think you had those thoughts? What did you notice in your body? How do you respond to those thoughts?

4. Can you describe how societal narratives about ideal bodies impacts your perspective of yourself and your clients?

Prompts: What narrative about weight and shape exist within your culture? What narratives are you most aware of/ struck by? Do you notice when these narratives are the most present in therapy? Are there any times when they are not present? Why do you think that is? How does this interact with your personal characteristics (e.g., cultural/religion/gender etc)

5. Overall, how would you describe your beliefs about eating, weight and shape, both generally and in relation to yourself?

   Prompts: What beliefs do you have about your body? What physical sensations strike you?

6. Can you describe how you reflect on your attitudes to appearance ideals and diet culture in your clinical practice?

Prompts: do you notice anything coming up for you during therapy or during supervision (thoughts, feelings, values)? Have you received any training on this? What is it like reflecting on your attitudes to weight/shape? Why?

7. Could you describe your experiences of the therapeutic relationship when working with ED clients?

Prompts: Can you describe times when the relationship has been remarkably positive? Particularly challenging? Why do you think that was? What was the most challenging thing/ what did you enjoy the most? Do you ever notice that beliefs about yourself are present in the therapy room? What about beliefs about others? How do you manage this?

8. Thinking back to a recent therapy session (you can refer to the form provided before the interview if you wish), did you notice any thoughts or uncomfortable feelings in the session?

Prompts: If so, what were they? What was that session like? Did you notice any narratives about diet culture or appearance ideals during the session (either your own or your client's)? If so, what did you make of them?

9. In relation to the previous question, can you describe any impact that your work has on your wellbeing? How do you think services can best support clinicians working with EDs?

Prompts: Do you notice any interaction between attitudes to weight and shape (either your own, your clients' or societal narratives) and your wellbeing when doing therapeutic work? How do you manage this? How does your service support you?

10. Is there anything else we have not covered about how attitudes to weight and shape impact the therapeutic relationship that you would like to discuss now?

Appendix I - Summary table of themes with additional extracts

Superordinate theme	Subordinate theme	Supporting quotes
	Definitions	*"So and I guess appearance ideals for me would be... the, I guess, societal... standards, like beauty standards..." – Harry* *"My understanding is like beauty standards that are upheld by society in the media about... yeah, the ideal of what people should look like". - Grace* *"you're supposed to be cutting out specific foods in order to gain a beautiful, beautiful body in the sense that whatever the... the ideal is...' – Francesca* *"I guess the narrative that you need to look a certain way to be treated a certain way" – Harry* *"I need to [...] go to the gym and I need to eat these like umm... these foods to... to look a certain way" – Diana* *"So, Diet Culture to me is kind of the the general..umm thing that's in society about kind of what you should be having to eat, what you should be having to drink [...]And I guess it's the, I guess the culture around it is like drink this or eat this and you'll look like this or drink this and... and have this and you'll be able to have this stomach or this this amount of kind of muscle or and I guess it's like the views around it" – Diana* *"Umm so with diet culture, I guess that's like all of the myths that we hear in the media around, like, ways to lose weight. What's healthy, what's not and just, yeah, lots of misinformation about how to lose weight and also like the pressure of always having to...I dunno...the work out ways to lose weight." - Grace*

Clinician understanding of diet culture and appearance ideals	*1.1 The expectation and pressure to meet the ideal*	*I need to do it go to the gym and I need to eat these like umm… these foods to… to look a certain way – Diana* *"buy all these creams to kind of… saying "if you put this on your thigh, you know your thigh, reduce the size". - Carolina* *' I have lots of conversations about this big, big, big bit on capitalism and trying to get people to spend money and feel bad about themselves so that they kind of feed into this this ideal' – Emilia* *it's kind of a thing hard not to be influenced because it's really everywhere. I just find it quite… I guess… I don't know… messages [at the] back of my head - Carolina* *"And I guess there's also so many like…things that promote it from like a business perspective, whether it was Weight Watchers or like Noom or Zoe" – harry* *"I remember seeing Noom and it been advertised like a psychological way of losing weight and I remember, you know from a psychologist being like "oh I wonder how helpful it is, and what what they've done, that must be good, it must be healthy it must be appropriate, "but actually again it's it's a business thing and it's a marketing that it's psychologically OK, whereas I don't know exactly what they're doing, probably not". - Harry* *[when talking about hypothetical weight gain] "I guess part of that is part of why there would be so much tension in accepting that is probably knowing that I would be treated differently probably I think just based on…. and type of society we live in. Yeah. And I think that would make it harder to to accept" – Alice*

		"This society does have things to say about people that are overweight [...] You're probably gonna have people judge you because of the way you look, because that's just unfortunately, the way humans work and the way that the world works".... - Diana *"There's an influence from society in general anyway, because you read so many different things. Umm, but I guess sometimes hard to know what's right, not right. [...]"* - Carolina *"I can completely understand how for some people, if, for example, they're very overweight and for their entire life has they've been very overweight, how that can impact on the way that they relate to people and how other people relate to them and how they feel about themselves and that is a very important part of their identity."* - Francesca
	1.2 Culture and Identity	*"[Beauty standards] are always changing as well ...umm...to do with trends and stuff...."* – Emilia *"dieting is seen as I guess being maybe powerful and self restrained being actually something that's valued in society"* – Carolina *"But I guess changing, but slightly, so in the 90s for example, you had a big emphasis on the... umm very skinny supermodels and now, thankfully I think it's...I think there's not quite as much of an emphasis on it, but it's still there in the background"* - Beatrice *"....I guess it's different in different times, but it's kind of what's like the popular way to look at the moment...And I think that have been a bit of a shift like*

		relatively recently from maybe kind of like… well, just like kind of thin to more like thin but toned and you know kind of a gym…. a gym look," Diana *"Yeah, and yeah, there's a lot of a lot of the male clients I've worked with have come from kind of like LGBT backgrounds and I feel like there is like a lot of pressure for gay or non-straight men to s- a certain body type" – Emilia*
Therapist experience of the narratives	*2.1 Early experiences*	*"When I was a child, like my parents used to kind of say the different benefits of food to make us eat them and like the… and that was really helpful, I guess to kind of get you excited about eating a range of foods as as as a kid." – Alice* *"I can't help but… think about the way that I've grown up and the way that I view the world…umm, being quite pathological, maybe because it's all it also gets confirmed within work and these fads" – Francesca* *I did have some people around me who were very conscious […] later in like in high school they were very self-conscious about their bodies and they would say things like oh, I need to get fit for this event. I'll just eat apples for three days and I'll be fine because I can do it. – Francesca* *"I think I have like a relatively healthy view towards body image like I do value appearance and I do care about my appearance maybe more than I guess I should [laughs] and but I don't put all of that on like shape and weight, so I think I have quite a healthy view towards shape and weight, even though there are still aspects of my body that I'm like maybe unhappy with" – Grace* *'… I'm not a very confident person when it comes to my body and I think it comes from, from that how other people treated me when I was younger' – Harry*

		“I remember when I was younger my mum [had] anorexia [...] there was something around that... Yeah, “buy all of these creams” [...] All the things online or things on TV shows [...]but I just remember when I started having my eating disorder when I was seventeen. Kind of....Yeah, started buying all of these things, [...] and so it did kind of impact the way I see my body” - Carolina
	2.2 Clinician attitude to weight and shape	*“Like, sometimes you'd see obviously...See someone who looks really, really lovely and in the media but...umm... it doesn't kind of motivate me to change much. I think I've got a lot.... I'm less so much less determined that I used to be in that in that side of things” – Beatrice* *“There have been times when I was a little bit younger where I kind of...wished for something a little bit different..” – Alice* *“I personally am a pescatarian so I don't eat meat, but I'm... have no kind of feelings about how other people eat or what they believe in. If they want to kind of eat meat, eat meat, be vegan. Whatever it is, that's... their choice I feel like that's kind of flexibility and room for all people's eating patterns and in terms of like body and weight and stuff like that” - Emilia* *Like I think I've always had that awareness, not awareness, but like... wanting to be a certain body image or wan-wanting to look a certain way and stuff like that,- Emilia* *“I say eat healthy as a clinician versus eat healthy as a person, it probably means very different things. So I'm always very aware when I say, you know, people say, “eat healthilly” in the session. I'm like, “well, what does healthy eating mean to you? Because to me it means a balance”. [...] And whereas when I say it to myself, it means probably what they mean and it means probably*

		cutting down on takeaways and probably like really greasy carby food and introducing more veg" - Harry *"I think I have like a relatively healthy view towards body image like I do value appearance and I do care about my appearance maybe more than I guess I should [laughs] and but I don't put all of that on like shape and weight, so I think I have quite a healthy view towards shape and weight, even though there are still aspects of my body that I'm like maybe unhappy with." - Grace*
	2.3 Reflecting on the narratives	*"Everything is so much about like genetics and you don't really realize that and you think if you just follow the same plan as someone else you might look like them but actually you might have completely different like genetic makeup - Diana* *"We're in a very appearance based society. I guess the one thing to challenge is that not everyone thinks like that...." – Diana* *"a lot of the diets can be quite restrictive and unhealthy, ummm ....they're not necessarily perceived that way in kind of a diet culture that perceives dieting is a normal part of life, I guess." – Alice* *"...Frustration really with society and a bit of a mixture of feelings.... I think frustration and also just really wanting people to change." – Beatrice* *I appreciate that the technical term for diet is everything that you've consumed. But the way that I've grown up and the way that I've seen patients talk about diet, is restrictive diets. – Francesca*

The Impact of working in an ED service	*3.1 Professional knowledge as a protector*	*"...'cause I've learned so much through working in eating disorders, lots of psychoeducation has been really interesting," - Diana* *"I no longer want to be the skinny person. I want to be healthy, so the emphasis now is just being healthy and looking after your body." – Beatrice* *"I've been able to see how kind of like regular eating and stuff...[pause] like kind of has an impact on like you're your weight for one and stuff and it's kind of undone a lot of the things that I've been told about, like dieting and umm... body image and stuff throughout, like my upbringing and things like that." – Emilia* *"So then it's kind of hard, I think, to balance things out. See, I'm aware probably I still rules, but also I'm not trying to follow them because I know I didn't....The carbs are important and your brain only uses glucose, so I kind of had like, a science scientific background aswell I started when I was trying to think about actually....Why? Before it was fine and in society now it's not fine" - Carolina*
	3.2 Push and pull	*"Since working in eating disorders, I feel like I've built my own acceptance of the way I look." - Emilia* *I think that, like I said, I think there is almost like this more awareness... on like body image and body shape and weight and things like that. Umm... I've also.... And this isn't just from this, this is sort of from way back when I first started working at eating disorders as well. A lot more awareness of things like calories in certain foods and things like that. And...like I you know, I said before, I don't really allow it to kind of change what I do – Emilia* *I'm being silly, I know I'm going against everything I'm trying to teach my patients, so yeah, definitely just try and just like trying to rationalize them and just be like no...come on, just being silly! Yeah, I think it's important to like, I do*

		think it's an important to notice those thoughts though, because I and yeah, it it can, I'm sure effects that somehow your relationship with patients or your your therapeutic work even if it's not like known or not obvious - Diana *"I guess that maybe I felt a bit like "ohh I'm a bit of a like an hypocrite here" or like a fool because I kind of, you know I say it's OK to eat that , but then you're like...but I don't know if I would do that every day." – Carolina*
	3.3 Managing the impact	*I don't necessarily know how you would navigate it to be like a part of supervision because some people might really not want to... Kind of talk about it and that's fair as well. – Alice* *but I think yeah, the service overall having like a healthy approach to eating and body image and making space for like these difficulties when they do come up, whether it's a supervision or reflective practice ...- Grace* *And I think probably you can work to unlearn those, but that is a time consuming process - Alice* *.... I guess if the patient isn't progressing as much as like the textbook would have, expect or umm... I don't know, things come up that are more complex that I feel I don't know how to like go about that. then I think I can feel... like quite negative on myself, like quite anxious umm....and that can, like, really impacts my mood of that day – Grace* *, I guess reflective spaces, but not everyone uses them in the way and they're certainly meant to be. Umm... and also I don't know how I'd want to reflect on my body in a group reflective space and how it affects my body, whether that's like something to think about in supervision – Harry*

		"And one morning [...] I was making oatmeal, I was adding banana and I thought to myself "ohh [patient]... does not eat banana [...] [and] my initial reaction was a little bit "Oh, this is bad because this is a lot of sugar, but then I [...] the conscious mind came, and it was like "no man, I need carbs." – Francesca
Clinician experience of therapy	*4.1 The Therapeutic relationship*	*"I can see how people can get caught up in those things [very restrictive diets]" – Alice* *I think I'm quite positive and encouraging, ummm...but also like empathic towards people's experiences umm having gone through it myself as well. But having come out the other side and noticing how it's like completely much better world and yeah, I think I tried to show people... try to and help people see that. – Beatrice* *Maybe I spent much more time listening and validating and acknowledging all the positives - Carolina* *I think I guess I can understand they feel about it and I guess maybe there is a sense or even though I used to struggle with my body image. I guess I'm not as obsessed as I used to be or so maybe I kind of have a bit of hope[...] but probably [I take a position of] hope and that things can change. I'm really aware that it's a process where it takes time – Carolina* *"As it does... with as it does with in any situation, you know you sometimes you get on with some people more than other people. On the whole, though, I think I've had good relationships with people. Umm. And you know, they come to the sessions and ...and yeah, have been able to confide in me" – Beatrice*

		So definitely the ones that are healthier weight that comes with more emotional[…] regulation and the ability to feel their emotions a bit more […] Often they want to change. …They want to get rid of their […] symptoms." – Diana *Like am I….Is this transference, am I picking up on how the patient feels that they're like not doing good enough and they need to do more than like not doing the right thing – Grace* *"…The relationship with an anorexic patient….um…. And I guess the… the connotations of what anorexia is, and the lying and hiding and manipulation and dishonesty and being cynical from my side and maybe not believing people and something to the relationship, or even it doesn't add it in the room" - Harry* *"But I think that probably just speaks to like my own insecurities, cause the thing I'm most anxious about is, like doing a good job as psychologist as opposed to, like, my body….So yeah" – Grace*
	4.2 Awareness of the clinician's body	*I I work with people who have […] [BMI] around you know 15 or 16 but have a few like are weight restored like around 22 or 23. So I guess that's kind of when I work with them, maybe it's a bit easier because I don't feel like too big maybe [laughs] but we may be more kind of similar - Carolina* *I've never had to fight for that, you know the same way some people have… some people I know have had to. – Emilia* *[In response to something a patient said in therapy, I thought] "my gosh, but she doesn't want to be like me, and I'm probably very big obviously"…. – Carolina*

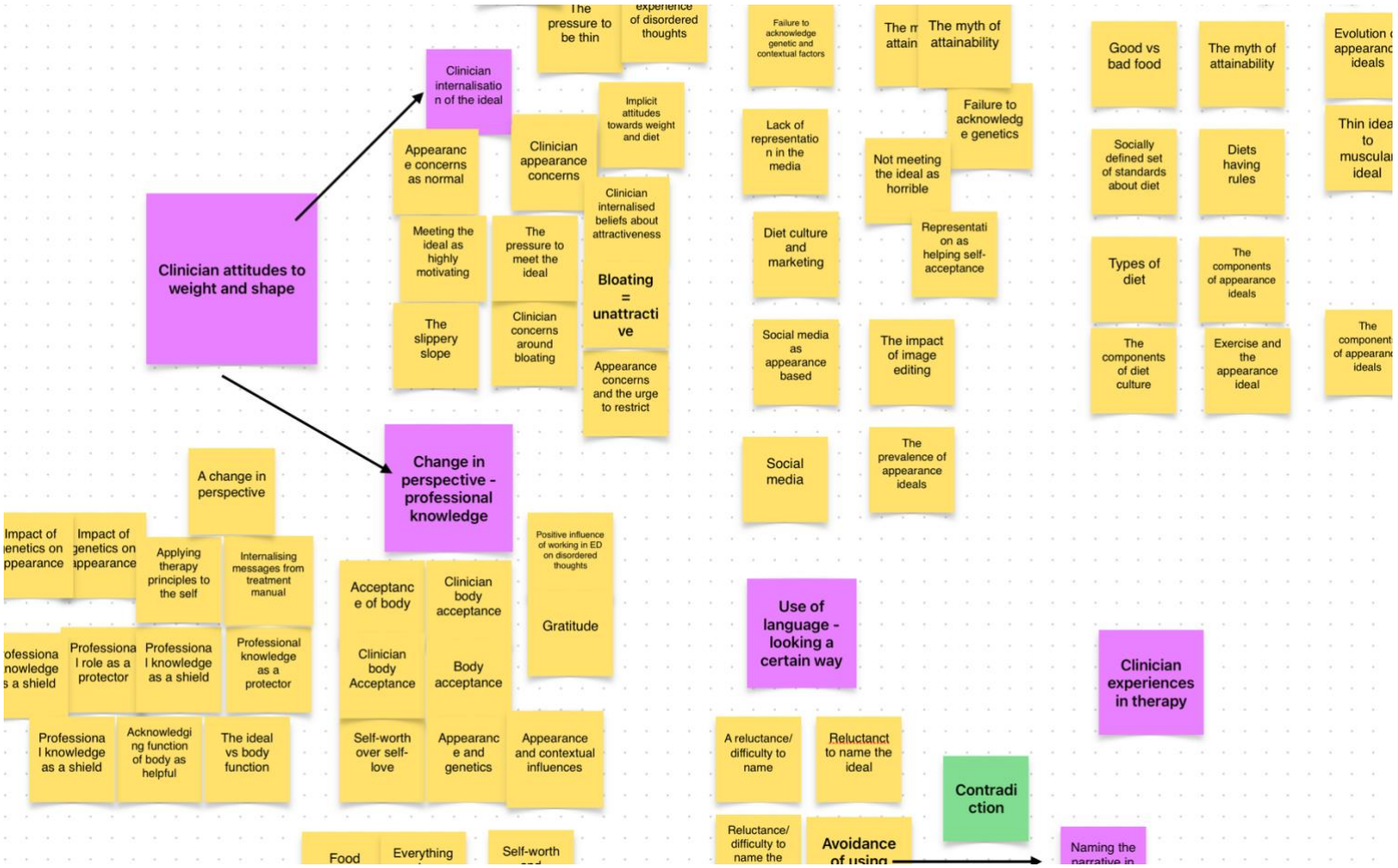
		"I've experienced those like strong and thoughts of like, dislike towards my body or like noticing my body much more than I would before." - Grace
	Making sense of the client's body	*"when you first meet someone [...] [you might have an unconscious thought, or] might judge that person based on what I judged to be the societal ideal for a man or a woman. And but then my clinician hat comes on and goes well [...] "doesn't matter what they look like", and I don't think I'm even really conscious of that happening [...]. I'm in the room and I'm aware of where I sit and the power I hold, or the dynamic and whatever, and that's not a thing..." – Harry* *And I guess I become very...used to them looking this particular way that sometimes when I see them recovered or a healthy weight range, my first thought is "your face looks chubby. You put weight on" and and then I go "What the hell is that?" – Harry* *"I don't know if that's there like size per se or more, just like with healthy weight comes the emotional... Yeah, I guess it's like it's about like the ability to like get in touch with those feelings or like you're willingness to engage." - Diana*
	The tension of doing individual work in an unjust society	*"I think like in the kind of 1 hour sessions or whatever it may be, you can say all these things and someone can kind of be agreeing, but then they have to go out into the world. And yeah, as you said, they're gonna get bombarded. Probably on social media, with really unhelpful things" – Alice* *Because they've existed in this narrative their entire lives, they haven't necessarily become aware that this is being dictated by someone else,[...]I feel like as long as people are aware of this then they will be better able to make a decision for themselves[...], so it's a long hard reflection on how is this serving*

		you and is it not? […]if not, how can we try and stay conscious of this and carefully examine any and all advice and anything we hear? - Francesca *When working with higher weight clients, clinicians considered how societal fatphobia was relevant to formulating their difficulties.* *"[Fatphobia] affected how they see themselves and how others see them, because that's also a very real factor. I've met so many people actually outside of work who are really angry and disgusted by overweight people. They see them as extremely selfish, so I'm very aware that […] the threats that they've been facing [are very real]. Umm, so that's changes the work, […] because the focus is something else [in comparison to working with underweight clients] like […] I get why you want to fit in and to look a certain way." - Francesca*

Appendix J – Example of transcript analysis –

Body image concerns as inaccurate The use of language Clinician body image Taking a dual position re body image The impact of working on ED and BI Awareness of the body and of thoughts Tension Clinician body checking A pressure to follow the treatment values	definitely did care very much about, like my body and how I looked in photos and keeping up appearances on social media and things like that. And and I don't. I don't really care so much about that anymore. R: Thank you very much for that. OK, the next question, I think maybe kind of links in a little bit with kind of what you've been saying. But can you describe how working with eating disorders makes you feel about your own body? P: It's again...it's such a weird, weird things to think about because I think I have a lot more awareness of when I'm thinking about my body, so there's almost like this additional pressure to... 'cause, like I've always had that. Like I think I've always had that awareness, not awareness, but like... wanting to be a certain body image or wan-wanting to look a certain way and stuff like that, but never really gave it that much thought or consideration because it was always quite manageable like I was always reasonably content with how I looked and stuff like that. Like, I wasn't ever striving to lose massive amounts of weight. It was just sort of like more of a standard wanting to be a certain way. Umm... so I think I'm more aware of that now and I'm more aware of like, like my weight and body changes and stuff like that. So there is an element of there being more pressure on that and more kind of like focus on my body in general or my weight in general and what I eat and things like that. I don't kind of allow myself to sort of giv in to what that means. If... and like act on those thoughts and feelings because yeah, I try and challenge that. So it's it's weird, it's better, but then it's also worse. I don't know. Yeah. R: Yeah. So almost kind of feels like you're being, like, pulled into directions, I guess at once. Can you can you maybe give some examples of like the thoughts or the feelings that you get kind of when you're experiencing that? P: Yeah. So I suppose there's... like I'm I'm... like I said, I'm always sort of very aware of my body. Like I always like look at my body in the mirror, I do my weight kind of semi-regularly and and I think that kind of obviously provokes some sort of feelings from time to time, whether it's positive or negative. But then I also feel like there's a real pressure from myself too like, eat consistently and allow myself to have nice foods. And you know what I mean? Like not giving in to these ideas around like weight loss or trying to change what you do to do with your weight and shape and and yeah, so yeah....	Something about if you're in the bottle it's hard to read the label Is aware of body and body image, wanting to look "a certain way" *Difficulty naming? Goes without saying? What is getting in the way here??* You can compare yourself to the ideal, have desires to meet the ideal and also be content at the same time Is more self-aware re thoughts, but also more aware of body and its changes and diet. But also doesn't want to "give in" to the thoughts There's a tension between two positions Body checking, checking weight and emotions associated with that But then also feeling a pressure not to do the diety behaviours and follow the treatment values

Appendix K - Example of pulling together emergent themes



Appendix L - Example of reimbursement receipt

Clinician perspectives on how their attitudes to weight and shape impact the therapeutic relationship when working with eating disorders.
Receipt of payment for experts by experience

I confirm I have received a payment of £25 cash or voucher for participating in the above research study, conducted by Catherine Dyer, Trainee Clinical Psychologist, Doctorate in Clinical Psychology, Royal Holloway University of London

No.	Date	Name	Amount	Signature

EBE Signature .....

Trainee Signature .....

Supervisor Signature .....