ELIZABETH A. DUNN BSc Hons

CLINICIAN EXPERIENCES OF TREATING EATING DISORDERS AND THE USE OF CLINICAL SUPERVISION.

Section A: Experiences of Clinicians Providing Treatment for Individuals with Eating Disorders – A Literature Review.
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Section B: Clinician Experience and Supervision when Working Therapeutically with Individuals with Anorexia Nervosa – A Delphi Study.
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A huge thank you to my amazing husband, family and friends for their unwavering confidence, support and patience. Thank you mum, for inspiring me and teaching me the value of education, hard work and persistence. Thank you also, to the participants who took part in this study for their commitment to this project, and for their dedication to the field of eating disorders. Thank you to my supervisors, Dr Anna Oldershaw and Professor Tony Lavender; your knowledge, guidance and enthusiasm for this research has been invaluable.

Summary of the Major Research Project

Section A: Experiences of Clinicians Providing Treatment for Individuals with Eating Disorders – A Literature Review.

A systematic review of empirical literature was conducted exploring the experiences of clinicians working with individuals with eating disorders and the resultant impact on clinician wellbeing. The literature search yielded seventeen relevant studies. Results indicated that clinicians from a variety of professional backgrounds experience a range of emotional, cognitive, behavioural and physical responses in their work with individuals with eating disorders. Negative reactions were related to emotional exhaustion, decreased desire to work in the field and reduced quality of care. Clinician reactions were mediated by clinician, client and therapy factors. Supervision was the most frequently cited form of support and self-care.

Section B: Clinician Experience and Supervision when Working Therapeutically with Individuals with Anorexia Nervosa – A Delphi Study.

A three round Delphi study was conducted exploring the experiences of a sample of 69 international experts working therapeutically with individuals with anorexia nervosa, and the core requirements of clinical supervision. Positive experiences were more frequently reported than negative experiences. Key negative emotions comprised sadness, anxiety, frustration and inadequacy. The impact on clinicians thinking about food and body-image were inconclusive. A large number of statements were produced, reflecting the core elements of supervision, encompassing areas of discussion, reflection, supervisor qualities, the supervisory relationship, barriers and facilitators, and supervision outcomes.

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Abstract

Eating disorders are serious mental health conditions which adversely affect an individual's eating, shape or weight-controlled behaviours. They have poor treatment outcomes, high rates of chronicity, medical complications and mortality. As such clinicians working with individuals with eating disorders may encounter a unique range of experiences and difficulties, and thus have particular support needs. Despite this, no systematic literature review focusing on the empirical literature relating to the treatment experiences of clinicians in this field has been conducted. An electronic search of three databases and complementary manual searches yielded 17 relevant studies. Clinicians from a variety of professional backgrounds were found to experience a range of emotional responses in their work with individuals with eating disorders, comprising frustration, anger, anxiety, inadequacy and sadness. Evidence of cognitive, physical and behavioural responses were limited. Negative reactions related to emotional exhaustion, decreased desire to work in this field and reduced quality of care. Clinician reactions were mediated by clinician, client and therapy factors, most notably level of clinician experience. Clinical implications are discussed, as is the need for future high quality research in this area, particularly a more detailed consideration of factors influencing clinician responses and the use of supervision in managing these.

Keywords: Eating Disorder; clinician; response; emotion; countertransference

1. Introduction

1.1 Eating Disorders

Eating disorders (EDs) are characterised by a disruption to eating or weight-controlled behaviour, creating subjective distress, and impeding psychosocial functioning and physical health (Murphey, Straebler, Cooper & Fairburn, 2010). ED prevalence is greatest in females, likely developing during adolescence or early adulthood (Neuber et al., 2014). EDs have high rates of chronicity, medical complications and death, due to suicide and physical health complications (Wentz, Gillberg, Anckarsäter, Gillberg, & Råstam, 2009). As such, EDs have the highest rates of mortality of all mental health (MH) difficulties (Mitchell & Crow, 2006).

At present, diagnostic classificatory systems such as the International Classification of Diseases, 10th revision (ICD-10; World Health Organisation, 1992) and the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V; American Psychiatric Association, 2013) are often used to classify groups of clinical features of EDs and other MH difficulties, to determine an individual's access to treatment and specialist psychological services. Such diagnostic systems currently lack validity and reliability (British Psychological Society, 2013). Diagnostic labels, such as "Anorexia nervosa" (AN) are therefore limited in their utility and do not capture the unique factors influencing the development and maintenance of each individual's difficulties surrounding eating, shape and weight. Such labels also risk pathologising the individual and minimising the importance of psychological and social factors relating to the individual's distress (BPS, 2013). The Division of Clinical Psychology (2011) therefore recommend that all interventions should be supported by evidence-based psychological theory, models and formulations. Despite this, diagnostic labels are frequently utilised within psychological services and literature. Whilst the authors of this paper do not endorse the medical model or support the use of diagnostic labelling, for

brevity, and to best reflect the current evidence-base this paper will employ the diagnostic terminology used within the literature reviewed.

AN is characterised by the pursuit of weight loss and maintenance of abnormally low body weight, body-image distortion, and fear of eating and weight gain (Walsh, 2013). Bulimia nervosa (BN) is described as periods of binge eating (i.e., eating large quantities of food in a short period of time, whilst feeling out of control), followed by periods of purging calorific intake through compensatory behaviours encompassing, vomiting, laxatives, diuretics and excessive exercise (Fairburn & Harrison, 2003). There is increasing recognition of atypical EDs, commonly referred to as 'eating disorder not otherwise specified' (ED-NOS; APA, 1994), whereby the presentation does not fully match the diagnostic criteria of either AN or BN (e.g., binge eating disorder, BED). The formal name for such atypical EDs was recently re-classified to 'other specified feeding or eating disorder' (OSFED; APA, 2013).

1.1.1 Eating disorder treatment.

Across EDs, the National Institute for Clinical Excellence (2004) recommend psychological therapies. The modality of therapy and its utilisation varies across ED subtype and client age. For instance, family interventions are strongly supported for young people with EDs. Cognitive behaviour therapy (CBT) is well evidenced with both adolescent and adult BN populations. There is no clear first choice of psychological therapy for adults with AN, however CBT, cognitive analytic therapy (CAT), interpersonal therapy (IPT), focal psychodynamic therapy and family interventions are all supported.

Multidisciplinary team (MDT) treatment is advocated in order to support holistic recovery (Williamson, Martin & Stewart, 2004). MDTs may include medical doctors, psychiatrists, nutritionists, dieticians, clinical psychologists, and psychotherapists, nurses, social workers and support workers (National Eating Disorder Association, 2014c). People

should receive outpatient treatment, with routine medical monitoring, and if required, inpatient admission for re-feeding and medical stabilisation (NICE, 2004).

1.1.2 Treatment outcomes.

ED treatment outcomes are typically poor (Bulik, 2014). This may occur for numerous reasons. For instance, early intervention is associated with better outcomes, however late diagnosis is common (Treasure & Russell, 2011). Moreover, EDs are often perceived by the sufferer as a solution to a problem rather than a problem itself, and low weight and ED behaviours are often viewed as an accomplishment (Rieger, Touyz, Swain & Beumont, 2001). 'Thinness' is often associated with self-worth and serves a powerful maintaining factor (Thompson & Heinberg, 1999). Attempts to treat the ED can thus be distressing and unwelcome (Geller, Williams, & Srikameswaren, 2001a). Consequently, individuals with EDs can be ambivalent to engage in treatment (Strober, 2004). EDs additionally have high rates of concurrent mood and personality disorders which can complicate treatment (Godart et al., 2007; Strober, Freeman, Lampert & Diamond, 2007).

Due to these factors, clinicians often struggle to engage sufferers in treatment. It is not uncommon that it is the family members of the ED sufferer who will have concerns and instigate help seeking (PwC, 2015). A high proportion of individuals with EDs, disengage from treatment, are unable to recover despite treatment or relapse following treatment (Mahon, 2000; Steinhausen, 2002). Treatment leads to the remission of symptoms in approximately 40-60% of cases (Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000). Ergo, EDs have poor treatment outcomes and their treatment and management is complex (Szmukler, Dare & Treasure, 1995). Poor treatment outcomes result in continued psychological distress and physiological consequences for ED sufferers. Families who are supporting a loved one with an ED, additionally experience a high level of burden, impacting

their social and family life, work, education and finances (Pricewaterhouse Coopers, 2015). Furthermore, a high level of cost to the NHS exists, with the average annual cost of treatment for one ED sufferer estimated as £8,850 (PwC, 2015).

EDs therefore, have a high level of impact on the individual, their family and the NHS. This places pressure and stress upon ED services. Clinicians thus face a range of factors making the treatment of EDs a more challenging experience.

1.2 Clinicians, Countertransference and Eating Disorders

Given the difficulties which may arise within the provision of psychological interventions for individuals with EDs, it is important to consider the experiences of the clinicians involved.

1.2.1 Countertransference.

Within psychological literature, the reactions experienced by a clinician towards their client are often termed countertransference. Whilst countertransference has been defined in various ways since its inception by Freud (1959), the following definition is frequently applied in modern empirical literature, whereby countertransference refers to "all the reactions a clinician has towards a patient, regardless of their source" (Satir, Thompson-Brenner, Boisseau & Crisafulli, 2009, p. 511). Countertransference by this definition comprises all clinician countertransference reactions which occur regardless of their origins in client, clinician and therapy factors. It further encompasses the clinician's emotions, attitudes and beliefs about their clients, which may or may not result in changes in a clinician's behaviour in response to their client (Thompson-Brenner, Satir, Franko & Herzog (2012).

1.2.2 Experiences of clinicians.

Substantial literature affirms the potential impacts of therapeutic work on clinicians delivering treatments and therapy across multiple clinical populations (Linely, & Joseph, 2007). A meta-analysis reported that 21-67% of MH clinicians experienced high levels of burnout (Morse, Salyers, Rollins, Monroe-De Vita & Pfahler, 2012). Further studies found that clinicians commonly report emotional exhaustion, depersonalisation and compassion fatigue (Figley, 1999).

Unique impacts have been found relating to individual MH populations. For instance, trauma clinicians may experience vicarious traumatization and secondary traumatic and post-traumatic reactions (McCann & Pearlman, 1990; Stamm, 1999). Identification of population specific impacts, allow for the identification of areas where greater therapist self-care is required and can be supported through formal support such as supervision (Baker, 2003).

1.2.3 Experiences of eating disorder clinicians.

Evidence suggests that clinicians working with individuals with EDs are at high risk of stress, and may experience a unique range of difficulties such as body-image disturbance and altered eating attitudes (Bordo, 2003). Negative reputations about working with ED populations exist, in that they are difficult to treat, and that clinicians have negative experiences (Kaplan & Garfinkle, 1999). Such perceptions likely contribute to individuals with EDs being viewed as undesirable patients, resulting in shortages of clinicians in this field (Thompson-Brenner & Westen, 2005).

A number of studies have looked at the reactions of clinicians towards patients with EDs. A systematic literature review (Thompson-Brenner et al., 2012) explored the reactions and attitudes of clinicians towards individuals with EDs and the impact on treatment. Clinicians were from a variety of therapeutic and non-therapeutic professions. Frustration,

hopelessness, and worry were frequently reported experiences. Limited education, training, and perceived knowledge and competency were reported by clinicians, resulting in a lack of confidence in their respective roles. Some clinicians held blaming and stigmatising beliefs about individuals with EDs. It is argued, if such emotional experiences of clinicians are not recognised, then they may have a deleterious effect on the therapeutic relationship and may undermine treatment outcomes, as well as impacting on clinician wellbeing (Shisslak, Gray & Crago, 1989).

1.3 Summary and Aims

The views of clinicians working with individuals with EDs have begun to be systematically explored, focusing on attitudes towards ED clients, and the resultant impact on treatment. Earlier reviews failed to assess the impact on the clinicians themselves and their consequent needs. To date there has been no reviews on the lived experience of clinicians, and the impact of working in this field on the clinician's own wellbeing. An important area of research therefore is an up-to-date review of the literature focusing on clinician's countertransference responses, in their work treating individuals with EDs, in relation to clinician wellbeing. This review aims to provide a summary of the published empirical literature which has explored the experiences of clinicians providing treatment to individuals with EDs, and provide a synthesis of the resultant findings.

2. Method

2.1 Literature Search

2.1.1 Search strategy and scope.

Initial literature searches and consultation with colleagues, working within the clinical area, identified appropriate search terms for ED type, clinician role and clinician experience (Table 1). The broad terminology of 'Eating Disorder' and alternative permutations were

used within this review, as an initial literature search indicated that many papers discuss results relating to EDs generally, rather than exploring ED subtypes. Studies including any type of professional working with individuals with EDs were included, due to the recommendations of treatment involving a range of professions.

Ovid literature searching software searched across PsychINFO and MEDLINE using a search matrix (Table 1). CINAHL was searched separately using the same search matrix.

Table 1

Key Search Terms for Clinician Experiences when Working with Individuals with EDs

Key terms related to Eating Disorders		Key terms related to clinician title/role		Key terms related to impact on the clinician
Eating Disorder or Anorexia Nervosa or Bulimia or Binge Eating Disorder	**AND**	Clinician* or Clinical Psychologist* or Counselling Psychologist* or Medical Personnel or Mental Health Personal or Physician* or Psychiatrist* or Therapist*	**AND**	Countertransference or Emotion* or Reaction* or Response or Defence* or Burnout* or Experience* or Wellbeing or Transference

Note. A compound search of the above searching matrix was applied.

The search was applied with no date restrictions, so that all relevant literature was identified. No exclusion criteria were set for client age, thus literature relating to both adolescent and adult ED populations were included. Search results are presented in a PRISMA diagram (Figure 1).

All records identified through the database searches were combined, and all duplicates removed. Abstracts of all remaining references were retrieved and read. If a title or abstract indicated that the paper might meet the inclusion criteria, articles were read in full. Manual

reference list searches were conducted for all included papers to identify any further potentially relevant references. Author searches were completed where two or more papers shared the same author. All studies included in Thompson-Brenner and colleagues' (2012) review were read in full in order to determine inclusion.

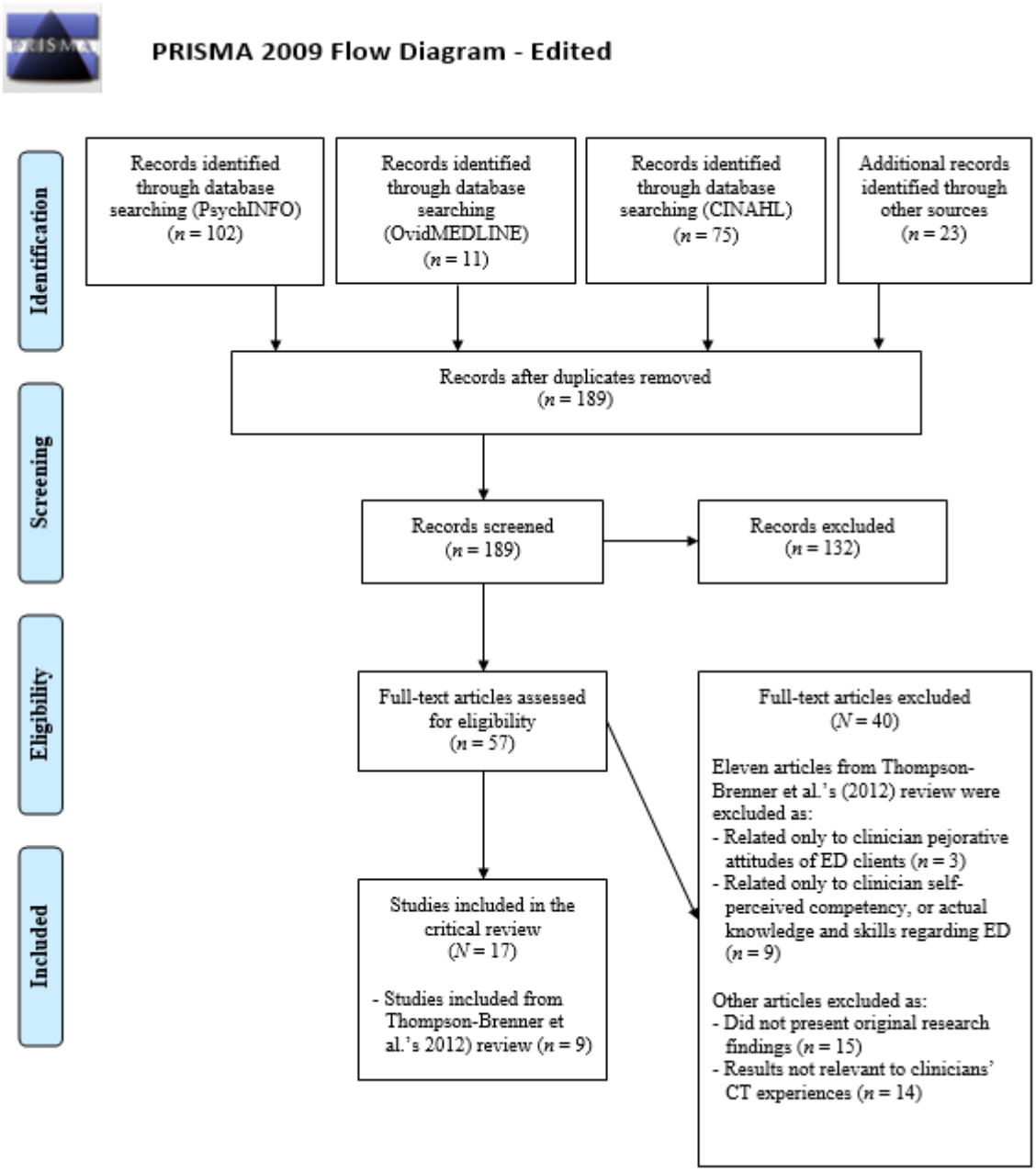

Figure 1. PRISMA flow chart showing systematic literature search (Liberati et al., 2009).

2.1.2 Inclusion criteria.

Inclusion and exclusion criteria are outlined in Table 2.

Table 2

Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Presents original research findings	Conference/presentations
Includes empirical evaluation of the experiences of clinicians working clinically with individuals with eating disorders	Unpublished works (e.g., unpublished thesis)
	Individual case studies
Published in a peer-reviewed journal	Non-peer reviewed literature
Written in English	Non-empirical literature, including opinion articles

2.2 Data Extraction and Analysis

All final papers were read and critically appraised. Quantitative studies were considered in relation to the relevant subsections of the NICE (2012) quality appraisal checklist for quantitative intervention studies (Appendix A). Qualitative studies were considered using Mays and Pope's (2000) assurance for qualitative research (Appendix B). A table was used to extract and compare data across studies to aid a thorough review of the literature (Table 3).

2.3 Structure of the Review

This review is reported in two sections. The first section outlines the literature relating to the varied experiences of clinicians when working with ED populations and provides a synthesis of the reported findings. The second section provides an appraisal of strengths and limitations of the papers discussed.

3. Review

3.1 Literature Identified

The final literature search retrieved 17 relevant papers dated between 1984 and 2015 (summarised in Table 3).

Eleven papers used quantitative methodologies, utilising experimental paradigms (Crisafulli, Von Holle & Bulik, 2008) and survey methods (Brotman, Stern & Herzog, 1984; Burket & Schramm, 1995; Colli et al., 2015; Daniel, Lunn & Poulsen, 2015; Franko & Rolfe, 1996; Kosmerly, Waller & Robinson, 2015; Sansone, Fine & Chew, 1988; Satir et al., 2009; Shisslak et al., 1989; Warren, Schafer, Crowley & Olivardia, 2013a).

Four papers employed qualitative methodologies and two employed mixed methodologies. Three qualitative studies employed semi-structured interviews (Long, Wallis, Leung, Arcelus & Meyer, 2012; Palmer, 2015; Linville, Benton, O'Neil & Sturm, 2010), and three utilised qualitative survey methods (Warren, Crowley, Olivardia & Schoen, 2009; Warren, Schafer, Crowley & Olivardia, 2012, 2013b).

Table 3.
Summary of Literature Reviewed.

Study	Sample	Methodology	Measures	Findings
Brotman, A. W., Stern, T. A., Herzog, D. B. (1984). Emotional reactions of house officers to patients with anorexia nervosa, diabetes and obesity.	First year residents at Massachusetts General Hospital (N = 46) Psychiatry (n = 9, f 5, m 4) Paediatrics (n = 6, f 2, m 4) Medicine (n = 14, f 4, m 10) Convenience sampling	Between-groups survey. Measuring clinician responses to hypothetical patients with either AN, Diabetes or Obesity.	Non-validated dysphoria scale (0 = absence of feeling, 1 = mild feeling, 4 = strong feeling) measuring reactions of anger, sadness, helplessness, anxiety and stress.	All three groups reported greater overall dysphoria to AN, than obesity or diabetes patients (trend). Psychiatrists and paediatricians significantly greater dysphoria than medics. AN typically evoked stronger reactions across all emotions on dysphoria scale than diabetes or obesity.
Burket, R. C., & Schramm, L. L. (1995). Therapist's attitudes about treating patients with eating disorders.	Mixed sample of therapists comprising clinical faculty and trainees and clinical staff of private psychiatric hospital (N = 90) Psychiatry (n = 38) Clinical psychology (n = 36) Counselling psychology (n = 6), Social work (n = 5) Nursing (n = 5) Purposive sampling	Survey measuring clinician attitudes, desire to treat, countertransference, treatment approaches and prognosis, to both AN and BN.	Non-validated questionnaire multiple choice and yes/no questionnaire with space for qualitative answers.	Most common feelings were frustration (87%), and anger (63%). Thirty-one percent indicated they did not want to treat EDs, due to countertransference (30%), treatment resistance (17%), concurrent mental health related difficulties (9%), physical problems (9%) and time demands (4%). Men were more likely than women to not want to treat EDs.

Study	Sample	Methodology	Measures	Findings
Colli, A., Speranza, A. M., Lingiardi, V., Gentile, D., Nassisi, V., & Hilsenroth, M. J. (2015). Eating disorders and therapist emotional response.	Italian clinicians with minimum of three years post-licensure psychotherapy experience. (N = 149) Purposive sampling through contacting a random sample of 850 ED psychotherapists.	Survey battery completed for a randomly selected female ED patient of at least 18 years old.	Shedler-Westen Assessment Procedure-200 (SWAP-200). Therapist Response (Countertransference) Questionnaire (TRQ). Clinical Questionnaire-Eating Disorder Form.	Therapist patterns of emotional responses are influenced by different ED diagnoses i.e., AN and EDNOS were associated with similar presentation of clinician responses. Levels of therapist experience and gender, and patient variables (e.g., sexual abuse history, personality pathology) impact therapists' emotional experiences.
Crisafulli, M. A., Von Holle, A., & Bulik, C. M. (2008). Attitudes towards anorexia nervosa: The impact of framing on blame and stigma.	Nursing students from the School of Nursing at University of North Carolina. Female. (N = 115) Convenience sampling.	Experimental design. Random allocation. Participants provided with vignettes with either a biological or social cultural explanation of AN.	Characteristics scale. Affective reaction scale. Opinions scale. Behavioural intention. A mixture of validated, adapted, and non-validated measures.	No significant difference between groups on affective reactions. Significant difference between groups on blaming, wherein the group provided with information on social cultural influences on AN reported more blaming attitudes than those provided with information on the biological influences.

Study	Sample	Methodology	Measures	Findings
Daniel, S. I. F., Lunn, S., & Poulsen, S. (2015). Client attachment and therapist feelings in the treatment of bulimia nervosa.	University based psychotherapy research clinic. Eight clinical psychologists (f 6, m 2) each saw and rated their feelings towards multiple patients with BN (N = 70). Clients were randomly assigned to treatments using block randomisation.	Between groups survey battery as part of a randomised trial of Psychoanalytic psychotherapy (PPT) and CBT, for BN.	Feelings Word Checklist (FWC) post session; Adult Attachment Interview (AAI) - reliable; Eating Disorder Examination, EDE); The Symptom Check List 90 Revised.	Positive feelings were rated more frequently than negative feelings. Open, calm and free had the highest mean scores. Most frequent negative feelings were, tense and powerless. CBT therapist had significantly higher levels of happy/enthusiastic feelings, than PPT therapists. Across therapy type symptom improvement was associated with increased clinician positive feelings increased, and decreased negative feelings.
Franko, D. L., & Rolfe, S. (1996). Countertransference in the treatment of patients with eating disorders.	Mixed sample of clinicians from variety of settings whom self-identified as ED experts. (N = 32; f 22, m 10). Psychiatry (n = 10) Psychology (n = 12) Social work (n = 10) Purposive sampling	Between-groups survey. Comparing clinician responses to last therapy session with patients with AN, BN or depression.	Non-validated measure using visual analogue scale to rate intensity of emotional responses. 34 items dived into internally consistent subscales measuring the following Connectedness; Frustration; Hopelessness/helplessness; Engagement; Success.	Frustration was most common emotional response (87%). Clinician connectedness was associated with ED diagnoses. Less ED experience and ED caseload (>8 per week) were associated with greater negative experiences. 98% report supervision or consultation promote coping feelings.

Study	Sample	Methodology	Measures	Findings
Kosmerly, S., Waller, G., & Robinson, A. L. (2015). Clinician adherence to guidelines in the delivery of family-based therapy for eating disorders.	Clinicians who use family-based therapy (N = 117) Psychology (n = 51) Psychiatry (n = 12) Nursing (n = 4) OT (n = 3) Social work (n = 34) Purposive and snowball sampling.	Online survey relating to clinician characteristics, case load, and reported use of FBT manuals and core therapeutic tasks, and clinician anxiety.	Survey of use of specific FBT techniques. Brief Symptom Inventory-Anxiety Scale (BSI-Anxiety) – validated.	Approximately 1/3 of clinicians reported delivering FBT that deviated substantially from the evidence-based protocols. Clinician caseload and anxiety were associated with differences in the utilisation of specific FBT tasks. More anxious clinicians more likely to state they weigh clients only ‘occasionally’ or ‘rarely’.
Linville, D., Benton, A., O’Neil, M., & Sturm, K. (2010). Medical providers’ screening, training, and intervention practices for eating disorders.	Mixed sample of medical providers (family physicians, nurse practitioners, G.Ps paediatricians, paediatric nurse practitioners, obstetrics and gynaecologists). Survey sent to random sample of 750 medical providers in Oregon: (N = 183; f 70%, m 30%) Purposive sampling to recruit interview participants: (N = 12; f 8, m 4)	Mixed method. Survey and qualitative interviews exploring clinicians’ experiences of providing care, screening and intervention practices and training needs. Thematic analysis.	Survey created from existing literature and professional expertise. Likert items and open-ended questions. Reviewed for face validity by ED individuals, medical and MH providers. Interviews lasted between 40-90 minutes.	78% of providers reported having patients with EDs that they were unsure how to treat. 92% believed they had missed an ED diagnosis. Low self-perceived knowledge and skills linked to reluctance to screen for EDs. Qualitative themes included challenges and barriers to effective screening, desire for further training, and fear of incompetence.

Study	Sample	Methodology	Measures	Findings
Long, S., Wallis, D. J., Leung, N., Arcelus, J., & Meyer, C. (2012). Mealtimes on eating disorder wards: A two-study investigation.	Mixed sample of staff who support meal times from three UK inpatient-ED units. (N = 16, f 14, m 2)	Qualitative interviews. Thematic analysis (Braun & Clarke, 2006).	Semi-structured interview schedule developed to explore staff perceptions of mealtimes. Interviews lasted no longer than 60 minutes.	Three overarching themes relating to preparation, role during mealtime and barriers were identified. Barriers related to personal difficulties and negative emotional experiences; uncertainties about the provision of care; and, frustration regarding implementing change.
Palmer, E. A. (2015). The lived experience of dance/movement therapists working with patients with eating disorders.	Dance movement therapists who were currently working with ED clients, or had within the last 3 years (N = 5, f 5) Purposive and snowball sampling.	Qualitative study. Phenomenological (Kvale, 1996)	Semi-structured interviews exploring the lived experience of dance/movement therapists working with patients with EDs. Interviews lasted between 30-90 minutes.	Six overarching themes were identified relating to: kinaesthetic awareness; countertransference; somatic countertransference: boundaries: therapist body image; and, negative and positive experiences. Emotional responses comprised fear, anger, hopelessness, frustration, concern, protectiveness, compassion, discomfort in clinician's body, boredom and irritation.

Study	Sample	Methodology	Measures	Findings
Sansone, R. A., Fine, M. A., & Chew, R. (1988). A longitudinal analysis of the experiences of nursing staff on an inpatient eating disorders unit.	Newly hired primary care nurses in private hospital (N = 23) ED unit (n = 12) Non-psychiatric wards (n = 11) Convenience sampling.	A longitudinal analysis comparing mood, eating disorder symptoms, body weight, attitudes towards patients, and general job satisfaction of nursing staff in ED or general health wards.	Beck Depression Inventory (BDI). Eating Attitudes Test. Newly created measures: Impressions of the Patient Population Survey. Job Satisfaction Inventory. Attitude toward Patients Questionnaire.	ED unit nurses reported less distorted attitudes towards eating, less positive impressions of patients, and lower body weights than non ED unit nurses, all at the trend level of significance. Nurses from both groups had progressively less positive impressions of their patients and job satisfaction over the course of the study.
Satir, D. A., Thompson-Brenner, H., Boisseau, C. L., & Crisafulli, M. A. (2009). Countertransference reactions to adolescents with eating disorders: Relationships to clinician and patient factors.	Psychiatrists (n = 38) and psychologists (n = 82) who were currently treating a female ED patient between 15 and 18 years old. (N = 120; f 61, m 59) Average post-qualification experience 21.7 years. Self-endorsed ED specialty (17.5%) Randomly selected from clinician network.	Clinician survey of countertransference reactions and clinician assessment of adolescent ED client factors.	Clinical Data Form for Adolescents (CDF-A). Adolescent Eating Symptom Form. Shedler-Westen Assessment Procedure for Adolescents (SWAP-200-A). Psychotherapy Effectiveness Form (PEF). Countertransference Questionnaire for Adolescents (CQ-A).	Clinicians did not report high levels of negative feelings. Highest overall affect reported was Warmth. Highest negative affect was Incompetence. Client personality pathology associated with higher frustration and lower warmth. Males reported greater warmth and more feelings of frustration than females. Psychiatrists endorsed greater frustration than psychologists.

Study	Sample	Methodology	Measures	Findings
Shisslak, C. M., Gray, N., & Crago, M. (1989). Health care professionals' reactions to working with eating disorder patients.	Mixed sample of professionals attending an annual ED conference. (N = 71; f 58, m13). Sample comprised psychologists, psychiatrists, physicians, psychiatric nurses, counsellors, social workers, nutritionists and others. Convenience sampling	Survey comparing clinician responses across clinicians who engage in current binge eating; and clinicians with a prior history of AN and/or BN with clinicians who were normal eaters.	Newly created 40 item questionnaire to explore reactions to working with patients with EDs. Focus on clinician eating and body image.	Clinicians who engage in binge eating and individuals with a history of AN/BN were significantly more aware feelings about their bodies than normal eaters. 28% of the total sample reportedly being moderately to greatly affect by their work, characterised by a positve change in body image.
Warren, C. S., Crowley, M. E., Olivardia, R., & Schoen, A. (2009). Treating patients with eating disorders: An examination of treatment providers' experiences.	Mixed sample of ED professionals attending ED conference (N = 43) Comprised, social workers, those with clinical or counselling psychology PhDs or masters. Social workers, nurses, dietitians, and doctors. Historical ED (n = 12) Convenience sampling	Mixed qualitative and quantitative survey. General inductive approach (Thomas, 2006).	Newly created questionnaire designed by the authors, exploring personal experiences of working with ED clients. Using yes/no questions, K scale questions and qualitative open-ended questions.	54% reported eating habits were affected by working with patients with EDs; greater number of clinicians reported more positive habits. 50% reported increased-self-criticism and vigilance regarding their own and others' body size following sessions with ED patients.

Study	Sample	Methodology	Measures	Findings
Warren, C. S., Schafer, K. J., Crowley, M. E., & Olivardia, R. (2012). A qualitative analysis of job burnout in eating disorder treatment providers.	Mixed sample of psychotherapists, psychologists and psychiatrists (N = 298, f 273, m 23) Data mined from larger study.	Online qualitative survey. General inductive approach (Thomas, 2006).	Newly created questionnaire designed by authors, examining the perceived contributors to burnout, efforts to manage burnout and recommendations for avoiding burnout.	Most participants worried about patient health, resulting in negative affect. Frequently cited contributors to burnout included common ED characteristics, patient characteristics, work-related factors, and financial issues. 90% engaged in self-care to avoid burnout.
Warren, C. S., Schafer, K. J., Crowley, M. E., & Olivardia, R. (2013a). Demographic and work-related correlates of job burnout in professional eating disorder treatment providers.	Mixed sample of ED treatment providers including psychotherapists, psychologists and psychiatrists (N = 296) Purposive sampling	Online survey exploring demographic and work related correlates with burnout in ED treatment providers.	Maslach Burnout Inventory – Human Services Survey (MBI-HSS). Newly created questionnaire evaluating degree to which various factors common to treating ED patients contribute to perceptions of burnout (EDBURN). Demographic questionnaire.	Participants reported comparable levels of emotional exhaustion but significantly less cynicism and lack of personal accomplishment relative to norms for MH providers. High levels of burnout were associated with being younger, female, overweight, working longer hours, having less experience, and experiencing a patient death.

Study	Sample	Methodology	Measures	Findings
Warren, C. S., Schafer, K. J., Crowley, M. E., & Olivardia, R. (2013b). Treatment providers with a personal history of eating pathology: A qualitative examination of common experiences.	Mixed sample of psychotherapists, psychologists and psychiatrists with a personal history of eating pathology (N = 139) Purposive sampling	Online qualitative survey. General inductive approach (Thomas, 2006).	Newly created questionnaire developed by the authors, exploring demographics, perceived influence of personal history of eating pathology on treatment with ED patients, and recommendation for others in the field.	The large majority of participants (94%) believed their ED history influences their treatment of patients (e.g., increased empathy). Only 8% identified negative influences (e.g., being personally 'triggered'). Importance of personal recovery before treating this population and monitoring own countertransference reactions in sessions were recommended.

This literature review will be reported in three key sections: countertransference reactions, experience of ED-historied clinicians, and the overall impact of countertransference on the clinician.

3.1.1 Countertransference reactions.

The final studies report countertransference reactions and identified contributing factors. This section reviews the findings relating to emotional, cognitive, behavioural and physical reactions.

3.1.1.1 Emotional countertransference reactions. A number of emotional countertransference were identified within the literature. As the literature provided greater detail relating to negative emotional responses, these are discussed individually. Positive emotional responses are then outlined.

3.1.1.1.1 Frustration. Frustration was reported by eight studies (Burket & Schramm, 1995; Franko & Rolfe, 1996; Linville et al., 2010; Long et al., 2012; Palmer, 2015; Satir et al., 2009; Warren et al., 2009; Warren et al., 2012). In early literature, frustration was the most frequently reported (87%) countertransference reaction in ED therapists (Burket & Schramm, 1995).

Frustration was more frequent with clients with AN than BN, or depression, in clinicians with limited ED experience, but no difference was found in more experienced clinicians (Franko & Rolfe, 1996). The same study found that AN dominant caseloads ($\geq$ 8) were linked to greater frustration. Frustration was more common in male clinicians than female clinicians, and in psychiatrists than psychologists (Satir et al., 2009). Clinicians were more likely to report frustration when clients had concurrent personality difficulties (Satir et al., 2009).

Physical health clinicians further reported frustration regarding a dearth of treatment options and limited knowledge of referral pathways (Linville et al., 2010). Similarly, clinicians supervising in-patient meal times conveyed frustration about limited personal power to influence decisions to improve care (Long et al., 2012). Frustration thus arises both within the clinician-client relationship, mediated by clinician and client characteristics, and in the systemic issues surrounding treatment.

3.1.1.1.2 Anger. Five studies reported clinician anger (Brotman et al., 1984; Burket & Schramm, 1995; Franko & Rolfe, 1996; Palmer, 2015; Satir et al., 2009). Burket and Schramm (1995) found that 63% of clinicians from varied clinical backgrounds reported feelings of anger.

Differences in reported anger across clinician characteristics and diagnosis were observed. Anger was more frequently reported by paediatric (83%) and psychiatry (77%) residents, than medical residents (43%; Brotman et al., 1984). Similar levels were reported towards AN and obese populations, however significantly lower levels were reported towards diabetes populations (Brotman et al., 1984). Anger was more likely to occur in clinicians with less experience (Franko & Rolfe, 1996), and in males than females (Satir et al., 2009). Psychiatrists reported more anger reactions than psychologists, and anger was more likely to occur when clients had concurrent personality difficulties than when they did not (Satir et al., 2009).

Results indicate that clinicians may experience anger when treating individuals with EDs, and anger countertransference may be greater towards ED populations than non-ED populations. Anger may differ between clinician gender and profession, and client personality pathology.

3.1.1.1.3 Sadness. Five studies reported clinician sadness (Brotman et al., 1984; Franko & Rolfe, 1996; Palmer, 2015; Warren et al., 2009; Warren et al., 2012). General negative affect including sadness was reported by two studies, particularly regarding poor prognosis, high relapse rates, chronicity and risk of death (Palmer, 2015; Warren et al., 2009). In relation to having a client die, 57% of clinicians discussed feelings of grief and sadness (Warren et al., 2012).

Brotman et al. (1984) found that all psychiatry residents and the majority of paediatric residents (83%) reported sadness in response to individuals with AN; however medical residents were significantly less likely to report sadness (43%). Brotman et al. also found that psychiatrists reported identical levels of sadness for individuals with diabetes as with AN (100%), but only 67% reported sadness for individuals who were obese.

ED clinicians may therefore experience sadness in relation to poor treatment outcomes and mortality. The experience of sadness may differ across professional discipline, however no study has compared levels of sadness across ED subtypes.

3.1.1.1.4 Fear, anxiety and worry. Eight studies reported reactions of fear, anxiety and worry (Crisafulli et al., 2008; Franko & Rolfe, 1996; Linville et al., 2010; Long et al., 2012; Palmer, 2015; Warren et al., 2009; Warren et al., 2012, 2013b).

Burket and Schramm (1995) found that 29% of therapists reported anxiety. Brotman et al. (1984) however, found that levels of anxiety differed across profession with similar levels across psychiatry and paediatric residents (67%), but significantly lower for medical residents (21%). Trend level differences were observed across patient groups, with AN eliciting greater anxiety than diabetes or obesity (Brotman et al., 1984).

Clinicians held fears about upsetting ED patients, such as when overseeing meal times on ED in-patient wards (Long et al., 2012). Some physical health clinicians feared offending

patients by asking about their ED, or worried about not having the right questions at their disposal (Linville et al., 2010). Physical health clinicians further reported themes of fear in relation to risk of death (Linville et al., 2010).

A recent exploration of burnout in ED clinicians revealed that 93% felt worried and fearful about their patients' health; many reported that this impacted them personally causing general negative affect (61%) and impacted on their personal life (36%; Warren et al., 2012).

Anxiety is variable across professions. Specific anxieties relate to upsetting or offending patients, and worries about health and risk of mortality. Such worries may impact clinicians' emotions and personal lives.

3.1.1.1.5 Helplessness. Six studies explored feelings of helplessness (Brotman et al., 1984; Burket & Schramm, 1995; Franko & Rolfe, 1996; Linville et al., 2010; Palmer, 2015; Warren et al., 2012). Burket and Schramm (1995) found that nearly half of clinicians reported feeling helpless.

Helplessness was greater in response to AN populations than diabetes or obesity populations across psychiatry, paediatric and medical professionals (Brotman et al., 1984). Perceived helplessness was identified in relation to why physical health clinicians avoided screening for EDs (Linville et al., 2010). Therapeutically trained clinicians reported helplessness in relation to patient health, or having experienced a patient die (Warren et al., 2012). Helplessness was higher for AN than BN patients, although both groups generated similar levels of helplessness to depressed patients (Franko & Rolfe, 1996).

Clinicians may experience feelings of helplessness both in relation to anxiety about health and mortality. Clinician helplessness may be greater with AN populations than with non-MH populations, and with clients with AN than BN.

3.1.1.1.6 Feelings of inadequacy. Three studies reported feelings of inadequacy or lack of perceived competency (Linville et al., 2010; Satir et al., 2009; Warren et al., 2012). Of Linville et al.'s (2010) physical health clinician sample, 78% reported having patients with EDs that they were unsure how to treat. Furthermore, 92% believed they had missed an ED diagnosis; Interviews revealed themes of "fear of incompetence", "difficulty treating EDs", and "desire for increased eating disorder training".

Greater perceived competence was reported in male clinicians than female clinicians, and by clinicians working with AN than BN and EDNOS, and for BN than EDNOS (Satir et al., 2009). Those working with individuals with EDNOS also had higher scores for failing/incompetence than those with AN (Satir et al., 2009). Clinicians reported less confidence if the client also had personality pathology (Satir et al., 2009), or if they experienced an ED related client death (Warren et al., 2012).

In short, clinicians report feeling incompetent in a small number of studies. Perceived incompetency was related to difficulties in treating EDs and a desire for further training. Perceptions of competence varied across clinician gender, ED subtype, presence of personality pathology or death of a client.

3.1.1.1.7 Sexual feelings. Two studies reported on sexual feelings (Colli et al., 2015; Satir et al., 2009). Using a subscale measuring responses to seven items, such as "Her sexual feelings towards me make me anxious or uncomfortable" male clinicians reported more sexual reactions than female clinicians, and psychiatrists were more likely to report sexual countertransference than psychologists, despite both groups having similar gender ratios (Satir et al., 2009).

Greater sexual countertransference was found towards individuals with EDs who also had a history of sexual abuse (Colli et al., 2015). Therefore, sexual feelings may occur for

clinicians working with individuals with EDs, particularly when clinicians are male, or the client has a sexual abuse history. Such reactions may be more likely in psychiatrists than psychologists.

3.1.1.1.8 Manipulation. Only one study reported manipulation (Franko & Rolfe, 1996). Clinicians with a higher proportion of AN clients on their caseloads (≥ 8) reported greater manipulation. Clinicians who saw more patients (> 20) per week reported higher levels of manipulation across AN and BN populations, than clinicians who saw less patients (< 20) per week. Significant differences in feelings of manipulation were therefore found across AN caseload size and number of client contacts, however manipulation was only reported in one study.

3.1.1.1.9 Positive emotions. Eight studies reported positive emotions (Colli et al., 2015; Crisafulli et al., 2008; Daniel et al., 2015; Franko & Rolfe, 1996; Palmer, 2015; Sansone et al., 1988; Satir et al., 2009; Warren et al., 2013a). In three studies, positive feelings were generally rated more frequently than negative feelings, and overall negative countertransference frequencies were typically low (Crisafulli et al., 2008; Daniel et al., 2015; Satir et al., 2009). Yet in comparison to general physical health patients, ED patients evoked less overall positive impressions (Sansone et al., 1988).

In adult samples, individuals with BN were found to evoke more general positive reactions, as well as feelings of success and connectedness than individuals with AN (Colli et al., 2015; Franko & Rolfe, 1996). Individuals with BN were also found to evoke more general positive reactions than individuals with EDNOS (Colli et al., 2015). Of clinicians treating individuals with BN, CBT clinicians had greater happy and enthusiastic feelings than clinicians providing psychodynamic psychotherapy (Daniel et al., 2015). In the same study, clinicians' positive feelings increased consonant with improvements in the client's symptoms. Therefore, in adult populations clinicians experience greater positive emotions

when working with individuals with BN, than individuals with AN; such feelings may be mediated by therapeutic orientation and symptom reduction.

In contrast to adult populations, adolescents with AN evoked more general positive reactions than adolescents with BN (Satir et al., 2009). Feelings of clinician warmth were greater with adolescents with AN, than BN or EDNOS, and additionally greater with BN than EDNOS (Satir et al., 2009). In the same study, male clinicians experienced greater warmth than female clinicians, and clinicians reported less warmth when adolescents had concurrent personality difficulties than just ED diagnoses. In adolescent populations therefore, general positive responses and warmth are influenced by ED subtype, clinician gender and coexisting client personality difficulties.

General and specific positive emotions thus appear mediated by clinician gender, and by client age, ED subtype and concurrent personality difficulties.

3.1.1.2 Cognitive countertransference reactions. A number of studies reported changes in ED clinicians thinking or attention.

3.1.1.2.1 Body-image and attention to appearance. Three studies reported changes in clinicians' body-image or attention to appearance (Shisslak et al., 1988; Warren et al., 2009; Warren et al., 2013a). Self-consciousness and hypervigilance of the clinician's own appearance were reported during the provision of treatment of individuals with EDs (Warren et al., 2009). The same study reported that half of clinicians experienced heightened awareness of others' appearance, with nearly half reporting that this impacted them negatively.

Clinicians reported increased awareness of their feelings about their body, clothes and appearance after beginning work with individuals with EDs, and further reported improved body-image (Shisslak et al., 1998). In a study of correlates of burnout, the influence of

working with individuals with EDs on the therapist's body-image was not a significant contributing factor (Warren et al., 2013a).

Only a small number of studies reported a change in body-image or attention to appearance. Increased attention to the appearance of others was experienced negatively by some clinicians, whilst increased attention to one's own appearance was linked to an improvement in body-image among some clinicians. Changes to clinician body-image were not associated with burnout.

3.1.1.2.2 Eating attitudes. Three studies reported clinician eating attitudes (Sansone et al., 1988; Shisslak et al., 1988; Warren et al., 2009). Clinicians from a range of disciplines became more aware of food (Shisslak et al., 1988). Warren et al. (2009) found that 70% of clinicians experienced changes in their attitudes to food, including: increased awareness of food (40%); greater conceptualisation of food as a source of fuel or nutrition (23%); and, increased enjoyment and appreciation of food (21%). In-patient ED nurses also had less distorted eating attitudes than general nurses, which the author posited may be due to ED nurses seeing the undesirable consequences of disordered eating and thinking (Sansone et al., 1988).

Only a small number of studies reported changes to clinicians' thinking about food. No studies reported more disordered thinking, indeed less distortion and greater enjoyment towards food were found.

3.1.1.3 Behavioural countertransference reactions. Three studies found that clinicians experienced behavioural countertransference reactions; these will be discussed in relation to eating, changing appearance and self-care.

3.1.1.3.1 Eating. Changes to clinicians' eating behaviours were explored in four studies (Shisslak et al., 1989; Warren et al., 2009; Warren et al., 2012, 2013a). Shisslak et al.

(1989) reported that clinicians ate more healthily after beginning treating individuals with EDs. Warren and colleagues (2009) found changes in eating behaviour in 54% of clinicians; consistent with Shisslak et al. (1989), 30% reported eating more healthy, and in addition more mindfully, however, 19% reported more 'disordered' eating (i.e., unhealthy, over-eating, emotional-eating). Furthermore, 3% of another sample reported binge-eating and emotional eating and/or purging as a way of managing negative emotions from their work (Warren et al., 2012). Clinician eating behaviours were endorsed as contributing to burnout "not at all" or "a little" by 80% of participants in a correlation study (Warren et al., 2013a).

Findings suggest that some ED clinicians experience positive or negative changes to their eating, such changes are not thought to be associated with job-burnout. Why some clinicians experience healthy changes and others experience less healthy changes remains unexplored.

3.1.1.3.2 Changing appearance. One study reported that a 28% of clinicians made changes to their appearance (e.g., having haircuts and buying new clothes) in response to their increased focus on personal appearance from treating individuals with EDs (Warren et al., 2009).

3.1.1.3.3 Self-care. Two studies reported an increase in self-care behaviours (Warren et al., 2009; Warren et al., 2012). Regarding worrying about patients' health, 31% of clinicians reported seeking their own therapy or other help (Warren et al., 2012). In managing increased focus on personal appearance clinicians reported a variety of self-care approaches, including consultation and supervision, cognitive reframing, social interaction, reading and exercise (Warren et al., 2009).

In Warren et al.'s (2012) study, to reduce the impact of negative countertransferences and avoid burnout, 92% of clinicians reported using professional support (e.g. supervision),

and engaging in self-care which comprised: social support (64%), hobbies and leisure (46%), time off (22%), eating well (16%), relaxation (12%), detaching from work (12%), boundaries including work-life balance (7%), personal time (7%), sleep (6%) and meditation (5%). A minority of clinicians (10%, n = 25) reported potentially unhealthy coping behaviours comprising: drinking (56%), binge eating/emotional eating/purging (28%), smoking (12%), and self-injury (4%).

Clinicians therefore utilise coping strategies when working with people with an ED. The majority of strategies comprise helpful self-care, however some clinicians may increase reliance on potentially unhealthy coping strategies.

3.1.1.4 Physical countertransference reactions. Further studies reported findings relating to ED clinicians' physical responses.

3.1.1.4.1 Weight. One study reported about clinician's weight (Sansone et al., 1998). In-patient ED nurses had lower body weights at the trend level compared with physical health nurses. Over one year, no changes to body weight were found in either group. Despite the behavioural responses reported above, working with individuals with EDs is not suggested to impact on clinician weight. Nurses who were interested in working on the in-patient ED ward may have had predisposing factors for lower weight than the nurses working on general wards. No further studies have reported the impact of treating EDs upon clinicians' weight.

3.1.1.4.2 Somatic experiences. Somatic countertransference was explored in only one study (Palmer, 2015). Somatic countertransference was identified as one of the key experiences of Dance Movement (DM) therapists, and comprised warming sensations, headaches, feelings of anxiety, fluttering in the chest, bodily discomfort and postural shifts. These allow the therapist to track shifts in the client's body, and energy in the room throughout the therapy sessions. It is unclear from the studies included in this review whether

clinicians from other professions have somatic countertransference reactions or how they make sense of them.

3.1.2 Experiences of ED historied-clinicians.

Three papers explored the experiences of clinicians who had a personal history of an ED (Shisslak et al., 1998; Warren et al., 2013a, 2013b). Since working with individuals with EDs, clinicians who currently engaged in binge eating or had AN/BN behaviours, perceived themselves as more aware of: food; their feelings about their bodies; their physical appearance and clothes; and their physical condition, than normal eaters (Shisslak et al., 1988). ED-historied clinicians noted reduced vigilance about other peoples' appearance after treating individuals with EDs, contrasting the increased vigilance of clinicians without an ED history (Warren et al., 2009).

ED-historied clinicians also reported increased empathy and 14% believed their experiences facilitated them in maintaining a positive and hopeful outlook in their work (Warren et al., 2013b). ED- historied clinicians also had lower cynicism and greater feelings of personal accomplishment than clinicians without (Warren et al., 2013a). A minority (3%) however, believed that they were at risk of being 'triggered' by their work or experiencing negative countertransference reactions (Warren et al., 2013b).

Findings suggest that ED-historied clinicians, alongside those with current disordered eating, may be affected differently than clinicians who are normal eaters, and do not have ED histories.

3.1.3 Overall impact of countertransference reactions on clinicians.

A number of papers discussed the negative implications of countertransference reactions experienced by clinicians in this field. The three main areas of burnout, job satisfaction and quality of care are discussed.

3.1.3.1 Burnout. ED clinician burnout was discussed in two studies (Warren et al., 2012, 2013a). Low levels of burnout were reported, and were not statistically different from general MH practitioner norms; however emotional exhaustion, a core characteristic of burnout, was reported by half of clinicians, at a moderate or high level (Warren et al., 2013a). Burnout was associated with clinicians being younger, less experienced, being female, having a higher body mass index, working greater hours, and experiencing a client death. Working privately, being a parent, having a higher proportion of ED clients on one's caseload, and having a personal history of ED were associated with lower levels of burnout (Warren et al., 2013a).

Clinicians reported a range of factors contributing to feeling burnout, encompassing: treatment resistance; chronicity; relapse rates; anxiety about patient mortality; ego-syntonic symptoms; difficult patient personalities; concurrent psychological difficulties; overall emotional impact; limited financial reimbursement; overtime; and, difficulties managing negative countertransference (Warren et al., 2012, 2013a).

Approximately half of clinicians who work with individuals with EDs report emotional exhaustion, but not burnout. Numerous clinician and ED specific factors may contribute to burnout. Notably, having a higher proportion of ED clients on a caseload and a personal ED history were protective factors.

3.1.3.2 Job satisfaction and desire to work with ED populations. Two studies looked at clinician attitudes towards treating individuals with EDs (Burket & Schramm, 1995; Sansone et al., 1988). In-patient ED nurses reported lower levels of job satisfaction than general health nurses, however for both groups job satisfaction decreased at similar rates over one year (Sansone et al., 1988). Burket and Schramm (1995) found that 47% of clinicians from a range of professional backgrounds reported feeling satisfied in their work, yet 31%

did not want to treat patients with EDs. Male clinicians were more likely than female clinicians to not want to treat individuals with EDs.

Among those who did not wish to treat EDs, the most common reason cited was negative countertransference (39%), other reasons included treatment resistance (30%), concurrent psychological difficulties (17%), associated physical problems (9%) and excessive time demands (4%; Burket & Schramm, 1995). Presently there is limited research investigating clinicians' desire to treat ED populations and the contributing factors. No comparison to other MH populations were found in this review. Men were more likely not to want to treat ED populations. Countertransference was cited as the biggest contributing factor.

3.1.3.3 Quality of care. In four studies the experiences of clinicians outlined previously were reported to impact the quality of care provided (Brotman et al., 1984, Kosmerly et al., 2015; Linville et al., 2010; Warren et al., 2012). Brotman et al (1984) found that psychiatry (100%), paediatrics (67%) and medical residents (64%) agreed that their levels of anger, stress, helplessness, sadness and anxiety influenced the quality of care they delivered to patients with AN.

Anxiety about patient health was also thought to influence 33% of clinicians approach to treatment, specifically that they might feel less patient and may try to rush therapy (Warren et al., 2012). Physical health clinicians reported that they might avoid screening for EDs due to perceived helplessness, discomfort and self-rated deficits in knowledge, skills and training (Linville et al., 2010). Additionally, Kosmerly et al. (2005) found that more anxious clinicians were significantly more likely to weigh their clients only occasionally or rarely.

As such, clinicians who experience negative countertransference reactions, particularly anxiety may alter their treatment practices in relation to screening and weighing. Research relating to the impact on quality of care is limited at present.

3.2 General Methodological Considerations

The research to date highlighted a number of positive and negative experiences relating to the emotional, cognitive, behavioural and physical responses of clinicians who treat individuals with EDs. To place these findings into context, this section provides a critical appraisal of the selected studies (see Appendix C and D for appraisal tables).

3.2.1 Quantitative methodologies.

The main limitation across studies is the simplicity of design which fails to reduce potential confounding variables, thus limiting internal validity and the conclusions that can be drawn (Table 3). At present, quantitative quality appraisal tools are largely focused on appraising randomised control trials. For non-randomised control trials the key appraisal areas are population, analysis, and outcomes which help determine the overall validity and generalisability. The relevant items of the NICE (2012) quality appraisal tool (Appendix A) will be used flexibly to support the appraisal of these areas.

3.2.1.1. Population. Population is one of the areas explored by the NICE (2012) quality appraisal tool. Whilst all studies provided a description of the patient populations, no studies gave a good description of the clinician source population or area in which the research took place; it is therefore difficult to determine the representativeness and generalisability of the findings produced.

Only three studies provided sufficiently clear descriptions of the method of recruitment (Burket & Schramm et al., 1995; Colli et al., 2015; Daniel et al., 2015). Five studies used convenience sampling (Brotman et al., 1984; Crisafulli et al., 2008; Sansone et

al., 1988; Shisslak et al., 1988; Warren et al., 2009); such as, all student nurses in a university lecture (Crisafulli et al., 2008). All other studies used purposive sampling to identify clinicians who treated individuals with EDs. One study used snowballing strategies to identify further suitable participants (Kosmerly et al., 2015).

Two studies (Colli et al., 2015; Satir et al., 2009) randomly selected participants from relevant ED clinician lists or practice-research networks; willing participants were then checked against inclusion criteria. Non-probability sampling procedures used by the majority of studies in this review incurs poor representativeness, and limits the internal and external validity of the findings.

The majority of studies reported completion/return rates of questionnaires to be approximately 25% - 50%, consistent with response rates across similar studies (e.g. Farber, 1985b). A self-selection bias likely exists between those who respond and those who do not, limiting the generalisability of the conclusions drawn.

Clinicians from a range of clinical backgrounds and levels of experience were included in the studies reviewed. All studies' samples were representative of those that are likely included in the treatment journey of individuals with EDs. Crisafulli et al.'s (2008) sample of undergraduate nurses, who were unlikely to have had clinical experience in this field, was likely most limited in representativeness. Warren et al.'s (2013b) study of ED-historied clinicians only included ED specialist clinicians, the findings therefore are not representative of less experienced clinicians, or clinicians new to the field.

A range of EDs were explored including AN, BN and EDNOS, however no studies explored clinician experiences with individuals with BED, which is an increasingly recognised and treated ED (Hoek & van Hoeken, 2003).

Individuals with EDs frequently have concurrent MH diagnoses and/or substance or alcohol misuse (Rastam, 1992) which may impact the experiences of clinicians. The exclusion of such clients within most of the studies reviewed, limits the generalisability of the reported findings. One exception is Satir et al. (2009) who specifically explored the impact of concurrent personality difficulties.

3.2.1.2 Analysis. The quality appraisal tool (NICE, 2012) states that all quantitative research must use appropriate statistical analysis. Most studies were preliminary or exploratory in nature, as such, all were limited in their control of extraneous variables. The majority of studies used statistical analysis which appeared appropriate, however one study (Brotman et al., 1984) provided no description of the analysis conducted. No studies reported power calculations, and only one reported effect sizes (Kosmerly et al., 2015). All quantitative studies used appropriate levels of significance. The main limitation across analyses is the limited control of confounding variables, such that causality cannot be determined.

3.2.1.3 Outcome measures. Outcomes are another key area of quality assessment (NICE, 2012). A variety of outcome measures were utilised by the studies in this review (see Table 3). Three studies used well validated measures (Daniel et al., 2015; Kosmerly et al., 2015; Satir et al., 2009), four studies used a mixture of validated and non-validated measures (Colli et al., 2015; Crisafulli et al., 2008; Sansone et al., 1988; Warren et al., 2013a) and four early exploratory studies solely utilised non-validated measures (Brotman et al., 1984; Burket & Schramm et al., 1995; Franko & Rolfe, 1996; Shisslak et al., 1988). The majority of validated measures related to client outcomes and characteristics, and the majority of non-validated measures related to clinician experience. Comparisons of findings across studies are problematic due to the range of measures used, and use of non-validated instruments.

All studies used self-report to explore clinicians' emotions; negative reactions could be influenced by socially desirable responding and thus be underreported. Objective measures were rarely used to corroborate clinicians' perceived changes (i.e. changes to eating behaviours), thus reducing the overall internal validity of the findings reported in this review.

3.2.2 Qualitative methodologies.

All qualitative and mixed methodological studies were evaluated using qualitative quality assurance criteria (Mays & Pope, 2010; see Appendix B).

3.2.2.1 Triangulation. All studies apart from Palmer (2015) used triangulation through obtaining heterogeneous samples to improve the validity, comprehensiveness and representativeness of the data. Linville et al. (2010) and Warren et al. (2009) further collected data through both survey and interviewing, increasing the triangulation of data sources and thus validity.

3.2.2.2 Respondent validation. Two studies (Linville et al., 2010; Palmer, 2015) implemented respondent validation methods, through utilising member checking by providing participants with a summary of initial coding and inviting their feedback to promote accuracy of the interpretation of the data.

3.2.2.3 Clear exposition of methods of data collection and analysis. The process of coding and theme development was described well, improving the replicability of all studies apart from Long et al. (2012). All but one study (Palmer, 2015) reported using independent raters to promote trustworthiness. All studies provided sufficient quotes to support each theme discussed in order to demonstrate the accuracy of the researcher's interpretation. Four studies therefore fully met the criteria for clear exposition (Linville et al., 2010; Warren et al., 2009; Warren et al., 2012, 2013b), whilst Long et al. (2012) and Palmer (2015) met the criteria in part.

3.2.2.4 Reflexivity. Two studies (Linville et al., 2010; Palmer, 2015) demonstrated reflexivity, through utilising research journals, audit trails or bracketing in order to aid dependability; thereby limiting the likelihood of their own biases or assumptions influencing data analysis.

3.2.2.5 Attention to negative cases. Long et al. (2012) and Linville et al. (2010) did not report any cases which contradicted the emerging explanation. The remaining four studies, did not explicitly address negative cases, yet were scored as partially meeting the criteria as they reported numbers of participants whose data supported each theme; thus making it possible to determine the extent to which each theme was supported by all participants within the sample.

3.2.2.6 Fair dealing. Three studies were judged as not meeting the criteria (Long et al., 2012; Linville et al., 2010; Palmer et al. 2015) as no acknowledgement was made of competing narratives, and no information was provided about the number of participants whose data supported each narrative. All other studies partially met the criteria (Warren et al., 2009; Warren et al., 2012, 2013b) through obtaining varied samples, and whilst none explicitly discussed non-dominant narratives they provided the frequency of participants supporting each theme, therefore themes were not represented as sole truths supported by the whole sample.

3.2.2.7 Relevance. Three studies (Warren et al., 2009; Warren et al., 2012, 2013b) fully met the criteria for relevance, adding new information to the evidence base as they had large and representative samples. They provided sufficient detail for readers to judge whether findings may apply in other settings. Three studies (Long et al., 2012; Linville et al., Palmer et al., 2015) partially met the criteria for relevance. Whilst all three added to the evidence base, Long et al. (2010) provided limited description of the data, Linville et al. (2010)

provided insufficient detail about their sampling technique to determine representativeness, and Palmer's (2015) small homogenous sample lacked representativeness.

Although the qualitative studies in this review varied in quality, each study adds depth of knowledge and understanding to areas of clinician experience in which limited or no previous research existed.

4. Discussion

Limited research has investigated the experiences of clinicians who treat individuals with EDs. Although the quality of research included in this review is limited, a number of important clinician experiences were identified relating to emotional, cognitive, behavioural and physical responses.

Consistent with the previous review (Thompson-Brenner et al., 2012) frustration, helplessness, anxiety, and inadequacy were indicated as key negative emotions. Anger, sadness and sexual reactions were further identified as potentially important emotional responses. Positive emotions were noted in eight studies, and were reported more frequently than negative emotions in three studies; such findings could help contest the perception that individuals with EDs are not desirable to treat (Burket & Schramm, 1995). It is unclear whether further studies included in this review measured positive emotions but did not include these in their reports due to findings being insignificant or not considered to be key findings. It may be that positive emotions were not explored due to the nature of the studies reviewed and a tendency to focus on problematic clinician responses; clinicians' positive emotions and responses may therefore be underrepresented in the findings of this review.

Further to Thompson-Brenner and colleagues' (2012) review, frustration was found to not only occur in the client-clinician dyad but also be related to wider systemic factors comprising limited treatment or referral options. Similar themes were found regarding

inadequacy and helplessness, where clinicians reported insufficient training and a desire for further training. Previous literature however, found that whilst knowledge based training programs improved clinicians' overall ED knowledge and practices, self-perceived competence did not improve post-training; thus may not be related to actual knowledge and abilities, and persist despite training and experience (Gurney & Halmi, 2001).

This review identified specific anxieties of clinicians relating to upsetting or offending individuals with EDs. Furthermore, anxiety particularly in relation to physical health risks and risk of death, were reported to impact on clinicians' overall wellbeing, and personal lives; and were linked to a reduction in weighing and screening practices. Avoidance of screening for EDs is particularly worrying, and may undermine early intervention, as screening provides the gateway to treatment (Boulé & McSherry, 2002). As such, ED clinician anxiety is an important area for further exploration.

There are limited results which indicate that ED clinicians experience changes relating to improved body-image and less distorted eating attitudes, or influence appearance or eating behaviours. Such findings appear unique to clinicians working with EDs (Satir et al., 2009). Despite changes to eating behaviours, no changes in clinician weight were indicated.

The findings outlined in this review appear mediated by a range of clinician factors (e.g., gender, level of experience, caseload size and proportion of ED clients, profession and personal ED history), and client factors (e.g., age, ED subtype and personality pathology). Therapist gender, caseload size, years of experience and client personality pathology have all been found to influence countertransference responses in other MH populations (Gabbard, 1993). As less experienced clinicians were more likely to experience negative countertransference, increased support is likely warranted. Adults with EDs are more likely to have severe and enduring EDs with poorer treatment outcomes, which may account for some

differences in clinician responses across client age (Bulik, 2014). Currently no comparisons exist across client gender, despite approximately 11% of all individuals with EDs being male (NICE, 2004). No studies have explored the quality of supervision received, which may further explain variance in clinician wellbeing (Satir et al., 2009).

Clinicians were found to experience emotional exhaustion; moreover, burnout may have been underreported, as burnout predicts employment termination, reducing the likelihood of them being represented within research samples (Maslach, Jackson & Leiter, 1996). Factors associated with burnout in ED clinicians were consonant with predictors of burnout across general MH staff (Alarcon, 2011). Specific factors relating to the ego-syntonic nature of EDs, high relapse rates and physiological risk were all reported to increase feelings of burnout and undermine staff retention. Factors influencing burnout and staff retention are of particular importance in light of the Mental Health Workforce Strategy's aims to improve staff retention across the NHS (Health Education England, 2017).

The most frequently reported resultant self-care behaviour was clinical supervision. In line with DCP (2014), Franko and Rolfe (1996) posited that supervisors need to be made aware of the potential for negative countertransferences, and should encourage open expression of these transferences within supervision. Such discussions are important to minimise the impact on clinician wellbeing, therapeutic relationship and treatment outcomes (Shisslack et al., 1989). Nevertheless, only a small number of papers discussing supervision for clinicians working with EDs exist, highlighting the need for further research in this area (DeLucia-Waack; 1999; Hamburg & Herzog, 1990).

The findings should be considered within the overall limitations of the research. At present, results lack concrete observable measures; all studies included relied on self-report data which can be biased by the extent to which clinicians remember their responses and pressures of desirable responding (Vazire & Carlson, 2011). Alternative definitions of

countertransference refer to clinician's unconscious responses, which cannot be captured using self-report methodologies, therefore the countertransference responses in this review only relate to conscious countertransference reactions.

4.1 Implications for Clinical Practice

The quality of studies investigating the experiences of clinicians treating individuals with EDs, is arguably weak. Despite this, findings suggest that clinicians should pay careful attention to their own responses when treating individuals with EDs. Particular clinician-client dyads may make challenging experiences more likely, and thus warrant greater self-awareness and self-care. Clinicians reported utilisation of self-care behaviours, may normalise the need for clinicians to seek appropriate support. The importance of ensuring that trainee or newly qualified staff, or qualified staff who are new to the field arrange appropriate supervision is also highlighted. This review identifies both positive and negative experiences that clinicians could be invited to consider within supervision, although how clinicians feel about raising these issues and whether they would consider it beneficial remains unknown.

4.2 Implications for Research

The validity and generalisability of current research investigating the experiences of ED clinicians is limited due to significant methodological limitations. Nevertheless, the range of experiences identified and their impact on clinician wellbeing and quality of care suggest that further research in this area is warranted. Future research could explore the factors mediating changes in ED clinicians' attention to appearance, and eating behaviours. High quality research utilising psychometrically sophisticated instruments and independent observations, exploring the role of clinician and client factors would be beneficial in order to continue to replicate current findings and identify ED clinicians' unique support needs. Supervision was the most frequently reported method of self-care. Future research should

explore the role of supervision in supporting clinicians treating individuals with EDs, and should attempt to distil the supervision needs unique to ED clinicians.

4.3 Conclusion

This review has demonstrated that clinicians working with individuals with EDs experience a wide range of countertransference reactions, including emotional, cognitive, physical and behavioural responses. Key emotional responses included frustration, helplessness, anger, anxiety, inadequacy and sadness. Understanding clinicians' experiences and implementing appropriate support for ED clinicians has far reaching implications for the clinician wellbeing, self-care, and, staff retention and provision of care. It is important that these factors continue to be investigated, particularly the role of supervision, so that clinicians can be provided a space to explore their experiences in relation to their clinical work and personal wellbeing.

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ELIZABETH A. DUNN BSc Hons

Section B: Clinician Experience and Supervision when Working Therapeutically with Individuals with Anorexia Nervosa – A Delphi Study.

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SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

Abstract

Objective: Clinicians working with individuals with eating disorders encounter unique emotional, cognitive and behavioural responses. Such responses may impact clinician self-care and wellbeing, and are linked to clinician emotional exhaustion and poor treatment outcomes. Supervision can protect against such consequences. There is limited theoretical literature and no empirical literature relating to the supervision of eating disorder clinicians.

Method: A three round Delphi Methodology explored the experiences of 69 clinicians working therapeutically with individuals with anorexia nervosa, along with the relevant core supervision requirements.

Results: Key negative emotions comprised sadness, anxiety, frustration and inadequacy. The impact on clinicians' thinking about food and their own body-image were divergent. A large number of statements reflecting the core elements of supervision including areas of discussion, reflection, outcomes, supervisor qualities, the supervisory relationship, barriers and facilitators reached consensus. No consensus was reached regarding discussing clinicians' thoughts about food, body-image or personal eating disorder history.

Discussion: Implications for clinical practice include using these findings to challenge persistent beliefs that individuals with anorexia nervosa are undesirable to treat, and promote appropriate support where challenging experiences arise. Results relating to supervision can form the basis of future supervision guidelines for this field. Study limitations and implications for future research are discussed.

Keywords: Anorexia nervosa, clinician, therapeutic, response, clinical supervision

1. Introduction

1.1 Anorexia Nervosa

Anorexia nervosa (AN) is an eating disorder (ED) characterised by the pursuit of low weight, distorted body-image, and fear of eating and weight gain (Walsh, 2013). AN typically occurs in girls and women, usually beginning during adolescence (NHS Choices, 2015). AN is associated with serious psychological distress including high levels of anxiety, depression and low self-esteem (Lock, 2010). Individuals with AN often have reduced social functioning, family difficulties and overall poor quality of life (Murphy, Straebler, Cooper & Fairburn, 2010).

AN is known for having low recovery rates, and high levels of chronicity, with an average duration of eight years (Hudson, Hiripi, Pope, & Kessler, 2007). AN can have severe physiological complications, which combined with risk of suicide, result in AN having the highest mortality rate of all psychological disorders (Arcelus, Mitchell, Wales & Nielsen, 2011). The annual costs of EDs to sufferers, carers, and the UK economy is estimated at approximately 14.2 to16.8 billion pounds; inclusive of costs of NHS and private treatment, travel costs to treatment, and loss of income due to time off work, and impacted educational or professional development (Pricewaterhouse Coopers, 2012).

The National Institute for Clinical Excellence (2004) suggest that "Therapies to be considered for the psychological treatment of anorexia nervosa include cognitive analytic therapy (CAT), cognitive behaviour therapy (CBT), interpersonal psychotherapy (IPT), focal psychodynamic therapy and family interventions focused explicitly on eating disorders" (p. 8). Unlike for bulimia nervosa (BN), for which the use of CBT and IPT is well evidenced; Bulik (2014) found limited evidence of a clear first choice of psychological treatment for AN,

and posited that, due to the current poor treatment outcomes and high mortality rates, better intervention options are needed.

One consistent predictor of treatment outcomes of psychotherapy is the therapeutic relationship, which refers to the collaborative relationship between therapist and client (Bordin, 1979; Martin, Garske, & Davis, 2000). The therapeutic relationship is influenced by a range of therapist and client factors. Therapeutic relationship core conditions comprise genuineness, empathy and unconditional positive regard (Rogers, 1980). This requires a range of therapist skills and attitudes including flexibility, honesty, warmth, interest, openness, respectfulness, trustworthiness, ability to provide feedback, manage countertransference, and repair relationship ruptures (Ackerman & Hilsenroth, 2003; Norcross, 2002). Client capacity to build a therapeutic relationship is influenced by the client's past interpersonal experiences (Horvath, 2006). Individuals with AN often have concurrent mental health diagnoses and interpersonal difficulties that manifest within the therapeutic relationship (Kaplan & Garfinkel, 1999). Individuals with AN may also struggle to relinquish power and control, undermining the therapeutic relationship (Burket & Schramm, 1995). Recent models have highlighted the importance of clinician emotion in the treatment of EDs, with some emotionally-driven processes unintentionally contributing to ED maintenance, thus undermining treatment outcomes (Treasure, Crane, McKnight, Buchanan & Wolfe, 2011; Waller, 2009).

Both client relational difficulties and clinician responses influence the therapeutic relationship and therapeutic outcomes. Research has begun to investigate the degrees and nature of emotional, cognitive and behavioural responses of clinicians in their work with individuals with EDs. Positive emotions were found in clinicians working with individuals with EDs, however common negative emotions included frustration, anger, anxiety, helplessness and inadequacy (Franko & Rolfe, 1996; Thompson-Brenner, Satir, Franko &

Herzog, 2012). Cognitive changes in relation to attention and attitudes to appearance and food were observed (Shisslack, Gray & Crago, 1998; Warren, Crowley, Olivardia & Schoen, 2009). Changes were found in clinicians' eating behaviours, with 30% eating more healthily and mindfully, whilst 19% engaged in more disordered eating (Shisslak et al., 1989). Clinicians increased self-care behaviours (e.g. personal therapy, exercise, supervision), however a minority reported potentially unhealthy coping behaviours, including smoking, drinking, binge-eating/purging (Warren et al., 2009; Warren, Schafer, Crowley & Olivardia, 2012). Clinicians reported moderate to high levels of emotional exhaustion; and burnout was associated with being young, female, having a high body mass index, limited experience, or experiencing a client death (Warren, Schafer, Crowley & Olivardia, 2013a). Clinicians reported that their negative emotional responses reduced quality of care and staff retention (Brotman, Stern & Herzog, 1984; Burket & Schram, 1995; Linville, Benton, O'Neil & Sturm, 2010).

Clinicians' responses may depend on a range of clinician factors including past history of an ED or current eating, weight or shape related issues, gender, profession, therapeutic orientation and level of experience (Brotman et al., 1984; Daniel, Lunn & Poulsen, 2015; Satir, Thompson-Brenner, Boisseau & Crisafulli, 2009; Shisslak et al., 1989). Clinicians' experiences appear further mediated by client factors comprising age, and ED subtype, and concurrent personality difficulties (Franko & Rolfe, 1996; Satir et al., 2009). This body of research suggests that a multitude of clinician factors, client factors and the model of therapy delivered can mediate the experience of the clinician.

1.2 Clinical Supervision

Clinical supervision (hereafter termed supervision), is the formal process of professional support and learning, which enables development of clinician knowledge,

competency and autonomy, and promotes patient safety and quality of care (Division of Clinical Psychology, 2014). Supervision is guided by clinical governance across a range of professional backgrounds and is outlined in key clinical governance policies (e.g., Care Quality Commission, 2010).

Regular supervision is preventative of job-burnout and negative clinician experience across clinical populations (Morse, Salyers, Rollins, Monroe-De Vita & Pfahler, 2012). Supervision further provides a safe space to allow supervisees to "reflect on the personal impact of their work and manage concerns in order to assist them in maintaining their level and standard of functioning" (DCP, 2014, p. 4). Supervision may also facilitate clinicians in maintaining morale and motivation, particularly when working with highly complex cases (DCP, 2014). Supervision is thus important to client care and clinician wellbeing.

The delivery of supervision varies widely across settings, professions and therapeutic modalities (DCP, 2014). Supervision can be highly structured and may follow a specific supervision model, for instance within IAPT services (Roth & Pilling, 2009). It has been suggested that specific supervision guidelines may be created for particular clinical populations which present with unique or complex needs, such as with those with personality disorders (DCP, 2014; Edmunds, 2012).

1.3 Clinical Supervision and Eating Disorders

Supervision was recommended by 98% of therapists in one sample of clinicians working with individuals with EDs as the best way of managing the personal impact of this work (Franko & Rolfe, 1996). At present there is no empirical literature exploring the use of supervision with ED populations. The existing theoretical literature suggests that supervision for clinicians working with ED clients is largely similar to the supervision of clinician's

working with other clinical populations, however some unique themes exist (DeLucia-Waack, 1999).

DeLucia-Waack (1999) posited that a key element of supervision for ED clinicians was to enable clinicians to maintain a "realistic sense of body-image, food and weight" (p. 380), both in order to maintain the clinician's own wellbeing, and reduce the likelihood of the clinician inadvertently reinforcing unhelpful beliefs and attitudes about food, weight or shape to clients.

Hamburg and Herzog (1990) suggested that clinicians may want to respect their client's privacy about their food and eating behaviours, and avoid evoking strong negative reactions in their clients; consequently avoiding asking important questions and not adequately ensuring client safety. A distinctive element of ED supervision may be facilitating supervisee knowledge and confidence of the monitoring and management of physical health (Castro-Fornieles et al., 2007).

Countertransference refers to the reactions experienced by a clinician toward their client, and can include all reactions regardless of whether they originate from the client or therapist (Satir et al., 2009). Countertransference issues from within the client-therapist relationship can manifest within the supervisory process in the form of parallel processes (Hamburg & Herzog, 1990). Difficulties of control, secrecy and perfectionism that arise in the client-therapist relationship may also manifest within the supervisee-supervisor relationship. Hamburg and Herzog (1990) and DeLucia-Waack (1999) highlight the importance of recognising difficult responses evoked in clinicians, and subsequent parallel processes, and validating and exploring them in supervision, to make sense of their therapeutic value. Such literature highlights the importance of supervision for ED clinicians, including some of the unique factors for this population. Despite this, no empirical research

has explored the supervision needs of ED clinicians, or the key requirements of supervision in this field.

1.4 Summary

AN is associated with a high level of cost to clients, clinicians and services. A lack of a clear first choice of psychological treatment, poor treatment outcomes for individuals with AN, and low recovery and high mortality rates present unique challenges to clinicians. There is a paucity of literature regarding the unique experiences and needs of clinicians working with individuals with AN and their supervisors. Understanding these common experiences and needs can better prepare clinicians and supervisors and can encourage open expression to help process common personal experiences and reactions (Warren et al., 2009). In keeping with this, the needs from supervision may require particular attention from both the clinician and their supervisor.

At present there are no supervision models or guidelines to facilitate the supervision of clinicians working therapeutically with individuals with AN. This study intends two main aims. The first is to further explore the experiences of clinicians who provide therapeutic interventions to individuals with AN. The second is to identify the core elements of supervision needed by such clinicians.

2. Method

2.1 Design

The Delphi technique was considered a suitable methodology as it allowed for the exploration of an important area of limited research which was context and expertise specific (Helmer, 1967). Delphis are frequently used to inform theory and model production (Holsapple & Joshi, 2002). They have been widely utilised within business, government, environmental, medical, and social studies (Linstone & Turoff, 2002), and across a number of

areas relevant to clinical psychology, including child and adolescent mental health (Sayal et al., 2012); dementia (Ferri et al., 2005); learning disability (Petry, Maes & Vlaskamp, 2007) and EDs (Tierney & Fox, 2009). Delphis further support the production of recommendations for clinical intervention and service standards (Day & Bobeva, 2005).

Delphis structure group communication for the purpose of gathering a range of expert views around a particular subject and pursue group opinion to establish consensus (Linestone & Turoff, 1975). Delphis are beneficial where there is a complex problem, about which there is limited knowledge (Skulmoski, Hartman & Krahn, 2007).

Delphi studies combine qualitative and quantitative methodologies and are implemented flexibly to best meet the research aims (Skulmoski et al., 2007). They utilise iterative feedback rounds, ensuring reliability, and generalisability by following principles of the democratic process and participant anonymity (Stone-Fish & Busby, 2005).

Dialogue between participants may be facilitated using online questionnaire platforms (Iqbal & Pipon-Young, 2009), allowing for the inclusion of a diverse range of international experts. A large quantity of rich data, can be collected from an ideal panel of experts, with efficiency of time and money (Petry et al., 2007). Using Delphis, over other methods (e.g., focus groups), allows anonymous communication reducing social pressure and potential bias of conforming and normative influence, thereby facilitating free expression (Bowles, 1999).

2.2 Participants

Purposive sampling was used to select participants (hereafter referred to as ‘panellists’) who met a number of expertise requirements including: experience of and specialist knowledge about the subject being explored, ability, readiness, time to participate and appropriate communication abilities (Adler & Ziglio, 1996; Keeney, Hasson & McKenna, 2001). A diversity of viewpoints generates curiosity and involvement (Linstone &

Turoff, 1975). Heterogeneous panels produce rich data and a high quality of acceptable solutions to problems (Delbecq, Van de Ven & Gustafson, 1975). Thus, experts with a variety of clinical and model specific backgrounds were sought. The criteria of 'expertise' utilised by this study are outlined in Table 1.

Table 1

Panellist Inclusion Criteria

Over 3 years' experience working therapeutically with individuals with anorexia nervosa.
And/or good current knowledge of the current evidence base and relevant research relating to the clinical application of therapy for anorexia nervosa.
Impartiality (panellists may not have any conflicting interests which may influence their participation).
Willingness, ability and availability to complete all three rounds.
Ability to read and write in English.

Note. Panellists were contacted if the author believed they met the inclusion criteria. In addition, panellists were asked to self-assess their suitability for participation.

Prospective panellists were identified through literature database searches (PsychInfo, Medline), and conference proceedings (e.g. International Conference of Eating Disorders). Specialist ED services both nationally and internationally were invited to participate, as were specialist ED organisations (e.g. national charity Beating Eating Disorders, BEAT). Potential panellists were further identified through professional and research networks (The British Psychological Society [BPS] Faculty for Eating Disorders; Research Gate).

Original searches identified 59 potential panellists who appeared to meet the inclusion criteria and were contactable. Of these, 39 (66.1%) went on to participate. A 'snowballing' strategy (Iqbal & Pipon-Young, 2009) was utilised by asking established panellists to forward the research invitation to further potential suitable panellists; identifying 27 panellists who

participated in round one (R1). In total, 69 panellists consented to take part. Of these, 66 completed R1, 39 completed round two (R2) and 32 completed round three (R3).

Due to snowball sampling it is not possible to determine the overall response rate. The attrition rate of 53.6% from R1 to R3 fell within the expected completion rate margins for Delphi studies (i.e. 40-75%; Gordon, 1994). High attrition rates are common as Delphis require lengthy responses and active participation over several months (Borg & Gall, 1983).

2.3 Ethics

The study adhered to the British Psychological Society (2014) code of ethics and ethical approval was successfully acquired from Salomons Ethics Panel, Canterbury Christ Church University (Appendix E). Panellists were provided with a comprehensive information sheet (Appendix F) outlining the aims, purpose and procedure of the study. Issues of confidentiality, anonymity, right to withdraw and information governance were outlined. Consent was obtained using an electronic consent form (Appendix G).

2.4 Measures and Procedure

Due to the iterative process of data collection, analysis, and production of subsequent questionnaires, this section will discuss both measures and procedure together in relation to each of the three rounds. The present study utilised the following key aspects of the Delphi technique (Powell, 2003):

- Purposive sampling of participants with ‘expert’ knowledge of the subject.
- Iterative stages of data collection and analysis which distil information through multiple feedback rounds of individual and group views.

- A qualitative R1 questionnaire (R1Q) consisting of open-ended questions explored participant views on a subject without imposing the pre-existing views of the author or evidence base.
- Qualitative analysis of R1Q data to construct a number of statements.
- A quantitative R2 questionnaire (R2Q) comprising of R1 statements using Likert scales (Likert, 1932) to evaluate participant attitudes towards each statement.
- Individualised quantitative R3 questionnaires (R3Q) enclosing the individual's R2 responses to each statement, along with the general group rating for each statement and qualitative comments. Participants were invited to review and revise their response in consideration of the group response.

The three round Delphi took eleven months to complete (see Appendix H for Delphi procedure flowchart). Panellists were given three weeks to complete R1, four weeks to complete R2, and three weeks to complete R3. Between each round, data were analysed and the subsequent questionnaire was created and piloted. Questionnaire rounds were conducted using the internet survey platform 'Survey Monkey' for R1 and R2, and 'Qualtrics' for R3. For each round, each panellist was sent a personalised invitation email with a link to the online survey. To improve response rates, panellists were sent up to two personalised reminder emails for each round, thanking them for their participation. Participants who completed all three rounds were entered into prize draw to win one of four vouchers to the value of £25 or equivalent.

2.4.1 Round one questionnaire (R1Q).

This questionnaire was informed by a literature review and discussions with experts working therapeutically with individuals with AN. The original questionnaire comprised eight open-ended questions indicated by gaps within the literature. Piloting by five professionals who met the inclusion criteria, led to the clarification of wording, to increase

content validity, and an additional question pertaining to service user views (see Table 2 for final R1Q questions). R1 took approximately one hour to complete.

Table 2

Round One Questionnaire Open-Ended Questions

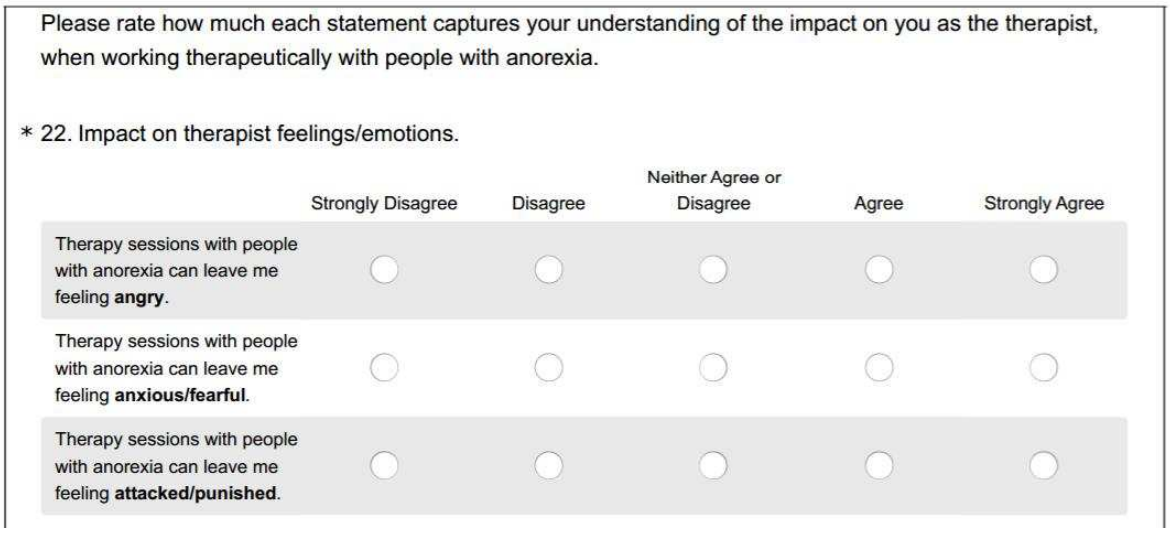
1. Thinking about your own clinical experiences of providing therapy to individuals with Anorexia Nervosa what factors have the most significant impact on you during sessions and following sessions?
2. In your opinion should the impact on the therapist of working with a particular client be used to inform their clinical formulation, and if so, how? (What would the potential benefits include?)
3. Reflecting back on your answers for so far, how does building a therapeutic relationship with an individual with Anorexia Nervosa affect you, the clinician?
4. What issues/areas would need to be covered in order for supervision to be useful when working with individuals with Anorexia Nervosa? (You may wish to consider things that you see as important but might feel uncomfortable raising).
5. What impact does good supervision have on you and on your therapeutic work?
6. How does the length of time you have worked therapeutically with this population influence your need for supervision, and what topics are discussed?
7. What do you consider to be the main barriers to developing a good supervisory relationship?
8. How do you as supervisor/supervisee overcome these barriers?
9. If a person with Anorexia Nervosa could observe your supervision/supervisory relationship what do you think they would want to change or add?

Panellists were asked to provide demographic information and information pertaining their qualifications, experience, publication history, preferred therapeutic models and supervision. R1 data were collated and analysed using Thematic Analysis (Braun & Clark, 2006) to produce R2 statements. The process of data analysis is outlined in the ‘data analysis’ section.

2.4.2 Round two questionnaire (R2Q).

The R1Q data produced 42 statements relating to the first research aim exploring the experiences of clinicians, 89 statements for the second research aim relating to supervision, and an additional 45 statements exploring the wider context. Statements were presented in the

R2Q (Appendix I) relating to themes, but at times were chunked into smaller sections to improve panellists experience. Statements were worded similarly to reduce participant cognitive load (de Jong, 2010). See Figure 1 for an example of RQ2 statements.


Please rate how much each statement captures your understanding of the impact on you as the therapist, when working therapeutically with people with anorexia.

* 22. Impact on therapist feelings/emotions.

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Therapy sessions with people with anorexia can leave me feeling **angry**.	○	○	○	○	○
Therapy sessions with people with anorexia can leave me feeling **anxious/fearful**.	○	○	○	○	○
Therapy sessions with people with anorexia can leave me feeling **attacked/punished**.	○	○	○	○	○

Figure 1. Example of final R2Q Statements.

Panellists were asked to rate their level of agreement with each statement using five point Likert scales (Likert, 1932), wherein (1 = Strongly Disagree, and 5 = Strongly Agree). Comment boxes were provided to allow panellists to comment on their responses. Three of the five professionals who piloted the R1Q, piloted the R2Q. The R2Q took approximately 30-to-45 minutes to complete during piloting; minor alterations were made to the wording of some statements.

2.4.3 Round three questionnaire (R3Q).

As R2Q statements related to the panellists' personal lived experiences of working therapeutically with individuals with AN, it was not considered appropriate to invite panellists to review their responses to these statements in order to establish a consensus. As such, these statements were included in R2 only. Statements relating to supervision, were automatically included in the final Delphi recommendations if consensus was reached during

R2 and were thus not included in the R3Q. Statements included in R3 were those that were divergent or approaching consensus.

The R2Q analysis revealed 47 statements which had not reached consensus. All participants who had completed the R2Q received an individualised R3Q (Appendix J), highlighting their own response to each statement, marked with blue 'X', accompanied by the percentage of people who selected each response (Figure 2). The most frequently selected rating was highlighted in bold (Hardy et al., 2004). R2 panellist comments were displayed with the corresponding statements. Panellists were provided the opportunity to revise their rating of each statement in light of the overall group response and comments, using a Likert scale. To obtain further sample information three additional questions were included (see Appendix J, p. 57). The R3Q was piloted by the three professionals who piloted the R2Q. During piloting the R3Q took approximately 20 minutes to complete and no amendments were necessary.

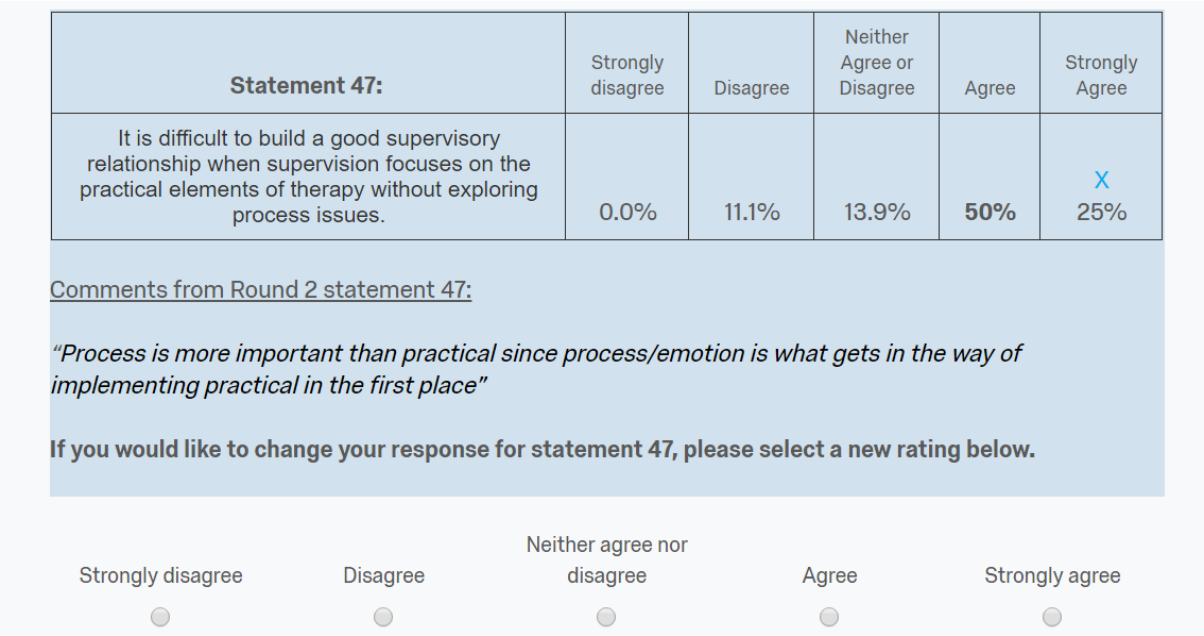


Figure 2. Example of individualised R3Q Items. Panellists' individual rating from R2Q are identified with a Blue 'X'. The response most frequently selected by panel is displayed in bold.

2.5 Data Analysis

2.5.1 Qualitative data analysis.

The data produced from the R1Q were analysed using Thematic Analysis (Braun & Clark, 2006) in order to increase the methodological robustness of the Delphi (Iqbal & Pipon-Young, 2009). As recommended by Booth and Carroll (2015), R1Q data were analysed both inductively and deductively. Deductive coding facilitated the author in identifying codes that were 'theory-driven', in that they specifically pertained to answering the research question investigated. Additionally, inductive coding allowed for meaningful categories to emerge which were 'data-driven' rather than led by the pre-existing beliefs of the researcher; this allowed for a richer context to be drawn upon for understanding the deductive codes. The full coding and statement production process is outlined in Appendix K.

In essence, data extracts were coded and collated within common themes. Statements were then produced and reviewed until they accurately reflected the common codes and themes found within the data.

2.5.2 Quality assurance.

A number of quality assurance criteria were employed to determine the 'credibility' (i.e. confidence in the 'truth' of the findings) and 'trustworthiness' of the data (Lincoln & Guba, 1985; Shenton, 2004). The following strategies were used to monitor and improve the validity and accuracy of the collected data.

Triangulation of data sources was promoted by creating a heterogeneous panel; furthermore, triangulation of data collection approaches is intrinsic to the mixed qualitative and quantitative methodology (Green, 2014). Member-checking, which is fundamental within the Delphi methodology was utilised throughout as emerging themes, represented as statements, were iteratively fed-back for confirmation by the panellists, to continuously check

the accuracy of the previous rounds findings (Gibson & Miller, 1990). 'Confirmability' (i.e. researcher neutrality) was addressed through researcher self-reflection and regular meetings with supervisors. As outlined by Powell (2003), a clear decision trail was kept to aid the 'dependability' of the Delphi technique; this was kept in the form of a research diary (Borg, 2001; see Appendix L). The process of analysis, and statement production was reviewed across multiple stages by each supervisor independently in order to enhance validity (see Appendix M for an example of themes and corresponding subthemes).

2.5.3 Analysis of consensus and divergence.

All quantitative analysis was conducted using the Statistical Package for Social Science 22 (SPSS 22, 2013). Consensus was defined consistent with Graham and Milne (2003) who defined consensus as the amount of agreement between panellists. In keeping with previous Delphis (e.g. Hacket, Masson & Phillips, 2006) the total percentages of agreement or disagreement to each statement was calculated to determine the strength of consensus of opinion relating to each statement. Scores from the 5-point Likert scale were collapsed as outlined in Figure 3, into three bands (1-2 = Disagreement, 3 = Neutral, 4-5 = Agreement). As established by Jones and Hunter (1995), medians and interquartile ranges (IQR) were calculated as they are less influenced by extreme data values than means and standard deviations and are helpful in determining the variability and distribution of the responses to each statement (Marsh, 1998).

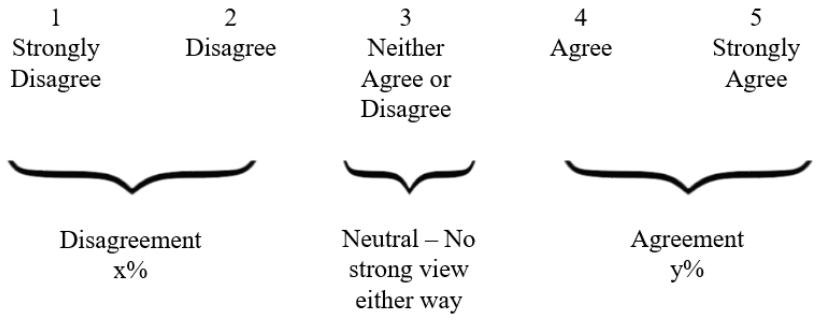


Figure 3. Collapsed Likert rating categories.

The operationalisation of consensus, is poorly reported across Delphi studies, and is highly variable (Hsu & Sandford, 2007). In order to establish a high level of consensus, this study chose to utilise Hackett, Masson and Phillips' (2006) consensus criteria (Table 3) which defined overall consensus as ≥ 80% disagreement/agreement across panellists.

Table 3

Consensus Categories Criteria

	Agreement (inclusion in final recommendations)	Disagreement (exclusion from final recommendations)
Overall Consensus	Collapsed (4-5) scores ≥ 80% AND IQR <1 AND Median 4-5.	Collapsed (1-2) scores ≥ 80% AND IQR <1 AND Median 1-2.
Approaching Consensus	Collapsed (4-5) scores 65%-79% AND IQR <2 AND Median 4-5.	Collapsed (1-2) scores 65%-79% AND IQR <2 AND Median 1-2.
Overall Divergence	Collapsed (4-5) scores <65% OR IQR >2 OR Median <4.	Collapsed (1-2) scores <65% OR IQR >2 OR Median >2.

The above analysis was conducted for all R2Q statements, and all R3Q statements where panellists had altered their previous responses. Where participants were unable to

complete the R3Q, their responses from their R2Q were taken as their final responses and were included in the R3Q analysis, as demonstrated in previous Delphi studies (e.g. Kennedy & Llewleyn, 2001; Pipon-Young, Cuppitt & Callanan, 2010). Divergence occurred if no consensus was reached by the end of R3.

3. Results

3.1 Demographic Information

Of the final sample (N = 69), 56 (81.2%) were female and 13 (18.8%) were male. Thirty-three (47.8%) were of white British origin, and a further 13 (18.8%) identified themselves as Caucasian. The rest of the sample were diverse (Australian n = 5 [7.2%]: Latin American n = 2 [2.9%]: Caribbean n = 2 [2.9%]: Canadian n = 2 [2.9%]: Mediterranean n = 2 [2.9%]: New Zealand European n = 2 [2.9%]: Irish n = 2 [2.9%]: Mixed ethnicity n = 6 [8.7%]).

The age range was 25 – 63 (M = 43, SD = 9.49). Their level of general clinical experience ranged from three to 37 years (Mdn = 16, IQR = 17), and specialist ED experience ranged from three to 36 years (Mdn = 9.5, IQR = 11). Of the sample, 55.1% had ED related publications (1309 publications in total, range 1 - 300, Mdn = 6, IQR = 8). They worked in a range of countries (Britain n = 41, Australia n = 7, Canada n = 7, Chile n = 5, New Zealand n = 2, Channel Islands n = 2, USA n = 1, Mexico n = 1), and reported a diverse range of professions (Table 4).

Table 4

Professional Backgrounds

	Frequency	Percentage
Psychology		
Clinical Psychologist	21	30.4%
Counselling Psychologist	1	1.45%
Psychologist (non-specified)	10	14.5%
Psychotherapist	5	7.25%
CBT Therapist	2	2.9%
Family Therapist	4	5.79%
Therapist (non-specified)	2	2.9%
Doctor		
General	2	2.9%
Psychiatrist	7	10.1%
Nursing		2.9%
Nursing (general)	4	5.79%
Mental Health Nurse	2	2.9%
Clinical Nurse Specialist	2	2.9%
Occupational Therapy	4	5.79%
Social Work	2	2.9%
Service Manager	1	1.45%
Academia		
Professor	2	2.9%
Academic	2	2.9%
Researcher	1	1.45%

Note. N = 69. Panellists could have more than one professional background or role.

Panellists reported using a broad range of therapeutic models in their work with individuals with AN, although CBT (63.2%) was the most frequently reported (Appendix N). Most panellists (79.9%) received supervision and a variety of types and models of supervision were described (Appendix N). Panellists worked across a range of care pathways working with individuals with AN with varying levels of risk (Low 55.2%; Moderate 72.4%;

High 79.3%). All panellists reported feeling well supported by their team or service in monitoring and managing physical health risk.

3.2 Consensus Analysis

The results of this Delphi are outlined in relation to the two overarching research aims. The results for each aim are presented in tables presenting the overall consensus category, percentage of agreement and disagreement, IQR and median (see Appendix O for further consensus results breakdown) and are outlined in the text. Qualitative comments are used to provide context to panellists' responses. The results will be discussed by theme, and within each theme, results will be discussed in order of the level of consensus reached, with those which reached overall consensus, approaching consensus and overall divergence discussed respectively. The results for the statements relating to the wider context are not outlined here and will be written up separately for publication.

In total, 94 R2Q statements reached consensus. In R3, 83% of panellists made changes to their R2Q responses, making an average of 4.86 revisions across 47 items.

3.2.1 Research aim one: Clinician experiences.

The first research aim sought to explore the experiences of clinicians working therapeutically with individuals with AN. The R1 analysis yielded 42 statements related to four themes: clinician emotion; clinician thinking; clinician behaviours; and challenges. The final data comprised R2Q responses for each statement. The R2Q analysis revealed that nine statements met the criteria for overall consensus; six yielded a strong agreement consensus thus were included in the overall understanding of clinicians' experiences, whilst three yielded a strong disagreement consensus thus were excluded. Eleven statements were approaching consensus, and responses to 22 statements were overall divergent.

3.2.1.1 Clinicians emotion. The emotional experiences of clinicians identified in the R1Q analysis were reflected in 26 statements (Table 5). The consensus analysis suggests that there was overall consensus that panellists enjoyed the complexity of working with individuals with AN, enjoyed their connection with clients, found their work rewarding and experienced a sense of achievement when their clients made changes. Sadness was the only negative emotion which reached overall consensus of agreement. There was also overall consensus that clinicians did not feel disgust or jealousy of clients' body shapes.

Anxious/fearful emotions, feelings of inadequacy and protectiveness were all approaching consensus. Similarly, frustration, both in relation to the individual with AN being ambivalent or having limited motivation or due to the slow progress of the therapy itself, were also approaching consensus. As indicated in Table 5, responses were divergent for 14 emotional reactions.

Table 5

Clinician Emotional Responses

	Disagreement %	Agreement %	Median	Interquartile Range
Overall Consensus				
I enjoy the complexity of working with individuals with anorexia.	2.7%	86.4%	1	4
I enjoy the connection with my clients	2.7%	91.9%	1	4
I can feel a sense of achievement when my client makes changes	0.0%	97.3%	1	4
I find working with individuals with anorexia rewarding	2.7%	83.7%	1	4
Therapy sessions with people with anorexia can leave me feeling sad	8.1%	83.8%	1	4
Therapy sessions with people with anorexia can leave me feeling disgust	83.7%	8.1%	1	2
Working with individuals with anorexia can make me feel jealous of their body shape	97.3%	2.7%	1	1
Approaching Consensus				
Therapy sessions with people with anorexia can leave me feeling frustrated due to the person with anorexia's ambivalence/low levels of motivation	13.5%	78.4%	1	4
Therapy sessions with people with anorexia can leave me feeling frustrated due to slow progress	24.3%	67.6%	1.5	4
Therapy sessions with people with anorexia can leave me feeling inadequate	21.6%	67.6%	1	4

	Disagreement %	Agreement %	Median	Interquartile Range
Therapy sessions with people with anorexia can leave me feeling anxious/fearful	27%	67.6%	2	4
Therapy sessions with people with anorexia can leave me feeling protective	13.5%	70.3%	1	4
Overall Divergence				
Therapy sessions with people with anorexia can leave me feeling angry	29.7%	56.8%	2	4
Therapy sessions with people with anorexia can leave me feeling attacked/punished	32.4%	56.8%	2	4
Therapy sessions with people with anorexia can leave me feeling bored	48.6%	40.5%	2	3
Therapy sessions with people with anorexia can leave me feeling dismissed	21.6%	54.1%	1	4
Therapy sessions with people with anorexia can leave me feeling hopeless	32.4%	54.1%	2	4
Therapy sessions with people with anorexia can leave me feeling like I want to shut off from the person with anorexia	59.4%	32.4%	3	2
Therapy sessions with people with anorexia can leave me feeling overwhelmed	35.1%	48.6%	2	3
Therapy sessions with people with anorexia can leave me feeling powerless	21.6%	59.5%	1	4

	Disagreement %	Agreement %	Median	Interquartile Range
Therapy sessions with people with anorexia can leave me feeling uncomfortable about the power imbalance	43.2%	32.4%	2.5	3
Therapy sessions with people with anorexia who are very underweight can leave me feeling shocked about their physical state	21.6%	51.3%	1	4
Therapy sessions with people with anorexia can leave me feeling anxious that they will die or become increasingly unwell	16.2%	64.8%	1	4
Therapy sessions with people with anorexia can leave me feeling a pressure to please my client	54%	29.7%	2	2
I find working with people with anorexia repetitive/tedious	64.8%	18.9%	1.5	2
People with anorexia are often critical of themselves and others, so I can feel rubbished or inadequate	40.5%	45.9%	1	3

Note. N = 37. All results displayed are from R2Q data.

3.2.1.2 Clinician thinking. Five statements referred to the impact of working therapeutically with individuals with AN on clinician thinking (Table 6). There was overall consensus that working with individuals with AN does not increase clinician's feelings of insecurity about their own body. Clinicians agreed that they had adapted their expectations as a therapists to value small changes. There was an overall divergence for three statements relating to whether working with individuals with AN impacts on clinicians thinking about food or their body.

Table 6

Clinician Thinking

	Disagreement %	Agreement %	Median	Interquartile Range
Approaching Consensus				
Working with individuals with anorexia has made me more insecure about my own body	70.2%	12.8%	2	2
I find I need to adapt my expectations as a therapist to value small changes	8.1%	75.6%	1.5	4
Overall Divergence				
Working with individuals with anorexia has changed the way that I think about food	48.6%	32.4%	2	3
Working with individuals with anorexia has changed the way that I think about my body	59.4%	24.3%	2.5	2
Working with individuals with anorexia has made me more accepting of my own body	29.7%	48.6%	2	3

Note. N = 37. All results displayed are from R2Q data.

3.2.1.3 Clinician behaviours. One statement from the R1Q analysis reflected the impact on clinician behaviours (Table 7). Panellists disagreed, at the approaching consensus level, that working with individuals with AN impacted their eating behaviours after sessions.

Table 7

Clinician Behaviours

	Disagreement %	Agreement %	Median	Interquartile Range
Approaching Consensus				
Working with individuals with anorexia can impact on my eating behaviours (e.g. eat more or less after a session)	70.2%	24.3%	2	2

Note. N = 37. All results displayed are from R2Q data.

3.2.1.4 Challenges. The R1Q analysis also revealed 10 statements relating to general challenges of working with individuals with AN. There was overall consensus that clinicians need to be personally resilient. There was overall disagreement that clinicians avoid emotional factors by focusing on behavioural and cognitive change. Results, at the approaching consensus level, also suggested that clinicians do not find it difficult to empathise with their clients, do feel under pressure from their respective services and notice different feelings as they became more experienced. Responses to the remaining five statements were overall divergent (Table 8).

Table 8

Challenges

	Disagreement %	Agreement %	Median	Interquartile Range
Overall Consensus				
I need to be personally resilient when working with people with anorexia	2.7%	91.9%	1	4
Sometimes I avoid emotional factors by focusing on behavioural and cognitive change	81.1%	16.2%	0.5	2
Approaching Consensus				
It can feel difficult to empathise with such a life threatening condition that is difficult to understand "logically"	78.3%	18.9%	1	2
As a therapist I often feel under pressure from my service and the wider system to be ‘doing something’ in therapy.	16.2%	75.7%	1.5	4
Different feelings emerge as I get more experienced.	2.7%	73%	1	4
Overall Divergence				
It can feel hard to be honest with clients sometimes.	56.7%	27%	2	2
I can feel bad if I don't manage to connect in some meaningful way when working with individuals with anorexia.	13.5%	62.2%	1	4
I can sometimes get lost in the details and/or wrong issue.	29.7%	45.9%	1	4
I can sometimes worry about pushing for change.	32.4%	48.6%	2	3

	Disagreement %	Agreement %	Median	Interquartile Range
Sometimes I feel like I have to work too hard in therapy (i.e. with questions and lines of enquiry) when working with people with anorexia.	18.9%	59.4%	1	4

Note. N = 37. All results displayed are from R2Q data.

3.2.2 Research aim two: Supervision needs.

The second research aim sought to explore the expert opinions concerning supervision for clinicians working therapeutically with individuals with AN. The R1 analysis yielded 89 relevant statements. The final data comprises panellists R3Q responses for each statement, or R2Q responses for panellists who were unable to complete R3.

The R2Q analysis revealed that 69 statements met the criteria for overall consensus; all of which yielded a strong consensus of agreement. Twenty R2Q statements were approaching consensus or overall divergent, as such they were included in the R3Q. The R3Q analysis revealed that six statements reached overall consensus of agreement in R3. Six statements were approaching consensus, and eight remained overall divergent.

Statements will be discussed in relation to the seven overarching themes encompassing: areas of discussion; areas of reflection; outcomes; qualities of the supervisory relationship; supervisor qualities; barriers and facilitators to supervision.

3.2.2.1 Areas for discussion. Eighteen areas of discussion were identified as important (Table 9). Eleven reached overall consensus in R2. At the end of R3 responses to two statements were approaching consensus, and five were overall divergent.

Areas of discussion reaching consensus level included clinician and relationship factors, such as the clinician's defences and coping mechanisms, clinician's unhelpful habits,

issues within the therapeutic relationship and resultant stresses and frustration, the client's experience of emotion, successful cases and small successes. Other areas reaching consensus includes ways of working with ED symptoms, how to use new techniques and troubleshooting with practical strategies, finding solutions and ways forward. Discussing case management and clinicians' beliefs and schemas and the impact on their work were both approaching consensus.

Four of the five statements which were divergent related to discussing clinician's own relationship to, and beliefs about food and their body, and clinicians' experiences of having an ED, or food or body image related issues. Qualitative comments related to clinicians experiences of having an ED, or food or body image related issues. One panellist stated:

> If the therapist appears to have adopted a problem i.e. losing a lot of weight, talking about being on a diet with their patients (hopefully this would not happen). But if this was happening then yes it ought to be addressed (P17).

Another panellist stated "Some of these issues might be identified but may be better addressed in personal therapy" (P23).

Table 9

Areas for Discussion

	Disagreement %	Agreement %	Median	Interquartile Range
Overall Consensus				
The clinician's defences/coping mechanisms (e.g. too detached vs. too involved, rescue/avoid) (R2)	2.7%	86.5%	1	4
The stresses and frustrations of the therapeutic relationship (R2)	0.0%	97.2%	1	4
The client’s experience of emotion (including individual and familial avoidance patterns) (R2)	0.0%	89.2%	1	4
Cases that are going well (R2)	2.7%	91.9%	1	4
Small successes made in the clinician's clinical work (R2)	2.7%	94.6%	1	4
Ways of working with eating disorder symptoms (R2)	2.7%	97.3%	1	4
How to use techniques from other therapies outside of the clinician's current skill set (R2)	0.0%	89.1%	1	4
Trouble shooting difficulties with practical strategies (R2)	0.0%	94.5%	1	4
The clinician's unhelpful habits (R2)	2.7%	89.2%	1	4
Solutions/ways forward in the clinician's therapeutic work when stuck (R2)	0.0%	100%	1	5
Issues within the therapeutic relationship (R2)	0.0%	100%	1	4

	Disagreement %	Agreement %	Median	Interquartile Range
Approaching Consensus				
The clinician's schemas/belief systems, and their impact on the clinician's clinical work (R3)	2.6%	79.5%	0	4
Case management (R3)	10.3%	76.9%	1	4
Overall Divergence				
The impact of the therapeutic work on the clinician's relationship with food and their body (R3)	10.3%	41.1%	1	3
The clinician's beliefs about food (R3)	12.9%	46.2%	1	3
The clinician's beliefs about their body (R3)	12.9%	38.5%	1	3
The clinician's experiences of an eating disorder, or food or body image related issues (R3)	10.3%	59%	1	4
Broad themes more than individual cases (R3)	20.5%	48.7%	1	3

Note. Round 2: N = 37. Round 3: N = 39.

3.2.2.2 Areas for reflection. Six areas of reflection were identified as important (Table 10), all statements reaching overall consensus during R2. It was considered important to reflect on why change has not occurred, and the clinician's anxiety about requiring change. It was also considered key to reflect on transference and countertransference issues arising within the clinicians' work, and parallel processes which may arise. Broader areas included team and system issues and ethical issues.

Table 10

Areas for Reflection

	Disagreement %	Agreement %	Median	Interquartile Range
Overall Consensus				
Why change has not happened (R2)	2.7%	94.6%	1	4
The clinician's anxiety about requiring change (R2)	0.0%	97.3%	1	4
Transference and counter-transference that arises in the clinician's work with people with anorexia or their families (R2)	0.0%	89.2%	1	4
Parallel processes that may arise within therapy, supervision, the family and the wider system (R2)	0.0%	94.6%	1	4
Issues relating to the team/wider system (R2)	0.0%	83.7%	1	4
Ethical issues relating to working with individuals with anorexia, for instance, the question of whether or not free will can extend to starving one's self to death, and how much can we as health professionals intervene (R2)	2.7%	86.4%	1	4

Note. N = 39.

3.2.2.3 Outcomes of 'good' supervision. Twenty-three outcomes of good supervision were identified in the R1Q analysis (Table 11), all outcome statements reaching overall consensus of agreement during R2. Outcomes related to four sub-themes: practical tasks; improved understanding; therapeutic relationship; and clinician wellbeing. Practical task statements included intervention planning, goal setting, identifying individual outcomes and promoting evidenced based practice. Supervisees gaining an improved understanding related

to becoming aware of their blind spots and biases, gaining a deeper understanding of their client's difficulties, mentalising their client's view, formulating within specific therapeutic models as well as formulating difficulties which arise in therapy.

Statements relating to the therapeutic relationship referred to helping supervisees to notice if they are colluding with AN, improve engagement with their clients, repair therapeutic ruptures and notice unhelpful patterns of interacting. Clinician wellbeing statements involved helping clinicians identify how they feel in relation to their client work, and normalising their experiences. It also required helping to improve supervisee hopefulness, motivation, resilience, and confidence in managing risk. Furthermore, improving clinician enjoyment of their work and protecting against burnout.

Table 11

Outcomes of 'Good' Supervision

	Disagreement %	Agreement %	Median	Interquartile Range
Overall Consensus				
Good supervision helps the supervisee to plan their interventions (R2)	0.0%	97.3%	1	4
Good supervision helps the supervisee to develop clear goals for future therapy sessions (R2)	0.0%	100%	1	4
Good supervision helps the supervisee to focus on outcomes at the level of the individual client (R2)	0.0%	86.4%	1	4
Good supervision helps the supervisee to develop a deeper understanding of the individual with anorexia's difficulties (R2)	0.0%	97.3%	1	5
Good supervision helps the supervisee to understand the individual with anorexia's difficulties within specific therapeutic models (R2)	0.0%	97.3%	1	4
Good supervision helps the supervisee to formulate difficulties that arise within the therapy (R2)	0.0%	100%	1	5
Good supervision helps the supervisee to mentalise the individual with anorexia's view (R3)	2.6%	82.1%	1	4
Good supervision helps the supervisee to notice if they are colluding with anorexia (R2)	0.0%	97.3%	1	5

	Disagreement %	Agreement %	Median	Interquartile Range
Good supervision helps the supervisee to be aware of their blind spots and biases, thus promoting safer decision making (R2)	0.0%	100%	1	5
Good supervision helps to normalise some of the difficulties that the supervisee may experience when working with people with anorexia (R2)	2.7%	94.6%	1	4
Good supervision has a careful balance between being directive and offering teaching, and allowing supervisee to develop his/her own ideas (R2)	2.7%	89.1%	1	4
Good supervision supports clinical work in being evidence based (R2)	2.7%	86.4%	1	4
Good supervision helps the supervisee to identify and explore what they are feeling in relation to their client work (R2)	0.0%	97.3%	1	5
Good supervision helps the supervisee to resolve ruptures or problems within the therapeutic relationship (R2)	0.0%	100%	1	5
Good supervision helps the supervisee to notice when they become stuck in unhelpful relationship patterns in therapy (R2)	0.0%	97.3%	1	5
Good supervision helps the supervisee to engage and connect with the individual with anorexia (R2)	0.0%	91.9%	1	4
Good supervision helps to instil hope (R2)	0.0%	94.6%	1	4

	Disagreement %	Agreement %	Median	Interquartile Range
Good supervision helps the supervisee to feel more confident in managing risk (R2)	0.0%	97.3%	1	4
Good supervision helps the supervisee to stay motivated in their therapeutic work (R2)	0.0%	97.3%	1	4
Good supervision helps the supervisee to feel more resilient (R2)	0.0%	94.6%	1	4
Good supervision helps the supervisee to not burnout (R2)	0.0%	94.6%	1	4
Good supervision helps the supervisee to remember that they are not a terrible therapist, and that they are "doing alright / well' (R2)	0.0%	81.1%	1	4
Good supervision helps improve the supervisee's enjoyment of the work (R3)	0.0%	82%	1	4

Notes. Round 2: N = 37. Round 3: N = 39.

3.2.2.4 Qualities of the supervisory relationship. Four statements explored the qualities associated with a good supervisory relationship (Table 12), all statements reaching overall consensus in R2. It was considered important that supervision holds a compassionate and respectful stance to individuals with AN, be containing of the clinicians feelings around their work, and be a safe place to explore difficult emotions.

Table 12

Qualities of the Supervisory Relationship

	Disagreement %	Agreement %	Median	Interquartile Range
Overall Consensus				
Good supervision has a compassionate stance to people with anorexia and their experiences (R2)	0.0%	94.4%	1	5
Good supervision has a respectful stance to people with anorexia and their experiences (R2)	0.0%	100%	1	5
Good supervision helps to contain the supervisee's feelings around their clinical work (R2)	0.0%	94.4%	1	5
Good supervision should feel like a safe place to explore difficult feelings (R2)	0.0%	100%	1	5

Note. N = 36.

3.2.2.5 Supervisor qualities. Seven statements outlined important supervisor qualities (Table 13). Five statements reaching overall consensus in R2, and one reaching overall consensus in R3. It was considered that supervisors should be able to add something new to their supervisees' practice, should facilitate their supervisees' learning and development, have a good understanding of AN and have the expertise required to supervise the treatment approach in use. It was however believed that supervisors who were not experts on working with individuals with AN could still provide a reflecting opportunity, and that supervisors taking a non-expert role could facilitate a good supervisory relationship. There was an overall divergence of opinion relating to whether clinicians should only be supervised by somebody of the same profession.

Table 13

Supervisor Qualities

	Disagreement %	Agreement %	Median	Interquartile Range
Overall Consensus				
Supervisees need to feel confident that their supervisor has something new to add to their practice (R3)	0.0%	81.5%	1	4
Supervisors must have a good understanding of anorexia (R2)	0.0%	88.9%	1	4.5
Supervisors should have the expertise required to supervise the treatment approach in use (R2)	2.8%	86.1%	1	5
Supervisors who lack expert knowledge can still provide a reflecting opportunity (R2)	2.8%	91.7%	1	4
Supervisors taking a non-expert role can facilitate a good supervisory relationship (R2)	11.1%	80.5%	0	4
Supervisors need to facilitate appropriate learning and professional development for the supervisee (R2)	7.7%	83.3%	0.75	4
Overall Divergent				
Clinicians should only be supervised by somebody of the same profession as them (R3)	57.9%	21.1%	1	2

Note. Round 2: N = 36. Round 3: N = 38.

3.2.2.6 Barriers to supervision. Fourteen statements relating to barriers to supervision were produced reflecting the R1Q data (Table 14), half reaching overall consensus in R2, and two reaching overall consensus in R3. At the end of R3, three statements were approaching consensus and two were overall divergent.

There was overall agreement that inadequate boundaries and structure, or too great a focus on practical elements without exploring process issues created barriers to good supervision. Supervisor barriers reaching consensus included poor listening skills, being didactic, punitive or critical. Supervisee barriers meeting consensus were supervisees not bringing topics to supervision if their own schemas had been triggered, if they were anxious or felt judged by their supervisor.

At the approaching consensus level, panellists agreed that supervisees can struggle to bring cases to supervision if they felt they were not going well, and that supervisees not being open with supervisors would create a barrier. It was further agreed that finding appropriate supervision was a barrier. There was overall divergence of opinion as to whether limited time, or supervision being undervalued by services and management created a barrier to supervision.

Table 14

Barriers to Supervision

	Disagreement %	Agreement %	Median	Interquartile Range
Overall Consensus				
Supervision is less productive when boundaries and structure are not in place.	8.3%	88.9%	0	4
Supervisees can be reluctant to bring process issues to supervision, particularly ones that have triggered the supervisee's own schemas or more difficult emotions (R2)	8.4%	80.6%	0	4
When anxious, supervisees may avoid discussing important issues in supervision (R2)	2.8%	86.1%	0	4
If supervisees feel judged by their supervisor, the supervisee would not feel comfortable bringing their vulnerabilities, limitations and errors to supervision (R2)	0.0%	94.5%	1	4
Supervision can sometimes mirror the interpersonal processes that arise within therapeutic work (R2)	2.8%	88.9%	1	4
It is difficult to build a good supervisory relationship when the supervisor has poor listening skills (R2)	0.0%	100%	1	5
It is difficult to build a good supervisory relationship when the supervisor is critical or punitive (R2)	0.0%	100%	1	5
It is difficult to build a good supervisory relationship when the supervisor has a didactic supervision style (R3)	7.9%	79%	0	4

	Disagreement %	Agreement %	Median	Interquartile Range
It is difficult to build a good supervisory relationship when supervision focuses on the practical elements of therapy without exploring process issues (R3)	10.5%	84.2%	0.25	4
Approaching Consensus				
It can be hard to find appropriate supervision (R3)	10.5%	73.7%	1	4
Supervisees can find it uncomfortable to openly talk to their supervisor about their feelings (R3)	5.3%	71%	1	4
Supervisees can be reluctant to bring certain cases to supervision if the cases are giving them trouble, or if they haven't achieved therapy milestones with the person with anorexia (R3)	13.2%	76.3%	0.25	4
Overall Divergence				
Limited time is a barrier to supervision (R3)	36.9%	42.1%	2	3
Supervision is often not valued by services and management (R3)	50%	31.6%	2.5	2

Note. Round 2: N = 36. Round 3: N = 38.

3.2.2.7 Facilitators to supervision. Nine statements were produced from the R1Q data relating to factors which facilitated supervision (Table 15), all reaching overall consensus during R2.

A trusting, honest and authentic supervisory relationship was agreed to facilitate supervision, as was mutual respect and feedback. It was also agreed that both supervisees and supervisors discussing their needs and expectations of supervision was beneficial, as was supervisors being open about their own experiences.

Telephone supervision, and Skype were considered to facilitate supervision. Although, one panellists commented that “Skype and/or telephone supervision can increase access to supervision but I do feel that something is lost when not meeting in person, much as with client work. Therefore there might become a case of quantity over quality” (P3).

Table 15

Facilitators to Supervision

	Disagreement %	Agreement %	Median	Interquartile Range
Overall Consensus				
Good supervision requires an honest relationship (R2)	0.0%	91.6%	1	4
Authenticity contributes to a good supervisory relationship (R2)	0.0%	97.2%	1	4.5
Mutual respect between supervisor and supervisee contributes to a good supervisory relationship (R2)	0.0%	100%	1	4
Mutual feedback contributes to a good supervisory relationship (R2)	0.0%	91.7%	1	4
It is important to encourage clinicians to bring cases to supervision even if they feel ill prepared (R2)	0.0%	91.7%	1	5
It would be helpful for supervisors to be open about their own experiences (R2)	2.8%	88.9%	1	4
A trusting supervisory relationship facilitates supervisees in feeling more confident in raising difficult issues in supervision (R2)	0.0%	97.2%	1	4.5
Skype, or telephone supervision can increase access to supervision (R2)	2.8%	80.5%	1	4
Discussions around both the supervisee's and supervisor's need and expectations of supervision can help overcome barriers (R2)	0.0%	94.4%	1	4

Note. N = 36.

4. Discussion

A Delphi study explored the expert opinions of clinicians working therapeutically with individuals with AN in relation to how this work affected them personally, and the key requirements of supervision. The results are discussed relative to the existing evidence base and theoretical literature. The limitations are considered alongside the implications for clinical practice and future research.

4.1 Research Aim One

Panellists identified a range of clinician experiences in the context of working therapeutically with individuals with AN. Clinicians enjoyed the complexity of this work, found it rewarding and felt a sense of achievement, consistent with findings that ED clinicians report strong feelings of personal accomplishment (Warren et al., 2013b). Previous findings suggest that clinicians report greater connection with individuals with BN than AN (Franko & Rolfe, 1996). Yet, nearly all of the present study's sample (91.9%) reported enjoying their connection with their clients with AN.

The only challenging emotion which reached consensus of agreement was sadness. Sadness has not been explored in depth in previous studies and has not been found to be one of the most frequently reported challenging reactions, since Brotman et al.'s study (1984). It is not known whether sadness reported by clinicians in this field has any negative implications on their wellbeing, or whether sadness is reported as a consequence of the clinicians ability to build a strong therapeutic relationship and empathise well with their clients with AN.

Consistent with previous research (Thompson-Brenner et al., 2012), frustration was a key clinician experience, although this did not reach consensus level. Unlike previous

research, frustration was found both in relation to the low motivation of clients with AN, and the slow progress of therapy itself.

Despite this being an expert sample, feelings of inadequacy were reported. Such findings are consistent with previous research suggesting that feelings of inadequacy are a common clinician experience when working with ED populations, despite specialist knowledge, training and experience (Gurney & Halmi, 2001; Satir et al., 2009).

Anxiety was reported by 67.6% of clinicians. Moreover, 64.8% reported anxiety specifically regarding clients becoming unwell or dying. These findings are well supported by previous literature (Thompson-Brenner et al., 2012). In this study however, such anxiety was found despite 100% of the sample reporting that they felt well supported by their teams in monitoring and managing physical health risks. Such anxieties may be an important reality of working with individuals with AN, and one of the reasons why some clinicians choose not to work in the field. Further support in managing this anxiety may be needed to protect against job-burnout (Warren et al., 2013a).

Results relating to clinicians' body-image were divergent, suggesting that not all clinicians experience changes to their body-image, and that changes can be diverse in nature; this is consistent with previous findings (Shisslack et al., 1988; Warren et al., 2013b). A minority of clinicians reported eating changes. Previous research found that when working with individuals with EDs, clinicians who have a past ED history or strong ED symptoms were more likely to experience changes to their thinking and behaviours regarding food, eating and their body (Shisslak et al., 1989). Unfortunately this study did not ask panellists about their own ED or disordered eating experiences, so it is unknown whether such factors may have impacted these clinicians' responses.

4.2 Research Aim Two

The second aim sought to explore expert opinion relating to the core requirements of supervision for clinicians working therapeutically with individuals with AN. Clinicians reached consensus on a high majority of statements across all themes.

Many statements were reflective of supervision across other mental health populations and outlined in previous research and guidelines (e.g., DCP, 2014). For instance, discussing how to use new techniques or trouble shooting (Falender & Shafranske, 2004). Similarly, a number of supervision outcomes were produced, consistent with outcomes of supervision across clinical populations (e.g. helping the clinician to plan their interventions, DCP, 2014). Honesty, authenticity, mutual respect, mutual feedback, and a trusting relationship were all thought to facilitate 'good' supervision, consistent with previous literature (Beinart, 2012). Barriers were believed to occur where supervisors are didactic, punitive or critical as previously reported by Ladany (1996).

Specifically to supervision for clinicians working therapeutically with individuals with AN, the results indicated that the consideration of emotion is important. At the client level, discussing the client's experience of emotion was considered key, consonant with a growing body of evidence regarding the role of emotion in EDs (Oldershaw, Lavender, Sallis, Stahl & Schmidt, 2015). Reflection on clinicians' emotions were further considered important, such as exploring the clinician's anxiety about requiring change, and their resultant emotions when change does not occur, such as frustration and inadequacy.

As suggested by the findings, one way of doing this may be to discuss successful cases and small successes in order to adapt to the high levels of ambivalence and slow progress of therapy typical to working with AN, particularly in chronic presentations (Strober, 2004). Overall, consistent with previous research and guidelines, there was

consensus that supervision should contain the supervisee's feelings about their clinical work, and should be a safe place to explore difficult feelings (Beinart, 2012; DCP, 2014).

In relation to this, one barrier to 'good' supervision was focusing on the practical elements over process issues, and thus the consideration of transference, countertransference, and parallel processes were considered important, as posited by Hamburg and Herzog (1990). This is interesting considering only a small number of clinicians reported working psychodyamically (20%) or using psychotherapy (13.3%) suggesting that clinicians may draw on different models for supervision than they do for clinical work.

There was consensus that supervision should hold a compassionate and respectful stance to people with AN and their experiences. This is particularly important due to the high level of stigma associated with EDs (Roehrig & McLean, 2009) and the high level of shame experienced by people with EDs (Burney & Irwin, 1999). Such client experiences may evoke similar reactions in supervisees and supervisors (Hamburg & Herzog, 1990), and thus could influence both parties' openness and willingness to discuss particular topics.

This is interesting when considering that the majority of discussion and reflection statements reached consensus, apart from whether supervision should discuss the clinician's own relationship to, and beliefs about food and their body, or their experiences of having an ED, or food or body-image issues. This was reflective of the divergence relating to whether or not clinicians experienced changes to their eating, or thoughts and feelings about their body. A number of panellists (approximately 10-15%) however strongly agreed that such topics should be discussed, suggesting that not all but some supervisees may benefit from these discussions. These findings contrast with DeLucia-Waack (1999) who posited that helping clinicians maintain healthy beliefs about food, weight, shape and eating is a core task of supervision in this field. It is important to acknowledge that a relatively high number of

clinicians working with in this field may have a personal history of an ED or ED symptoms (Barbarich, 2002). Only a minority disclose this history to their employer, and a quarter will relapse after entering the field (Barbarich, 2002). Supporting clinicians in thinking about the impact of their experiences on their work, and vice versa may be an important area of discussion for some but not all supervisees.

It was further considered helpful if supervisors were open about their own experiences, and encouraged supervisees to bring cases to supervision even if they felt ill prepared or if the case was not going well. This could potentially normalise discussion of challenging experiences and reduce the likelihood of perfectionistic parallel processes occurring.

A large number of supervision outcomes were identified. Panellists appeared to have a clear sense of the outcomes that should occur from ideal supervision; however were not asked whether they experienced these outcomes themselves. Whilst many outcomes were similar to those expected with other clinical populations, others were more specific to working with individuals with AN, for instance helping the clinician to notice if they are colluding with the AN. Many of the outcomes were related to helping clinicians manage the challenging experiences identified in research aim one, for example, helping the supervisee to feel more confident in managing risk, as proposed by Castro-Fornieles et al. (2007).

4.3 Strengths and Limitations

The findings should be considered within the context of a number of limitations. Consensus was obtained for a large number of statements, however this does not ensure that those statements are ‘true’ or correct (Mullen, 2003). It is important to recognise that results are limited in their generalisability, and that a different panel may have generated different conclusions in answering the research aims (Iqbal & Pipon-Young, 2009).

A heterogeneous sample was sought, however, the final sample disproportionately comprised clinicians from psychological professions. Professionals from other backgrounds whom are involved in the delivery of therapy to individuals with AN, are therefore underrepresented, reducing the generalisability of the findings. As Delphis seek to obtain expert opinion, panellists are usually highly qualified and experienced, and thus clinicians with low levels of experience are likely underrepresented. Clinicians who have strong negative reactions and experiences, may not have stayed working in the field long enough to become 'experts' and may thus have been excluded from the study. The sample therefore, may be biased to those who perceive their experiences of working with this population more positively, thus negative experiences and challenges may be underrepresented in the findings.

Whilst obtaining consensus is the primary task of a Delphi, it is important to acknowledge areas of divergence. Clinician emotions at the divergent level included feeling attacked/punished, angry, bored, dismissed, helpless, powerless, shut-off, and overwhelmed for which levels of agreement were between 32.4% and 59.5%. For clinicians who reported personal experiences but were in the minority (e.g., 29.7% reported feeling a pressure to please their client, or 12.8% felt more insecure about their own body), it is likely that these are still important experiences which may impact their wellbeing and clinical work if not addressed in supervision (Shisslak et al., 1989; Waller, 2009). These experiences may be particularly difficult for supervisees to raise in supervision as clinicians may be aware that they are not experienced by the majority and may be related to specific clinician factors.

4.4 Implications for Clinical Practice

This present study indicates that clinicians experience a range of both positive emotions and challenges in the provision of therapy. More positive emotions reached consensus than challenging emotions, indicating that clinicians on the whole find this work

rewarding and enjoyable. This may help to challenge some of the persistent ideas which contribute to ED populations being viewed as undesirable to treat (Burket & Schramm, 1995). Emotions such as sadness, frustration, inadequacy and anxiety are all important emotions to normalise, so that appropriate support can be sought, to protect against the impact on clinician wellbeing, or the provision of therapy (Franko & Rolfe, 1996; Shisslak et al., 1989).

This study was the first study to empirically investigate supervision within this field. Clinicians reached consensus on a high majority of statements relating to supervision, suggesting that the statements produced were highly appropriate and acceptable, and thus may be suitable to support the development of guidelines for supervision in this field.

The exploration of clinicians' views relating to supervision suggest that supervisees and supervisors need to be aware of a diversity of clinician responses in relation to their own body-image and relationship to food and eating. Supervisors should remain aware of the importance of discussing such topics for some clinicians. Supervisors should be open to discussions about the supervisee's schemas, belief systems, and emotions in relation to their client work. Supervisors should avoid being didactic, or punitive and should be open about their own experiences. Supervisors should encourage discussion of cases even if supervisees feel ill prepared, and celebrate small successes and successful cases. Both parties should maintain awareness of parallel processes. As high levels of stigma and shame may silence supervisees in approaching certain topics, the onus may be on the supervisor to raise and explore whether or not such conversations may be beneficial.

4.5 Implications for Future Research

Future research could explore how supervisees rate their actual experiences of supervision against their experiences of therapeutic work, and the outcomes of supervision

produced in this study. Further research could explore whether implementing the identified areas of discussion and reflection help to achieve good supervision outcomes.

Exploration of how ED clinicians with a personal history of an ED approach and use supervision, along with their supervisors, may be beneficial in identifying what the specific barriers and facilitators might be for this population of clinicians, as previous research suggests they may have unique experiences and needs (Warren et al., 2013b). Research looking at the experiences and supervision needs of students, newly qualified clinicians, and clinicians new to the field may be of benefit, as findings within previous research suggest that less experienced clinicians have more negative experiences (Thompson-Brenner et al., 2012).

4.6 Conclusions

This research suggests that clinicians from a variety of clinical backgrounds whom work therapeutically with individuals with AN, report positive experiences more frequently than negative experiences. Commonly experienced difficult emotions include sadness, frustration, inadequacy, and anxiety, particularly in relation to client health. No consensus was found relating to the impact of this work on clinicians thinking about food or body-image. Clinicians reached consensus on a high majority of statements relating to supervision, suggesting that the statements produced were highly acceptable. Important areas of divergence exist in relation to discussing supervisees' beliefs about food, eating and body-image, or personal experiences of an ED or ED symptoms. This study is the first to attempt to explore the experiences of clinicians working therapeutically with individuals with AN alongside the use of supervision for this professional population. This study hopes to generate further conversations inside and outside of supervision, to normalise clinician experiences, promote staff retention, improve therapeutic relationships and outcomes, and enhance clinician wellbeing.

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Section C: Appendices of Supporting Material.

Appendix A: Quantitative Quality Appraisal Tool

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Appendix B: Qualitative Quality Appraisal Tool

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Appendix C: Example of Quantitative Studies Appraised

Quality Assurance Checklist: NICE (2012) Quantitative checklist		Brotman et al. (1984)	Burket & Schramm (1995)	Colli et al. (2015)	Crisafulli et al. (2008)	Daniel et al. (2015)	Franko & Rolfe (1996)	Kosmerly et al. (2015)	Sansone et al. (1988)	Satir et al. (2009)	Shisslak et al. (1988)	Warren et al. (2013a)
Population	Source population well described	Only very basic information of sample described. No further	No clear description of source population.	No real information given other than knowing it was	No clear description of source population.	No clear description of source population.	Source population was moderately described. Boston	No clear description of source population.	Moderate description of source population. Describes the hospital	Source population of clinicians generally described.	Source population of clinicians generally described.	Source population of clinicians generally described.
	Representative	Only AN, no other ED type. But included 3 professional groups	Well reprepresentative, although no physical	Representative of psychotherapeutically trained clinicians.	Not representative of general populations or of clinicians working	Both the therapists and the patients they were seeing were	Recruitment not very well described. No people working on	Recruitment through a larger study - no further info provided.	Fairly well described. But nurses w previous ED histories or	Only looked at psychologists and psychiatrists. And	Well described method of recruitment. Convenience	Method of recruitment not described as reported elsewhere in
	Method of selection well described	All 1st year residents at 1 hospital. No participants from other	No description of how participants were originally identified.	Recruitement well described. Contacted a random sample of	Convenience sampling of undergraduate nurses	No clear description. Part of larger randomised clinical	Sample moderately well described. 46% response rate. May be	Not possible to determine due to snowball sampling.	Good decription of the procedure of recruitment to the	Randomly selected clinicians from a practice-research	Response rate given 41%. Inclusion and exclusion were not	Inlcuded people not currently working with ED populations, to
Outcomes	Reliable	Very little info provided about the questionnaire devised	Previously unknown and unvalidated measure.	Used a battery of valid measures and a general demographic	Minor adaptation of previously validated measure.	AAI was a reliable measure. No information provided	Non-validated measure. Created from the literature on	One non-validated measure and one validated with good	A mixture of well know reliable measures, and previously	Use of validated instruments. Clinicial judgement was	Unvalidated questionnaire developed by the	A mixture of well know reliable measures, and previously
	Complete	63% of identified sample completed measures. Response	Survey method, so all willing participants completed all	Yes. Good sampling strategy utilised to selected a random	All identified participants completed. However	High levels of completion. All participants who met	Not all participants completed affect scales in relation to all	Cannot determine due to snowball sampling.	Described number who completed/dropped	Looked at a very broad range of factors. However limited	Limited response rate. Likely self-selection bias. Not all eligible	Difficult to determine due to lack of information about
	Important outcomes assessed	No comments in the paper about this. But unlikely to be any real	No comment about possible benefits and harms. Unlikely to be	No comment about possible benefits and harms. Unlikely to be	No comment about possible benefits and harms. Unlikely to be	No comment about possible benefits and harms. Unlikely to be	No comment about possible benefits and harms. Unlikely to be	Partially. Only looks at a measure of anxiety in relation to CT, but	No comments about the possible and benefits and harms.	No comment about possible benefits and harms. Unlikely to be	No comment about possible benefits and harms. Unlikely to be	No comment about possible benefits and harms. Unlikely to be
	Relevant	Measured responses to hypothetical patients and	Measured an appropriate range of areas including desire	Yes. Appropriate and well validated measures used across	Yes. Appropriate measures used across a variety of possible	Yes. Appropriate and well validated measures used across	Yes appropriate approach to measuring the	Difficult to determine from the information provided. Measure of	Yes. Appropriate and well validated measures used across	Yes. Appropriate and well validated measures used across	Difficult to determine due to limited information about the	Yes. Appropriate and well validated measures used across
Analyses	Power	Small sample size N = 46. No power calculation	No power calculation documented. N = 159. Adequate for	No power calculation documented. N = 149. Highly significant	No power calculation documented. N = 115.	No power calculation documented. N = 12 therapists. N = 69	No power calculation documented. N = 32. Small sample size.	No power calculation documented. N = 117.	No power calculation documented. Small sample size. N = 23.	No power calculation documented. Sample N = 120. However	No power calculation documented. Small sample size. N = 71	No power calculation documented. N = 296. Adequate sample size
	Effect size	No effect size reported or calculable.	No effect size reported or calculable.	No effect size reported or calculable.	Effect size calculable.	Effect size calculable.	Effect size calculable.	Effect size reported.	No effect size reported or calculable.	Effect size calculable.	No effect size reported or calculable.	Effect size calculable.
	Appropriate methods of analyses	No report of what analyses were actually conducted, so cannot	Limitated information about analysis provided but appears	Appropriate analyses conducted but not all confounders adjusted	Appropriate analyses conducted but not all confounders adjusted	Appropriate analyses conducted but not all confounders adjusted	Appropriate analyses conducted but not all confounders adjusted	Appropriate analyses conducted but not all confounders adjusted	Seemingly appropriate. No subgroups identified.	Appropriate analyses conducted but not all confounders adjusted	Appropriate analyses conducted but not all confounders adjusted	Appropriate analyses conducted but not all confounders adjusted
	Intervention effects given	Yes. $p < .05$	Yes. $p < .05$. Significance levels were reported,	Yes. $p < .05$*, $p < .01$**, $p < .001$***.	Yes. $p < .05$. However, scores for affective scale were collapsed,	Yes. Individual p values reported.	Yes. Individual p values reported.	Yes. Individual p values reported.	Yes. Individual p values reported.	Yes. Individual p values reported.	Yes. Individual p values reported.	Yes. Individual p values reported.
Summary	Validity	Unclear as no description given of any potential biases or	No description of potential biases given. No significant flaws.	Self-report bias but validated with psychometric	Likely to have limited validity due to using materials to prime	No control group without eating disorders, to see if	No objective measures of the patients characteristics, so	Participants may have had different interpretations of FBT	No description about how biases could have been accounted	Limited by self-report presentation concerns. No	41% response rate self-selection bias likely. No objective	Data was cross sectional, not allowing for causal inferences.
	Generalisability	Not generalisable as based on hypothetical patients, not real	Limited generalisability as majority of	Relatively large final sample 159. All Italian and caucasian.	Likely to have limited generalisability due to using a student based	Limited generalisability due to a small sample, and	80% of clinicians put psychodynamic therapy as their	Recruitment of snowballing and self-selection introduce	A lot of ED clinicians have a personal history of EDs, so their	Limited generalisability due to having a select group	Limited generalisability due to convenience	Self-selection bias, thus practitioners with high levels of burnout

Key	Criteria fully met	Criteria partially met	Criteria not met

Note. Please note only criteria relevant to the studies in this review were included. No criteria relating to 'Method of allocation to intervention (or comparison)' were included.

Appendix D: Example of Qualitative Studies Appraised

Mays and Pope (2000) Assurance Criteria for Qualititative Research	Long et al. (2012)	Linville et al. (2010)	Palmer (2015)	Warren et al. (2009)	Warren et al. (2012)	Warren et al. (2013b)
Triangulation	Triangulation of professions and ED-units used. Two NHS	Two data collection methods (survey n = 183, and interviews n	No triangulation of sample or data collection methods.	Triangulation of professions. Survey method only -	Triangulation of professions (psychotherapists,	Triangulation of professions. Survey only.
Respondent validation	No report of respondent validation.	Sent summary of initial codes. Used member checking to	Used member checking through skype or in-person to	No respondent validation or member checking.	No respondent validation or member checking.	No respondent validation or member checking.
Clear exposition of methods of data collection and analysis	Independent raters used to parallel code and check themes	Good description of data collection and coding process. Clear	Process of coding and theme development well	Process of coding and theme development well	Process of coding and theme development well	Process of coding and theme development well
Reflexivity	No report of any effort made to improve reflexivity.	Used an audit trail to aid dependebility. But no indication of	Used epoche to bracket off the researchers	No report of efforts to improve reflexivity. No	No report of efforts to improve reflexivity. No	No report of efforts to improve reflexivity. No
Attention to negative cases	No indication of deviant case analysis.	No indication of deviant case analysis.	Awareness of differences between participants p.124	Due to being a survey method, the % of people whose	Due to being a survey method, the % of people whose	Due to being a survey method, the % of people whose
Fair dealing	Only one narrative was discussed in relation to each	Mentioned how many of the sample supported each	No. Interpreted until there was ideally one possible	Range of professions, from a range of services, and levels	Range of professions, from a range of services, and levels	Range of professions, from a range of services, and levels
Relevence	Can be generalised to other in-patient ED units to an extent	Adds to the existing knowledge. Detailed write up helps	Worked various treatment settings, in range of urban	Adds to the knowledge base. Exploration about	Provided new information about burnout in clinicians	Provided information about the experiences of ED-

Key
Criteria fully met
Criteria partially met
Criteria not met

Appendix E: Ethics Approval Letter

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Appendix F: Information Sheet

Information about the research

Research Title: Working therapeutically with adults with Anorexia Nervosa: A Delphi Study

My name is **Elizabeth Dunn** and I am a trainee clinical psychologist at **The Salomons Centre of Applied Psychology, Canterbury Christ Church University.** I would like to invite you to take part in a research study. Before you decide it is important that you understand why the research is being done and what it would involve for you.

What is the purpose of the study?
This study hopes to explore the expert opinions of those with experience of providing therapy to individuals with Anorexia Nervosa. We hope this study will help to inform a new approach to working with individuals with Anorexia Nervosa. Further to this we hope that this study will inform a supervision model to help therapists best manage the therapeutic relationship and to feel supported in their work. This study is also part of the requirements of completing my Doctorate in Clinical Psychology.

Why have I been invited?
You have been invited to take part in this research as you have been identified as someone who has expert knowledge relating to the provision of therapy to individuals with Anorexia Nervosa or relevant research.

What will happen to me if I take part?
This study has three stages. If you consent to participate, you will be asked to complete three rounds of questionnaires which will be sent to you electronically.

Stage 1: You will be asked some open ended questions about your experience of working with individuals with Anorexia Nervosa. This may take up to 1 hour to complete.

Stage 2: You will receive a list of key themes identified from analysing the stage one answers (from yourself and other experts, this will not include any direct quotes from stage one but general themes identified). You will be asked your opinion on how much you agree or disagree with these themes.

Stage 3: You will be shown an overall consensus of everyone's feedback along with your own agreement ratings. At this stage you are allowed to change your opinion if you wish. The aim of this is to consider whether

there is a consensus among a variety of experts with experience of working with individuals with Anorexia Nervosa.

There will be a period of one to three months between each round to allow time for all experts to complete the questionnaire and for the data to be analysed prior to the next round beginning. In between rounds I will be in contact to thank you for your participation, and to provide you with updates regarding the next round. If at any time you would like to withdraw, you can do so without having to give a reason. If you do not officially withdraw from the research you will receive up to two email reminders to complete the most current questionnaire.

What are the possible disadvantages and risks of taking part?
You will be encouraged to reflect on emotions and thoughts that have arisen through your experiences of working with patients with Anorexia Nervosa. These experiences may be upsetting or negative in nature. You will also be asked to consider your beliefs and opinions with those of other expert panellists, in order to attempt to reach an expert consensus. This process may influence your personal and professional belief system in relation to the topic.

What are the possible benefits of taking part?
It is hoped that this research will provide information about the therapeutic relationship with individuals with Anorexia Nervosa and could inform a supervision model to help therapists best manage the therapeutic relationship and to feel supported in their work.

Do I have to take part?
It is up to you to decide to join the study. If you agree to take part, then please proceed with this online survey. You are free to withdraw at any time, without giving a reason.

All participants who complete all three questionnaires will be entered into a prize draw to win one of four vouchers to the value of £25 or equivalent.

What will happen if I do not want to carry on with the study?
You have the right to withdraw from the study at any point. If you decide to withdraw during or after completing stage one then all of your data can be destroyed prior to data analysis beginning.

However once key themes are identified and these are sent out to all participants in stage two, your data will have contributed to the key themes

and therefore cannot be destroyed. If you wish to withdraw after stage two then your opinion on the key themes can be destroyed but not any data collected at stage one. This is the same for stage three where your final opinion can be destroyed but not your answers given in stages one and two.

What if there is a problem?
If you have a concern about any aspect of this study you can email me **Elizabeth Dunn** at **e.a.hunt299@canterbury.ac.uk** or you can leave a message for me on a 24-hour voicemail phone line at **0333 0117070**. Please say that the message is for me and leave a contact number so that I can get back to you

If you remain unhappy you may speak to the supervisor for this research **Dr Anna Oldershaw** on **01622 729980** or **Professor Tony Lavender** by emailing **tony.lavender@canterbury.ac.uk**.

Or if you are a researcher or clinician you can contact Canterbury Christ Church University Applied Psychology **Research Director Professor Paul Camic** on **03330117114**.

Will my taking part in this study be kept confidential?
All data collected will be accessed by a password protected website. The password will be held by the researcher. Your data will be stored in an encrypted file. All personal, patient or service identifying information will be removed. Identifiable information will only be available to me.

Only the researcher will be able to identify each participant's answers at each round, this is to enable the participant to see their individual response compared to the consensus. The researcher's supervisors will have access to the data collected at all rounds once it is anonymised. Confidentiality will only be broken in the event that professional misconduct is disclosed.

You will not be personally identifiable in the write up of this research or any future publications or future studies relating to this research.

Your data will be kept securely for 10 years and will then be disposed of securely.

In the final report, a brief outline of the experts in the panel will be included. This information will include participant's area of expertise, and if appropriate general job description, number of years working in this field, and number of publications. For example '4 clinical psychologists working

with individuals with Anorexia Nervosa with between 3-10 years' experience were consulted'.

What will happen to the results of the research study?
We hope that this research will provide insight into the current experience of providing therapy to individuals with Anorexia Nervosa, and hope that this will inform future research, and the development of future treatment and supervision models. We aim to publish our research findings in relevant psychology journals. This research will also be shared with Canterbury Christ Church University to be entered into the University's repository which will be publicly available.

Who is organising and funding the research?
Canterbury Christ Church University

Who has reviewed the study?
All research is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Salomons Research Ethics Committee.

Further information and contact details
If you would like to speak to me and find out more about the study or have questions about it answered, please email me at **e.a.hunt299@canterbury.ac.uk** and I will get back to you. Or you can leave a message for me on a 24-hour voicemail phone line at **0333 0117070**. Please say that the message is for me Elizabeth Dunn and leave a contact number so that I can get back to you.

Debriefing:
If after taking part in this study you feel the need to talk to somebody about any issues or experiences that taking part may have brought up for you, please contact either of the contacts below who will be available for a debriefing.

Debriefing contact information 1:

Anna Oldershaw

Email: Anna.Oldershaw@kmpt.nhs.uk

Postal address: The Red House, 22 Oakapple

Lane, Maidstone, Kent ME16 9NW

Telephone number: 01622 729980

Debriefing contact information 2:

Tony Lavender

Email: tony.lavender@canterbury.ac.uk

Postal address: Canterbury Christ Church University, Salomons Campus at Tunbridge Wells, Oak Lodge, David Salomons Estate, Broomhill Road, Kent TN3 0TF.

Appendix G: Consent Form

The below consent form was used to gather consent. To agree to each statement participants were asked to select either Yes or No from the drop down boxes below each statement.

Working therapeutically with individuals with Anorexia Nervosa: A Delphi Study

Consent

I have read and understand the information provided about this research. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected.

I understand that relevant sections of the anonymised data collected during the study may be looked at by the lead supervisor Anna Oldershaw. I give permission for these individuals to have access to my anonymised data.

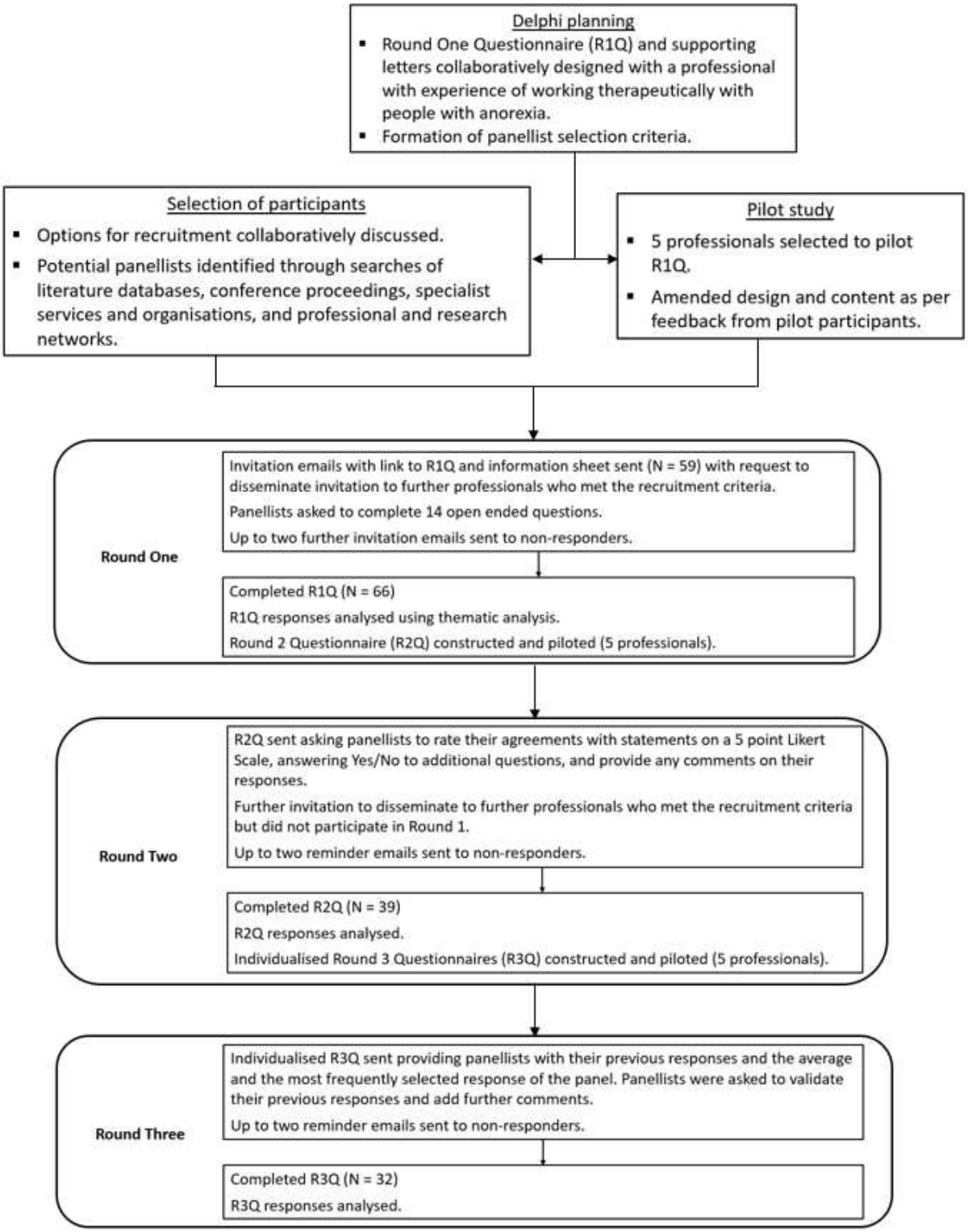
I agree that anonymous quotes from my questionnaire responses may be used in published reports of the research findings.

I agree that I am aware that the study consists of three rounds of questionnaires.

I agree to take part in the above study.

I would like to receive a copy of the main findings of this study.

Appendix H: Delphi Procedure Flowchart



Appendix I: Round Two Questionnaire

Working therapeutically with individuals with Anorexia Nervosa: A Delphi Study. Round 2

Introduction

Welcome to ROUND 2 of the Delphi consultation looking at the experience of experts working therapeutically with individuals with Anorexia Nervosa.

If you have not previously done so, please take the time to read the information sheet about this study which is attached to your email invitation.

This questionnaire consists of a series of statements that have been constructed from the responses provided by you and others in the first round of the study. You will be asked to rate how much you agree or disagree with each statement.

This questionnaire takes approximately 30 minutes to complete.

Thank you in advance for your time and participation.

INFORMATION ABOUT YOU

* 1. **Email address (An email address is needed so that we can create personalised questionnaires for Round 3 based on your Round 2 responses).** All questionnaire responses will be kept electronically by participant number only, so that your individual views will be anonymous.

* 2. I confirm that I have read and understood the information sheet and have consented to participate in this study in line with the consent form provided.

- ◯ YES
- ◯ NO

Working therapeutically with individuals with Anorexia Nervosa: A Delphi Study. Round 2

Below is a series of statements relating to working therapeutically with people with anorexia.

Please rate how much each statement captures your understanding of working therapeutically with people with anorexia.

* 17. Idiosyncrasies of working therapeutically with people with anorexia.

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Individuals with anorexia can be simultaneously asking for and rejecting of help.	○	○	○	○	○
Individuals with anorexia can often feel like younger teenagers and even children.	○	○	○	○	○
Individuals with anorexia may find it difficult to be honest when reporting eating disorder behaviours.	○	○	○	○	○
Individuals with anorexia may find it difficult to be honest when reporting emotions.	○	○	○	○	○
Individuals with anorexia often have a precarious sense of self.	○	○	○	○	○

If you have anything you would like to say about your answers, please write this in the box below.

Working therapeutically with individuals with Anorexia Nervosa: A Delphi Study. Round 2

Please rate how much each statement captures your understanding of working therapeutically with people with anorexia.

* 18. Helpful therapeutic approaches.

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Cognitive Analytic Therapy (CAT) is a helpful approach.	○	○	○	○	○
Cognitive Behaviour Therapy (CBT) is a helpful approach.	○	○	○	○	○
Dialectical Behaviour Therapy (DBT) is a helpful approach.	○	○	○	○	○
Emotion Focused Family Therapy (EFFT) is a helpful approach.	○	○	○	○	○
Enhanced Cognitive Behaviour Therapy (CBT-E) is a helpful approach.	○	○	○	○	○
Motivational Interviewing (MI) is a helpful approach.	○	○	○	○	○
Psychoanalysis is a helpful approach.	○	○	○	○	○
Psycho-education about AN and starvation is a helpful approach.	○	○	○	○	○
Schema therapy is a helpful approach.	○	○	○	○	○

If you have anything you would like to say about your answers, please write this in the box below.

19. Helpful **therapeutic approaches** that I use.

- [ ] I use **Cognitive Analytic Therapy (CAT).**
- [ ] I use **Cognitive Behaviour Therapy (CBT).**
- [ ] I use **Dialectical Behaviour Therapy (DBT).**
- [ ] I use **Emotion Focused Family Therapy (EFFT).**
- [ ] I use **Enhanced Cognitive Behaviour Therapy (CBT-E).**
- [ ] I use **Motivational Interviewing (MI).**
- [ ] I use **Psychoanalysis.**
- [ ] I provide **Psycho-education about AN and starvation.**
- [ ] I use **Schema therapy.**

* 20. Therapeutic focus and therapeutic techniques.

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
There should be an early focus on **behavioural change (reducing eating disordered behaviours and weight gain).**	○	○	○	○	○
There should be an early focus on **building the therapeutic relationship before making behavioural changes.**	○	○	○	○	○
There should be an early focus on **psycho-education.**	○	○	○	○	○
Outcomes from therapeutic work with people with anorexia are mostly about weight gain.	○	○	○	○	○
The family/system around the client should receive support and work to understand the eating disorder and mobilise their support.	○	○	○	○	○

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Identifying interpersonal schemas/patterns can highlight factors maintaining the person's difficulties.	○	○	○	○	○
Chair work can help people with anorexia to explore different parts of themselves.	○	○	○	○	○
Exposure-based methods are more effective than cognitive-restructuring methods.	○	○	○	○	○
Externalising different aspects of the client can help them to explore the different parts of themselves.	○	○	○	○	○
Therapists tend to make therapy up as they go because there is no gold standard of treatment.	○	○	○	○	○

If you have anything you would like to say about your answers, please write this in the box below.

Working therapeutically with individuals with Anorexia Nervosa: A Delphi Study. Round 2

Please rate how much each statement captures your understanding of the therapeutic relationship when working therapeutically with people with anorexia.

* 21. Idiosyncrasies of the therapeutic relationship.

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
The therapeutic relationship can feel like treading on eggshells and need very careful handling.	○	○	○	○	○
The therapeutic relationship is not crucial to recovery.	○	○	○	○	○
The therapist's appearance (too thin, too fat, too old, too young, male, female) can act as a barrier to achieving a good therapeutic relationship.	○	○	○	○	○
Lack of progress in therapy can be related to dynamics within the therapeutic relationship.	○	○	○	○	○
A good therapeutic relationship helps me feel more confident that change can occur when working with individuals with anorexia.	○	○	○	○	○
A good therapeutic relationship helps me feel hopeful for change.	○	○	○	○	○

If you have anything you would like to say about your answers, please write this in the box below.

Please rate how much each statement captures your understanding of the impact on you as the therapist, when working therapeutically with people with anorexia.

* 22. Impact on therapist feelings/emotions.

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Therapy sessions with people with anorexia can leave me feeling **angry**.	○	○	○	○	○
Therapy sessions with people with anorexia can leave me feeling **anxious/fearful**.	○	○	○	○	○
Therapy sessions with people with anorexia can leave me feeling **attacked/punished**.	○	○	○	○	○
Therapy sessions with people with anorexia can leave me feeling **bored**.	○	○	○	○	○
Therapy sessions with people with anorexia can leave me feeling **dismissed**.	○	○	○	○	○
Therapy sessions with people with anorexia can leave me feeling **frustrated due to the person with anorexia's ambivalence/low levels of motivation**.	○	○	○	○	○
Therapy sessions with people with anorexia can leave me feeling **frustrated due to slow progress**.	○	○	○	○	○
Therapy sessions with people with anorexia can leave me feeling **hopeless**.	○	○	○	○	○
Therapy sessions with people with anorexia can leave me feeling **inadequate**.	○	○	○	○	○
Therapy sessions with people with anorexia can leave me feeling **like I want to shut off from the person with anorexia**.	○	○	○	○	○
Therapy sessions with people with anorexia can leave me feeling **overwhelmed**.	○	○	○	○	○
Therapy sessions with people with anorexia can leave me feeling **disgust**.	○	○	○	○	○

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Therapy sessions with people with anorexia can leave me feeling **powerless**.	○	○	○	○	○
Therapy sessions with people with anorexia can leave me feeling **protective**.	○	○	○	○	○
Therapy sessions with people with anorexia can leave me feeling **sad**.	○	○	○	○	○
Therapy sessions with people with anorexia can leave me feeling **uncomfortable about the power imbalance**.	○	○	○	○	○
Therapy sessions with people with anorexia **who are very underweight** can leave me feeling **shocked about their physical state**.	○	○	○	○	○
Therapy sessions with people with anorexia can leave me feeling **anxious that they will die or become increasingly unwell**.	○	○	○	○	○
Therapy sessions with people with anorexia can leave me feeling **a pressure to please my client**.	○	○	○	○	○

If you have anything you would like to say about your answers, please write this in the box below.

* 23. Impact on therapist thinking and behaviours.

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Working with individuals with anorexia **can impact on my eating behaviours (e.g. eat more or less after a session).**	○	○	○	○	○
Working with individuals with anorexia **can make me feel jealous of their body shape.**	○	○	○	○	○
Working with individuals with anorexia **has changed the way that I think about food.**	○	○	○	○	○
Working with individuals with anorexia **has changed the way that I think about my body.**	○	○	○	○	○
Working with individuals with anorexia **has made me more accepting of my own body.**	○	○	○	○	○
Working with individuals with anorexia **has made me more insecure about my own body.**	○	○	○	○	○

If you have anything you would like to say about your answers, please write this in the box below.

* 24. Impact on therapist continued.

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
I enjoy the complexity of working with individuals with anorexia.	○	○	○	○	○
I enjoy the connection with my clients.	○	○	○	○	○
I can feel a sense of achievement when my client makes changes.	○	○	○	○	○
I find working with individuals with anorexia rewarding.	○	○	○	○	○
I find I need to adapt my expectations as a therapist to value small changes.	○	○	○	○	○
I find working with people with anorexia repetitive/tedious.	○	○	○	○	○
People with anorexia are often critical of themselves and others, so I can feel rubbished or inadequate.	○	○	○	○	○

If you have anything you would like to say about your answers, please write this in the box below.

* 25. Challenges and positives.

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
It can feel difficult to empathise with such a life threatening condition that it is difficult to understand "logically".	○	○	○	○	○
It can feel hard to be honest with clients sometimes.	○	○	○	○	○

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
As a therapist I often feel under pressure from my service and the wider system to be 'doing something' in therapy.	○	○	○	○	○
Different feelings emerge as I get more experienced.	○	○	○	○	○
I can feel bad if I don't manage to connect in some meaningful way when working with individuals with anorexia.	○	○	○	○	○
I can sometimes get lost in the details and/or wrong issue.	○	○	○	○	○
I can sometimes worry about pushing for change.	○	○	○	○	○
I need to be personally resilient when working with people with anorexia.	○	○	○	○	○
Sometimes I avoid emotional factors by focusing on behavioural and cognitive change.	○	○	○	○	○
Sometimes I feel like I have to work too hard in therapy (i.e. with questions and lines of enquiry) when working with people with anorexia.	○	○	○	○	○
One of the main challenges to working with people with anorexia is balancing the physiological and psychological aspects of the work.	○	○	○	○	○

If you have anything you would like to say about your answers, please write this in the box below.

Working therapeutically with individuals with Anorexia Nervosa: A Delphi Study. Round 2

* 26. Use of countertransference.

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Therapists need awareness of how they feel in the therapy room.	○	○	○	○	○
Therapists' countertransference reactions can maintain and reinforce the presenting difficulties.	○	○	○	○	○
The emotions that therapists feel with a person with anorexia can inform them about how the person with anorexia might be feeling.	○	○	○	○	○
The emotions that therapists feel with a person with anorexia provides information about the person with anorexia's relationships with others.	○	○	○	○	○
Countertransference helps therapists to identify the presence and function of the client's coping mechanisms (e.g. by distancing others in order to keep themselves safe).	○	○	○	○	○
The impact of the person with anorexia on the therapist should be included into the clinical formulation.	○	○	○	○	○

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
It is easy for therapists to get stuck in their own defence mechanisms (e.g. too detached vs. too involved; insufficient therapeutic boundaries vs. too strict etc.).	○	○	○	○	○
Personal therapy helps therapists to understand what belongs to them within the therapeutic relationship and what belongs to the person with anorexia.	○	○	○	○	○
Transference can be strong particularly when similarities are shared between client and clinician (e.g. both slim females, both perfectionist).	○	○	○	○	○
I would not want to record the impact of the client on myself in the clinical formulation on the computer.	○	○	○	○	○
Using transference and countertransference material is essential to working therapeutically with people with anorexia.	○	○	○	○	○

If you have anything you would like to say about your answers, please write this in the box below.

* 27. Service/therapist interaction.

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
The service/system prioritises keeping people 'in therapy' over getting them to 'do therapy'	○	○	○	○	○
Individual therapists can take on too much work (rescue the service) when it struggles due to limited resources.	○	○	○	○	○
Appropriate medical monitoring can help me to hold my nerve when my clients lose weight.	○	○	○	○	○

If you have anything you would like to say about your answers, please write this in the box below.

Working therapeutically with individuals with Anorexia Nervosa: A Delphi Study. Round 2

Below is a series of statements relating to clinical supervision when working therapeutically with people with anorexia.

Please rate how much each statement captures your understanding of clinical supervision for clinicians working therapeutically with people with anorexia.

* 28. General aspects of supervision.

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Supervision is a place of reflection and professional self-care.	○	○	○	○	○
Supervision is a collaborative thinking space.	○	○	○	○	○
Whatever the theoretical framework of the supervision, therapist's fears, frustrations and concerns should be discussed.	○	○	○	○	○
Caseload management within supervision can be protective against clinician burnout (i.e. working with other populations for a time, or not just working with individuals with chronic anorexia).	○	○	○	○	○
Supervision is essential in ensuring that clinical decision making is a shared responsibility.	○	○	○	○	○
Supervision is essential to helping clinicians understand the highly complex and risky presentations of people with anorexia.	○	○	○	○	○

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Clinicians need a lot of support in supervision to feel okay if their clients are not making many changes.	○	○	○	○	○
Supervisors need supervision of their own supervision work (i.e. relating to their supervisees).	○	○	○	○	○

If you have anything you would like to say about your answers, please write this in the box below.

* 29. The following should be discussed in supervision:

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
the impact of the therapeutic work on the clinician's relationship with food and their body.	○	○	○	○	○
the clinician's beliefs about food.	○	○	○	○	○
the clinician's beliefs about their body.	○	○	○	○	○
the clinician's defences/coping mechanisms (e.g. too detached vs. too involved, rescue/avoid).	○	○	○	○	○
the clinician's experiences of an eating disorder, or food or body image related issues.	○	○	○	○	○
the clinician's schemas/belief systems, and their impact on the clinician's clinical work.	○	○	○	○	○
the stresses and frustrations of the therapeutic relationship.	○	○	○	○	○

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
the client's experience of emotion (including individual and familial avoidance patterns).	○	○	○	○	○
cases that are going well.	○	○	○	○	○
small successes made in the clinician's clinical work.	○	○	○	○	○
ways of working with eating disorder symptoms.	○	○	○	○	○
how to use techniques from other therapies outside of the clinician's current skill set.	○	○	○	○	○
trouble shooting difficulties with practical strategies.	○	○	○	○	○
the clinician's unhelpful habits.	○	○	○	○	○
solutions/ways forward in the clinician's therapeutic work when stuck.	○	○	○	○	○
case management.	○	○	○	○	○
broad themes more than individual cases.	○	○	○	○	○
issues within the therapeutic relationship.	○	○	○	○	○

If you have anything you would like to say about your answers, please write this in the box below.

Working therapeutically with individuals with Anorexia Nervosa: A Delphi Study. Round 2

* 30. The following should be reflected upon in supervision:

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
why change has not happened.	○	○	○	○	○
the clinician's anxiety about requiring change.	○	○	○	○	○
transference and counter-transference that arises in the clinician's work with people with anorexia or their families.	○	○	○	○	○
parallel processes that may arise within therapy, supervision, the family and the wider system.	○	○	○	○	○
issues relating to the team/wider system.	○	○	○	○	○
ethical issues relating to working with individuals with anorexia, for instance, the question of whether or not free will can extend to starving one's self to death, and how much can we as health professionals intervene.	○	○	○	○	○

If you have anything you would like to say about your answers, please write this in the box below.

* 31. Outcomes of good supervision:

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Good supervision helps the supervisee to **plan their interventions**.	○	○	○	○	○

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Good supervision helps the supervisee to **develop clear goals for future therapy sessions.**	○	○	○	○	○
Good supervision helps the supervisee to **focus on outcomes at the level of the individual client.**	○	○	○	○	○
Good supervision helps the supervisee to **develop a deeper understanding of the individual with anorexia's difficulties.**	○	○	○	○	○
Good supervision helps the supervisee to **understand the individual with anorexia's difficulties within specific therapeutic models.**	○	○	○	○	○
Good supervision helps the supervisee to **formulate difficulties that arise within the therapy.**	○	○	○	○	○
Good supervision helps the supervisee to **mentalise the individual with anorexia's view.**	○	○	○	○	○
Good supervision helps the supervisee to **notice if they are colluding with anorexia.**	○	○	○	○	○
Good supervision helps the supervisee to **be aware of their blind spots and biases, thus promoting safer decision making.**	○	○	○	○	○

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Good supervision helps to **normalise some of the difficulties that the supervisee may experience when working with people with anorexia.**	○	○	○	○	○
Good supervision **has a careful balance between being directive and offering teaching, and allowing supervisee to develop his/her own ideas.**	○	○	○	○	○
Good supervision **supports clinical work in being evidence based.**	○	○	○	○	○
Good supervision helps the supervisee to **identify and explore what they are feeling in relation to their client work.**	○	○	○	○	○
Good supervision helps the supervisee to **resolve ruptures or problems within the therapeutic relationship.**	○	○	○	○	○
Good supervision helps the supervisee to **notice when they become stuck in unhelpful relationship patterns in therapy.**	○	○	○	○	○
Good supervision helps the supervisee to **engage and connect with the individual with anorexia.**	○	○	○	○	○
Good supervision helps to **instill hope.**	○	○	○	○	○
Good supervision helps the supervisee to **feel more confident in managing risk.**	○	○	○	○	○

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Good supervision helps the supervisee to **stay motivated in their therapeutic work.**	○	○	○	○	○
Good supervision helps the supervisee to **feel more resilient.**	○	○	○	○	○
Good supervision helps the supervisee **to not burnout.**	○	○	○	○	○
Good supervision helps the supervisee to **remember that they are not a terrible therapist, and that they are "doing alright / well'.**	○	○	○	○	○
Good supervision helps **improve the supervisee's enjoyment of the work.**	○	○	○	○	○

If you have anything you would like to say about your answers, please write this in the box below.

Working therapeutically with individuals with Anorexia Nervosa: A Delphi Study. Round 2

* 32. Qualities of supervision/supervisor relationship:

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Good supervision has a compassionate stance to people with anorexia and their experiences.	○	○	○	○	○
Good supervision has a respectful stance to people with anorexia and their experiences.	○	○	○	○	○
Good supervision helps to contain the supervisee's feelings around their clinical work.	○	○	○	○	○
Good supervision should feel like a safe place to explore difficult feelings.	○	○	○	○	○

If you have anything you would like to say about your answers, please write this in the box below.

* 33. Supervisor qualities:

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Supervisees need to feel confident that their supervisor has something new to add to their practice.	○	○	○	○	○
Supervisors must have a good understanding of anorexia.	○	○	○	○	○
Supervisors should have the expertise required to supervise the treatment approach in use.	○	○	○	○	○
Supervisors who lack expert knowledge can still provide a reflecting opportunity.	○	○	○	○	○
Supervisors taking a non-expert role can facilitate a good supervisory relationship.	○	○	○	○	○
Clinicians should only be supervised by somebody of the same profession as them.	○	○	○	○	○
Supervisors need to facilitate appropriate learning and professional development for the supervisee.	○	○	○	○	○

If you have anything you would like to say about your answers, please write this in the box below.

Working therapeutically with individuals with Anorexia Nervosa: A Delphi Study. Round 2

* 34. Barriers to supervision:

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
It can be hard to find appropriate supervision.	○	○	○	○	○
Limited time is a barrier to supervision.	○	○	○	○	○
Supervision is less productive when boundaries and structure are not in place.	○	○	○	○	○
Supervision is often not valued by services and management.	○	○	○	○	○
Supervisees can find it uncomfortable to openly talk to their supervisor about their feelings.	○	○	○	○	○
Supervisees can be reluctant to bring certain cases to supervision if the cases are giving them trouble, or if they haven't achieved therapy milestones with the person with anorexia.	○	○	○	○	○
Supervisees can be reluctant to bring process issues to supervision, particularly ones that have triggered the supervisee's own schemas or more difficult emotions.	○	○	○	○	○
When anxious, supervisees may avoid discussing important issues in supervision.	○	○	○	○	○

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
If supervisees feel judged by their supervisor, the supervisee would not feel comfortable bringing their vulnerabilities, limitations and errors to supervision.	○	○	○	○	○
Supervision can sometimes mirror the interpersonal processes that arise within therapeutic work.	○	○	○	○	○
It is difficult to build a good supervisory relationship when the supervisor has poor listening skills.	○	○	○	○	○
It is difficult to build a good supervisory relationship when the supervisor is critical or punitive.	○	○	○	○	○
It is difficult to build a good supervisory relationship when the supervisor has a didactic supervision style.	○	○	○	○	○
It is difficult to build a good supervisory relationship when supervision focuses on the practical elements of therapy without exploring process issues.	○	○	○	○	○

If you have anything you would like to say about your answers, please write this in the box below.

* 35. Facilitators to supervision:

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Good supervision requires an honest relationship.	○	○	○	○	○
Authenticity contributes to a good supervisory relationship.	○	○	○	○	○
Mutual respect between supervisor and supervisee contributes to a good supervisory relationship.	○	○	○	○	○
Mutual feedback contributes to a good supervisory relationship.	○	○	○	○	○
It is important to encourage clinicians to bring cases to supervision even if they feel ill prepared.	○	○	○	○	○
It would be helpful for supervisors to be open about their own experiences.	○	○	○	○	○
A trusting supervisory relationship facilitates supervisees in feeling more confident in raising difficult issues in supervision.	○	○	○	○	○
Skype, or telephone supervision can increase access to supervision.	○	○	○	○	○
Discussions around both the supervisee's and supervisor's need and expectations of supervision can help overcome barriers.	○	○	○	○	○

If you have anything you would like to say about your answers, please write this in the box below.

Working therapeutically with individuals with Anorexia Nervosa: A Delphi Study. Round 2

Thank you!

Thank you for taking the time to complete round 2 of this study. We hope that this study will yield helpful results which will be beneficial for those working in this field, and for those receiving therapy for Anorexia Nervosa.

There will be a break before round 3 begins to allow for the analysis of all the answers from round 2 to inform round 3. You will be emailed a new link in due course.

Thank you again for taking part in this research study.

Appendix J: Round Three Questionnaire

Welcome to the FINAL round of this Delphi consultation!

This questionnaire is a repeat of the questionnaire that you completed in Round 2. This questionnaire is shorter as it does not display questions from the previous round relating to your own personal experience of providing therapy. Additionally, questions from the previous round that had a high level of agreement among participants are not included in this round.

You will see your own responses to questions continued into this round, as well as the group's responses, and any comments that were provided. This round is an opportunity to validate your previous responses.

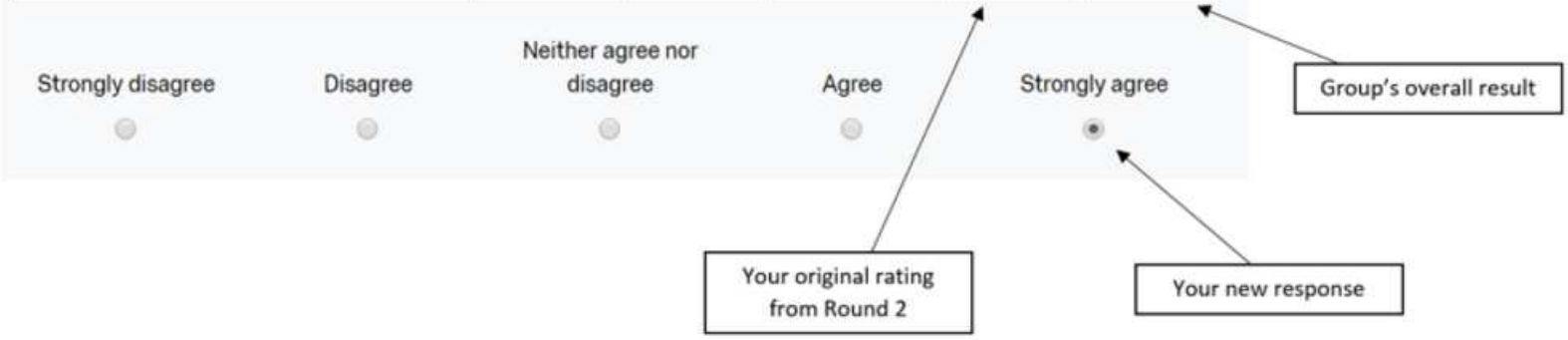
The figures displayed below represent the percentage of participants who selected each rating. **The most frequently selected response is highlighted in bold. Where a level of agreement was equal across categories, both are shown in bold.** The comments are included to stimulate further thought.

Your original rating is indicated with a blue 'X'. If you would like to alter your rating, please select your new rating on the likert scale provided. **However, please do not feel under any obligation to do so.** If you do not want to change your rating, please move on to the next question.

If you were unable to complete Round 2, you will only be shown a blue 'X' for questions that you previously answered. If you would like to rate your level of agreement with statements you have not previously rated, please do so using the likert scale provided.

EXAMPLE

	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Supervision is a place of reflection and professional self-care.	0.0%	5.4%	0.0%	32.4% X	**62.2%**



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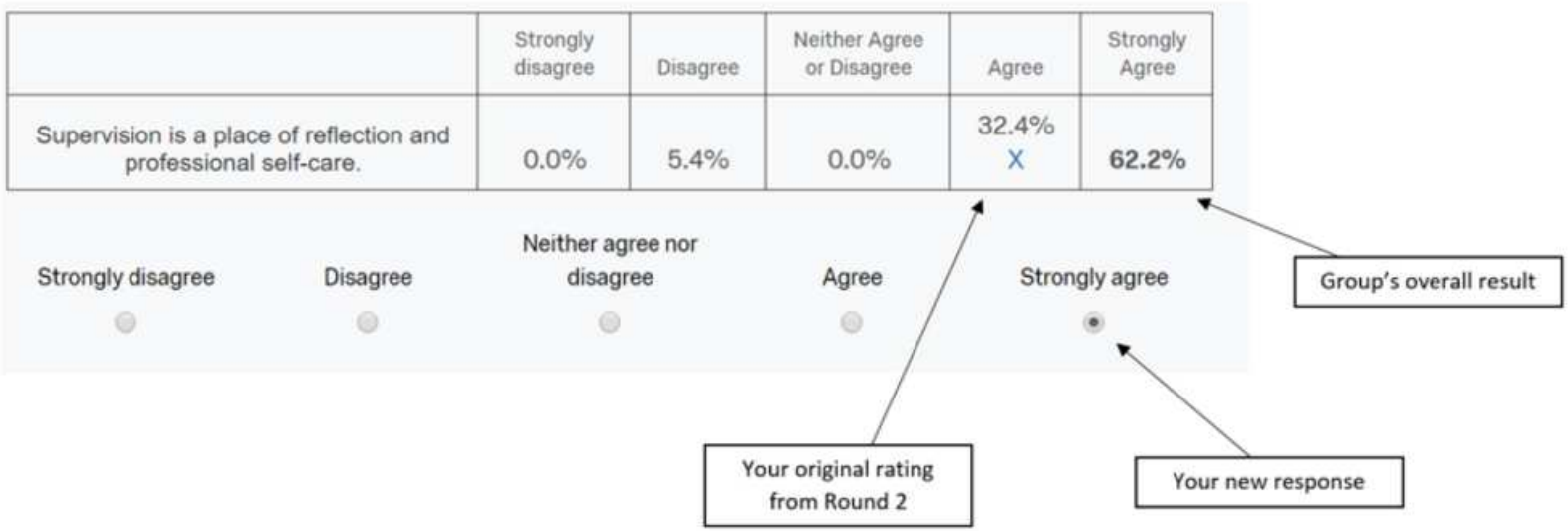
If you were unable to complete Round 2, you will only be shown a blue 'X' for questions that you previously answered. If you would like to rate your level of agreement with statements you have not previously rated, please do so using the likert scale provided.

EXAMPLE



Delphi Round Three Questionnaire:

Idiosyncrasies of working therapeutically with people with anorexia:

Statement 1:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Individuals with anorexia may find it difficult to be honest when reporting emotions.	0.0%	7.7%	17.9%	33.3%	X **41%**

Comments from Round 2 for statement 1:

"It feels rather than being honest about emotions it's more about being able to identify emotions."

"I have agreed with these statements as possibilities of working with people with a diagnosis of anorexia but I also think that these can be true of non-anorexic client groups as well, such as avoidant attachment styles finding it difficult to express emotions and possibly a precarious sense of self; clients who have experienced abuse/neglect (and haven't developed eating issues) can also feel a lot younger in the room. These are just examples."

"Difficulty being honest because they have a skewed sense of what is transpiring. Not necessarily saying that it is intentional dishonesty"

"I don't think they have difficulty being honest when reporting emotions - I would say it is more accurate to say they are not very aware of what emotions they are experiencing, and so have difficulty labelling/identifying them."

"Honesty re: emotions - not sure this is the case. More like difficulty identifying and communicating emotions rather than actively being dishonest about feelings."

"I believe it is not honesty but a psychic split that is created by the ED which acts as a protector and persecutor internally and externally. Honesty about feelings is more about not having the words for feelings. People lie about their ED as a protective factor and it is up to us not to become another judge."
"I don't think they are not honest about their feelings rather than not being aware of them, not being able to name them or to talk about them."

"With regard to the issue of honesty about emotions, for some young people, not being able to articulate their emotions may be to do with not being used to expressing or naming their emotions, or to do with family beliefs around keeping emotions to yourself, or protecting others from one's emotions."

"In relation to reporting emotions the issue is not so much one of honesty as one of awareness or ability to describe what is going on."

If you would like to change your response for statement 1, please select a new rating below.

Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree

Canterbury Christ Church University

Helpful therapeutic approaches:

Comments from Round 2 which apply across the following intervention questions:

"All of these may be helpful approaches for some people, but not others, so wording of questions feels not quite right. 'X may be a helpful approach' would have felt more accurate"

"I think all of the above therapies can have their uses. In my experience, it was particularly important to have a joint formulation of not just how the problem started and what maintains it, but also a heavy focus on interpersonal factors both historically as well as how they may present in meeting with the therapist. This also requires a heavy focus on emotions, not just in an educative sense, but trying to understand competing or conflicting emotions and urges, and helping the person with the eating disorder understand how one part of them may want things to be different whilst another part of them clings on to what they know etc."

"Each presentation is individual and treatment is often tailored to meet the individual needs of each patient"

"It is the relationship which is key to any/all of the above being effective"

"In our trials, patients often refused CBT (and CBT-E), as they had already tried it in the past and found it helpful to a certain point, then became stuck. As these patients are often highly cognitively focused, they often benefit from an approach which can also work at an integrative level with emotions (i.e. experiential work)" I don't have direct experience of all of these, in which case my judgements are based on client feedback of approaches that have helped them previously. I think different approaches are useful for different things, for example MI might be useful to motivate someone to come to therapy/for treatment whereas EFFT would be useful if there are maintaining factors within the family dynamic. I think psychoanalysis could be useful if there is time to do it fully, which there often isn't in an NHS setting and I have no experience of clients who have used it privately. There are also other ways of working which I have found useful which aren't on this list, such as psychodynamic approaches (as opposed to psychoanalytic), including relational as well as humanistic approaches"

Statement 2:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Cognitive Analytic Therapy (CAT) is a helpful approach.	0.0%	10.5%	21.1%	X **60.5%**	7.9%

If you would like to change your response for statement 2, please select a new rating below.

Strongly disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly agree ○

Statement 3:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Cognitive Behaviour Therapy (CBT) is a helpful approach.	0.0%	X 13.2%	23.7%	**52.6%**	10.5%

Comments from Round 2 for statement 3:

"Cbt useful for perfectionism as possible maintaining factor"

If you would like to change your response for statement 3, please select a new rating below.

Strongly disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly agree ○

Statement 6:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Enhanced Cognitive Behaviour Therapy (CBT-E) is a helpful approach.	0.0%	5.3%	36.8%	X **42.1%**	15.8%

If you would like to change your response for statement 6, please select a new rating below.

Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree

Statement 7:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Motivational Interviewing (MI) is a helpful approach.	2.6%	2.6%	21.1%	X **47.4%**	26.3%

Comments from Round 2 for statement 7:

"I use MI concepts within sessions but do not find it useful as a stand-alone intervention"

If you would like to change your response for statement 7, please select a new rating below.

Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree

Statement 8:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Psychoanalysis is a helpful approach.	10.5%	21.1%	**42.1%**	X 21.1%	5.3%

Comments from Round 2 for statement 8:

"I have no experience of the use of psychoanalysis in AN treatment"

If you would like to change your response for statement 8, please select a new rating below.

Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree

Statement 9:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Schema therapy is a helpful approach.	2.6%	7.9%	**39.5%**	36.8%	X 13.2%

Comments from Round 2 for statement 9:

"Not had much experience with schema therapy"

If you would like to change your response for statement 9, please select a new rating below.

Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree

<< >>

Therapeutic focus and therapeutic techniques:

Comments from Round 2 which apply across the following questions:

"I don't like to fix my interventions into the above boxes because there is no golden bullet. Individuals require someone who can explore the behaviours as a solution to a problem and then help them to explore the underlying reasons, thinking, emotions and interpersonal impact of above. In addition trauma focused therapy is also key"

"Focus on strengths, resilience and effective coping mechanisms are also important"

"Relationship is key to working with someone with an eating disorder and understanding transference and counter transference is fundamental to the therapeutic approach"

"the above is dependant on the severity of the anorexia nervosa"

Statement 10:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
There should be an early focus on **behavioural change (reducing eating disordered behaviours and weight gain).**	0.0%	X 5.3%	15.8%	**42.1%**	36.8%

Comments from Round 2 for statement 10:

"I understand from the evidence that early behavioural change predicts therapeutic alliance and treatment outcome and I have seen evidence of this working"

If you would like to change your response for statement 10, please select a new rating below.

Strongly disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly agree ○

Statement 11:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
There should be an early focus on **building the therapeutic relationship before making behavioural changes.**	5.3%	7.9%	7.9%	X **39.5%**	**39.5%**

Comments from Round 2 for statement 11:

"regarding building a relationship before working on behaviour change is not quite right - these are not mutually exclusive, and I believe should go together"

"From what I understand the therapeutic alliance alone does not predict outcomes, although it can't hurt to have a good alliance with them, particularly if motivation is ambivalent"

If you would like to change your response for statement 11, please select a new rating below.

Strongly disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly agree ○

Statement 12:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Outcomes from therapeutic work with people with anorexia are mostly about weight gain.	13.2%	**34.2%**	23.7%	X 26.3%	2.6%

Comments from Round 2 for statement 12:

"I think that outcomes as they are measured and reported are predominantly about the weight gain, but I personally do not agree that this is the only important outcome of therapy"

"In relation to the outcome question, I have rated according to my beliefs about outcome, that is, whilst weight gain is important in the long run, there are many other factors that are particularly important and should also be considered, as a focus solely on weight often trickles down into the therapy style, which may mean pushing patients faster than understanding and working with their ambivalence allows"

If you would like to change your response for statement 12, please select a new rating below.

Strongly disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly agree ○

Statement 13:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Chair work can help people with anorexia to explore different parts of themselves.	7.9%	0.0%	**39.5%**	34.2%	X 18.4%

Comments from Round 2 for statement 13:

"I can imagine chair work could be a helpful way to gain insight into the 'anorexic voice'"

If you would like to change your response for statement 13, please select a new rating below.

Strongly disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly agree ○

Statement 14:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Exposure-based methods are more effective than cognitive-restructuring methods.	2.6%	10.5%	X **36.8%**	**36.8%**	13.2%

If you would like to change your response for statement 14, please select a new rating below.

Strongly disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly agree ○

Statement 15:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Externalising different aspects of the client can help them to explore the different parts of themselves.	0.0%	2.6%	26.3%	X **55.3%**	15.8%

If you would like to change your response for statement 15, please select a new rating below.

Strongly disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly agree ○

Statement 16:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Therapists tend to make therapy up as they go because there is no gold standard of treatment.	15.8%	**39.5%**	18.4%	X 23.7%	2.6%

Comments from Round 2 for statement 16:

"I would say that therapists use clinical judgment to tailor their treatment to the client's presentation as they go along. Saying we "make therapy up" minimizes what we do, although I don't disagree that there is an element of not having a predetermined treatment plan. So I object to the wording of that phrasing, although I agree with the spirit of it"

"I don't agree that therapists 'make therapy up as they go' but I do agree that there is no clear recognised model for working with anorexia which may require therapists to be quite fluid in the techniques they use. However, I'm not sure that this is a bad thing, as having a 'gold standard' could lead to people becoming, or feeling the pressure to become, more rigid in their working, which mirrors part of the anorexic condition in its rigidity and concreteness. There is also something here about individual clients- some are more cognitive in which case emotion-based models could be really beneficial, whereas others are more emotional in which case more cognitive-restructuring may be more useful"

"I use an evidence based treatment with a set protocol and am supervised by one of the pioneers in CBT for AN. I think that despite CBT being the best evidence, the outcomes itself aren't great so can appreciate there being no 'gold standard' treatment but there is definitely an outline of treatment with CBT. Perhaps for other treatments such as psychodynamic/analysis work I can imagine this to be the case"

"I am heavily evidence based in my practice"

"I cannot sensibly answer the last one - the concept of 'gold standard' is meaningless (see recent IJED editorial paper), many do make up therapy as they go along, but that is not because of the lack of a gold-standard approach - just what clinicians do even if there is a best therapy. Therefore, my answer should be 'missing'"

"I don't think that therapists make the therapy up as they go along, but I think there tends to be two camps - those who rigidly stick to one approach (even if it's not working) and those who are more integrative and open to new and innovative approaches"

If you would like to change your response for statement 16, please select a new rating below.

Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree

<< >>

Idiosyncrasies of the therapeutic relationship:

Statement 17:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
The therapeutic relationship can feel like treading on eggshells and need very careful handling.	0.0%	16.2%	18.9%	X **48.6%**	16.2%

Comments from Round 2 for statement 17:

"if your therapeutic relationship is fragile it can feel like you are walking on egg shells at times"

"The relationship can feel like 'walking on eggshells' sometimes"

If you would like to change your response for statement 17, please select a new rating below.

Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree

Statement 18:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
The therapist's appearance (too thin, too fat, too old, too young, male, female) can act as a barrier to achieving a good therapeutic relationship.	2.7%	**37.8%**	32.4%	X 27%	0.0%

Comments from Round 2 statement 18:

"If the therapist's appearance seems to be a barrier, it needs to be addressed in treatment"

"I don't think that the appearance of the therapist needs to be a barrier unless it is allowed to be; I would try and make any of these issues or differences quite overt and bring them into the relationship/therapeutic discussion as to what the impact of that is"

"As a young, thin female I have been the subject to comparison in the therapy room. I am also just below the normal healthy weight range but have always been this way but I can understand why some patients would object to us reaching a BMI of 19/19.5+ if their therapist is not this"

If you would like to change your response for statement 18, please select a new rating below.

Strongly disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly agree ○

Statement 19:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Lack of progress in therapy can be related to dynamics within the therapeutic relationship.	0.0%	5.4%	24.3%	X **59.5%**	10.8%

Comments from Round 2 for statement 19:

"This is an important point - treatment engagement and drop-out rates are indicative of the quality of the therapy relationship. The CBT-E trial by Byrne et al (Perth, Australia) showed a 50% drop out rate for those with Anorexia Nervosa. We need treatments that are good at keeping patients in treatment"

"If there is a lack of progress then the first place I tend to look as a therapist is the relationship and see if I can affect any change there, but I'm sure it isn't always the case"

"a good therapeutic relationship can bring about effective change, it does not on its own always guarantee change or progress, which also is dependent on other factors such as the clients' own resources, resilience, motivations, as well as their wider personal, familial and social contexts and circumstances"

"I've had patients with whom we've had a good therapeutic alliance and they tell me repeatedly they are motivated, although I actually never saw change"

If you would like to change your response for statement 19, please select a new rating below.

Strongly disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly agree ○

Statement 20:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
One of the main challenges to working with people with anorexia is balancing the physiological and psychological aspects of the work.	2.7%	0.0%	18.9%	X **54.1%**	24.3%

If you would like to change your response for statement 20, please select a new rating below.

Strongly disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly agree ○

<< >>

Use of countertransference:

Comments from Round 2 which apply across the following questions:

"I think that we need to be encouraged to be more self-reflective within our training programs that facilitates openness and recognition of our own vulnerabilities as therapists"

Statement 21:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
The impact of the person with anorexia on the therapist should be included into the clinical formulation.	2.7%	10.8%	24.3%	X **43.2%**	18.9%

If you would like to change your response for statement 21, please select a new rating below.

Strongly disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly agree ○

Statement 22:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
It is easy for therapists to get stuck in their own defence mechanisms (e.g. too detached vs. too involved; insufficient therapeutic boundaries vs. too strict etc.).	0.0%	5.4%	27%	X **48.6%**	18.9%

If you would like to change your response for statement 22, please select a new rating below.

Strongly disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly agree ○

Statement 23:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Personal therapy helps therapists to understand what belongs to them within the therapeutic relationship and what belongs to the person with anorexia.	2.7%	2.7%	18.9%	**45.9%**	X 29.7%

If you would like to change your response for statement 23, please select a new rating below.

Strongly disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly agree ○

Statement 24:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Transference can be strong particularly when similarities are shared between client and clinician (e.g. both slim females, both perfectionist).	0.0%	5.4%	24.3%	**51.4%**	X 18.9%

If you would like to change your response for statement 24, please select a new rating below.

Strongly disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly agree ○

Statement 25:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
I would not want to record the impact of the client on myself in the clinical formulation on the computer.	8.1%	X **43.2%**	21.6%	21.6%	5.4%

Comments from Round 2 for statement 25:

"Recording the impact of the client on the therapist would depend on how personal to the therapist the impact is in terms of what history it touches on; I think that supervision should be a space where this can be discussed quite openly but recording it somewhere that other professionals can access should be done carefully"

"I strongly agree about working with counter transference but would not want it recorded on a NHS site"

If you would like to change your response for statement 25, please select a new rating below.

Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

Statement 26:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Using transference and countertransference material is essential to working therapeutically with people with anorexia.	0.0%	8.1%	24.3%	X **35.1%**	32.4%

Comments from Round 2 for statement 26:

"Referring to emotions is an essential part of the therapeutic relationship and work, and requires considerable skills and attention to timing of these conversations, to ensure these reflections can be heard and used in meaningful ways to further therapeutic progress, rather than in a critical or judgmental way which can impede therapy. Attention to these issues should be included in effective clinical supervision, but am aware these issues are often not given the attention they require in certain kinds of supervision, where being task focussed may take more prominence"

"Countertransference could be reframed using different language so it doesn't have to be a psychodynamic model. Countertransference implies unconscious is involved but can be understandable feeling in response to a client's behaviour"

If you would like to change your response for statement 26, please select a new rating below.

Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

Service/therapist interaction:

Statement 27:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
The service/system prioritises keeping people 'in therapy' over getting them to 'do therapy'	10.8%	X **45.9%**	18.9%	21.6%	2.7%

If you would like to change your response for statement 27, please select a new rating below.

Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

<< >>

General aspects of supervision:

Statement 28:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Clinicians need a lot of support in supervision to feel okay if their clients are not making many changes.	0.0%	5.4%	24.3%	X **40.5%**	29.7%

If you would like to change your response for statement 28, please select a new rating below.

Strongly disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly agree ○

Statement 29:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Supervisors need supervision of their own supervision work (i.e. relating to their supervisees).	0.0%	0.0%	24.3%	**37.8%**	X **37.8%**

If you would like to change your response for statement 29, please select a new rating below.

Strongly disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly agree ○

Focus of supervision:

Statement 30:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
The following should be discussed in supervision: **The impact of the therapeutic work on the clinician's relationship with food and their body.**	0.0%	10.8%	**45.9%**	X 32.4%	10.8%

If you would like to change your response for statement 30, please select a new rating below.

Strongly disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly agree ○

Statement 31:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
The following should be discussed in supervision: **The clinician's beliefs about food.**	2.7%	10.8%	X **43.2%**	29.7%	13.5%

If you would like to change your response for statement 31, please select a new rating below.

Strongly disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly agree ○

Statement 32:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
The following should be discussed in supervision: **The clinician's beliefs about their body.**	2.7%	10.8%	X **51.4%**	29.7%	5.4%

If you would like to change your response for statement 32, please select a new rating below.

Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree

Statement 33:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
The following should be discussed in supervision: **The clinician's experiences of an eating disorder, or food or body image related issues.**	2.7%	10.8%	X 32.4%	**35.1%**	18.9%

Comments from Round 2 for statement 33:

"Think it would be appropriate if the therapist appears to have adopted a problem i.e. losing a lot of weight, talking about being on a diet with their patients (hopefully this would not happen). But if this was happening then yes it ought to be addressed"

"Some of these issues might be identified but may be better addressed in personal therapy"

If you would like to change your response for statement 33, please select a new rating below.

Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree

Statement 34:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
The following should be discussed in supervision: **The clinician's schemas/belief systems, and their impact on the clinician's clinical work.**	2.7%	0.0%	27%	X **48.6%**	21.6%

If you would like to change your response for statement 34, please select a new rating below.

Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree

Statement 35:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
The following should be discussed in supervision: **Case management.**	0.0%	X 10.8%	13.5%	**40.5%**	35.1%

Comments from Round 2 for statement 35:

"Case management for me falls between clinical and managerial supervision"

"Case load management should be separate to supervision"

If you would like to change your response for statement 35, please select a new rating below.

Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree

Statement 36:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
The following should be discussed in supervision: **Broad themes more than individual cases.**	5.4%	X 13.5%	27%	**35.1%**	18.9%

Comments from Round 2 for statement 36:

"Broad themes and individual cases I feel are both relevant so would prioritise neither"

If you would like to change your response for statement 36, please select a new rating below.

Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree

<< >>

Good supervision:

Statement 37:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Good supervision helps the supervisee to **mentalise the individual with anorexia's view.**	2.7%	0.0%	X 18.9%	**43.2%**	35.1%

If you would like to change your response for statement 37, please select a new rating below.

Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree

Statement 38:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Good supervision helps **improve the supervisee's enjoyment of the work.**	0.0%	0.0%	X 21.6%	**54.1%**	24.3%

If you would like to change your response for statement 38, please select a new rating below.

Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree

Qualities of and barriers to supervision:

Statement 39:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Supervisees need to feel confident that their supervisor has something new to add to their practice.	0.0%	2.8%	19.4%	30.6%	X **47.2%**

If you would like to change your response for statement 39, please select a new rating below.

Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree

Statement 40:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Clinicians should only be supervised by somebody of the same profession as them.	13.9%	X **44.4%**	19.4%	8.3%	13.9%

Comments from Round 2 for statement 40:

"A supervisor and supervisee who each come from different professions and/or different therapeutic approaches can work well together, as long as the differences are acknowledged. If done well, this kind of supervisory relationship can really complement both supervisor and supervisee and be a platform of learning for both"

"Many professional bodies, such as UKCP, AFT, BACP, etc. require supervision from the same modality as part of their ongoing professional development and to remain informed about the regulatory requirements of their profession. Therefore, I am of the view that clinical supervision needs to be provided by same profession"

If you would like to change your response for statement 40, please select a new rating below.

Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree

Comments from Round 2 which apply across the following questions:

"Supervision is a varied process, and needs to be sensitive and responsive to the varied and diverse needs of the supervisee and the work with clients. Therefore, the supervisor needs to be versatile and flexible in their approaches and ways of working to reflect and be responsive to the varied needs of their supervisees and client presentations. Supervisors need to co-create with their supervisees a safe and creative space for talking, which also enables risk-taking to talk about difficult issues and feelings, such as stuckness, feelings of failure and despondency, without feeling they will be judged or criticised for these responses. Good supervision therefore is a space, like therapy, where the supervisee can over time feel able to bring anything into the meetings, positive or negative, helpful and unhelpful, with a confidence that these issues can be thought about, accepted and worked with"

Statement 41:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
It can be hard to find appropriate supervision.	5.6%	13.9%	8.3%	X **55.6%**	16.7%

If you would like to change your response for statement 41, please select a new rating below.

Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree

Statement 42:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Limited time is a barrier to supervision.	5.6%	**30.6%**	19.4%	27.8%	X 16.7%

If you would like to change your response for statement 42, please select a new rating below.

Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree

Statement 43:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Supervision is often not valued by services and management.	5.6%	**36.1%**	22.2%	X 25%	11.1%

If you would like to change your response for statement 43, please select a new rating below.

Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree

Statement 44:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Supervisees can find it uncomfortable to openly talk to their supervisor about their feelings.	0.0%	8.3%	22.2%	X **66.7%**	2.8%

Comments from Round 2 for statement 44:

"supervision is a two way process and I have found that the relationship between you is important here too with regards to how much you are willing/confident to share and how skilful your supervisor is in bringing out the best of you"

If you would like to change your response for statement 44, please select a new rating below.

Strongly disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly agree ○

Statement 45:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Supervisees can be reluctant to bring certain cases to supervision if the cases are giving them trouble, or if they haven't achieved therapy milestones with the person with anorexia.	5.6%	11.1%	11.1%	X **72.2%**	0.0%

If you would like to change your response for statement 45, please select a new rating below.

Strongly disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly agree ○

Statement 46:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
It is difficult to build a good supervisory relationship when the supervisor has a didactic supervision style.	0.0%	8.3%	22.2%	**52.8%**	X 16.7%

If you would like to change your response for statement 46, please select a new rating below.

Strongly disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly agree ○

Statement 47:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
It is difficult to build a good supervisory relationship when supervision focuses on the practical elements of therapy without exploring process issues.	0.0%	11.1%	13.9%	**50%**	X 25%

Comments from Round 2 statement 47:

"Process is more important than practical since process/emotion is what gets in the way of implementing practical in the first place"

If you would like to change your response for statement 47, please select a new rating below.

Strongly disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly agree ○

<< >>

The following questions, are additional questions raised within the analysis of Round 2.

Which interventions/therapies do you use when working therapeutically with individuals with Anorexia Nervosa? (Please select all that apply).

- [ ] Compassion Focused Therapy (CFT)
- [ ] Cognitive Remediation and Emotion Skills Training (CREST)
- [ ] Cognitive Remediation Therapy (CRT)
- [ ] Emotion Focused Therapy (EFT)
- [ ] Eye-movement Desensitisation and Reprocessing (EMDR)
- [ ] Family Therapy
- [ ] Interpersonal Therapy (IPT)
- [ ] Maudsley Anorexia Treatment for Adults (MANTRA)
- [ ] Mindfulness-based Cognitive Therapy (MBCT)
- [ ] Mentalisation-based Therapy (MBT)
- [ ] Psychoanalytic
- [ ] Psychodynamic
- [ ] Psychotherapy
- [ ] Specialist Supportive Clinical Management (SSCM)
- [ ] Other

If you would like to comment on the helpfulness of the above intervention(s) you have selected. Please do so here.

I feel well supported by my team/service in monitoring and managing physical risk.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
○	○	○	○	○

I work therapeutically with individuals with Anorexia Nervosa who are:
(Please select all that apply).

- [ ] Low risk
- [ ] Moderate risk
- [ ] High risk

<< >>

Congratulations, you have now completed this survey!

Thank you for your participation in this Delphi Study looking at the therapeutic relationship when working with individuals with Anorexia Nervosa, and the use of supervision with this client group.

We hope that this study will yield helpful results which will be beneficial for those working in this field, and for those receiving therapy for Anorexia Nervosa.

Thank you again for taking part in this research study.

(Prize draw winners will be contacted in due course).

Would you like to be sent a copy of the findings of this study?

- ○ Yes
- ○ No

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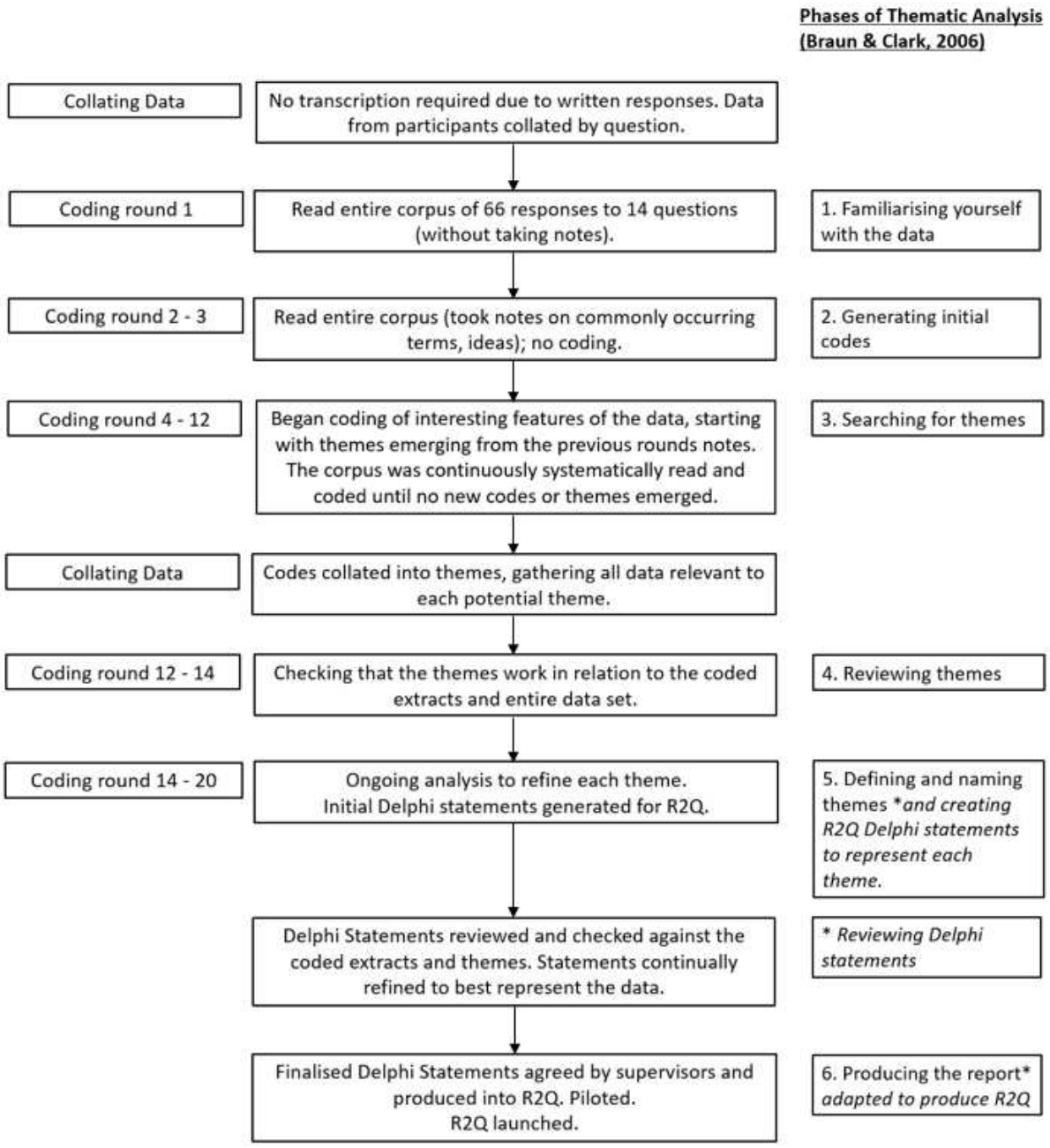
Appendix K: Coding and Statement Production Procedure Diagram



*Note. * is used to represent an adaptation to Braun & Clark's Phases of Thematic Analysis in line with the Delphi Process.*

Appendix L: Abridged Research Diary

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APPENDICES OF SUPPORTING MATERIAL

Appendix M: Example of Coding Table with Supporting Quotes

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APPENDICES OF SUPPORTING MATERIAL

APPENDICES OF SUPPORTING MATERIAL

APPENDICES OF SUPPORTING MATERIAL

Appendix N: Further Demographic Information

Therapeutic Models of Working Used

	Frequency	Percentage
Approaches Identified from R1Q Data and included in the R2Q		
Cognitive Analytic Therapy (CAT)	5	13.2%
Cognitive Behaviour Therapy (CBT)	24	63.2%
Dialectical Behaviour Therapy (DBT)	11	28.9%
Emotion Focused Family Therapy (EFFT)	7	18.4%
Enhanced Cognitive Behaviour Therapy (CBT-E)	11	28.9%
Motivational Interviewing (MI)	31	81.6%
Psychoanalysis	5	13.2%
Psycho-education about AN and starvation	34	87.2%
Schema therapy	5	12.8%
Additional Approaches Identified within the Evidence Base included in the R3Q		
Compassion Focused Therapy (CFT)	11	36.7%
Cognitive Remediation and Emotion Skills Training (CREST)	2	6.7%
Cognitive Remediation Therapy	4	13.3%
Emotion Focused Therapy (EFT)	3	10%
Eye-movement Desensitisation and Reprocessing (EMDR)	1	3.3%
Family Therapy	11	36.7%
Interpersonal Therapy (IPT)	4	13.3%
Maudsley Anorexia Treatment for Adults (MANTRA)	11	36.7%
Mindfulness-based Cognitive Therapy (MBCT)	5	16.7%
Mentalisation-based Therapy (MBT)	3	10%
Psychoanalytic	0	0%
Psychodynamic	6	20%
Psychotherapy	4	13.3%
Specialist Supportive Clinical Management (SSCM)	11	36.7%
Other		

Humanistic	1	3.3%
Multi-family Therapy (MFT)	1	3.3%

Note. Panellist could report using more than one therapeutic model. Panellists responses to Approaches Identified from R1Q data (N=38). Panellist responses to Additional Approaches Identified from the Evidence Base (N=30).

Panellists Supervision

	Frequency	Percentage
Panellists who currently receive supervision (individual, group or peer)	55	79.7%
Model of Supervision received		
Cognitive Behavioural Therapy (CBT)	17	24.6%
Cognitive Analytic Therapy (CAT)	4	5.8%
Compassion Focussed Therapy (CFT)	1	1.45%
Enhanced Cognitive Behavioural Therapy (CBT-E)	3	4.35%
Solution Focused Therapy	1	1.45%
Dialectical Behavioural Therapy (DBT)	1	1.45%
Emotion Focused Therapy (EFT)	1	1.45%
Systemic/Family Based Therapy (FBT)	7	10.1%
Schema Therapy	3	4.35%
Psychoanalytic	1	1.45%
Psychodynamic	4	5.8%
Interpersonal Therapy (IPT)	1	1.45%
Integrative	5	7.25%
Occupational Therapy Supervision	1	1.45%
Managerial	1	1.45%
Group/Peer	5	7.25%

Note. N=69. Panellists could receive supervision from more than one therapeutic modality, and could have more than one type of supervision.

Appendix O: Consensus Results Breakdown

Clinician's Feelings/Emotions

Statement	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Overall Disagreement	Overall Agreement	IQR	Median	Consensus Category
Therapy sessions with people with anorexia can leave me feeling **angry.**	16.2% (6)	13.5% (5)	13.5% (5)	56.8% (21)	0.0% (0)	29.7%	56.8%	2	4	Overall Divergence (R2)
Therapy sessions with people with anorexia can leave me feeling **anxious/fearful.**	10.8% (4)	16.2% (6)	5.4% (2)	51.4% (19)	16.2% (6)	27%	67.6%	2	4	Approaching Consensus (R2)
Therapy sessions with people with anorexia can leave me feeling **attacked/punished.**	13.5% (5)	18.9% (7)	10.8% (4)	51.4% (19)	5.4% (2)	32.4%	56.8%	2	4	Overall Divergence (R2)
Therapy sessions with people with anorexia can leave me feeling **bored.**	21.6% (8)	27% (10)	10.8% (4)	40.5% (15)	0.0% (0)	48.6%	40.5%	2	3	Overall Divergence (R2)
Therapy sessions with people with anorexia can leave me feeling **dismissed.**	8.1% (3)	13.5% (5)	24.3% (9)	51.4% (19)	2.7% (1)	21.6%	54.1%	1	4	Overall Divergence (R2)
Therapy sessions with people with anorexia can leave me feeling **frustrated due to the person with anorexia's ambivalence/low levels of motivation.**	2.7% (1)	10.8% (4)	8.1% (3)	51.4% (19)	27% (10)	13.5%	78.4%	1	4	Approaching Consensus (R2)
Therapy sessions with people with anorexia can leave me feeling **frustrated due to slow progress.**	5.4% (2)	18.9% (7)	8.1% (3)	51.4% (19)	16.2% (6)	24.3%	67.6%	1.5	4	Approaching Consensus (R2)

Therapy sessions with people with anorexia can leave me feeling **hopeless.**	13.5% (5)	18.9% (7)	13.5% (5)	51.4% (19)	2.7% (1)	32.4%	54.1%	2	4	Overall Divergence (R2)
Therapy sessions with people with anorexia can leave me feeling **inadequate.**	10.8% (4)	10.8% (4)	10.8% (4)	59.5% (22)	8.1% (3)	21.6%	67.6%	1	4	Approaching Consensus (R2)
Therapy sessions with people with anorexia can leave me feeling **like I want to shut off from the person with anorexia.**	29.7% (11)	29.7% (11)	8.1% (3)	32.4% (12)	0.0% (0)	59.4%	32.4%	3	2	Overall Divergence (R2)
Therapy sessions with people with anorexia can leave me feeling **overwhelmed.**	13.5% (5)	21.6% (8)	16.2% (6)	43.2% (16)	5.4% (2)	35.1%	48.6%	2	3	Overall Divergence (R2)
Therapy sessions with people with anorexia can leave me feeling **disgust.**	45.9% (17)	37.8% (14)	8.1% (3)	5.4% (2)	2.7% (1)	83.7%	8.1%	1	2	Overall Consensus (R2)
Therapy sessions with people with anorexia can leave me feeling **powerless.**	13.5% (5)	8.1% (3)	18.9% (7)	54.1% (20)	5.4% (2)	21.6%	59.5%	1	4	Overall Divergence (R2)
Therapy sessions with people with anorexia can leave me feeling **protective.**	5.4% (2)	8.1% (3)	16.2% (6)	64.9% (24)	5.4% (2)	13.5%	70.3%	1	4	Approaching Consensus (R2)
Therapy sessions with people with anorexia can leave me feeling **sad.**	2.7% (1)	5.4% (2)	8.1% (3)	54.1% (20)	29.7% (11)	8.1%	83.8%	1	4	Overall Consensus (R2)
Therapy sessions with people with anorexia can leave me feeling **uncomfortable about the power imbalance.**	24.3% (9)	18.9% (7)	24.3% (9)	27% (10)	5.4% (2)	43.2%	32.4%	2.5	3	Overall Divergence (R2)
Therapy sessions with people with anorexia who are very underweight can leave me feeling shocked about their physical state.	8.1% (3)	13.5% (5)	27% (10)	43.2% (16)	8.1% (3)	21.6%	51.3%	1	4	Overall Divergence (R2)

Therapy sessions with people with anorexia can leave me feeling **anxious that they will die or become increasingly unwell.**	2.7% (1)	13.5% (5)	18.9% (7)	48.6% (18)	16.2% (6)	16.2%	64.8%	1	4	Overall Divergence (R2)
Therapy sessions with people with anorexia can leave me feeling **a pressure to please my client.**	16.2% (5)	37.8% (14)	16.2% (6)	27% (10)	2.7% (1)	54%	29.7%	2	2	Overall Divergence (R2)
Working with individuals with anorexia can make me feel jealous of their body shape.	62.2% (23)	35.1% (13)	0.0% (0)	2.7% (1)	0.0% (0)	97.3%	2.7%	1	1	Overall Consensus (R2)
I enjoy the complexity of working with individuals with anorexia.	2.7% (1)	0.0% (0)	10.8% (4)	40.5% (15)	45.9% (17)	2.7%	86.4%	1	4	Overall Consensus (R2)
I enjoy the connection with my clients.	0.0% (0)	2.7% (1)	5.4% (2)	51.4% (19)	40.5% (15)	2.7%	91.9%	1	4	Overall Consensus (R2)
I can feel a sense of achievement when my client makes changes.	0.0% (0)	0.0% (0)	2.7% (1)	51.4% (19)	45.9% (17)	0.0%	97.3%	1	4	Overall Consensus (R2)
I find working with individuals with anorexia rewarding.	0.0% (0)	2.7% (1)	13.5% (5)	43.2% (16)	40.5% (15)	2.7%	83.7%	1	4	Overall Consensus (R2)
I find working with people with anorexia repetitive/tedious.	24.3% (9)	40.5% (15)	16.2% (6)	18.9% (7)	0.0%	64.8%	18.9%	1.5	2	Overall Divergence (R2)
People with anorexia are often critical of themselves and others, so I can feel rubbished or inadequate.	16.2% (6)	24.3% (9)	13.5% (5)	37.8% (14)	8.1% (3)	40.5%	45.9%	1	3	Overall Divergence (R2)

Note. N = 37.

Clinician Thinking

Statement	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Overall Disagreement	Overall Agreement	IQR	Median	Consensus Category
Working with individuals with anorexia has changed the way that I think about food.	21.6% (8)	27% (10)	18.9% (7)	29.7% (11)	2.7% (1)	48.6%	32.4%	2	3	Overall Divergence (R2)
Working with individuals with anorexia has changed the way that I think about my body.	27% (10)	32.4% (12)	16.2% (6)	21.6% (8)	2.7% (1)	59.4%	24.3%	2.5	2	Overall Divergence (R2)
Working with individuals with anorexia has made me more accepting of my own body.	13.5% (5)	16.2% (6)	21.6% (8)	40.5% (15)	8.1% (3)	29.7%	48.6%	2	3	Overall Divergence (R2)
Working with individuals with anorexia has made me more insecure about my own body.	40.5% (15)	29.7% (11)	16.2% (6)	12.8% (5)	0.0% (0)	70.2%	12.8%	2	2	Approaching Consensus (R2)
I find I need to adapt my expectations as a therapist to value small changes.	2.7% (1)	5.4% (2)	18.9% (7)	45.9% (17)	29.7% (11)	8.1%	75.6%	1.5	4	Approaching Consensus (R2)

Note. N = 37.

Clinician Behaviours

Statement	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Overall Disagreement	Overall Agreement	IQR	Median	Consensus Category
Working with individuals with anorexia can impact on my eating behaviours (e.g. eat more or less after a session).	24.3% (9)	45.9% (17)	5.4% (2)	21.6% (8)	2.7% (1)	70.2%	24.3%	2	2	Approaching Consensus (R2)

Note. N = 37.

Challenges

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Overall Disagreement	Overall Agreement	IQR	Median	Consensus Category
It can feel difficult to empathise with such a life threatening condition that is difficult to understand "logically".	32.4% (12)	45.9% (17)	2.7% (1)	18.9% (7)	0.0% (0)	78.3%	18.9%	1	2	Approaching Consensus (R2)
It can feel hard to be honest with clients sometimes.	13.5% (5)	43.2% (16)	16.2% (6)	27% (10)	0.0% (0)	56.7%	27%	2	2	Overall Divergence (R2)
As a therapist I often feel under pressure from my service and the wider system to be ‘doing something’ in therapy.	5.4% (2)	10.8% (4)	8.1% (3)	64.9% (24)	10.8% (4)	16.2%	75.7%	1.5	4	Approaching Consensus (R2)
Different feelings emerge as I get more experienced.	2.7% (1)	0.0% (0)	24.3% (9)	64.9% (24)	9.1% (3)	2.7%	73%	1	4	Approaching Consensus (R2)
I can feel bad if I don't manage to connect in some meaningful way when working with individuals with anorexia.	0.0% (0)	13.5% (5)	24.3% (9)	56.8% (21)	5.4% (2)	13.5%	62.2%	1	4	Overall Divergence (R2)
I can sometimes get lost in the details and/or wrong issue.	5.4% (2)	24.3% (9)	24.3% (9)	37.8% (14)	8.1% (3)	29.7%	45.9%	1	4	Overall Divergence (R2)
I can sometimes worry about pushing for change.	10.8% (4)	21.6% (8)	18.9% (7)	43.2% (16)	5.4% (2)	32.4%	48.6%	2	3	Overall Divergence (R2)
I need to be personally resilient when working with people with anorexia.	2.7% (1)	0.0% (0)	5.4% (2)	56.8% (21)	35.1% (13)	2.7%	91.9%	1	4	Overall Consensus (R2)
Sometimes I avoid emotional factors by focusing on behavioural and cognitive change.	24.3% (9)	56.8% (21)	2.7% (1)	13.5% (5)	2.7% (1)	81.1%	16.2%	0.5	2	Overall Consensus (R2)
Sometimes I feel like I have hard to work too hard in therapy (i.e. with	8.1% (3)	10.8% (4)	21.6% (8)	45.9% (17)	13.5% (5)	18.9%	59.4%	1	4	Overall Divergence (R2)

questions and lines of enquiry) when working with people with anorexia.										

Note. N = 37.

Areas for Discussion in Supervision

Statement	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Overall Disagreement	Overall Agreement	IQR	Median	Consensus Category
The impact of the therapeutic work on the clinician's relationship with food and their body.	0.0% (0)	10.3% (4)	48.7% (19)	30.8% (12)	10.3% (4)	10.3%	41.1%	1	3	Overall Divergence (R3)
The clinician's beliefs about food.	2.6% (1)	10.3% (4)	41% (4)	35.9% (14)	10.3% (4)	12.9%	46.2%	1	3	Overall Divergence (R3)
The clinician's beliefs about their body.	2.6% (1)	10.3% (4)	48.7% (19)	35.9% (14)	2.6% (1)	12.9%	38.5%	1	3	Overall Divergence (R3)
The clinician's defences/coping mechanisms (e.g. too detached vs. too involved, rescue/avoid).	0.0% (0)	2.7% (1)	10.8% (4)	59.5% (22)	27% (10)	2.7%	86.5%	1	4	Overall Consensus (R2)
The clinician's experiences of an eating disorder, or food or body image related issues.	2.6% (1)	7.7% (3)	30.8% (12)	43.6% (17)	15.4% (6)	10.3%	59%	1	4	Overall Divergence (R3)
The clinician's schemas/belief systems, and their impact on the clinician's clinical work.	2.6% (1)	0.0% (0)	17.9% (7)	59% (23)	20.5% (8)	2.6%	79.5%	0	4	Approaching Consensus (R3)
The stresses and frustrations of the therapeutic relationship.	0.0% (0)	0.0% (0)	2.7% (1)	48.6% (18)	48.6% (18)	0.0%	97.2%	1	4	Overall Consensus (R2)
The client’s experience of emotion (including individual and familial avoidance patterns).	0.0% (0)	0.0% (0)	10.8% (4)	54.1% (20)	35.1% (13)	0.0%	89.2%	1	4	Overall Consensus (R2)
Cases that are going well.	0.0% (0)	2.7% (1)	5.4% (2)	54.1% (20)	37.8% (14)	2.7%	91.9%	1	4	Overall Consensus (R2)
Small successes made in the clinician's clinical work.	0.0% (0)	2.7% (1)	2.7% (1)	59.5% (22)	35.1% (13)	2.7%	94.6%	1	4	Overall Consensus (R2)

Ways of working with eating disorder symptoms.	0.0% (0)	2.7% (1)	0.0% (0)	51.4% (19)	45.9% (17)	2.7%	97.3%	1	4	Overall Consensus (R2)
How to use techniques from other therapies outside of the clinician's current skill set.	0.0% (0)	0.0% (0)	10.8% (4)	45.9% (17)	43.2% (16)	0.0%	89.1%	1	4	Overall Consensus (R2)
Trouble shooting difficulties with practical strategies.	0.0% (0)	0.0% (0)	5.4% (1)	45.9% (17)	48.6% (18)	0.0%	94.5%	1	4	Overall Consensus (R2)
The clinician's unhelpful habits.	0.0% (0)	2.7% (1)	8.1% (3)	54.1% (20)	35.1% (13)	2.7%	89.2%	1	4	Overall Consensus (R2)
Solutions/ways forward in the clinician's therapeutic work when stuck.	0.0% (0)	0.0% (0)	0.0% (0)	43.2% (16)	56.8% (21)	0.0%	100%	1	5	Overall Consensus (R2)
Case management.	0.0% (0)	10.3% (4)	12.8% (5)	43.6% (17)	33.3% (13)	10.3%	76.9%	1	4	Approaching Consensus (R3)
Broad themes more than individual cases.	5.1% (2)	15.4% (6)	30.8% (12)	33.3% (13)	15.4% (6)	20.5%	48.7%	1	3	Overall Divergence (R3)
Issues within the therapeutic relationship.	0.0% (0)	0.0% (0)	0.0% (0)	56.8% (21)	43.2% (16)	0.0%	100%	1	4	Overall Consensus (R2)

Notes. Round 2: N = 37. Round 3: N = 39.

Areas for Reflection in Supervision

Statement	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Overall Disagreement	Overall Agreement	IQR	Median	Consensus Category
Why change has not happened.	0.0% (0)	2.7% (1)	2.7% (1)	54.1% (20)	40.5% (15)	2.7%	94.6%	1	4	Overall Consensus (R2)
The clinician's anxiety about requiring change.	0.0% (0)	0.0% (0)	2.7% (1)	56.8% (21)	40.5% (15)	0.0%	97.3%	1	4	Overall Consensus (R2)
Transference and counter-transference that arises in the clinician's work with people with anorexia or their families.	0.0% (0)	0.0% (0)	10.8% (4)	56.8% (21)	32.4% (12)	0.0%	89.2%	1	4	Overall Consensus (R2)
Parallel processes that may arise within therapy, supervision, the family and the wider system.	0.0% (0)	0.0% (0)	5.4% (2)	56.8% (21)	37.8% (14)	0.0%	94.6%	1	4	Overall Consensus (R2)
Issues relating to the team/wider system.	0.0% (0)	0.0% (0)	16.2% (6)	48.6% (18)	35.1% (13)	0.0%	83.7%	1	4	Overall Consensus (R2)
Ethical issues relating to working with individuals with anorexia, for instance, the question of whether or not free will can extend to starving one’s self to death, and how much can we as health professionals intervene.	0.0% (0)	2.7% (1)	10.8% (4)	45.9% (17)	40.5% (15)	2.7%	86.4%	1	4	Overall Consensus (R2)

Notes. Round 2: N = 37. Round 3: N = 39.

Outcomes of 'Good' Supervision

Statement	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Overall Disagreement	Overall Agreement	IQR	Median	Consensus Category
Good supervision helps the supervisee to plan their interventions.	0.0% (0)	0.0% (0)	2.7% (1)	51.4% (19)	45.9% (17)	0.0%	97.3%	1	4	Overall Consensus (R2)
Good supervision helps the supervisee to develop clear goals for future therapy sessions.	0.0% (0)	0.0% (0)	0.0% (0)	51.4% (19)	48.6% (18)	0.0%	100%	1	4	Overall Consensus (R2)
Good supervision helps the supervisee to focus on outcomes at the level of the individual client.	0.0% (0)	0.0% (0)	13.4% (5)	43.2% (16)	43.2% (16)	0.0%	86.4%	1	4	Overall Consensus (R2)
Good supervision helps the supervisee to develop a deeper understanding of the individual with anorexia's difficulties.	0.0% (0)	0.0% (0)	2.7% (1)	40.5% (15)	56.8% (21)	0.0%	97.3%	1	5	Overall Consensus (R2)
Good supervision helps the supervisee to understand the individual with anorexia's difficulties within specific therapeutic models.	0.0% (0)	0.0% (0)	2.7% (1)	56.8% (21)	40.5% (15)	0.0%	97.3%	1	4	Overall Consensus (R2)
Good supervision helps the supervisee to formulate difficulties that arise within the therapy.	0.0% (0)	0.0% (0)	0.0% (0)	43.2% (16)	56.8% (21)	0.0%	100%	1	5	Overall Consensus (R2)
Good supervision helps the supervisee to mentalise the individual with anorexia's view.	2.6% (1)	0.0% (0)	15.4% (6)	51.3% (20)	30.8% (12)	2.6%	82.1%	1	4	Overall Consensus (R3)
Good supervision helps the supervisee to notice if they are colluding with anorexia.	0.0% (0)	0.0% (0)	2.7% (1)	37.8% (14)	59.5% (22)	0.0%	97.3%	1	5	Overall Consensus (R2)

Good supervision helps the supervisee to be aware of their blind spots and biases, thus promoting safer decision making.	0.0% (0)	0.0% (0)	0.0% (0)	40.5% (15)	59.5% (22)	0.0%	100%	1	5	Overall Consensus (R2)
Good supervision helps to normalise some of the difficulties that the supervisee may experience when working with people with anorexia.	2.7% (1)	0.0% (0)	2.7% (1)	51.4% (19)	43.2% (16)	2.7%	94.6%	1	4	Overall Consensus (R2)
Good supervision has a careful balance between being directive and offering teaching, and allowing supervisee to develop his/her own ideas.	0.0% (0)	2.7% (1)	8.1% (3)	43.2% (16)	45.9% (17)	2.7%	89.1%	1	4	Overall Consensus (R2)
Good supervision supports clinical work in being evidence based.	0.0% (0)	2.7% (1)	10.8% (4)	40.5% (15)	45.9% (17)	2.7%	86.4%	1	4	Overall Consensus (R2)
Good supervision helps the supervisee to identify and explore what they are feeling in relation to their client work.	0.0% (0)	0.0% (0)	2.7% (1)	45.9% (17)	51.4% (19)	0.0%	97.3%	1	5	Overall Consensus (R2)
Good supervision helps the supervisee to resolve ruptures or problems within the therapeutic relationship.	0.0% (0)	0.0% (0)	0.0% (0)	43.2% (16)	56.8% (21)	0.0%	100%	1	5	Overall Consensus (R2)
Good supervision helps the supervisee to notice when they become stuck in unhelpful relationship patterns in therapy.	0.0% (0)	0.0% (0)	2.7% (1)	40.5% (15)	56.8% (21)	0.0%	97.3%	1	5	Overall Consensus (R2)
Good supervision helps the supervisee to engage and connect with the individual with anorexia.	0.0% (0)	0.0% (0)	8.1% (3)	51.4% (19)	40.5% (15)	0.0%	91.9%	1	4	Overall Consensus (R2)
Good supervision helps to instil hope.	0.0% (0)	0.0% (0)	5.4% (2)	59.5% (22)	35.1% (13)	0.0%	94.6%	1	4	Overall Consensus (R2)

Good supervision helps the supervisee to feel more confident in managing risk.	0.0% (0)	0.0% (0)	2.7% (1)	51.4% (19)	45.9% (17)	0.0%	97.3%	1	4	Overall Consensus (R2)
Good supervision helps the supervisee to stay motivated in their therapeutic work.	0.0% (0)	0.0% (0)	2.7% (1)	54.1% (20)	43.2% (16)	0.0%	97.3%	1	4	Overall Consensus (R2)
Good supervision helps the supervisee to feel more resilient.	0.0% (0)	0.0% (0)	5.4% (2)	51.4% (19)	43.2% (16)	0.0%	94.6%	1	4	Overall Consensus (R2)
Good supervision helps the supervisee to not burnout.	0.0% (0)	0.0% (0)	5.4% (2)	59.5% (22)	35.1% (13)	0.0%	94.6%	1	4	Overall Consensus (R2)
Good supervision helps the supervisee to remember that they are not a terrible therapist, and that they are "doing alright / well'.	0.0% (0)	2.7% (1)	16.2% (6)	54.1% (20)	27% (10)	0.0%	81.1%	1	4	Overall Consensus (R2)
Good supervision helps improve the supervisee's enjoyment of the work.	0.0% (0)	0.0% (0)	17.9% (7)	56.4% (22)	25.6% (10)	0.0%	82%	1	4	Overall Consensus (R3)

Notes. Round 2: N = 37. Round 3: N = 39.

Qualities of the Supervisory Relationship

Statement	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Overall Disagreement	Overall Agreement	IQR	Median	Consensus Category
Good supervision has a compassionate stance to people with anorexia and their experiences.	0.0% (0)	0.0% (0)	5.6% (2)	30.6% (11)	63.6% (23)	0.0%	94.4%	1	5	Overall Consensus (R2)
Good supervision has a respectful stance to people with anorexia and their experiences.	0.0% (0)	0.0% (0)	0.0% (0)	30.6% (11)	69.4% (25)	0.0%	100%	1	5	Overall Consensus (R2)
Good supervision helps to contain the supervisee's feelings around their clinical work.	0.0% (0)	0.0% (0)	5.6% (2)	25% (9)	69.4% (25)	0.0%	94.4%	1	5	Overall Consensus (R2)
Good supervision should feel like a safe place to explore difficult feelings.	0.0% (0)	0.0% (0)	0.0% (0)	19.4% (7)	80.6% (29)	0.0%	100%	1	5	Overall Consensus (R2)

Note. Round 2: N = 36.

Supervisor Qualities

Statement	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Overall Disagreement	Overall Agreement	IQR	Median	Consensus Category
Supervisees need to feel confident that their supervisor has something new to add to their practice.	0.0% (0)	0.0% (0)	18.4% (7)	36.8% (14)	44.7% (17)	0.0%	81.5%	1	4	Overall Consensus (R3)
Supervisors must have a good understanding of anorexia.	0.0% (0)	0.0% (0)	11.1% (4)	38.9% (14)	50% (18)	0.0%	88.9%	1	4.5	Overall Consensus (R2)
Supervisors should have the expertise required to supervise the treatment approach in use.	0.0% (0)	2.8% (1)	11.1% (4)	27.8% (10)	58.3% (21)	2.8%	86.1%	1	5	Overall Consensus (R2)
Supervisors who lack expert knowledge can still provide a reflecting opportunity.	0.0% (0)	2.8% (1)	5.6% (2)	63.9% (23)	27.8% (10)	2.8%	91.7%	1	4	Overall Consensus (R2)
Supervisors taking a non-expert role can facilitate a good supervisory relationship.	0.0% (0)	11.1%	8.3% (3)	58.3% (21)	22.2% (8)	11.1%	80.5%	0	4	Overall Consensus (R2)
Clinicians should only be supervised by somebody of the same profession as them.	13.2% (5)	44.7% (17)	21.1% (8)	7.9% (3)	13.2% (5)	57.9%	21.1%	1	2	Overall Divergence (R3)
Supervisors need to facilitate appropriate learning and professional development for the supervisee.	0.0% (0)	7.7% (3)	7.7% (3)	58.3% (21)	25% (9)	7.7%	83.3%	0.75	4	Overall Consensus (R2)

Notes. Round 2: N = 36. Round 3: N = 38.

Barriers to Supervision

Statement	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Overall Disagreement	Overall Agreement	IQR	Median	Consensus Category
It can be hard to find appropriate supervision.	0.0% (0)	10.5% (4)	15.8% (6)	57.9% (22)	15.8% (6)	10.5%	73.7%	1	4	Approaching Consensus (R3)
Limited time is a barrier to supervision.	5.3% (3)	31.6% (12)	21.1% (8)	28.9% (11)	13.2% (5)	36.9%	42.1%	2	3	Overall Divergence (R3)
Supervision is less productive when boundaries and structure are not in place.	0.0% (0)	8.3% (3)	2.8% (1)	66.7% (24)	22.2% (8)	8.3%	88.9%	0	4	Overall Consensus (R2)
Supervision is often not valued by services and management.	5.3% (2)	44.7% (17)	18.4% (7)	21.1% (8)	10.5% (4)	50%	31.6%	2.5	2	Overall Divergence (R3)
Supervisees can find it uncomfortable to openly talk to their supervisor about their feelings.	0.0% (0)	5.3% (2)	23.7% (9)	68.4% (26)	2.6% (1)	5.3%	71%	1	4	Approaching Consensus (R3)
Supervisees can be reluctant to bring certain cases to supervision if the cases are giving them trouble, or if they haven't achieved therapy milestones with the person with anorexia.	5.3% (2)	7.9% (3)	10.5% (4)	76.3% (29)	0.0% (0)	13.2%	76.3%	.25	4	Approaching Consensus (R3)
Supervisees can be reluctant to bring process issues to supervision, particularly ones that have triggered the supervisee's own schemas or more difficult emotions.	2.8% (1)	5.6% (2)	11.1% (4)	77.8% (28)	2.8% (1)	8.4%	80.6%	0	4	Overall Consensus (R2)
When anxious, supervisees may avoid discussing important issues in supervision.	0.0% (0)	2.8% (1)	11.1% (4)	75%	11.1% (4)	2.8%	86.1%	0	4	Overall Consensus (R2)

If supervisees feel judged by their supervisor, the supervisee would not feel comfortable bringing their vulnerabilities, limitations and errors to supervision.	0.0% (0)	0.0% (0)	5.6% (2)	52.8% (19)	41.7% (15)	0.0%	94.5%	1	4	Overall Consensus (R2)
Supervision can sometimes mirror the interpersonal processes that arise within therapeutic work.	0.0% (0)	2.8% (1)	8.3% (3)	58.3% (21)	30.6% (11)	2.8%	88.9%	1	4	Overall Consensus (R2)
It is difficult to build a good supervisory relationship when the supervisor has poor listening skills.	0.0% (0)	0.0% (0)	0.0% (0)	36.1% (13)	63.9% (23)	0.0%	100%	1	5	Overall Consensus (R2)
It is difficult to build a good supervisory relationship when the supervisor is critical or punitive.	0.0% (0)	0.0% (0)	0.0% (0)	33.3% (12)	66.7% (24)	0.0%	100%	1	5	Overall Consensus (R2)
It is difficult to build a good supervisory relationship when the supervisor has a didactic supervision style.	0.0% (0)	7.9% (3)	13.2% (5)	63.2% (24)	15.8% (6)	7.9%	79%	0	4	Overall Consensus (R3)
It is difficult to build a good supervisory relationship when supervision focuses on the practical elements of therapy without exploring process issues.	0.0% (0)	10.5% (4)	5.3% (2)	60.5% (23)	23.7% (9)	10.5%	84.2%	0.25	4	Overall Consensus (R3)

Notes. Round 2: N = 36. Round 3: N = 38.

Facilitators to Supervision

Statement	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Overall Disagreement	Overall Agreement	IQR	Median	Consensus Category
Good supervision requires an honest relationship.	0.0% (0)	0.0% (0)	8.3% (3)	44.4% (16)	47.2% (17)	0.0%	91.6%	1	4	Overall Consensus (R2)
Authenticity contributes to a good supervisory relationship.	0.0% (0)	0.0% (0)	2.8% (1)	47.2% (17)	50% (18)	0.0%	97.2%	1	4.5	Overall Consensus (R2)
Mutual respect between supervisor and supervisee contributes to a good supervisory relationship.	0.0% (0)	0.0% (0)	0.0% (0)	52.8% (19)	47.2% (17)	0.0%	100%	1	4	Overall Consensus (R2)
Mutual feedback contributes to a good supervisory relationship.	0.0% (0)	0.0% (0)	8.3% (3)	47.2% (17)	44.4% (16)	0.0%	91.7%	1	4	Overall Consensus (R2)
It is important to encourage clinicians to bring cases to supervision even if they feel ill prepared.	0.0% (0)	0.0% (0)	8.3% (3)	38.9% (14)	52.8% (19)	0.0%	91.7%	1	5	Overall Consensus (R2)
It would be helpful for supervisors to be open about their own experiences.	0.0% (0)	2.8% (1)	8.3% (3)	52.8% (19)	36.1% (13)	2.8%	88.9%	1	4	Overall Consensus (R2)
A trusting supervisory relationship facilitates supervisees in feeling more confident in raising difficult issues in supervision.	0.0% (0)	0.0% (0)	2.8%	47.2% (17)	50% (18)	0.0%	97.2%	1	4.5	Overall Consensus (R2)
Skype, or telephone supervision can increase access to supervision.	0.0% (0)	2.8% (1)	16.7% (6)	44.4% (16)	36.1% (13)	2.8%	80.5%	1	4	Overall Consensus (R2)
Discussions around both the supervisee's and supervisor's need and expectations of supervision can help overcome barriers.	0.0% (0)	0.0% (0)	5.6% (2)	58.3% (21)	36.1% (13)	0.0%	94.4%	1	4	Overall Consensus (R2)

Notes. Round 2: N = 36.

Appendix P: Round One Questions

1. What helps contribute to a good therapeutic relationship with individuals with Anorexia Nervosa?
2. What impact do you think a good therapeutic relationship has on an individual with Anorexia Nervosa?
3. What are the important similarities/differences in building a good therapeutic relationship with this population vs other populations that you have worked with?
4. What do you consider to be the main barriers to developing a good therapeutic relationship with individuals with Anorexia Nervosa? (You may want to consider external/internal barriers and client/system/therapist factors).
5. How do you overcome the barriers that you have described? (What do you do? What techniques do you use? What factors facilitate this?)
6. Thinking about your own clinical experiences of providing therapy to individuals with Anorexia Nervosa what factors have the most significant impact on you during sessions and following sessions?
7. In your opinion should the impact on the therapist of working with a particular client be used to inform their clinical formulation, and if so, how? (What would the potential benefits include?)
8. Reflecting back on your answers for so far, how does building a therapeutic relationship with an individual with Anorexia Nervosa affect you, the clinician?
9. What issues/areas would need to be covered in order for supervision to be useful when working with individuals with Anorexia Nervosa? (You may wish to consider things that you see as important but might feel uncomfortable raising).
10. What impact does good supervision have on you and on your therapeutic work?
11. How does the length of time you have worked therapeutically with this population influence your need for supervision, and what topics are discussed?
12. What do you consider to be the main barriers to developing a good supervisory relationship?
13. How do you as supervisor/supervisee overcome these barriers?
14. If a person with Anorexia Nervosa could observe your supervision/supervisory relationship what do you think they would want to change or add?

Notes. Questions 1-5 sought to explore an additional research question relating to the characteristics of the therapeutic relationship when working with individuals with Anorexia Nervosa. Responses were collated, and qualitatively analysed. Due to space limitations, and

feasibility relating to the size of subsequent questionnaire rounds, it was decided that it should form a separate research study. With permission of Salomon's Clinical Research Director, this study is not discussed here, but will be submitted separately for publication.

Appendix Q: Examples of Data Extracts, Codes and Statements

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APPENDICES OF SUPPORTING MATERIAL

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Appendix R: End of Study Notification Letter to Ethics Panel

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Appendix S: End of Study Report for Participants

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Appendix T: International Journal of Eating Disorders, Author Guidelines

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