WOMEN'S PERSPECTIVES ON WHAT HELPED AND HINDERED BUILDING SHAME RESILIENCE DURING AN ADOLESCENT EATING DISORDER

by

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ABSTRACT

Eating disorders (EDs) in adolescence are serious mental health disorders that commonly have noteworthy medical and mental health comorbidities (Fitzsimmons-Craft, Karam, Wilfley, 2018). Shame has been found to be a significant factor associated with EDs (Burney & Irwin, 2000; Goss & Allan, 2009; Waller, Ohanian, Meyer & Osman, 2000), yet no studies have explored what helps and hinders building shame resilience during adolescence from the perspective of the adult who lived through it. Shame resilience can be defined as moving through shame in a constructive way that allows one to grow from one's experiences (Brown 2006; Dayal, Weaver, & Domene, 2015). This retrospective qualitative study used the enhanced critical incident technique (Butterfield, Borgen, Maglio, & Amundson, 2009), where participants were asked to recall: (a) incidents that helped build shame resilience, (b) incidents that hindered building shame resilience, and (c) what they wished for that they think may have helped them build shame resilience. The sample of this study included women who received an ED diagnosis between the age of 11 and 21 ($N = 10$). Data analysis revealed 13 helping categories, 15 hindering categories, and 9 wish list items. Clinical implications and recommendations for future research are discussed.

Keywords: shame, shame-resilience, eating disorders, adolescence

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CHAPTER 1: INTRODUCTION

Eating disorders (EDs) are complex and serious illnesses that are difficult to treat (Halmi, 2013). They are associated with high mortality rates, medical and mental health comorbidities, and poor quality of life (Fitzsimmons-Craft, Karam, & Wilfley, 2018; Herpertz-Dahlman, 2009). Most EDs develop around adolescence to young adulthood, which poses further distinct risks to health (American Psychiatric Association [APA], 2013). Particularly, malnourishment has a noteworthy impact on important aspects of development such as the reproductive system and bone mass (Fitzsimmons-Craft et al., 2018).

Researchers and practitioners have progressively sought to better understand the biological, psychological, and social underpinnings of EDs that develop during adolescence (Latzer & Stein, 2016; Munro, Randell, & Lawrie, 2017). One of the salient but perhaps under researched areas is the interpersonal and intrapersonal experiences of shame for individuals diagnosed with EDs (Goss & Allan, 2009). The study of shame and EDs is important because the experience of shame appears to be integral to the psychological suffering associated with EDs (Duffy & Henkel, 2016) as well as a central feature of the maintenance of eating-related symptoms (Gois, Ferreira, & Mendes, 2018).

Shame can be defined as, "an intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging" (Brown, 2006). Shame is associated with ED behaviours and symptoms, and can be a significant barrier to treatment (Ali et al., 2016; Duffy & Henkel, 2016). In one study, shame associated with eating behaviours was the strongest predictor of the severity of ED symptoms (Burney & Irwin, 2000).

From a cognitive perspective, shame has been found to be a key aspect of core beliefs that are associated with some ED symptoms (e.g., bingeing and vomiting). For example, Waller et al. (2000) conducted a study that identified that core belief of shame predicted frequency of vomiting. In addition, in 2014, Kelly, Carter, and Borairi found that reductions in shame throughout the ED treatment have been associated with better outcomes. Specifically, these authors found that decreased levels of shame in the first 4-weeks of treatment predicted decreases in ED symptoms over a 12-week treatment period (Kelly, Carter, & Borairi, 2014). Further research has also shown that decreasing levels of shame has been found to improve treatment compliance, efficacy, and outcomes (Ali et al., 2016; Duffy & Henkel, 2016). In sum, research suggests that decreases in shame tend to correspond with improvements in ED symptoms.

In spite of the important role of shame in the onset, maintenance, and treatment of EDs, much remains to be known about this experience. For example, in light of how decreases in shame correspond to improvements in ED symptoms, more information is needed about constructively moving through shame during an ED. In particular, the current research literature has not yet addressed understanding how shame associated with an ED was dealt with during adolescence from the perspective of those who lived through it.

Although shame is recognized by most researchers as a universal and essential human emotion (Gilbert, 1998; Trindade et al., 2017), only a relatively small body of research has explored shame reparation and resilience (Alvarez, 2019; Brown, 2006; Dayal et al., 2015; Schill & Hayton, 2019). For the purposes of this study, Brown's (2006) shame resilience theory (SRT) will be used as a framework for understanding how individuals constructively move through shame. In particular, SRT (Brown, 2006) explicitly addresses the development of shame resilience. SRT proposes that shame is experienced in multiple contexts (e.g., body image, family, mental and physical health) and defines shame resilience as moving through shame in a constructive way that allows one to grow from one’s experiences (Brown, 2006; Dayal et al., 2015).

Although SRT represents a promising theoretical and practical framework for understanding how to constructively deal with shame, shame resilience research has rarely focused on EDs (Dayal et al., 2015). There have been no studies to date that explore what helps and hinders developing shame resilience, let alone investigated the development of shame resilience in adolescents diagnosed with EDs.

Given the physical, emotional, and psychological burden of trying to overcome an ED, studying this area remains to be a challenge. Methodological challenges also arise when considering interviewing adolescents during the height of a serious medical and mental health disorder such as an ED. One way to address this research problem is to attempt to understand how shame associated with an ED was dealt with from the perspective of adults who lived through it.

Adult perspectives on their adolescent experience of having an ED have not been explored thoroughly in the studies on adolescent EDs (Cella, & Cotrufo, 2016; Herpertz-Dahlmann, 2009; Iannaccone, D'Olimpio,; Jackson & Chen, 2014; Russell, 2013). Accordingly, an enhanced understanding from the perspective of an adult who has lived through an ED of what helps and hinders developing shame resilience will be helpful on many levels. Using a qualitative research design and the ECIT method, the present study aimed to examine what helped and hindered developing ED-related shame resilience during adolescence from an adult perspective.

CHAPTER 2: LITERATURE REVIEW

This chapter will present a review of the pertinent literature in the area of adolescent EDs, shame, and shame resilience, followed by the rationale, purpose, and research question of the proposed study. This chapter begins by reviewing the main features of EDs in adolescents, including diagnostic criteria, prevalence, and current empirically-supported treatment modalities. A review of the literature regarding shame, shame resilience, and their connection to EDs will follow, highlighting specific conceptualizations of relevance. Studies relevant to the area of shame, shame resilience, and EDs will be integrated and reviewed. The end of the chapter will include an overview of the current project, its purpose and research question.

Features of Eating Disorders in Adolescence

Research has indicated that the onset of most EDs occurs in middle to late adolescence (Micali, Hagberg, Peterson, & Treasure, 2013; Stice, Marti, & Rhode, 2013). Clinical criteria and symptoms found in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; APA, 2013) primarily reflect this reality. This section will provide a summary of the descriptions, prevalence, and epidemiology of EDs with the aim of offering a comprehensive picture of the reality of EDs in adolescence and the current options for treatment. The DSM-5 describes seven different types of EDs: anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), pica, rumination disorder, avoidant/restrictive food intake disorder, and other specified feeding or eating disorder (APA, 2013). Unspecified feeding or eating disorder is also listed in the DSM-5. For the purposes of this study, AN, BN, and BED are reviewed and focused on, as they are the most common EDs found in adolescence (Government of Canada, 2006; Smink, van Hoeken, Oldehinkel, & Hoek, 2014).

Nosological descriptions. This section will review the main symptoms**,** diagnostic criteria, and other pertinent information of AN, BN, and BED, and will also include transdiagnostic considerations. This information is pertinent as it helps provide a foundational understanding of EDs while also situating the significance of EDs in adolescence within the broader context of eating related issues and disorders.

Anorexia nervosa. AN has been included as a form of mental disorder since the publication of the first DSM in 1952 (Keel, 2018). The DSM-5 includes three core features of AN: significantly low body weight, intense fear of gaining weight and/or engaging in behaviours that interfere with weight gain, and disturbance of how one's weight or shape is experienced (APA, 2013). Body image disturbance may be experienced by an individual with AN as (a) misperception of the body or parts of the body as being overweight despite being underweight; (b) the undue influence of weight or shape on self-evaluation; or (c) lack of recognition of the medical danger associated with their low weight (Keel, 2018).

There are two subtypes of AN: restricting and binge-eating/ purging. The binge-eating/purging type involves an individual engaging in episodes of binge eating or purging behaviours, whereas the restricting type does not. Adolescents with AN often exhibit extreme weight loss or increased height growth without the complementary weight gain (Fitzsimmons-Craft et al., 2018). Body mass index, a measure of body fat identified through comparing one's height and weight, is often used to determine whether body weight is significantly low in comparison to the minimum expected BMI given the child or adolescents age, sex, and health (Fitzsimmons-Craft et al., 2018).

Risk of premature death is associated with AN (Keel, 2018; Keel & Brown, 2010), and the impact of AN on the sufferers' immediate and long-term physical health is particularly detrimental. This is especially because the usual onset of the disorder is during the maturation phase of development, adolescence, when malnourishment has a noteworthy impact on important aspects of health such as the reproductive system, the endocrine system, and bone mass (APA, 2013).

Bulimia nervosa. Fundamental to BN are binge-eating behaviours with compensatory behaviours (APA, 2013; Keel, 2018). Binge eating is characterized by eating large amounts of food in a discrete period of time coupled with a sense of loss of control over one's eating and distress (Burton & Abbott, 2017). Loss of control is defined as the inability to refrain from eating or to stop eating once starting (Fitzsimmons-Craft et al., 2018). Compensatory behaviours can include self-induced vomiting, the use of laxatives or diuretics, fasting, or over- exercising. Similar to AN, individuals with BN often experience body image distortions and disturbances of their perceived body shape (Crowthers & Williams, 2011). Unlike AN, individuals with BN may be normal weight or overweight (APA, 2013). BN is differentiated from the binge-purge subtype of AN, as individuals with BN maintain a minimally normal weight (Keel, 2018). This is an important distinction, as it is a reminder that not all adolescents who have an ED also have low body weight. In fact, in recent years, the percentage of individuals with BN who are overweight or obese has increased (Fitzsimmons-Craft et al., 2018).

Binge eating disorder. The DSM-5 describes BED as recurrent episodes of binge eating that occur at least once per week on average for at least 3 months (APA, 2013). In addition, the binge eating must cause marked distress and include three or more of the following five features listed in the DSM-5: eating much more rapidly than normal, eating until feeling uncomfortably full, eating large amounts of food when not feeling physically hungry, eating alone because of feeling embarrassed by how much one is eating, and feeling disgusted with oneself, depressed, or very guilty afterward (APA, 2013). The guidelines for determining what qualifies as a binge are the same as for BN. A key distinction between BN and BED is that BED does not involve compensatory behaviours (APA, 2013). While binge eating occurs along a continuum from normal to disordered eating and is even present in some capacities among the general community (Burton & Abbott, 2017), to be diagnosed with BED, the person must meet the requirements listed above regarding frequency and duration.

Transdiagnostic considerations. Research has often focused on specific disorders in isolation, which can be critiqued as it makes it difficult to identify psychological processes or factors that occur across many disorders (Insel, 2014). A transdiagnostic approach can be of benefit within ED research, as previous research has observed that the processes that maintain ED psychopathology are largely the same across different ED diagnoses (Fairburn et al., 2015). Clarifying the transdiagnostic understanding of EDs is important, as it provides a framework to recognize the shared clinical features of multiple ED and to identify the central cognitive disturbances.

Fairburn, Cooper, and Shafran (2003) propose that a network of, "inter-related maintaining mechanisms," account for the persistence of multiple EDs (p. 522). Among this network, a central cognitive disturbance among EDs is characterized by the over-evaluation of eating, shape, and weight and their control (Fairburn, Cooper, & Shafran, 2003). The same set of underlying dysfunctional self-worth beliefs, which Fairburn, Cooper, and Shafran (2003) refer to as, "core psychopathology," are proposed to be present in most individuals suffering from an ED. Specific key constructs, including perfectionism (Rodriguez Cano, Beato Fernandez, Mata Saenz, Rojo Moreno, Vaz Leal, 2016), low self-esteem, mood intolerance, and interpersonal difficulties (Fairburn, Cooper, & Shafran, 2003) have been identified as transdiagnostic elements as well.

Transdiagnostic Epidemiology

The following section will consider the DSM-5 eating disorders from the perspective of the transdiagnostic model. An overview of key information related to onset, prevalence and sex will be discussed as well as evidence-based treatment options for these conditions.

Onset. While the onset of EDs can vary, research has shown that typically the peak of onset tends to be in middle to late adolescence. According to the APA (2013), AN usually develops during middle to late adolescence (14-18 years). Studies have identified slight variation between peak ages of onset for AN, as some studies have found the peak age to be between 15 and 19 years (Micali et al., 2013), and others have found it to be 19 to 20 years (Stice et al., 2013). Early onset cases such as development before the age of 14 have also been found (Russell, 2013); however, they tend to be rather sporadic than normative.

BED and BN usually develop in late adolescence to early adulthood (between 18-20 years; Stice et al., 2013). The APA (2013) reports that early onset before puberty is uncommon for BN, and the course may be chronic or intermittent. An intermittent course means that the symptoms are not consistent or continuous, and therefore may occur at irregular intervals.

Incidence Rates & Prevalence. In recent decades, the prevalence and incidence rate of EDs in children and adolescents has increased significantly (Rosen, 2010). Regarding prevalence, research studies have indicated that AN and BED are the most common EDs among adolescents (Smink et al., 2014). In Canada, a 2002 survey indicated that 1.5% of women aged 15-24 had an ED, with AN and BN being the most common EDs among adolescent girls and young women (Government of Canada, 2006). Another study in 2013 found that the lifetime prevalence by age 20 ranged from 0.8% for AN to 4.4% for subthreshold BN (Stice, Marti, & Rohde, 2013). Subthreshold BN was defined by at least two uncontrollable binge-eating episodes per month for at least 3 months, at least two compensatory behavior episodes per month for at least 3 months, and having weight and shape as one of the main aspects of self-evaluation (Stice, Marti, & Rohde, 2013).

Incidence data, also known as the number of newly diagnosed cases, suggests that there has been an increase in incidence rates for the group of 15-19 year old girls (Smink et al., 2014). In a longitudinal study, incidence of AN for girls between 15 to 19 years was found to be 270 per 100,000 (0.27%) and for BN 300 per 100,000 (0.30%) for ages 16 to 20 years was found (Keski-Rahkonen et al., 2007).

When the DSM-5 was published, there were important changes in ED diagnostic criteria compared to the DSM-IV (Fitzsimmons-Craft et al., 2018). These changes are worth noting because it means that there is limited information available on the incidence of EDs in adolescence and young adulthood using the new DSM-5 criteria due to this change. For example, there are important differences relating to menses and weight for AN, and since BED is now recognized as a DSM-5 ED the rates listed in previous research may look different today.

Sex differences. In many ways EDs are a gendered phenomenon (Levine & Piran, 2004), as research has suggested that females account for approximately 90% of AN and BN diagnoses (Keel, 2016). Some researchers have concluded that sex should be considered a risk factor considering the high prevalence of EDs in girls (Jacobi, Hayward, de Zwaan, Kraemer, & Agras, 2004). It is common for studies to have samples that are primarily composed of females due to this high prevalence rate. While it is apparent that the prevalence of EDs is higher in females than it is in males, it is important to note that there is a body of research that has shown that there may be more males suffering from EDs than many would think. Collier (2013) advocates that up to 25% of individuals suffering from EDs are male, with rates being even higher when considering BED specifically.

Course and recovery. The course of AN is variable as some individuals experience recovery after one episode while other individuals experience periods of recovery and relapse or a chronic course (Fitzsimmons-Craft et al., 2018). A review by Steinhausen (2002) indicates that less than half (46%) of individuals with AN fully recover. Similarly to the rate of recovery for AN, a review indicated that less than half (45%) of individuals with BN exhibit full recovery (Steinhausen & Weber, 2009).

A study on the course of BN and BED found that the outcome of BN was, "relatively poor," however the outcome of BED was more favourable (Fairburn, Cooper, Doll, Norman, & O'Connor, 2000, p. 659). Research suggested that most individuals with BN are not receiving treatment, and those who do seek treatment have more severe symptoms and worse social adjustment (Fairburn et al., 2000). After a 5 year follow up for individuals with BN within this study, only 15% continued to meet diagnostic criteria for BN, however, up to two thirds had an ED of clinical severity. In comparison to BN, BED results found that in young women only 18% of individuals had an ED of clinical severity at their follow up after five years, and only 10% continued to meet diagnostic criteria for BED (Fairburn et al., 2000). After data collection at five year and twenty year follow ups, remission rates are not significantly different between BN and BED, as they are reported to be approximately 75% (Keel & Brown, 2010). The difference between some of the statistics that are recorded may have to do with the definitions of remission and recovery within each project.

Mortality rates. AN has a mortality rate of approximately 5% to 6% (Steinhausen, 2002), however, some studies suggest that 10% of individuals diagnosed with AN will die within the first 10 years of their diagnosis (Sullivan, 2002). Data suggests that mortality from BN is rare (Herzog et al., 2000), with some studies estimating that it is around 2% (Fichter & Quadflieg, 2004). The risk of suicide and suicide attempts is higher for BN (Herpertz-Dahlmann, 2009).

Etiology and risk factors. It is a common misconception of the public that EDs are the direct result of the following factors: psychological/emotional problems, media/culture ideals, or traumatic life events (Blodgett Salafia, Jones, Haugen, & Schaefer, 2015). Contrary to these perceptions, no one factor or specific group of factors can be named as the primary cause of EDs, and the etiology of EDs is multifaceted. A study that sought to review the research evidence regarding causes of EDs concluded that "reviewing the literature on EDs leaves us with many questions about how these disorders develop" (Polivy & Herman, 2002, p. 204). Polivy and Herman (2002) also commented that many studies have studied correlates of EDs "often in the vague hope that correlates can be persuasively argued into causes," (p. 190).

Biological, psychological, and social factors are jointly involved in the etiology of EDs (Fitzsimmons-Craft et al., 2018), which some refer to as the biopsychosocial framework of understanding the etiology of EDs (Polivy & Herman, 2002). The biopsychosocial framework acknowledges sociocultural dynamics such as media and cultural ideals, as well as familial influences and dynamics. Individual factors such as personality, cognition, and physiology are also addressed within the biopsychosocial framework (Polivy & Herman, 2002). Using this framework, risk factors can also be identified in each area (biological, psychological, and social). These include but are not limited to history of dieting, perfectionism, body image dissatisfaction, weight stigma, and bullying.

Transdiagnostic risk factors can be identified, as well as risk factors for different EDs independently (e.g. AN specific). Stice et al. (2017) identified that impaired interpersonal functioning and negative affect were transdiagnostic risk factors. A review of multiple prevention trials and annual diagnostic interview data found that thin-ideal internalization, positive expectancies for thinness, body dissatisfaction, dieting, overeating, and mental health care were predictors and risk factors for BN and BED (Stice, Gau, Rohde, & Shaw, 2017). Low BMI and dieting were factors that predicted onset of AN (Stice et al., 2017)..

In reviewing other research on risk factors and EDs in adolescence, a study on the prevalence and course of the EDs found within the DSM concluded that developmental experiences that commonly occur in late adolescence may increase risk for eating pathology because the findings indicate that most eating pathology tends to emerge in that time period (Strice, Marti, & Rohde, 2013). An example of a developmental experience that they referred to includes heightened importance placed on conforming to the thin ideal brought about by more time spent with peers and dating partners (Strice et al., 2013). Perceived appearance-based social pressure (from parents, peers, and/or mass media) has been identified as a predictor to increases in body dissatisfaction and eating pathology in multiple studies, and can therefore also be viewed as a risk factor (Jackson & Chen, 2014). Multiple reviews have also concluded that weight and body dissatisfaction are reliable risk factors for eating pathology (Jackson & Chen, 2014).

In summary, the causes of EDs are still not fully understood. While various risk factors can be identified, no one main cause or factor can be attributed to why EDs develop. However, some risk factors (e.g., shame) seem to play a significant role and show up in transdiagnostic research studies (Burney & Irwin, 2000; Duffy & Henkel, 2016; Kelly et al., 2014).

Models of treatment. Given the high morbidity, mortality and relapse rates in adolescents diagnosed with EDs, early intervention and prevention are essential (Fitzsimmons-Craft et al., 2018). There are currently multiple different approaches to treat children and adolescents with EDs (Fitzsimmons-Craft et al., 2018). However, there is no one treatment approach that has been identified as the one clear empirically supported choice for all individuals with an ED (Walsh, Attia, Glasofer, & Sysko, 2016). Some of the most prominent treatment models for adolescents with EDs are cognitive bhavioural therapy (CBT) and family based therapy (FBT) (Fitzsimmons-Craft et al., 2018; Fitzsimmons-Craft & Wilfley, 2019). Emotion focused family therapy (EFFT) is also regarded as a promising treatment model for EDs (Strahan et al., 2017) and is becoming more prevalent.

The CBT approach is arguably the treatment method with the strongest research base, but it is not without critique: some researchers and practitioners have raised concerns about its relative inattention to the emotional experience of the client, which would include experiences of shame (Williams, Tsivos, Brown, Whitelock, and Sampson, 2017). FBT, another prominent treatment approach for some EDs involves the family and health care professionals, but like CBT it tends to deemphasize emotional processing. EFFT, a relatively new treatment modality emphasizes emotion processing and emotion regulation and has been adopted by many FBT treatment providers. The development and reception of EFFT by researchers and practitioners is encouraging, especially insofar as it recognizes "emotion is a powerful healing tool in families struggling with an eating disorder," (Robinson et al., 2015, p. 75).

Conclusion. Existing literature has illustrated the importance of studying EDs in adolescence as: (a) the peak age of onset tends to be in middle to late adolescence (Micali et al., 2013; Stice et al., 2013); (b) the prevalence and incident rate of EDs in adolescence has increased significantly (Rosen, 2010); and (c) reported recovery rates are overwhelmingly low (Steinhausen & Weber, 2009). The causes for EDs are still not fully understood, and the biopsychosocial framework of understanding EDs is crucial (Polivy & Herman, 2002). While evidence based treatment methods for adolescent EDs exist, researchers like Robinson et al. (2015) suggest that further research and focus on emotions and emotional processing for adolescent EDs is warranted.

Theoretical Frameworks for Understanding Shame

Several research studies have indicated the role that shame has in EDs (Burney & Irwin, 2000; Goss & Allan, 2009; & Waller, Ohanian, Meyer and Osman, 2000). This section will look more closely at how shame is understood in current research, as shame is an emotion or experience that has been defined from many different perspectives and understandings. Specifically, this section will explore different definitions and theories of shame that researchers have proposed and clarify specific ways shame and EDs are connected in the research. Shame will be differentiated from guilt, and shame will be explored from the following perspectives: social and relational, functional, evaluative process, emotion focused, and psycho-social-cultural.

Shame versus guilt. An important distinction to make initially is that for the purposes of this study there will be a clear differentiation from the constructs of guilt and shame. Brown (2006) refers to guilt as being a feeling that results from behaving in a flawed or bad way, where as shame is a feeling that results from feeling as though the self is flawed or bad. Consistent with this understanding, this study will focus on experiences of shame as they relate to feelings about the self rather than to a behaviour. Ungvarsky (2019) explains shame as something that is experienced as an "all-encompassing failure" which can be the result of unintentional actions or no action at all (p. 1), as opposed to a single incident or behavioural failure.

Shame as a social and relational emotion. The social and relational model views shame as a social emotion (Ungvarsky, 2017), meaning that it is experienced in relation to other people. Although some believe that shame is created by not meeting personal expectations or standards, Leary (2015) states that shame is more of a social and relational emotion, rather than merely being a reaction to violating personal standards. Under this conceptualization, shame arises in situations that have potential implications for people's relational value to other people (Leary, 2015).

The evaluative process model of shame. In 1971, Lewis published an article that conceptualized shame as an emotion that could be experienced in both public and private spheres. This was significant for shame research, as before this shame was only conceptualized as an emotion that occurred due to public humiliation or condemnation. Along this line of research, Gilbert (1998) and Goss and Allen (2009) proposed a perspective on shame focusing on the two main evaluative processes that occur in shame. The two processes are: (a) what I think others think about me; and (b) what I think about myself. The first process, what I think others think about me, can be referred to as external shame. External shame is focused on the way others perceive the self, worries that others will believe or see the self as flawed or inadequate (Goss & Allan, 2009). Internal shame regards the inner experiences, self-evaluations, and sense of self (Goss & Allan, 2009). Internal shame is often associated with self-criticism or self-hatred. High significant correlations are found between measures of internal and external shame, and therefore often they are not differentiated between in some literature.

Functional perspective on shame. The functional perspective argues that shame can serve a person adaptively or maladaptively, depending on the situation, duration, and intensity (Dempsey, 2017). A premise underlying this argument is that shame is not only an experience felt by an individual, but also an experience that often leads to actions. Shame is regarded as a prewired emotion that enhances the survival of the species from a psycho-evolutionary perspective (Van Vliet, 2008). Often the discomfort caused by shame can be a motivation, and this motivation can serve individuals in either a positive or a negative way (Ungvarsky, 2017). In general, shame action tendencies can focus on “expressions of inadequacy, defectiveness, wishing to hide or escape, wanting to save face,” (Dempsey, 2017, p.2). This means that the behaviours behind shame are often made with a focus of wanting to hide, protect themselves, or in response to an expression of inadequacy. If shame is present, and one of its prominent action tendency is to want to hide or escape, it makes sense that this would be a barrier in treatment.

Shame can potentially be adaptive when it helps to shape behaviour in a way that conforms with social norms. Behaviour change in this way can in many ways be viewed as giving individuals a higher chance of feeling accepted in a certain society or cultural group. From an evolutionary point of view, shame was adaptive in some scenarios in the sense that it motivated individuals to engage in prosocial responses (Dempsey, 2017).

Even though shame can cause prosocial responses such as modifying behaviour to fit in, it can also cause self-protective responses such as hiding (Dempsey, 2017). Some degree of shame is useful in helping to shape human behaviours to conform to expected norms, but excessive or unwarranted shame can have a detrimental effect on a person's mental and physical health (Ungvarsky, 2017). Shame may become maladaptive when it leads to maladaptive strategies to change perceived attributes of the self, disordered eating in response to body dissatisfaction or body shame (Gilbert & Miles, 2002).

Emotion focused model of shame. Goldman and Greenberg (2015) state that shame is not adaptive, but instead mainly a core maladaptive emotion that results in “increasing difficulties as the individual attempts to navigate life’s emotionally evocative events and developmental challenges.” (p. 24). However, Goldman and Greenberg (2015) do agree that there is a functional element of shame, stating that the maladaptive emotion schemes function to manage difficult feelings. Greenberg (2002) states that there is a difference between shame that makes a person feel that they are “defective to the core” and healthy guilt about making a mistake.

Psycho-social-cultural understanding of shame. Brown (2006) refers to shame as a psycho-social-cultural construct. This understanding was born out of a grounded theory research study, which asked over 200 women to describe their experiences of shame (Brown, 2006). This understanding of shame will be the one that is focused on throughout this study. While many definitions or understandings of shame focus on one of the three factors listed (psychological, social, or cultural), Brown (2006) found that individuals were not able to consider shame exclusively psychological, social, or cultural. Instead, shame represented an interplay between these three factors. The psychological aspect refers to the emphasis on emotions, thoughts, and behaviours of self. The social component refers to the interpersonal dynamic and how shame is often tied to relationships and connection. The cultural component refers to the prevalent role of cultural expectations and how individuals experience shame when there is a real or believed failure to meet a culturally sanctioned expectation.

Summary. Across all frameworks , shame is understood to be a powerful emotion (Goss & Allan, 2009). Indeed, Scheff (2003) has called shame the “master emotion of everyday life,” (p.1). Many theoretical models of shame have been developed, and collectively these have helped to establish shame as a legitimate focus of research and clinical attention across many clinical concerns, including eating disorders.

Shame and Eating Disorders

Two decades worth of research has established shame as a significant factor in EDs (Burney & Irwin, 2000; Duffy & Henkel, 2016; Kelly et al., 2014). Shame can be found in higher levels among patients with EDs, and shame is also a predictor of ED development (Duffy & Henkel, 2016). Further, shame is considered by many to be a central phenomenon in the onset and maintenance of EDs (Goss & Gilbert, 2002). In the context of an ED, shame may be experienced in a multitude of ways, such as in regard to the body and appearance or in connection with one's self-control or lack thereof (Skårderud, 2007).

Shame and eating disorder onset and maintenance. EDs have a profoundly relational dimensions and meanings (Bryant-Waugh, Markham, Kreipe, & Walsh, 2010). The idea of EDs being relational emphasizes that the context in which the individual lives is crucial. Research on early emotional experiences and disordered eating highlight that dominant culture, including family members and peers' ideals and values, can provide young people with either body-accepting or body-shaming experiences (Gois, Ferreira, & Mendes, 2018). For example, research suggests that parental attitudes and behaviours have a significant impact on how children and adolescents experience their body as acceptable or unacceptable (Gilbert & Miles, 2002).

Moreover, research studies have found that shame has a significant impact on body image and eating difficulties in general (Gois, Ferreira, & Mendes, 2018). Specifically, shame is both a risk factor and a predictor of body image and eating-related psychopathology (Gois, Ferreira, & Mendes, 2018). Research findings suggest that there is a self-perpetuating cycle between shame and disordered eating (Duffy & Henkel, 2016; Goss & Allan, 2009; Goss & Gilbert, 2002; Skårderud, 2007). This may be because as individuals struggling with EDs restrict food intake or purge to alleviate feelings of shame, yet these disordered eating behaviours enhance shame (Goss

& Allan, 2009). One study on the experience of having an ED (specifically AN) highlights the dual role and cyclical nature of an ED as both a problem and a solution (Rance, Clarke, Moller, & 2017). An ED can be both a problem and solution in the sense that an ED can be, "a form of distress that make its suffers feel both better and worse," (Rance et al., p. 133). This is consistent with Goss & Gilbert's (2002) theory that shame is a part of a cycle that helps maintain the ED, as the ED may lead to shame, and the shame may be coped with using ED behaviours.

Shame as treatment barrier in eating disorder treatment. While certain treatment methods such as CBT or FBT for EDs have garnered significant empirical support (Fitzsimmons-Craft & Wilfley, 2019), barriers to treatment still exist, with shame being an important factor to consider (Duffy & Henkel, 2016). Shame is seen to impact the likelihood to (a) seek help; (b) engage in the therapeutic process, and (c) enter or stay in remission (Duffy & Henkel, 2016). Regarding the likelihood to seek help, Duffy and Henkel (2016) confirm that high levels of shame reduce likelihood of treatment seeking, and it is also thought that shame represents one of the most prominent barriers to help-seeking and treatment compliance (Ali et al., 2016). Secondly, while in treatment, shame reduces the likelihood of disclosing behaviours regarding eating pathology, which is deemed as a necessary part of therapy (Skårderud, 2007). In addition, treatment compliance may also be affected by shame. Thirdly, shame also serves as a risk factor for relapse. Without examining the role of shame in EDs, a central feature to the onset and maintenance of the disorder would be overlooked. Due to all of this information, there is a high need for research that looks specifically at EDs and the phenomenon of shame.

Overcoming Maladaptive Shame

Current models for overcoming shame. Dearing (2011) has identified four different theoretical approaches to overcoming shame, namely: EFT (Greenberg & Iwakabe, 2011), a functional analytic approach (Koerner, Tsai, & Simpson, 2011), compassion focused therapy (CFT; Gilbert, 2011), and shame resilience theory (SRT; Brown, 2006). While SRT is not a type of therapy for overcoming maladaptive shame, it is a theory of overcoming shame that has many inherent clinical implications. Similar to the other therapies listed, it outlines principles of working with shame and ways in which shame can be reduced.

Emotion-focused therapy. EFT outlines four main principles for working with shame: relational validation, accessing and acknowledging shame, regulating shame, and transforming shame (Greenberg & Iwakabe, 2011). Accordingly, the EFT model suggests that once relational safety is established, "the focus shifts to accessing shame, overcoming the avoidance of shame, symbolizing it, and allowing the painful feelings of shame to be experienced" (Greenberg & Iwakabe, 2011, p. 73). Following this, regulation is focused on within counselling sessions, with the main goal of transforming shame by exposing shame to other emotions.

Functional analytic approach. Functional analysis involves, "understanding behaviour in terms of its antecedents and consequences and ties directly to principle-based intervention," (Koerner et al., 2011, p. 91). Consideration for how how the emotion of shame may have developed as a rapid response system, and how it may be helpful or unhelpful in different contexts, is key within this framework of overcoming shame. The therapist within this model helps the client focus on relevant behaviours and create conditions that reinforce positive changes (Koerner et al., 2011).

Compassion focused therapy. CFT was developed for individuals with high levels of shame and self-criticism (Gilbert, 2000). Gilbert (2011) states that, "compassion, with its focus on acceptance, understanding, and affiliation, can be a powerful antidote to the alienating experiences of shame," (p. 339). A main premise of CFT is that if individuals learn to be self-accepting, kind, and self-soothing it will help them deal with various difficulties in life (Gilbert, 2011). Specific aspects of CFT involve compassionate mind training, which entails specific exercises and interventions used in therapy with a goal of developing self-compassion and experiencing compassion. Compassionate reasoning and thinking is also focused on, as it involves various cognitive skills (Gilbert, 2011).

Shame resilience theory. Shame resilience theory (SRT; Brown, 2006) addresses the process of shame resilience, often referred to as the process of overcoming shame. As mentioned previously, while SRT is not a therapy per say, it includes an understanding of how to work through shame. Whereas shame can be either adaptive or maladaptive (Dempsey, 2017), shame resilience represents an adaptive response to shame (Dayal, et al., 2015). The term shame resilience can be defined as moving through shame in a constructive way (Brown, 2006; Dayal et al., 2015). It is important to note that shame resilience does not mean the elimination or suppression of shame. Instead, it means an adaptive response to shame including being able to tolerate, attend to, and move through shame. Even Greenberg and Goldman (2019) who label shame as primarily maladaptive state that for emotional distress like shame to be "cured," one must access the emotion and experience it.

Resilience theory in general states that humans are seen as "active agents who maximize their use of available resources to rebound from major life stressors," (VanVliet, 2009, p. 242). The focus of resilience research is therefore on understanding the processes that help individuals "bounce back from severe life stressors," (Van Vliet, 2008, p. 234). A metaphor to describe resilience is that adversity causes pieces of one's world to fall apart but resilience allows those pieces to be integrated with new ones to form a new equilibrium (Richardson, 2002; VanVliet, 2009). Shame resilience in this sense recognizes that shame and EDs are an adversity that requires "bouncing back" from, and requires a way for new pieces of information to be integrated to form a new equilibrium. Shame resilience is based on the principle that by responding to shame in an adaptive way, which will be explained next, feelings of shame will be improved (Dayal et al., 2015).

SRT proposes that individuals need to recognize shame and move through it in a way that allows for authenticity and growth (Brown, 2006; Brown, 2004). Research on addressing shame in clients with EDs are aimed at increasing connection with others (Keith, Gillanders, & Simpson, 2009), which is consistent with Brown's (2006) research that promotes reaching out to others because connection is crucial. Van Vliet's (2008) research on resilience also aligns with underlying principles that social connection is crucial to overcoming shame, identifying that there are five main processes of rebuilding and resilience that include: (a) connecting, (b) refocusing, (c) accepting, (d) understanding, and (e) resisting. In addition to these processes, Brown (2006) proposes that shame resilience is the interplay of four factors: "(a) the ability to recognize and accept personal vulnerability; (b) the level of critical awareness regarding social/cultural expectations and the shame web; (c) the ability to form mutually empathic relationships that facilitate reaching out to others, and (d) the ability to 'speak shame' or possess the language and emotional competence to discuss and deconstruct shame," (Brown, 2006, p. 47-48).

Research on the processes involved in overcoming shame continues, but there exist research-based models for how practitioners may best help individuals reduce levels of shame and cope with maladaptive shame. While the functional analytic perspective, CFT, and EFT offer frameworks for dealing with shame, SRT offers the most detailed framework for being able to adaptively move through the specific emotion of shame. SRT also uses the psycho-social-cultural framework of understanding shame (Brown, 2006), which as mentioned earlier is a comprehensive model that recognizes the interplay of different factors.

Rationale for Study

Previous research has consistently indicated that EDs diagnosed in adolescence are serious, detrimental to health and functioning, and demand clinical attention. Research has also consistently suggested the increased prevalence of EDs in adolescence and early adulthood (Micali et al., 2013; Stice et al., 2013). Shame is a consistent and prominent factor strongly and positively correlated to ED onset and maintenance (Goss & Gilbert, 2002; Pinto-Gouveia et al., 2014; Trindade et al., 2017). Shame has also been identified as a risk factor for the onset of EDs in some samples (Iannaccone et al., 2016), and also as a risk factor for relapse (Berends et al., 2016).

While shame is a prominent part of the clinical picture of EDs in adolescence, it is sometimes overlooked in treatment and recovery process (Duffy & Henkel, 2016). Even within the evidence-based treatment models such as CBT and FBT there are significant critiques regarding not having adequate attention devoted to emotion processing built into the treatment models (Robinson et al., 2015). It is only within the last 5 years that a more prominent modality for ED treatment has been developed to address a deficit in previous treatment methods regarding the emotion processing and regulation component of care (i.e., EFFT). While it is promising that new modalities like EFFT are addressing the deficits in previous treatment methods such as emotion processing and regulation, much remains to be understood about the ways in which shame is approached.

The literature is clear that shame has a role to play in the onset, maintenance, and treatment of EDs, yet much remains to be known about this construct, especially in terms of how adolescents adaptively work through experiences of shame related to their ED. Given the physical, emotional, and psychological burden of trying to overcome an ED, studying this area remains to be a challenge. Methodological challenges also arise when considering interviewing adolescents during the height of a serious medical and mental health disorder such as an ED. One way to address this research problem is to attempt to understand how shame associated with an ED was dealt with from the perspective of adults who lived through it. Adult perspectives on their adolescent experience of having an ED have not been explored thoroughly in the studies on adolescent EDs (Cella, & Cotrufo, 2016; Herpertz-Dahlmann, 2009; Iannaccone, D'Olimpio,; Jackson & Chen, 2014; Russell, 2013). Accordingly, an enhanced understanding from the perspective of an adult who has lived through an ED of what helps and hinders developing shame resilience will be helpful on many levels. Using a qualitative research design and the ECIT method, the present study aimed to examine what helped and hindered developing ED-related shame resilience during adolescence from an adult perspective.

Purpose and Research Question

The purpose of this study was to explore what helps and hinders developing shame resilience for adolescents diagnosed with an ED from the perspective of an adult who lived through it. The design of this study was chosen with the intention of bringing client perspectives, voices, and experiences into the research to improve the understanding of what can be done to support the development of adaptive responses to shame in adolescents diagnosed with an ED.

This study involved interviewing adults and asking them to reflect on their experience of having an ED diagnosis during adolescence. Interviewing adults about their previous experience having an ED intentionally addresses a common issue in interviewing adolescents during the height of an ED, which is their level of impairment in reasoning and cognitive abilities (Matusek

& Wright, 2010). In particular, individuals suffering from the effects of starvation or malnourishment commonly struggle with impaired reasoning and cognitive abilities. Vitousek, Watson, and Wilson (1998) state that this may impede their ability to, "appraise their condition rationally or shift to other patterns of thought and behaviour," (p. 393). Interviewing adults who now self-identify in recovery allows for participants to recall information when they are not being impacted by malnourishment.

The contribution of this study was illuminating the helping and hindering factors in developing shame resilience for adolescents with an ED. It sought to clarify what individuals who had an ED in adolescence thought was helpful or hindering for developing shame resilience, and what they wished for.

CHAPTER 3: METHODS

The aim of this research was to explore what helps and hinders developing shame resilience related to an ED in adolescence from the perspective of an adult who lived through it. The research question for this project was what helps and hinders developing shame resilience in adolescents diagnosed with an ED from the perspective of an adult who experienced it? This chapter will begin with an overview of the theoretical framework and paradigm used in this study, followed by an overview of the Enhanced Critical Incident Technique (ECIT) and its suitability to address the problem and research question. This chapter will also describe the research design, research paradigm, recruitment, data collection and analysis, and methodological rigour and quality.

Research Paradigm and Design

Research paradigms inform the researcher's approach to scientific discovery (Mertens, 2010), and help to resolve confusions and unquestioned assumptions that can distort research when not addressed (Alderson, 2016). Each paradigm is comprised of philosophical assumptions that function as a basis for understanding the world (Mertens, 2015). These assumptions are important to recognize and discuss in research as they not only guide the research process (Ponterotto, 2005) but determine the standards by which the research ought to be evaluated (Haverkamp & Young, 2007).

ECIT is a method that has historically fit with both the postpositivist and constructivist paradigms (Butterfield, 2005). Originally, the critical incident technique (CIT) was used from a postpositivist perspective as a practical scientific tool (Flanagan, 1954). In more recent years, CIT was adapted for use in more qualitative and constructivist approaches, becoming known as the "enhanced" CIT (Butterfield, Borgen, Maglio, & Amundson, 2009). This flexibility fits with the method's original development, as Flanagan (1954) initially wrote that CIT should be understood as a flexible framework that consists of a set of principles that are modified to meet a specific situation being studied.

Critical realism. For the purposes of this study, neither of the main frameworks of postpositivism or constructivism comprehensively fit with the use of ECIT. Instead, critical realism (CR), a framework that emerged out of the positivist/constructivist 'paradigm wars' allows for a better philosophical fit (Denzin & Lincoln, 2011). CR draws on strains of both original paradigms, offering a framework that helps researchers, "explain social events and suggest practical policy recommendations to address social problems" (Fletcher, 2017, p. 181). Prioritizing and privileging personal experience is a hallmark of CR, similar to that of constructivism. In addition, drawing from post-positivism, CR also recognizes and values objectivist accounts (Pilgrim, 2019). Critical realism offers a way to explore the spectrum between strong subjectivist views on one side, and reductionist views on the other (Pilgrim, 2019). A framework to explore this spectrum is an appropriate fit for this study, as this study seeks to provide practical, specific results while still emphasizing the lived reality of each participant.

Critical realism would take the following stance in regards to ontology, epistemology, methodology, and axiology. First, CR combines a "realist ontology with an interpretive epistemology" (Hoddy, 2018, p. 3). This link between the ontology and epistemology, along with the choice of methodological importance is of major importance within CR (Zachariadis, Scott, & Barrett, 2013). Regarding ontology, the CR framework asserts that human knowledge only captures a part of a vaster reality (Fletcher, 2017). In this way, CR is different from positivism as CR posits that reality should not be limited to what can be observed directly and the world cannot be reduced to statements about knowledge (Fletcher, 2017; Hoddy, 2018). The ontological stance of CR is also different from constructivism in this sense as CR contends that there is more to be known than, "what is constructed through and within human knowledge or discourse," (Fletcher, 2017, p. 182). Epistemologically, CR's approach assumes that, "the development of new knowledge about the social world can be generated through the scientific discovery of objects, structures and generative mechanisms in the domain of the 'real' and the conditions under which these mechanisms are activated" (Hoddy, 2018, p. 2).

Methodologically, CR is concerned with objective empirical observations and discovering the truth involves getting a consensus within a scientific audience (Jarvensivu & Tornroos, 2010), while also valuing personal accounts as important research data (Pilgrim, 2019). Regarding axiology, values of the researcher are not central to reality and knowing, as the CR goal is to gather data in a way that will maximize valid and reliable information without distortions (Jarvensivu & Tornroos, 2010).

Within qualitative research, it is important to address the stance of the researcher and how the researcher situates themselves in a study. As the primary researcher, I am an individual with professional and clinical experience working with EDs, but limited personal experience. I value and desire to seek out not only empirical knowledge but also accounts of human experience. I resonate with the desire for balance between empiricism and subjectivism within CR, as I believe in championing and emphasizing both the observed reality and personal story. As a researcher I also value practical implications, which aligns with the main goals of ECIT as it was designed to be a flexible method to solve a practical problem.

I believe that shame and EDs are connected. I expected that incidents regarding the responses of others would have a significant impact on how individuals move through shame, in both a positive and negative way. I was curious as to whether there was going to be patterns about socio-cultural narratives, and around family expectations. I was also highly aware of ways that this study would or would not adhere to Brown's (2006) SRT framework.

Research Design

Rationale for using enhanced critical incident technique. ECIT is a qualitative research method that has been extensively used in mental health and medical research (DeJesse & Zelman, 2013). The enhanced version of the original method was chosen because it involves the addition of a wish list along with the traditional critical incidents (Butterfield, 2005; Butterfield et al., 2009). In this study, ECIT was used as the research tool to study incidents that facilitated or helped adaptive responses to shame, and incidents that hindered adaptive responses to shame. The wish list element of the study's enhanced design is helpful for this study as it allows participants to discuss what they wish they could have received or experienced from important others and/or the structures and systems around them as they encountered and dealt with shame experiences related to their ED.

ECIT is an appropriate method for this research study as it has the ability to provide qualitative understandings of factual incidents in a real-world environment and provides insight on critical incidents that may help discern differences or turning points (Woolsey, 1986). This method is also an appropriate method for the goal of this research study, as it is an action-oriented method that focuses on solving practical problems which will therefore lend well to clarifying what helps and hinders adaptive responses to shame throughout adolescent EDs (Flanagan, 1954). The concept of reaching consensus was described earlier under the methodology aspect of CR, and this fits within ECIT's design as there needs to be a certain consensus (25% agreement) among participants before a category can be established. A key element of ECIT is the attention to participants' perspectives (Butterfield et al., 2009), which is appropriate for this study as a goal was to incorporate client voices into the research.

Participants. Participants were women ($N = 10$) who had been diagnosed with an ED between ages 11 and 21. While the sample was heterogeneous in the sense that participants could be different ages at the time of interview and had different EDs, participant criteria required that participants have accessed professional help at some point throughout their ED, and that they have experienced shame in relation to their ED as an adolescent.

Participants also had to self-identify as being in partial or full recovery. Participants were excluded from the study even if they met the criteria if they were in acute psychological distress. Participants had to speak English fluently in order to participate. A list of inclusion criteria can be found in Appendix A.

Sample size. The sample size for ECIT is unique in comparison to quantitative methods, as the adequacy of the sample size is not associated with the number of participants but instead on data exhaustiveness (Butterfield, 2005; Butterfield et al., 2009). Redundancy is an indicator that the domain being studied has been adequately covered (Butterfield,2005). In other methods this is occasionally referred to as "data saturation." Although exhaustiveness was reached after the ninth interview, the tenth interview was completed since the researcher had already scheduled it with the participant. This meant that the tenth interview did not yield any new categories, and instead all the incidents that the tenth participant reported fell into existing categories. In this way, the tenth interview served to increase the participation rate and incident rate in some senses but did not add any categories.

Sampling strategies and recruitment. Participants were recruited via social media, posters (Appendix B), and word of mouth. Eighteen participants contacted the researcher through email, text, or Facebook expressing interest in the study. All individuals who contacted the researcher were sent the Introductory Letter (Appendix C) and asked if they felt that the study may be a good fit for them. The introduction letters explained that interviews would focus on what helped and hindered moving through shame related to their ED as an adolescent. Screening calls were then booked with the participants who thought the study would be a good fit for them. During the phone screening the researcher reminded them of the focus of the interviews and told participants that they were welcome to start thinking of incidents in advance that they can recall during the interview. The researcher went through the inclusion criteria during the screening call (Appendix A), the demographic information form (Appendix D), and if the participant met the criteria the researcher arranged a time to meet with participants either at the university campus or over Zoom. Eight interviews were held on campus, and two interviews were held over Zoom. For participants who were not suitable for the study, they were thanked for their interest in the study and told that if they needed support regarding disordered eating, they were welcome to contact the researcher for resource information. Some individuals were deemed not suitable for the study as they were never formally diagnosed with an ED, and other individuals were not suitable for the study as they did not identify as being in recovery.

The informed consent was emailed to the participants before the first interview, and then reviewed again verbatim with the primary researcher at the beginning of the first interview (Appendix E). The researcher conducted all interviews. Participants were asked if they had any questions and if they wished to continue, and then once they consented they signed the informed consent form. The interviewer gave each participant a $10 Starbucks card at the beginning of every interview. Most Starbucks cards were sent electronically, and the researcher checked in (in person or via email) with each participant to make sure they received it.

Demographics. All ten participants were female and born in Canada. The participants ranged in age from 22 to 40 (*M* = 25, *SD* = 6.29). Eight participants identified as Caucasian and Canadian, one identified as Indo-Canadian, and one identified as French-Canadian. Participant's education levels included high school diplomas (*n* = 6), a college diploma (*n* = 1), bachelors degrees (*n* =2), and a masters degree (*n* =1). Five participants were married, four were single, and one was common law. All participants had been diagnosed with AN. In addition to AN, one participant was diagnosed with Eating Disorder Not Otherwise Specified (EDNOS), one was diagnosed with BED, and one was diagnosed with BN. Participants accessed a variety of treatments, including outpatient, inpatient, and residential treatment as well as private counselling. Details regarding how many participants accessed each treatment can be found in Appendix F (Participant Demographics) along with other pertinent demographic information.

Data collection. Data collection in ECIT focuses on identified critical incidents that reflect the phenomenon being considered (in this case shame-resilience), has a clear purpose and significance recognized by the participant and researcher, and for which the consequences are acknowledged (Flanagan, 1954). While data can be collected by observation or interview using this method, this study utilized interviews for data collection.

Interview format. According to Butterfield et al. (2009), the first interview is the most important as it allows the participant to share their story, feel heard, and feel understood. Appropriate clinical skills including empathy and reflective listening were used by the researcher throughout the interview with the goal of providing a safe and respectful environment for the participant and gaining study-relevant data. The length of the initial interviews ranged between 70 and 127 minutes (*M* = 88.5, *SD* = 17.67; Appendix G)

The researcher followed an interview guide throughout the face-to-face interview (see Appendix H). The researcher invited participants to share a detailed description of an event or events where they experienced shame related to their ED during their adolescence, along with any thoughts, feelings, and reflections they had during and after the event (Schluter, Seaton, & Chaboyer, 2008). While many of the questions were open ended, clarifying or follow up questions were asked when needed to identify specific behavioural, interpersonal or intrapersonal helping and hindering incidents related to the intent of the study. After the interviews were completed, the researcher and participants informally debriefed the participants' experiences before reviewing together a study debrief document (see Appendix I). The informal debrief including asking the participant how they felt about recalling incidents related to their ED, and if they were surprised by anything that came up for them. The debrief document was reviewed by the researcher before the participant left, and all participants were offered a copy of the resources that were included in the debrief document.

Recording and storing the information. Interviews were audio recorded using a password protected cellular phone. Immediately after the interview and before leaving the interview space, the audio recordings were transferred to a password protected computer or encrypted USB and permanently deleted from the cell phone. Participant ID numbers were used instead of identifying information when storing recordings to ensure confidentiality. Data were viewed in a private location, such as the primary researcher's home or a private office, to ensure confidentiality. In order to protect anonymity, during the transcription process the primary researcher edited any details of a participant's story that may have allowed for members of the research team to identify the participant. For example, the primary researcher replaced the exact city or hospital names with general terms such as 'Canadian city' or 'local children's hospital'. Any paper copies of transcripts or informed consent forms were stored in a locked filing cabinet at the researcher's office during the conduct of the study.

Research team. The research team was comprised of four graduate counselling psychology students (masters, *n* = 3, doctoral, *n* = 1), and one counselling psychology professor. The primary researcher transcribed all interviews, and the research team assisted the primary researcher in coding transcripts, putting incidents into categories, listening to interviews to ensure fidelity, and clarifying summaries. The function of each of the research team members is further explained throughout the data analysis section. The research team provided assistance with tasks, as well as important insight into the project through various roles such as cross-checks. All individuals on the research team had graduate level training on qualitative research, and each had a basic knowledge of ECIT. All individuals on the research team also have had varied experience with ED research. Before each task was completed, the Butterfield et al. (2009) article was reviewed and explained by the primary researcher if there were any questions.

Data Analysis

The purpose of data analysis is to summarize and describe data for practical purposes (Flanagan, 1954). The principal researcher transcribed the audio recordings verbatim, and used these transcripts throughout the data analysis process. The protocol outlined by Flanagan (1954) and Butterfield (2005) was followed for this study. There are three main steps outlined in the process: (a) determine the frame of reference, (b) formulate the categories, and (c) determine the level of specificity or generality to be used in reporting the data (Butterfield, 2005, Butterfield et al., 2009).

The frame of reference for this study was understanding the participants’ perspective on what helped or hindered adaptive responses to shame related to their ED during their adolescent phase. The aspects that emerged from the data that help clarify what helped an adaptive response to shame were defined as what “helped.” The aspects that were aversive to adaptive responses to shame were defined as what “hindered.” The aspects that participants believed would have improved adaptive responses throughout treatment were defined as the “wish list.” After this frame of reference was reviewed, the data was reviewed for incidents.

Incidents were identified from the transcripts by the principal investigator and members of the research team, and the second component of data analysis was the formulation of categories from the incidents that were identified. As the selection of categories is unavoidably subjective, the principal researcher involved the research team throughout this process. The function of the research team in this sense was to provide an alternative perspective to compare with the perspective of the PI. Flanagan (1954) states that forming categories requires insight, experience, and judgment. Because of this recommendation, the principal researcher sought counsel from her research supervisor to ensure agreement among categories. The process of category formation was done using a table that was updated after each transcript was coded, as per the recommendation of Butterfield (2009). This table helped track the number of new categories emerging and at what point exhaustiveness was reached. The process of placing incidents into categories and examining categories continued until the critical incidents and wish list items from all interviews had been placed. There were five incidents that were completely unique and did not fit into any category that the primary researcher consulted with her supervisor about. These five incidents included either events that participants recalled that did not seem to be related to the research question, or concepts that a participant discussed without describing an actual incident. For these reasons, it was decided that these five incidents would not be included in any categories.

The third and last component of the analytical procedure was the level of specificity or generality. Determining the level of specificity-generality refers to deciding whether it is more appropriate to present a higher number of specific categories, or a smaller number of more general categories. A higher number of specific categories was originally presented, but after consultation with the researcher's thesis supervisor and the research team, the number of categories was condensed into a smaller amount of more general categories. For example, specific categories such as praying, talking about spiritual dynamics with a therapist, and experiencing God's presence at a church service were condensed into "Spiritual Connection."

Trustworthiness and Rigour

The concept of trustworthiness is a core criterion for quality, or rigour, in qualitative research (Morrow, 2005). In addition, an ethic of trustworthiness must be developed in qualitative research, as it involves the recognition that, "participants can be vulnerable and that researchers carry a responsibility to promote their welfare and guard against harm" (Havercamp, 2005, p. 146). The following section will review the nine credibility checks that the ECIT method outlines (Butterfield, 2005). It will also include a detailed description of how each of the nine credibility checks was adhered to for the purposes of this study. A discussion of ethical considerations will follow this section.

Step 1: audiotaping interviews. This credibility check concerns descriptive validity. Butterfield et al., (2005) recommend audiotaping the data collection interviews so that participants exact words are used. All interviews were recorded by the interviewer on a password protected phone, and immediately transferred to a password protected laptop and deleted from the phone.

Step 2: interview fidelity. Butterfield et al. (2005) list three reasons that an expert in the CIT research method listen to every third or fourth taped interview. The first is to ensure the research method is being followed, the second is to ensure the interviewer is not asking leading questions or prompting the participant, and thirdly to ensure the interview guide is being followed (Butterfield et al., 2005). The study supervisor listened to two interviews and provided feedback to the researcher. After the first interview, it was recommended by the supervisor that the primary researcher shorten the warm-up section of the interview and move more directly into the prompts for eliciting CIs and wish list items. The study supervisor affirmed that both of the interviews she listened to adhered to the interview guide.

Step 3: extracting the critical incidents using an independent coder. Butterfield et al. (2005) state that approximately 25% of the transcripts need to be coded and extracted by an independent coder. This is done with the purpose of ensuring that the incidents that the researcher extracted have a concordance rate with the incidents extracted by the independent extractors. A high agreement between the independent extractors and the researcher is said to strengthen the validity and credibility of the incidents extracted by the researcher (Butterfield et al., 2005). Butterfield et al. (2009) recommend that in the event of a discrepancy, decisions need to be made about how to reconcile differences. The researcher and her supervisor discussed this, and decided that if an agreement could not be made by discussing with the independent coder, participants may be asked during the cross-check interview.

Three individuals from the research team coded one transcript each. In total, 30% of the transcripts were independently coded. Independent coding means that a member of the research team codes a transcript independent of the primary researcher, and then after coding is finished the codes are compared. If a discrepancy was found between the primary researcher and an independent coder, the discrepancy was discussed between the researcher and independent coder. All discrepancies were minor in nature, for example using different wording to explain the same general idea. Through discussion all discrepancies were resolved, and no participants were contacted regarding coding discrepancies.

Step 4: tracking category exhaustiveness. The principal researcher tracked the emergence of new categories throughout the interviews by keeping a document consistent with what is outlined by Butterfield et al. (2009). This involved creating an electronic word document for each participant number with headings for helping CIs, hindering CIs, and WL CIs.

Exhaustiveness refers to the point at which, "participants mention no new CIs or WL items and no new categories are needed to describe the incidents," (Butterfield et al., 2009, p. 270). Exhaustiveness was reached by the ninth interview, and the tenth interview had incidents that fit into the respective categories already created. After all of the interviews were completed and categories were formed, new more general categories were formed after consultation with the researcher's supervisor and research team. A member of the research team helped the principal investigator with the last stages of putting incidents into categories.

Step 5: calculating participation rates. The participation rate for each category was calculated by counting the number of participants who endorsed a specific critical incident, and dividing that number by the total number of participants (Butterfield et al., 2009). Butterfield (2005) suggests that there be a minimum of 25% for a category to be valid. Participation rates ranged from 30-100% and can be found next to each category within the results section.

Step 6: placing incidents into categories by an independent judge. A member of the research team placed approximately 25% of the incidents chosen at random into categories. This was done by writing down incidents on cue cards, and categories on cue cards, and having the independent researcher put the incidents beside the category they felt best fit. Butterfield et al. (2009) recommend that the match rate between the researcher and independent judge be 80% and above. For this study, the match rates were 88.9% for the helpful categories, 95.7% for the hindering categories, and 83% for the WL categories.

Step 7: cross-checking by participants. The cross-check with participants was conducted after all of the first interviews were completed, coded, analyzed, and placed into categories. This step in the research process has four main functions: (a) inviting participants to review interpretations and ensure they are supported, (b) to provide an opportunity to review what categories their CIs and wish list items have been placed and comment on category titles, (c) to confirm whether the CI and wish list items have been placed in appropriate categories, and (d) to ensure participants' voices have been honoured and represented accurately (Butterfield et al., 2009). Butterfield et al. (2009) refer to this step as a "second interview" however the cross-check does not occur in an interview context similar to the first interview. Instead, the cross-check is generally conducted by e-mail or telephone in ECIT, and it is not normally taped or transcribed. For the purposes of clarity, this step will be described as the cross-check by participants instead of the second interview.

All participants were followed up with via email (Appendix J) and were sent a summary of results (Appendix K) and as well as Figure 1. The time elapsed between the first interview and cross check was between three and six months depending on the date of the first interview.

Participants were invited to either respond via email with their feedback, or arrange for a time to speak with or meet up with the researcher if they would prefer to give their feedback in person.

Most participants responded via email, and one participant met up with the researcher to discuss the results. Participants commented that they felt that the results fit with their experience, and that they enjoyed reading the examples. One participant commented in response,

> I've found it really interesting that even though experiences of eating disorders tend to vary from person to person, it seems that what helps/hinders shame resilience is very similar. Also, the support aspect has really stood out to me, because it seems like support is really needed and wanted in ED recovery, yet (from what I know/experience) there are so few resources for friends, family, etc on how to support someone recovering from/struggling with an ED.

Step 8: eliciting expert opinions. A summary of the results as well as Figure 1 was sent to two experts in the field by email (Appendix L). The experts were asked to consider the following questions as per the suggestion by Butterfield et al., (2009): (a) do you find the categories to be useful, are you surprised by any of the categories, and (c) do you think there is anything missing based on your experience. Two researchers in the field of EDs in adolescence were contacted from the local children's hospital. After about two weeks of not getting a response, a second round of individuals was contacted. The second round of individuals contacted was Esther Naayer and Hillary McBride, who both responded and agreed to review the results. I have former relationships with both experts, which are disclosed below.

Esther Naayer, a clinical counselor at Fraser Health in the adult disorder unit, was one of the experts. Esther has a masters in counseling psychology degree, and also has over 8 years of experience working with EDs primarily in an adult context. She consistently provides and receives supervision alongside clinicians who specialize in adolescent EDs, and has experience providing counselling with this population. Further, she commonly works with individuals who are in later adolescence who have transitioned to the adult program from the adolescent program that ends at age 18. Over the past year, Ms. Nayer was also my clinical supervisor as I completed a placement at Fraser Health in the adult ED unit.

After reviewing the results, she responded stating that she felt that the categories were comprehensive of the ED client's experience. She stated that overall she was not surprised by the results, but she was curious about the wish list item of wanting people to reach out. She stated that usually people reaching out is not welcomed for client's in pre-contemplative or contemplative stages of recovery. She stated that she wondered if this was listed because it was retrospective in nature or because it demonstrates an underlying desire for support. She also stated that she was curious about the hindering category of "feeling watched or controlled by others," as she thinks this could be to do with the perception due to the ED as opposed to people's behaviours. However, she did also state that this can be the experience of some clients due to the inpatient protocols, which seems to fit with the experiences of the clients in this study.

The second expert that was contacted was Hillary McBride. Hillary recently finished her doctorate degree in Counselling Psychology and has extensive experience doing research on EDs. She also has clinical experience working with adolescents with EDs as well as adults with EDs. Ms. McBride's masters thesis was on the subject of EDs, and she has also written two books on the subject of EDs. One of them is based on her master's thesis, and the second is a textbook on embodiment and EDs. In my first year of my masters program, Ms. McBride was my instructor for Advanced Counselling Skills.

After reviewing the results, she stated that the categories were absolutely helpful, and reading them did not surprise her. She stated that she thought it was interesting that the categories represented the Bronfenbrenner's (2005) ecological systems approach of the whole person. When answering the question about whether everything is missing, she stated that she thinks it is important to note that patriarchal narratives and sociocultural contexts are important to mention, even though participants did not specifically state this. She stated that not all individuals think about this and it depends on the level of sociopolitical insight of the participants in a given study. Due to this feedback, this is touched on in the discussion chapter.

Step 9: theoretical agreement. Part of performing this credibility check has involved making the underlying assumptions of the study explicit, and carefully examining the newly formed categories in light of the current literature (Butterfield, 2005). A discussion about the theoretical fit within the current literature is outlined in chapter five, where this topic is elaborated.

Ethical Considerations

This study received ethics approval from Trinity Western University's ethics board. In recognition that participants would be recalling personal experiences that may be associated with challenging feelings, informed consent was treated as an ongoing process. This meant that if a participant showed strong emotional discomfort, participants would have been encouraged to share in a way that felt comfortable to them. Participants were also informed at the beginning of their first interview that they were allowed to take breaks if they found that helpful, and they were able to keep the Starbucks card whether or not they finished the interview.

Qualitative research interviews often involve, "high levels of rapport, intimate disclosure, and potentially strong emotion" (Havercamp, 2005, p.153). The informed consent form included stating that involvement in the study was not a form of therapeutic intervention. This was also reviewed during the screening phone calls. Included in the second credibility check (interview fidelity), the study supervisor was attentive to listening to whether the researcher's role ever deviated from that of researcher into that of therapist. Interview protocols were reviewed prior to each interview and any questions about adhering to the protocol were discussed with the study supervisor.

In order to ensure confidentiality, any names or locations that were mentioned in interviews were removed from transcripts. Locations, treatment centres, or hospital names were removed and replaced with general descriptors (such as "local hospital"). Minor elements of the descriptions from each participant were altered to safeguard the confidentiality of participants. As per the recommendation of Havercamp (2005), any third party information that was shared by participants was also carefully attended to and safeguarded.

CHAPTER 4: RESULTS

Using a qualitative research design and the ECIT method, the present study aimed to examine what helped and hindered developing ED-related shame resilience during adolescence from an adult perspective. This was done with the goal of gaining an enhanced understanding from the perspective of someone who has lived through an ED on what facilitated and got in the way of adaptively moving through shame. Semi-structured interviews using the ECIT method (Butterfield, 2009) were conducted with ten women who experienced an ED between the ages of 11 and 21 and identified as being in recovery at the time of the study

Participants were asked to share about what they thought were helpful and hindering incidents for developing shame resilience, as well as what they would like to see that might help improve or change their ability to develop shame resilience (i.e. the wish list items). Demographic information was confirmed at the beginning of the interviews (see Appendix D), along with warm-up questions (included in Appendix H) that helped participants think about their experience of having an ED.

After transcribing the audio recordings of the interviews, critical incident (CI) extraction of the interviews yielded through an inductive approach a total of 455 CIs (Appendix M). Of the total amount of incidents, 206 were in the category of helpful incidents, 172 were in category of hindering, and 77 were in the category of wish list incidents. All 455 CIs were sorted into 37 categories, forming 13 helpful categories, 15 hindering categories, and nine wish list items. Figure 1 provides an overview of the results.

HELPFUL
- Social Support
- Personal Connection with Healthcare Professionals
- Psychological Counselling
- Practical Support from Parents
- Humour and Celebrating Victories in Treatment
- Spiritual Connection
- Positive Embodied Experience of Body and Eating
- Knowledgable Health Professionals
- Helping Others
- Freedom to Make Choices
- Education/Access to Information
- Awareness of Other People with an Eating Disorder
- Supportive Significant Other

HINDERING
- Perceived Inconsiderate Actions and Comments from Healthcare Professionals
- Feeling Watched and Controlled by Others
- Perceived Unhelpful Behaviour from Family
- General Comments from Others about One's Body
- Comments about being Underweight
- Falling Short of Expectations of Self
- Comments about being Overweight
- Perceived Unhelpful Behaviour from Friends
- Witnessing Mom's Concern about her own Body and Food Intake
- Dance Teacher's Comments & Behaviour Regarding Body
- Feeling Exposed by Others
- Being Weighed and Discussing Weight
- Abuse from Men
- Unhelpful Use of Social Media
- Specific Spiritual Practices

WISHLIST
- More Support and Understanding from Family
- More Education for Self on Eating Disorders
- Improved Support and Knowledge of Eating Disorders among HealthcareProfessionals
- People and Society were better Educated on Eating Disorders
- People would have Reached out to Me
- More Accepting and Safe Environments
- More Social Support
- More Access to Eating Disorder Specific Support
- People didn't make Comments about the Body

Figure 1. Overview of the results

A 25% participation rate inclusionary criteria was used for the categories, as outlined by Butterfield et al. (2009). This means that if only 20% of the participants reported something that they found helpful, the category would not be formed.

Incident rate, which is the percentage of incidents within the total amount of incidents, was calculated for each category. For example, if the incidence rate for a helping category was 10%, that means that one tenth of all of the helpful incidents belong to that category. Participation rate, which is the percentage of participants who contributed to a specific category, was also calculated. For example, if the participation rate for a category is 50%, half of the participants contributed to that category.

To display the results, the data are shown in a table format that lists the incident rate and participation rate beside each category.

Overview of Helpful Incidents

Out of the total of 455 extracted CIs, 206 were deemed to be helping incidents and were further broken down/ grouped into thirteen categories. Table 1 shows the helpful categories along with the incident and participation rates.

Table 1

Helpful Categories

Category Name	Incident Rate	Participant Rate
Social Support	20.87%	90%
Personal Connection with Healthcare Professionals	13.10%	60%
Psychological Counselling	11.65%	80%
Practical Support from Parents	9.22%	90%
Humour & Celebrating Victories in Treatment	8.25%	40%
Spiritual Connection	6.30%	70%
Positive Embodied Experience of Body and Eating	5.82%	40%
Knowledgeable Health Professionals	5.83%	40%
Helping Others	4.85%	60%
Freedom to Make Choices	3.88%	50%
Education/Access to Information	3.88%	50%
Awareness of Other People with an Eating Disorder	3.40%	40%
Supportive Significant Other	2.91%	40%

Helpful Categories

Social support. Within the helping category, social support had the highest frequency (CIs = 43) and the highest participation rate of 90%. This category represented forms of support by both family, friends, and other individuals involved in the participant’s life as an adolescent, including teachers or coaches. Participants described that it was helpful for them when friends invited them to spend time with them, when they reached out to show their support, or when they encouraged them. It is worth noting that participants commented on general social support such as “friends showing me love when I was at all different sizes”, and specific support such as, “my brother came to the hospital to visit me and brought me presents.” One participant described social support by saying,

> It was at that community that I had, um, that was positive and kind of fighting the shame because even though they knew about it, they weren't like judging me, um, or like criticizing me. And they were, um, like more like concerned and, um, just still treated me like a friend, which is what I needed.”

Another participant discussed her teachers and the support that they gave her, as she stated:

> They were thinking outside of just like the, the system and they were thinking like, I really care about this person. Like I want to help them, I want to spend extra time with them or I want to take them under my wing.

Personal connection with a health professional. Many participants (60%) reported that they found their personal connection with a health professional to have helped them move through shame. Participants described health professionals going out of their way to care for them or encourage them, and often participants recounted these incidents with vivid detail.

Participants also commented on how they found it very helpful when health professionals treated them as a human as opposed to someone with an ED. When asked for how they did this, participants reported incidents such as a psychiatrist taking a participant for a walk, or a counselor using self-disclosure appropriately in session. One participant described a moment with her nurse, saying, “you know it was just like her, like speaking life over me and just being like this, you’re going to get better.” Another participant described a moment with her healthcare professional, saying, “she saw like my being… not just someone with an ED. It was like ya, seeing me.”

Psychological counselling. Distinct from the personal connection with a health professional, this category refers to participants recalling specific interventions in therapy that were helpful for them. Participants referred to externalizing the ED, focusing on family therapy, helping them understand where the ED had come from, and more. Most participants referred to their counselling experience being with a therapist, however one participant reported that her counselling experience was with a psychiatric nurse, and one participant reported that her experience of counselling was with a psychiatrist. A participant stated while describing her experience of counselling:

> There was like this kind of inward battle going on and how I was able to kind of separate yeah. The eating sort of for myself, she was very good at like separating those two things. Oh, for sure. And she did a lot of like, um, like externalizing I think.

Practical support from parents. The majority of participants (90%) reported that the practical support that their parents gave them was helpful for them in developing shame resilience while they had an ED. Participants reported that practical support such as driving them to and from appointments, doing their laundry, and helping them with meal support was helpful.

One participant (referring to her Mom) stated, "she would try and distract me, but that's what I need to, like, she was in tune and aware of the struggle that was going on."

Participants also specifically reported that their parents being willing to pay for things was helpful. Counselling was one service parents offered to pay for that participants reported as being helpful, and buying new clothes was another specific way parents practically supported some participants. Participants reported that having their parent buy them new clothes during their treatment was helpful, as they found it shaming to wear clothes that did not fit them and they underwent body changes throughout their recovery process. One participant stated, "my mom bought me so many new clothes that fit me throughout every stage of my eating disorder and recovery."

A participant also recalled:

> There was no question whether I was allowed to eat or not. Like I, whatever she made, I had to eat. And, um, and so whenever I had like breakdowns or anything, like she was very comforting, very empathetic, um, and really like spoke to like the emotion I was feeling or the fear I had.

Humour and celebrating victories in treatment. Just under half of the participants (40%) reported that humour and celebrating victories in treatment were beneficial for their experience of moving through and dealing with shame. The participants that reported humour and celebrating victories in treatment listed multiple incidents each (CIs = 17). Participants reported humour occurring in incidents where they either laughed with others or had fun with others. A participant stated, "joking about it in an appropriate way was really helpful." Examples include doing wheely rides in a wheelchair down the hallway of the hospital, having secret dance parties with siblings, laughing while eating ice cream with a parent, and joking with a roommate.

Participants reported incidents of celebrating victories that were similar to that of humour, as they were also incidents that were shared with another person while experiencing the emotion of joy. Examples include taking photobooth pictures with a parent after reaching a milestone in recovery, celebrating with a teacher after school, and running up to a dance teacher to share encouraging news.

Spiritual connection. Even though certain spiritual practices emerged as a hindering category, a spiritual connection was reported as being helpful for developing shame resilience for 60% of the participants. Some participants reported being a part of a specific religious background or tradition (Christianity or Hinduism), and others did not disclose a particular religious affiliation and used the term spiritual broadly. Incidents that were reported ranged from participants recalling specific times where they felt that they had directly connected with God to incidents that involved spiritual integrations into treatment. Regarding incidents that involved connections with God, one participant stated, “I was just at church and in the back and they were just like laying hands on me and praying and I just felt like I was crying and I just was like, like yeah, it was just like this, like my eyes are open.”

When referring to spiritual integrations in treatment, one participant stated, “and then [counsellor name] just was just very, very, um, wonderful. And I think the fact that she shared the same faith as me was huge. She didn't like, she was very good at, um, I was always the one to bring it up.” Another participant stated that, “I had another counselor come in and I just connected because it was like she's a lot more like spiritual. Um, and just kind of understood it.”

It was interesting to note that within this category there was a broad range of incidents. It seemed as though some people experienced spiritual connections as turning points in recovery, for example the quote above that discusses her eyes being opened during a spiritual encounter.

For others though, spiritual connections were more consistent parts of their recovery as opposed to big turning point moments. An example of this is that a participant stated that she put Bible verses that encouraged her and helped her connect with God on the bottom of her toilet seat cover, so that when she was tempted to purge she would see the verse. She described this as being a spiritual incident that helped her overcome shame resilience.

Positive embodied experience of body and eating. The term embodiment refers to the way in which individuals inhabit their bodies (Piran, 2016). For the purposes of this study, positive embodied experiences of body and eating refer to incidents where participants reporting having an incident of connecting with or experiencing their body or consuming food in a way that they reported as helpful. Incidents included enjoying or finding pleasure in eating food, and experiencing their body in a positive way. Finding pleasure in food involved incidents such as a participant recalling eating pizza and enjoying the pleasure of eating food. Another incident includes a participant enjoying the experience of eating cake at a birthday party with her friends.

Some participants recounted experiencing their body in a positive way through dance, or separate from any activities (for example, reporting "feeling strong and fit in my body,"). One participant talked about an experience of dance, stating, "I think that was very positive because I was able to experience my body in a positive way. Um, and I do like when I dance, like there is a very fulfilling, um, like feeling that comes with it." Another participant recounted, "dancing was a way, um, sort of to positively experienced my body and it was like a very like, inward experience." These experiences of embodiment stuck out for participants, as they were able to recount specific moments where they experienced this and they felt it was helpful.

Having knowledgeable health professionals. Four of ten participants reported having a knowledgeable health professional as being helpful for developing shame resilience (40%).

Some participants reported that this was because when they knew their health professional knew what to do, they did not have to worry about next steps. Participants also reported that it was helpful when health professionals knew what to say and what not to say to them, as participants often contrasted this with their hindering experiences of inconsiderate actions by health professionals. One participant stated, "that's actually a helpful thing. Having a family physician who knew about EDs." The concept of "being in good hands" was discussed, as participants stated that there was comfort from feeling as though they were in the care of a knowledgable healthcare professional.

Helping others. Participants reported that helping others in various ways was beneficial for them in developing shame resilience. Participants reported helping others with ED related issues, but also reported helping others with general things such as math homework or getting food onto a plate in the cafeteria. One participant recalled:

> I was helping this woman who like […] with just some like food at like the cafeteria or whatever. And that was really helpful for me, feeling like I could help other people in the future.

Participants described getting a sense of purpose from helping others. When helping others with ED related issues, participants also commented on how they felt good knowing something good was coming from their ED.

Freedom to make choices. Fifty percent of participants reported incidents where they felt that others respected their privacy, space, or timeline as being helpful for them in developing shame resilience. Multiple participants reported that it was helpful when others used "did not rush" them, whether it was a parent or counselor. This category can likely be associated with the hindering incident of feeling watched or controlled, as many participants reported that they felt that when they had their personal freedoms taken away they experienced shame. Participants also commented on how they appreciated being given the ability to make choice in various settings, such as the grocery store. One participant stated, "if we were grocery shopping, she would make sure that I had some choice about like, um, foods that I wanted her to buy or to make that I really enjoyed eating." Some, but not all, participants talked about control when discussing incidents that happened in this category. For example, some talked about how if they had some choice it helped them not want to take control of everything and that was helpful for their ED behaviours.

Education on eating disorders for self and others. Participants described finding it helpful when they learned about EDs or the body, but they also described incidents of when other people learned about EDs to be helpful. One participant described loving the multiple workbooks that she was given in treatment, and still reading through them every once and a while. Another participant stated that she found reading about EDs helpful. One participant stated, "I think it was helpful when [the doctor] explained things medically." More than one participant commented on how gaining insight into what was happening to their body biologically helped provide them with more compassion for their experience. An example of this is a participant stating that learning about how her body was trying to protect her when she was malnourished (for example, growing little hairs on her body) helped her realizes that her body was trying to work for and not against her. Another example of this was a participant commenting on how learning more about nutrition made her feel more empowered to eat.

Awareness of other people with an eating disorder. Participants reported that meeting another person who had experienced an ED was helpful, but they also reported that hearing about, without meeting, someone with an ED was also beneficial. Some participants reported that connecting with others who experienced something similar online was helpful, or hearing about someone with a diagnosis through a family member or friend. When describing an interaction with someone else with an ED, a participant stated:

> At the time it was helpful because I was able to feel not alone and that she actually understood what I was going through and… she didn't think I was crazy for having the thoughts that I was so fat or anything, she understood.

Participants talked about how feeling misunderstood was difficult, and also commented on how they felt understood when they heard of other people struggling with the same thing. It is important to note that many participants who commented on how this was helpful also stated that they found it was not helpful to talk extensively about their ED with someone else who struggled with an ED. This is because participants stated that when they spoke with other individuals who had an ED it was common to get triggered, or to start unofficially competing about ED symptomatology and severity.

Supportive significant other. Forty percent of participants reported that the support of their significant other was helpful for them in developing shame resilience. Participants referred to incidents where their partner was supportive, showed they were interested in what they were going through, or offered them reassurance. One participant, describing her significant other, stated:

> And he wanted to know more and he wanted to educate himself and then the next time we talked about it, I could tell that he went and did that because he was saying all these things and I'm like, okay. He obviously did some research.

It was clear from the reports of participants that it was not only the efforts of significant others to understand or support them during an ED that was helpful, but also a non-judgmental and consistent presence. Another participant stated, "he just didn't treat me differently when I was sick versus when I was healthy."

Overview of Hindering Incidents

From the participant interviews, hindering incidents were extracted (CIs = 172) and grouped into fifteen categories. Table 2 below shows the hindering categories along with the incident and participation rates. Comments about body represented 23% of all hindering incidents (CIs = 40), so it was decided to separate comments about body into three sections: general comments about body, comments about being overweight, and comments about being underweight.

Table 2

Hindering Categories

Category Name	Incident Rate	Participant Rate
Perceived Inconsiderate Actions and Comments from Healthcare Professionals	13.95%	70%
Feeling Watched or Controlled by Others	11.05%	60%
Perceived Unhelpful Behaviour from Family	9.88%	70%
General Comments from others about One's Body	9.30%	70%
Comments about being Underweight	8.14%	70%
Falling Short of Expectations of Self	6.40%	50%
Comments about being Overweight	5.81%	50%
Perceived Unhelpful Behaviour from Friends	5.81%	50%
Witnessing Mom's Concern about her Own Body and Food Intake	5.23%	40%
Dance Teacher's Comments & Behaviour Regarding Body	4.65%	50%
Feeling Exposed by Others	4.65%	50%
Being Weighed and Discussing Weight	4.07%	40%
Abuse from Men	4.07%	40%
Unhelpful use of Social Media	3.49%	40%
Specific Spiritual Practices	3.49%	30%

Hindering Categories

Perceived inconsiderate action and comments from health professionals. This category was mentioned by 70% of the participants, and represented the highest percentage of the hindering categories with 13.95% (CIs = 24). Participants reported that it was hindering when health professionals either said or implied with their language that the participants were choosing to do this to themself. One participant stated:

> The counsellor encounter, um, probably did… well I don't know, maybe it did add a bit of shame because it was kind of like she was talking about it in a way like, why are you doing this to yourself? Like you're hurting yourself.

Participants also commented on the some of the ways that their health care professionals talked about their body as being detrimental to developing shame. One participant stated that their doctor, "said I look like a survivor from the Holocaust, which was a little extreme." Incidents also included participants recounting events where they did not think their health professional was treating them as significant or showing them empathy. Examples of this included being in a therapy session and having their therapist check their cell phone while they were talking, but more commonly participants commented on how they noticed if a healthcare professional did not seem to take an interest in their wellbeing. Participants stated that when they felt that they were "just another patient ID" they felt that hindered developing shame resilience.

Feeling watched and controlled by others. Participants described having their personal freedoms being taken away from them throughout treatment, often feeling as though they were no longer trusted by others. Some participants described feeling as though they were small children again and were made to have assistance with small tasks. A participant stated,

> Just the feeling of like not being able to wheel the wheelchair to the washroom or shower without my mom. […] it was just like very humiliating to […] girl. Um, and so ya a lack of freedom. It made things worse. It was like, well, I need to, I, I can't control anything.

Another participant also commented on her experience of having to be escorted to the washroom:

> People were taking control from me in every single way. Like I couldn't even use like the washroom without someone going and following me into the washroom. So it was like, I felt like no one trusted me.

Participants commented that they felt as though they were not trustworthy when they were being constantly supervised. Participants commented that they found it hindering when it felt like people (healthcare professionals, family, or others) all of a sudden thought you were a suspicious individual.

Participants also described feeling controlled by other people making decisions about them or their treatment. One participant stated:

> And I think I was just mad because I didn't, I truly, truly believed that I was fine. So to have someone diagnose you, even though they were right, yeah. It just took away all my voice. Yeah.

Perceived unhelpful behaviour from family. This category was endorsed by 70% of participants, and involved the actions that family members did that were unhelpful (such as yelling at a participant or verbalizing mean comments) as well as inaction by family members (refusing to come to therapy or not saying anything). Participants described both the unhelpful actions and inactions to be hindering for developing shame resilience. Examples include one participant stating, “my Dad would be like, ‘what is wrong with you? Like why don't you eat like you're fucked up’.” It was common for participants to report that their parents did not seem to understand, and their comments that came out of a place of misunderstanding were hurtful and hindering for developing shame resilience. Participants also commented that even some comments that were meant to be encouraging were not helpful, as they were not sensitive to what they needed. For example, a compliment about an adolescents body may be meant as an encouragement but the adolescent could experience this as an inconsiderate action or comment.

Another participant commented on how the disciplinary measures that were used in her house were unhelpful. She stated, “it was quite common for my mom to take away like sweets for me [as a punishment], which makes sense. But, um, also I don't think food should be a reward or punishment.”

General comments about body. Comments from others was such a prominent category that it was decided that it was decided to split up the category into three separate categories. General categories about body include comments made by others to participants that were not specific to being overweight or underweight, such as comments about the body that were made as compliments, comments about specific body parts, and comments made as jokes. This category is evident in the helpful categories too, as some participants reported that it as helpful when people were educated because they knew not to comment on the body. This category is also represented in the wish list items, as some participants reported that they wished people would not comment on their body. A participant recalled:

> I had quite enough [pressure] coming from myself and any other comments that people made about you look fit, you look good, you look slim you or anything like that. Right? Like even though they were compliments they weren't because they were telling me you your body is for other people to look at and it is only going to be okay if it looks like this.

Comments about being underweight. Participants described comments that others made about them being underweight (using terms such as skinny or bony) were harmful for their process of developing shame resilience. Participants stated that even though sometimes they felt proud that they had lost weight, they found these comments unhelpful for their experience of shame and process of developing shame resilience. A participant stated that in the change room before gym class, "girls would say, oh, like, wow, how are you so skinny?" It is noteworthy that participants stated that even when they recognized that some comments were meant as compliments and they were proud of themselves for weight loss, they were still hindering for developing shame resilience. Often, participants would describe thinking that if they received positive affirmation about their appearance when they are underweight, people must think differently of them if they gain weight.

Falling short of expectations for self. A common description that participants gave for incidents under this category was describing an incident that was accompanied with, "feeling like I failed myself." Incidents in this category included doing a behaviour that they did not want to do or felt shameful about, such as having a meltdown about a meal that they later regretted or lying to someone they cared about. One participant recalled an incident that she stated was vivid in her memory:

> I felt so ashamed after this. I thought I was just like such an idiot…I hated myself for it. It was a morning and um, I did my breakfast was like, I don't know, it could've been like five minutes for all I know. And I was like sitting in bed and I was like, where's my breakfast mom? She's like, it's coming. It's no problem. And I had a full blown like tantrum […] like a five-year-old kid would have. And my mom, that was the one time when she just was like, I can't deal with this right now. And she went home for the day.

> […] I felt like shit. I felt like I was like the worst person. Like how could I have a tantrum like that? Um, I felt like it wasn't me. It wasn't me at all.

Participants described that incidents where they felt they fell short of the expectations of themselves were also difficult because it made them lose their trust in themselves.

Comments about being overweight. Fifty percent of participants commented on how it was not helpful for developing shame resilience when people made comments that implied they thought the participant was overweight, or when people commented on weight gain. A participant recalled an incident where someone stated, "you left for [province] and like, you came back like twice as chunky or something like that as you were before." Participants commented that hearing comments about being overweight made them self-conscious about their body. Some participants stated that even when comments about weight gain were meant as compliments, such as when individuals would point out that they look more healthy, these type of comments were still not helpful as they made the individual hyper aware of their body size and shape.

Perceived unhelpful behaviour from friends. Participants recalled incidents of friends' unhelpful behaviour that were both intentional, such as bullying in high school or making mean comments towards them. However, some participants also recalled incidents of friends' unhelpful behaviour that they reported they knew was not intended to hurt them. Both intentional and unintentional unhelpful behaviour by friends was reported to be hindering in developing shame resilience. When describing her relationship with a friend, one participant stated, "she just kind of stopped talking to me and I would try to like connect when we were both in town or whatever and she would just always be busy and we just stopped talking." Another participant stated, "friends from school and stuff, when I told them so many of them withdrew and I feel like

I lost a ton of friends through that time."

Witnessing mom's concern about her own body and food intake. Four participants referred to observing their Mom's dieting behaviours, comments about food, or reactions to food to be harmful to developing shame resilience. One participant recalled:

> My mom is really like the, again, the foundation of like some of those main comments that were made growing up about body image, what you look like status based on what you look like.

Another participant also discussed her Mom's behaviours and comments about food and stated:

> My mom would bake a bunch of cookies and she'd eat like four fresh cookies cause they're so amazing out of the oven. And then she'd say, oh I'm, I'm so bad. I have no self-control.

The participant who discussed her Mom's reaction to fresh baked cookies commented on how her Mom's use of moral words such as "good" or "bad" regarding food impacted her significantly. She expanded that she felt like she made moral conclusions about herself based on her food intake. Other participants also commented on their Mom's use of language and how that impacted them.

Dance teacher's comments & behaviour regarding body. Half of the participants commented on how their dance teacher had a negative impact on their experience of developing shame resilience. Participants recounted incidents where dance teachers emphasized the body or criticized the body throughout dance. One participant stated:

> My dance teacher and like, um, instructor or director somehow, like they, um, take the liberty to weigh me and I don't know why. And they never told me what it was, but they

> would weigh me and I don't know why. And so like, but they would make comments about if I had gained or lost or if it was good or bad. And so that was like, that was really difficult for me too, cause that would happen like in the studio and like nobody else was around, but it still just felt really weird.

It was common for participants to discuss the comments that their dance teacher would make about their body, both when they were in private and when they were in front of the rest of the dance class. Participants described times when dance teachers would touch their stomach and ask them to suck it in, or comment on the size or fit of the clothing they were wearing.

Feeling exposed by others. The most common incident in this category involved people sharing information that the participant wanted to be private with others. An example of this is a participant's parent telling her friends information about her daughter's ED. When recalling this incident, a participant stated, "my mom would disclose what I felt to be too much personal information to friends about my weight and recovery." Other examples include a doctor sharing information with a parent, or a counselor sharing information with a parent. The common thread throughout all eight incidents in this category was that someone else controlled or disclosed something that was private without the participant's consent.

Being weighed and discussing weight. Forty percent of participants reported that being weighed was hindering for developing shame resilience. Interestingly, participants described multiple different people weighing them while all commenting that the experience was not helpful. The people who weighed participants included parents, dance teachers, and healthcare professionals. One participant stated, "Going for weigh-in's and stuff like that. I found that kind of shame inducing." As mentioned earlier, a participant described an incident when her dance teacher weighed her as well. Participants described that it was difficult during a weigh in partially because they wanted to know their current weight, but also knew that knowing their current weight would not be helpful for them. They described feeling torn during most weigh in's, and finding it challenging if a healthcare professional did share their weight with them.

Abuse from men. Abuse was disclosed by 40% of the participants as something that was hindering for developing shame resilience. Some participants disclosed physical or sexual abuse from men, and others disclosed verbal or emotional abuse from men. The abusers included boyfriends, brothers, and fathers. Verbal abuse included calling participants cruel names, screaming at them. One participant who reported sexual abuse stated, "I was confused what had happened because I thought it was the shame that I felt for doing sexual acts I didn't want to do. And that's why I feel so guilty?" It was common for participants to link their abuse with feelings of guilt, and state that they felt as though their relationship with the person who abused them was tied to their current weight.

Unhelpful use of social media. Participants reported that unhelpful use of social media got in the way in developing shame resilience, often commenting that it involved comparing themselves to others. A participant recalled, "I hated what I looked like when I'd compare myself to the fitness models on Instagram or something."

Some participants also reported that they had visited pro-anorexia websites which they stated were hindering for developing shame resilience as it encouraged their ED symptomatology. Some participants also referred to viewing "thinspo," which refers to inspiration for thinness, on social media was hindering for them. They commented that viewing these pictures made them fixate on their current body shape and weight, and try to make new body or weight loss goals.

Specific spiritual practices. Thirty percent of participants listed incidents that were related to spiritual practices as being unhelpful. Some participants listed that specific practices such as lent or fasting was not helpful for them, as they chose to use food within these practices. A participant that discussed fasting said, "I know fasting is a spiritual practice in many different religions, but I don't think for myself that was helpful. Especially to be encouraged in that." She commented that fasting was difficult for her because it provided a way for her to effectively conceal her ED behaviours, and she received praise for completing fasting behaviours. Participants stated similar sentiments around lent, as they described that they would be praised for an ED behaviour that they chose as a form of this spiritual practice. Separate to these two practices, one participant also commented on how she was asked to stand up and be prayed for in front of her entire church, and she felt embarrassed by this. She commented that she was not ready to be so public about her ED, and although she understood the spiritual discipline and practice of prayer, she wished it would not be so public.

Overview of Wish List Incidents

The wish list items contained significantly less items than the other two categories, containing less than half the amount of incidents than each of the helping and hindering categories. From the participant interviews, wish list items (CIs = 77) were extracted and grouped into nine categories. Table 3 below shows the wish list item categories along with the incident and participation rates.

Table 3

Wish List Categories

Category Name	Incident Rate	Participant Rate
More Support and Understanding from Family	19.48%	60%
More education for self on eating disorders	15.50%	50%
Improved Support and Knowledge of Eating Disorders among Medical Professionals	14.29%	60%
People and Society are better Educated on Eating Disorders	10.38%	50%
People Would Have Reached Out to Me	10.38%	40%
I had More Accepting and Safe Environments	10.38%	40%
More Social Support	7.79%	30%
More Access to Eating Disorder Specific Support	6.40%	40%
People Did Not Make Comments about the Body	5.19%	30%

Wish List Categories

More support and understanding from family. This category can be seen as individualized wishes by participants that are related to participants wishing their family members either took more of a stance towards their ED treatment, had more empathy for them, or acted in a more helpful way throughout treatment. Participants described items such as wishing their parents would come to therapy, wishing a parent would have spoken up, or wishing a sibling was more caring and involved. One participant reported:

> In hindsight I think I wish they noticed cause I think I was crying out for help and none of them noticed until the collar bone or something was showing then they would just think, oh you, you lost a lot of weight and they would help me or for my behavior.

Participants often commented that they recognized that the experience of them having an ED must have been very challenging for their parents. Multiple incidents under this category involved participants wishing their parents would have made more of an effort to understand what was going on for them.

More education for self on eating disorders. Fifty percent of participants stated that they wished they could have had more education about EDs. One participant said, "it would maybe just be helpful to talk to people who are fully recovered well or just like very much on the road to recovery." Some participants were specific, stating they wished they could have had education on topics such as how social media affects body image, about healthy sport, or about food and nutrient content. An example of a comment made by a participant in this regard includes the following quote: "I think it would've been helpful to have some sort of discussion or crash course about how social media and those influences affected like the view of what was healthy."

Participants often commented that they have only learned more about EDs since having one, and they wished they could have learned more about EDs before they experienced one or throughout their treatment. Participants described wanting education in various forms, not simply one (i.e. a book). For example, participants wanted education from someone in recovery, or through the internet as well.

Improved support and knowledge of eating disorders among healthcare professionals. This category represents the wishes of participants for health professionals who are better educated on EDs and how to speak to someone who has an ED. In addition, it also represents the wishes of participants for health professionals to be more empathetic and supportive. One participant remarked:

> I think that like, yeah, like more education for like certain care workers, especially people working in the industry. Like, for instance, like, yeah, that the women who were like social or support workers, like they're literally working with these people. So I like either I feel like they should have gone through it or they should have education on it.

Often participants would almost laugh when stating their wish for this, and commented on the absurdity of the fact that some healthcare professionals are not educated on EDs and yet they work with the population. An example of a participant commenting on the absurdity includes a participant stating:

> I think having the medical professionals quite educated if they're working when people have eating disorders disorders...Yeah. Cause I would hear from doctors like go eat a burger and stuff like that.

People and society were better educated on eating disorders. Half of participants stated that they wished that society in general knew more about EDs. Some participants commented on wishing people knew that they were not attention seeking, and other participants commented on how they wished others had more of a general awareness. These comments included a participant saying, "I think just for people to know more about EDs would have been helpful, you know, like for people, um, to know more about, okay these are warning signs." Participants commented that they felt they may have been better supported if more people were educated on EDs.

People would have reached out and asked. Participants commented that they wished that a friend or family member would have privately had a conversation with them about what they have noticed while expressing concern. One participant said, "I wished that like, you know, people who cared about me would have expressed their care and their concern." Participants commonly commented on how they wished people would have recognized that some of their behaviours were "cries for help" and they wished people would have been bold enough to inquire.

My environments were more accepting and safe. This category represents how participants wished that their environments at home or in treatment were more accepting, and that they could talk about their ED without it being a secret. Some participants commented on wanting a safe Christian environment, as she felt as though the spiritual environments she was in were not emotionally safe. Another participants described wanting an after school program for girls struggling with disordered eating. When asked about wish list items, one participant stated that she wished, "that there was an environment that was created where I felt safe enough to tell them without it being months."

More social support. This category included participants stating they wished for further connection with others. Participants stated they wished that their friends handled their ED in a more compassionate way and were not so intrusive, and also commented on how they wished they could have had more friends in general. One participant stated, "I feel like it would have been really helpful to have a solid group of friends." This is likely tied to the hindering category of "perceived unhelpful behaviour from friends," as within that category participants commented that the withdrawal from participants was difficult for them.

More access to eating disorder specific support. Forty percent of participants commented on how they wanted more access to support in various ways including in rural settings, after the age of 25, or throughout different stages of recovery. Some participants stated that they wished that they had more support after they were doing better because they were not allowed to be in a program after they had reached a certain milestone in recovery. When asked what she wished for, one participant stated, "Um, maybe more accessibility? Like, because I'm a rural person, it was like an hour and a half drive to get to a counselling appointment." Another participant shared a similar sentiment, stating, "So I honestly wish there was more resources for people who are like over 25 yeah. That's the biggest thing for me."

People did not make comments about bodies. This category represents participant's wishes for others to not make comments about both their body and other people's bodies. One participant stated that she wished, "people didn't make bloody comments about my body, but there's no way to stop that from happening. But that was extremely damaging." Another participant stated, "I wish people wouldn't have made shitty comments," referring to comments about the body.

Summary and Conclusion

The perspectives of ten women who experienced EDs in adolescence in this study point to thirteen categories that help developing shame resilience, fifteen categories that hinder developing shame resilience, and nine wish list categories. Areas such as social support, family involvement, and healthcare professionals were common across all three sections (helping, hindering, and wish list). Participants found social support helpful, unhelpful behaviour from others hindering, and wished for more social support. Similarly with family they found support from parents helpful, unhelpful behaviour from parents hindering, and they wished for more support from family. Again echoing the same pattern, participants found knowledgable healthcare professionals and personal connections with healthcare professionals helpful, inconsiderate actions from healthcare professionals to be hindering, and they wished for improved support and knowledge from healthcare professionals.

The results include psychological, social, and cultural aspects of the participant's lives. For example, psychological counselling is mentioned, and social factors relating to peers, family, or professionals are mentioned. Culture is also addressed through the categories on social media, and wishing for a more educated society. The following chapter will further summarize the results before this study's fit within current literature, the findings that depart from current literature, contributions, clinical implications, limitations, and future research directions.

CHAPTER 5: DISCUSSION

To address the research question of this study, the enhanced critical incident technique (ECIT) was used to explore what helped and hindered developing shame resilience from the perspective of adults who were diagnosed with an ED as an adolescent. This chapter will discuss how the results listed in the previous chapter relate to existing literature on EDs, shame, and shame resilience as well as specific ways in which the current findings depart from existing literature. Discussing the fit within the literature also serves as the final credibility check within ECIT (i.e., theoretical agreement; Butterfield, et al., 2009). Contributions of the study, clinical implications, and strengths and limitations will be discussed next, and the chapter will conclude with recommendations for future research.

Summary of Present Findings

Thirteen helping categories were established. Among these categories, social support stood out as it represented one fifth of the total incidents disclosed, and was endorsed by 90% of participants. It is also of note that the second and third most listed category involved healthcare professionals, as the second category was personal connection with healthcare professionals, and the third was psychological counselling. Fifteen hindering categories were identified. It is noteworthy that comments from others was listed repeatedly, and if all categories about comments were considered one category they would account for almost a quarter (23%) of all hindering incidents reported. Nine wish list categories were found. More knowledge about EDs was a strong desire of participants, as they specifically wished for this for themselves, for healthcare professionals, and for general society.

Certain topics were present under all three categories: helpful, hindering, and wish list. This presence within multiple sections may underscore the importance of these factors in developing shame resilience for adolescence. The topics that were found in all three sections involved social support, family support, and healthcare professionals. The presence of social support was helpful, perceived unhelpful behaviour from friends was hindering, and participants also wished for more social support. Similarly, practical support from family (specifically parents) was helpful, unhelpful behaviour from family was hindering, and more support and understanding from family was wished for. Personal connection with healthcare professionals and having knowledgeable health care professionals represented two helpful categories, and perceived inconsiderate actions and comments from health professionals was hindering. Participants also wished for improved support and knowledge of EDs among healthcare professionals.

The concept of spirituality was present in both the helpful and hindering categories, as having a spiritual connection was helpful and specific spiritual practices were hindering. In addition the idea of personal freedom was present in both the helping and hindering categories, as having freedom to make choices was helpful but feeling watched and controlled by others was hindering. Education was also listed as something that was helpful, and more education for self and more education for society were listed as wishes.

This study had original findings that did not occur in the relevant scholarly literature. For example, the helpful category of humour and celebrating victories in ED treatment has not appeared during any of the research studies reviewed in preparation for this study. Participants described humour to be helpful not only with family, but also with healthcare professionals and peers. Many participants shared touching stories where they laughed until they cried with a parent, even during difficult stages of treatment. Participants described that appropriate joking and the use of humour with medical professionals was helpful as well, and in many ways they described the use of humour as being therapeutic.

An additional novel finding was the category called "spiritual connection." Research in the area of innovative treatments for EDs that involve psycho-spiritual elements is still growing (e.g., Lafrance et al., 2017), and this study may contribute in this area as it has found that a spiritual connection is a helpful category, and specific spiritual practices may get in the way of developing shame resilience (e.g., lent or fasting). Some participants described their spiritual connection as being a meaningful moment that represented significant turning point in their recovery, but some participants described their spiritual connection as something that was more ongoing. An example of a spiritual connection that was ongoing was a participant discussing how reading her Bible and praying regularly was helpful for her.

Fit with the Extant Research Literature

As mentioned previously, assessing the fit within the current research literature is a part of the ninth credibility check within ECIT (Butterfield et al., 2005). Even though ECIT is by definition an exploratory method, it is important to compare the emergent categories with relevant research (Butterfield et al., 2009). If a category is not consistent with previous research, it is important to note that this may mean that the study may have novel results as opposed to implying that a category is not valid (Butterfield et al., 2009). The categories that are not consistent with previous research warrant further investigation (Butterfield et al., 2009). Instead of reviewing each category one by one, this was discussed in: (a) theoretical agreement of helpful categories, (b) theoretical agreement of hindering categories, (c) theoretical agreement of wish list categories, (d) summary.

Theoretical agreement of helpful categories. The category of education for self and others may overlap with the second factor of Brown's (2006) SRT, namely critical awareness regarding social/cultural expectations. Many participants commented on how education helped them better recognize, understand, and critically engage with social media and culture. For example, one participant stated that learning about consumerism and advertisements in the media helped her understand and think about pictures in the media differently. Within the helpful category of psychological counselling, participants commented on how it was helpful when their counsellor helped them process and articulate their feelings, as well as externalize what was going on for them. This could be considered in line with Brown's fourth factor, which is "the ability to speak shame or possess the language and emotional competence to discuss and deconstruct shame," (Brown, 2006 p. 48). Participants often reported that psychological counselling was helpful because they were able to talk about their shame and "break it down."

The two categories of social support and helping others that were found in this study seem to fit with the third tenet of SRT, "the ability to form mutually empathetic relationships that facilitate reaching out to others" (Brown, 2006, p. 47). Within the social support category participants described appreciating empathetic friendships. Within the helping others category participants also described finding it helpful to support other people. A clarification that is important to make is that the participants in this study did not specifically state that they had mutually empathic relationships, although for some this may have been the case. While the two categories of helping others and social support are similar to the third SRT factor, the two experiences of receiving social support and helping others seem to be separate in some ways. More specifically, while Brown (2006) discusses a mutually empathic relationship in SRT, many participants talked about finding it helpful to receive support from one person, and it being helpful to offer support to a person, but often these were different people.

Regarding supportive relationships, the helpful CI of support from parents that was found in this study is consistent with current research that suggests support from parents is helpful in ED treatment (Halmi et al., 2005). In addition, this CI also fits with APA (2010) practice guidelines which state that family involvement, especially in the initial assessment of an ED in adolescents, is essential. It is important to note that the participants in this study did not only discuss general family involvement, as outlined in previous research. Instead, the participants in this study were specific that practical support from parents was helpful as opposed to support in general. Examples of practical support include participants commenting on parents paying for new clothing or driving them to appointments.

Theoretical agreement of hindering categories. As has been mentioned, comments from others was prominent as it represented not only one but three hindering categories (comments about being overweight, comments about being underweight, general comments about one's body). This fits with existing literature, as Goss and Allan (2009) suggest that there are two processes in shame: (a) what I think others think about me (i.e., external shame) and (b) what I think about myself (i.e., internal shame). Comments from others fit into the first process that Goss and Allan (2009) describe, external shame, as participants comment that this related to what they thought others thought of them.

Another category was, "falling short of expectations of self." Goss and Allan (2009) refer to two processes of shame, and the second is often referred to as internal shame, or, "what I think about myself." The finding of not meeting personal expectations fits with Goss and Allan's second process well, as participants described that it was hindering for them when something occurred that they felt was not up to their personal standard. For example, participants described incidents of binging or cutting to be hindering for them because they interpreted these incidents as being failures to meet their personal expectations of themselves. They also described incidents such as lying to others to be hindering in this way as well.

The category of unhelpful use of social media is in many ways connected to Brown's (2006) SRT, as she comments that part of building shame resilience involves increasing the "level of critical awareness regarding social/cultural expectations and the shame web," (p. 48). The connection between unhelpful use of social media and Brown's tenet of SRT just listed is that participants commented that consuming social media (without being critical and aware of sociocultural messaging) hindered developing shame resilience. It can be inferred that, because of this, one may benefit by increasing the level of critical awareness with respect to consuming social media. In addition, participants did discuss incidents related to learning about the media and marketing that were helpful (under the education/access to information helpful category). However, it is surprising that, in this research study, participants did not discuss social pressures and patriarchal narratives more in the research.. This may be partly due to the fact that media likely looked different for the participants when they were adolescents. For example, for one participant approximately 30 years had passed since she was an adolescent with an ED, meaning that Instagram, Facebook, or other social media platforms were not developed yet.

Theoretical agreement of wish list categories. It is difficult to accurately comment on the fit of the wish list items within current literature, as wish list items are often hypothetical. However, it is possible to comment on the subject matter that is discussed within the wish list items and how that fits within relevant literature. The wish list item of more understanding and support from family makes sense given research findings that show that parental involvement in treatment has also been found to, "reduce symptom severity and treatment attrition rates," (Marcon et al., 2017). Regarding shame specifically, Van Vliet's (2008) research on shame reparation and resilience discusses a finding called, "finding allies," which refers to individuals finding people within their existing social network or making new connections to gain support (p. 238). Van Vliet (2008), states that for most, these allies are usually close friends, family members, or one's partner. This aligns with not only the wish list item regarding more support and understanding from family, but also the wish list item of more social support. Van Vliet, (2008) states, "finding just one or two allies—people who know the individual well, provide unconditional acceptance, and come to the individual's side when needed—can make a critical difference" (p. 238).

Summary. The findings of this study are consistent with Goldman and Greenberg's (2015) understanding of shame as an emotion that increases difficulties as an individual attempts to navigate life's emotionally evocative events. When participants discussed incidents that hindered developing shame resilience, they often remarked that the experience of shame made treatment very difficult. Participants also commented that counselling was helpful, and within counselling there were incidents listed that included experiencing and processing shame. This is consistent with EFT's theory that experiencing emotion is a key method of processing emotions (Goldman and Greenberg (2015).

The findings of this study are consistent with the psycho-social-cultural understanding of shame, as there were categories present that were psychological in nature, social in nature, and cultural in nature. For example, categories include psychological counselling, social support, and wishing for improved understanding of ED's in the general society (cultural). It was common for participants to bounce between psychological factors, social factors, and cultural factors throughout each interview, and often the incidents they listed included aspects of each. Individuals were not able to consider shame exclusively psychological, social, or cultural, which aligns with Brown's (2006) understanding of shame. Instead, shame represented an interplay between these three factors.

Contributions to Literature

The current study makes contributions to the literature in the area of shame resilience and adolescent EDs. While there are many studies that investigate adolescent EDs (Fairburn et al., 2000; Fitzsimmons-Craft et al., 2018; Herpertz-Dahlmann, 2009; Iannaccone et al., 2016) and some that study shame resilience (Brown, 2006; Dayal et al., 2015), there are no previous research studies completed on shame resilience and EDs in adolescence. Specifically, this study adds a qualitative perspective of shame resilience and eating disorders to the pre-existing literature that is dominated by quantitative studies. The incorporation of the experiences and voices of individuals who have had an ED into the research literature is valuable as counselling psychology is defined by the intersection between research and practice (Bedi, Sinacore, & Christiani, 2016).

This study also makes a contribution through offering a different perspective on SRT in two distinct ways. First, this study uses the framework of SRT in relation to a specific subpopulation, adolescents diagnosed with EDs. This is different than previous research, as in Brown's (2006) study, she interviewed over 200 women with diverse backgrounds. The second way this study offers a new perspective on SRT is through the practical methodology chosen, ECIT. Brown's (2006) study used grounded theory, and the goal of her study was to understand the participants' "main concerns" related to experiencing shame. Instead, this study aimed to identify clear incidents that helped or hindered the development of shame resilience.

Even though it is not a predominant finding, the hindering category that involved dance instructors was noteworthy, as the body of research on EDs in sport and dance has been steadily increasing over the last three decades (Voelker & Galli, 2019). This research study may add to this area, as half of the participants in the present study listed incidents to do with dance and their dance teachers. Dance teachers comments and behaviour regarding body was a hindering category for developing shame resilience. Current research suggests that treatment approaches should tailor ED treatment to the sport and dance experience (Voelker & Galli, 2019), which makes sense due to the prevalence of dance related incidents listed in this study.

Clinical Implications

The findings of this study have implications for clinical practice even though this was not a clinical or treatment study. This study highlights a client-oriented perspective and the results suggest ways of addressing shame and building shame resilience in clinical practice. For example, participants were clear that having a personal connection with a healthcare professional was helpful for developing shame resilience. Being more deliberate in building a personal connection with an adolescent with an ED may therefore be valuable. This may also impact the way that a professional chooses to interact with an adolescent with an ED. Having knowledgeable healthcare professionals was also a category that has clinical implications. For example, a clinical implication would be that healthcare professionals specifically gain knowledge in the area of EDs to better assist clients in building shame resilience. This could potentially be built into continuing education requirements or staff training. In addition to finding it helpful when they had knowledgeable healthcare professionals, participants also found it helpful when they had education and access to information themselves. This is clinically relevant as it relates to the importance of psycho-education and information accessibility.

Clients not only wished for more education for self and others, but also wished for more accessibility to ED specific support. They hoped for more accessibility not only location wise, but also to have access to support even when they aged out of the child and youth mental health system. For example, one participant stated that it was very frustrating and unhelpful when she was no longer allowed to access support where she had previously accessed support due to her age. Program delivery options may be considered in light of these findings. For some participants who lived in more rural settings, online options may be considered. Bridging programs between adolescent and adult access to support may also be considered.

The results of this study also highlight that perceived inconsiderate actions from healthcare professionals get in the way of developing shame resilience or makes developing shame resilience harder. While some healthcare professionals may think that adolescents do not notice small actions, a clinical implication of this study is that even quick comments from healthcare professionals are noticed and can be significant to adolescents with an ED. Many participants, when recalling incidents related to healthcare professionals, remembered vividly and with detail an incident where they perceived inconsiderate behaviour from one of their healthcare professionals.

Clinicians who are working with adolescents with EDs who are experiencing high levels of shame may find the results of this study helpful, as it may act as a prompt for clinicians to address aspects of an adolescent's life that they may not have otherwise. For example, a clinician may address social media use with a client or encourage education and access to information. Clinicians may also ask questions about a participant's spiritual life, or how some of their extracurricular activities have impacted them (for example, dance).

Strengths and Limitations

A strength of this study includes the high participation and incidence rates. Participation rate refers to the number of participants that endorsed a specific category, and incident rate refers to the amount of incidents that are in each category. Regarding participant rate, Butterfield et al. (2005) recommends a 25% endorsement rate for a category to be formed, but it was common for the categories in this study to have a much higher endorsement rate. For incident rate, a strength of this study is the amount of incidents that were yielded from ten interviews (CIs = 455), meaning that each participant recalled an average of 45.5 incidents. This amount of incidents per participant was a surprise to the primary researcher.

Another strength of the study was the variation in the type of treatment modality participants experienced, as it provides results that are not specific to one treatment experience. Participants accessed a combination of outpatient treatment (*n* = 6), inpatient treatment (*n* = 4), residential treatment (*n* = 2), and private counseling (*n* = 4)

Participants often stated that they had a difficult time separating what was shame from the ED and what was shame in general. This could be seen as a limitation as some may criticize that some of participant's responses may have regarded their experience of shame in general as opposed to strictly their experience of shame to do with their ED. This being said, an important takeaway message from this is that shame from other areas of an individual's life may still be prominent when thinking about or going through a recovery process from an ED.

This study was retrospective in nature and required that participants recall incidents from their experience having an ED during their adolescence. For most participants this was within the last 5 to 8 years, however for a small number of participants this required recalling incidents from 20 or more years ago. Further insight may have been gained between adolescence and their current age, which may impact how they view what was helpful and hindering. As mentioned, one of the experts said they were curious about the participants wish for people to have reached out to them, as her experience as an ED clinician is that usually people do not like, appreciate, or respond well to people reaching out. It is a curiosity as to whether or not this wish list item emerged due to retrospective recall or due to an actual wish that was present during adolescence.

During recruitment, the primary researcher was surprised by how many people asked if they could participate but were excluded due to not having a formal diagnosis of an ED. This may suggest that future research would be helpful for individuals who have diagnosed themselves independent of a formal diagnosis. Many of the individuals who asked to participate asked to be sent the final copy of this study due to interest in the subject matter.

Future Research Directions

This study continues the line of research that documents that shame and EDs are connected. Since many treatment methods for EDs in adolescence involve the family, it would be useful for future research to involve both the family members (parents in particular) and adolescents together. Involving the family in further study may also be helpful, as participants commonly mentioned family members in both helpful, hindering, and wish list categories. Further insight about the relational dynamics at play could be gained by involving the family in further study on adolescent EDs and shame as well.

Considering that ED treatment is typically urgent and intense due to the severity of the disorders, it is often difficult for treatment providers to maintain and involve holistic aspects of healing. Participants commented on holistic aspects of healing such as embodied experiences and spiritual connections, and also wished for things such as more education. Participants also commented on human connection, whether that be from a family member or health care professional. Further research on these holistic aspects of healing would be helpful, as it appeared from this study that these holistic and human elements were critically helpful.

Each participant in this study had a wealth of information about their experience, and many were able to give vivid descriptions of their lived experience of shame or inner experience of working through their feelings. While the method of ECIT did capture helpful results, it may be helpful to incorporate an additional method such as narrative analysis as a way to capture the participants lived experience in a way that recalling incidents cannot. It is recommended that a secondary research method, such as a narrative analysis or thematic analysis, be conducted with the same data to see if there are further findings.

As mentioned previously, there was a high level of interest in the study by people who experienced disordered eating but never received an official ED diagnosis. Even when informed that they did not meet the eligibility requirements, many asked to be sent the final results as they were curious to see the findings. Some individuals also asked for referrals for counselling, or other resources to get help with their relationship with food or disordered eating behaviours. Future research on shame resilience with disordered eating may be a needed area. This also may be helpful so that shame can be better addressed for disordered eating behaviours before the onset of a diagnosable ED.

Conclusion

When adolescents develop EDs, it can impair their quality of life (Jenkins, Hoste, Meyer & Blissett, 2011), have significant impacts on development (APA, 2013), and result in a 25-year decrease in lifespan (Norris, Bondy, & Pinhas, 2011). The scarcity of studies on shame resilience and EDs in adolescence is frightening, as EDs typically develop in adolescence (Jaffa & McDermott, 2007), and research has previously shown that shame is a core experience in the onset, maintenance and recovery from EDs (Kelly et al., 2014), a key risk factor for EDs (Burney & Irwin, 2000), and a predictor of EDs (Duffy & Henkel, 2016).

This study highlighted that shame is an emotion that results in, "increasing difficulties as the individual attempts to navigate life's emotionally evocative events and developing challenges" (Goldman & Greenberg, 2015). Ten women recalled incidents during their ED in adolescence that they felt helped or hindered developing shame resilience, and also recalled what they wished for. Using the ECIT method, 455 incidents were extracted and grouped into 13 helpful categories, 15 hindering categories, and 9 wish list categories. These categories represented an intersection of psychological, biological, and cultural factors, and also involved both internal and external factors. This is fitting as EDs in adolescence, "challenge clinicians to expand their understanding beyond the individual and consider external pressures that trigger and maintain the process of disordered eating," (Jaffa & McDermott, 2007). Results of the study have clinical implications, such as making suggestions as to what healthcare professionals may focus on when working with adolescents with an ED.

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APPENDIX A: INCLUSION CRITERIA

- Participant must be 19 or older, and have received a diagnosis of an eating disorder between the ages of 11 and 19
- Participant must self-identify as being in recovery from the ED
- Participant must have accessed professional help specifically for their eating disorder
- Participant must have experienced shame in relation to their eating disorder

Screening Questionnaire	
	Are you 19 or older? Current age:
	Did you receive an ED diagnosis between the ages of 11 and 19? What type of ED? Who diagnosed you? What age were you when you were diagnosed?
	Do you self-identify as being in recovery? _______
	Did you access professional support while you had the ED?

	What type of help? ________________________
	Did you experience shame in relation to your eating disorder?

APPENDIX B: RECRUITMENT POSTERS

WERE YOU DIAGNOSED WITH AN EATING DISORDER BETWEEN 11-19?

IF YOU ARE 19 OR OLDER AND ARE CURRENTLY IN RECOVERY...

YOU COULD PARTICIPATE IN A RESEARCH STUDY!

PLEASE CONTACT HILARY AT HILARY.EVANS@MYTWU.CA FOR MORE INFORMATION.

PARTICIPANTS WILL RECEIVE A $10 STARBUCKS CARD FOR THEIR TIME

WERE YOU DIAGNOSED WITH AN EATING DISORDER BETWEEN THE AGES OF 11 AND 19?

WE ARE CONDUCTING A RESEARCH STUDY AND WOULD LOVE TO HEAR FROM YOU!

YOUR EXPERIENCE AND INSIGHT ARE IMPORTANT.
PARTICIPATION WILL TAKE APPROXIMATELY 90 MINUTES PLUS A BRIEF FOLLOW-UP CONVERSATION. YOU WILL RECEIVE A $10 STARBUCKS CARD.

TO PARTICIPATE OR FOR MORE INFORMATION PLEASE CONTACT HILARY AT
HILARY.EVANS@MYTWU.CA

Other Email Announcements will also be used with the following information on them:

Did you have an eating disorder between the ages of 11 and 19 and identify as being in recovery?

If so, you may be a great fit for this study! Your experiences are important to us and we need your help to learn more about responses to shame throughout the recovery process.

We are looking for:

- Adults 19+ who received a diagnosis of an eating disorder between the ages of 11 and 19
- Participants must self-identify as being in recovery
- Participants must have accessed professional help during their ED.

What will it involve?

- Total time commitment will be less than three hours
- The research team is willing to travel to a location that is convenient for you
- Confidentiality will be maintained
- Participants will receive a $10 starbucks card for their time

For more information or to participate please contact Hilary Evans at Hilary.Evans@mytwu.ca

APPENDIX C: INTRODUCTORY LETTERS

INTRODUCTORY LETTER A (RECRUITMENT)

Dear Prospective Participant,

This letter describes a research project that I am conducting as a part of my Masters degree in Counselling Psychology at Trinity Western University. The goal of my research is to understand what helps and hinders adaptive responses to shame throughout the recovery process of an ED throughout adolescence.

Even though this is a part of my Masters degree in Counselling Psychology and I am currently being trained as a clinical counsellor, my role as a researcher in this study will not involve working with you in a therapeutic or treatment role. Instead, the purpose of this research is to gain a greater understanding of what helps and hinders adaptive responses to shame. The goal of this study is to contribute to practice oriented research with the overarching goal of improving clinical practice and clinical outcomes.

Who can participate?

We are looking for individuals 19 and older who received a diagnosis for an eating disorder between the ages of 11 and 19, and self-identify as being in recovery. Participants must have accessed professional support throughout their ED.

What will participation look like?

Participation will include one face-to-face interview that will last between one and two hours. Participants will be asked about specific incidences where they felt something helped or hindered their responses to shame. Participants will then be contacted afterwards for their feedback.

What's in it for me?

Each participant will be given a $10 Starbucks gift card to thank them for their time. Many individuals also experience a sense of fulfillment in contributing to further research in the area of eating disorders.

Can I change my mind, and is my participation confidential?

Absolutely. Participation in this study is voluntary, and consent can be revoked at any time throughout the process.

How do I get more information or sign up?

If you would like to participate or learn more information, please contact me at Hilary.Evans@mytwu.ca

Thank you for your interest,

Hilary Evans, BA, MA in progress

INTRODUCTORY LETTER B (PARTICIPANTS)

Dear Participants,

Thank you so much for being willing to participate in this study. Your participation is greatly appreciated and so important to us. This letter describes a research project that I am conducting as a part of my Masters degree in Counselling Psychology at Trinity Western University. The goal of my research is to understand what helps and hinders adaptive responses to shame throughout the recovery process of an ED throughout adolescence.

Even though this is a part of my Masters degree in Counselling Psychology and I am currently being trained as a clinical counsellor, my role as a researcher in this study will not involve working with you in a therapeutic or treatment role. Instead, the purpose of this research is to gain a greater understanding of what helps and hinders adaptive responses to shame. The goal of this study is to contribute to practice oriented research with the overarching goal of improving clinical practice and clinical outcomes.

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Absolutely. Participation in this study is voluntary, and consent can be revoked at any time throughout the process.

How do I get more information or sign up?

If you would like to participate or learn more information, please contact me at Hilary.Evans@mytwu.ca

Thank you for your interest,

Hilary Evans, BA, MA in progress

APPENDIX D: DEMOGRAPHIC INFORMATION FORM

Demographic Questionnaire: Adolescent	
Age:	
Sex/Gender:	
Marital Status:	
How many people total live in your home?	
What is the highest level of education you have completed? If in high school, what grade are you in?	
Employment status:	
Ethnic/ Cultural Background	
What was your country of birth?	
To your knowledge how long have you had an eating disorder?	
What type of eating disorder do you have?	
What are some symptoms of your eating disorder?	
To your knowledge does anyone else you know have an eating disorder? (Family, friends, peers, etc.)	

APPENDIX E: INFORMED CONSENT

Thank you for your interest in the project, Shame Resilience in Adolescents Diagnosed with Eating Disorders: A Critical Incident Technique Study

About the Project

The purpose of this research is to gain a greater understanding of what adolescents with a diagnosed eating disorder develop shame resilience. The goal of this study is to contribute to practice oriented research with the overarching goal of improving clinical practice and clinical outcomes.

Confidentiality

All information given in this study will be kept strictly confidential. When applicable, your name will be associated with a numerical code to be matched with the data. All data will be stored on an encrypted USB after being recorded. The limits to confidentiality are when the researcher has the right to believe that any participant is planning on harming himself or herself, others, they disclose child abuse, or the data are subpoenaed by court.

Commitment

Participation in this study will require 2-3 hours in total, and will include one face-to-face interview and potentially one phone call.

Honorarium

Participants will receive a $10 starbucks gift card at the beginning of the interview process to thank them for their time. Participants will be allowed to keep the gift card if they decided to withdraw from the study at any time.

Potential Risks & Benefits

There is a potential risk that some of the interview questions may cause emotional distress or negative feelings. Eating disorders are diseases that have both physiological and psychological elements, and they may be distressing to talk about for some individuals. Some may feel as though the questions are personal. If you do experience distress and do not wish to continue in the study, please let the researcher know and you can be withdrawn and will be connected with appropriate resources without penalty.

A potential benefit is that you may feel as though your past experiences will help adolescents experiencing eating disorders in the future. This may give a sense of purpose or fulfillment to participants. There is also the possibility to feel a sense of pride as you are treated as the expert in the area of eating disorder recovery.

Right to Withdraw

You have the right to withdraw from this project at any time. If at anytime you would like to withdraw, please let the researcher know and you will not be asked any further questions. If any data has been recorded, the data will be destroyed. If an informed consent form has been received, a copy will be kept in an encrypted format.

Contact Information

If you have any questions or concerns, please do not hesitate to contact Hilary or her supervisor.

Principle Investigator: Hilary Evans: Hilaryevans19@gmail.com 604-786-8208

Supervisor: Mihaela Launeanu: Mihaela.Launeanu@twu.ca 605-513-2121 ex. 3351

If you have any questions about your treatment or rights as a research participant, you may contact Elizabeth Kreiter in the Office of Research, Trinity Western University at 604-513-2167 or researchethicsboard@twu.ca

Your signature below indicates you have had your questions about the study answered to your satisfaction and have received a copy of this consent form for your own records. Your signature also indicates that you consent to participate in this study.

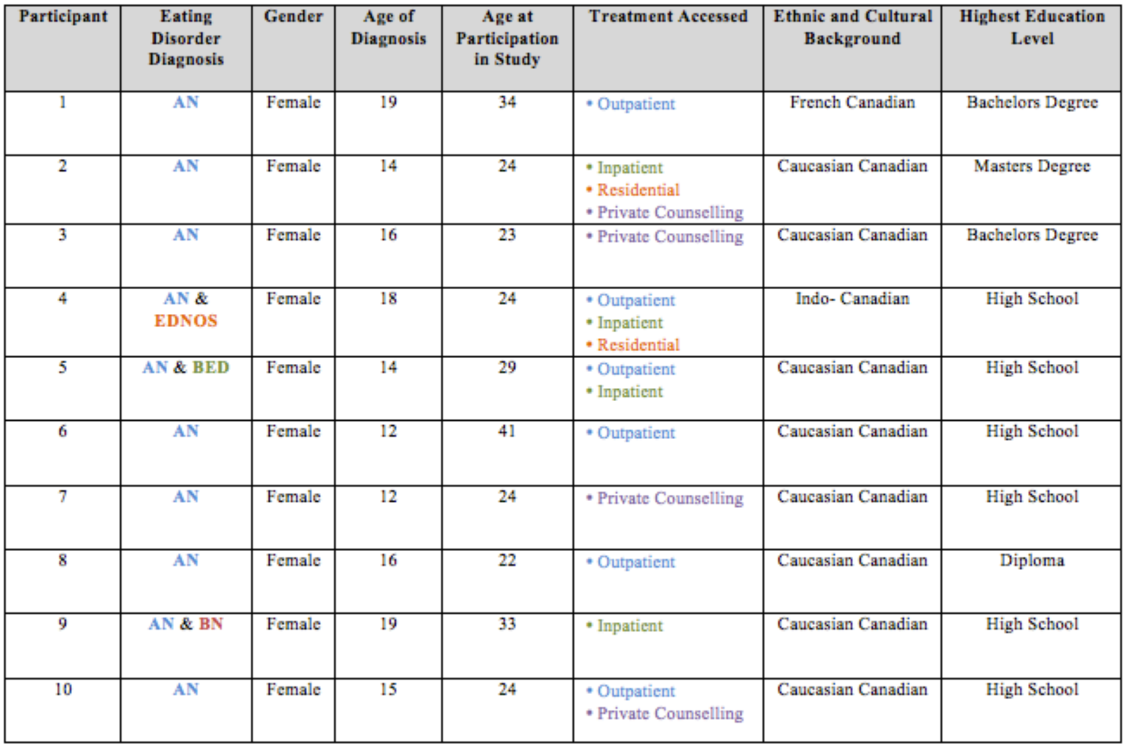
Signature: ______________________________________ Date: ___________________

Printed Name: ___________________________________

Please list your email below if you are interested in receiving an email with the findings of the research:

Email: ____

APPENDIX F: PARTICIPANT DEMOGRAPHICS



Participant	Eating Disorder Diagnosis	Gender	Age of Diagnosis	Age at Participation in Study	Treatment Accessed	Ethnic and Cultural Background	Highest Education Level
1	AN	Female	19	34	• Outpatient	French Canadian	Bachelors Degree
2	AN	Female	14	24	• Inpatient • Residential • Private Counselling	Caucasian Canadian	Masters Degree
3	AN	Female	16	23	• Private Counselling	Caucasian Canadian	Bachelors Degree
4	AN & EDNOS	Female	18	24	• Outpatient • Inpatient • Residential	Indo- Canadian	High School
5	AN & BED	Female	14	29	• Outpatient • Inpatient	Caucasian Canadian	High School
6	AN	Female	12	41	• Outpatient	Caucasian Canadian	High School
7	AN	Female	12	24	• Private Counselling	Caucasian Canadian	High School
8	AN	Female	16	22	• Outpatient	Caucasian Canadian	Diploma
9	AN & BN	Female	19	33	• Inpatient	Caucasian Canadian	High School
10	AN	Female	15	24	• Outpatient • Private Counselling	Caucasian Canadian	High School

APPENDIX G: INTERVIEW INFORMATION TABLE

Participant	Primary Interview Length	Date	Location
1	127 minutes	May 17, 2019	In Person
2	91 minutes	April 16, 2019	In Person
3	73 minutes	May 3, 2019	In Person
4	86 minutes	May 20, 2019	Zoom
5	97 minutes	April 5, 2019	In Person
6	70 minutes	June 7, 2019	In Person
7	70 minutes	May 14, 2019	Zoom
8	76 minutes	May 20, 2019	Zoom
9	97 minutes	June 7, 2019	In Person
10	98 minutes	July 9, 2019	In Person

APPENDIX H: INTERVIEW SCRIPT

Researcher Interview Guide

- ➢ Double check informed consent is completed.
- ➢ Introduce self and ask participant if they have any questions.

Semi-Structured Interview Questions:

1. Initial open-ended (warm up) questions:
    a. Please tell me the story of your experience with an eating disorder throughout adolescence.
    b. Please tell me about your experience of shame in relation to your eating disorder throughout adolescence.

*** EXPLAIN ECIT & THE THREE CATEGORIES: HELP, HINDER, WL HERE*

2. Can you think of any incidents that helped you move through shame?
    a. Prompts:
        i. Can you think of a time when ___?
        ii. What happened?
        iii. If I was a fly on the wall, what would I see?
3. Can you think of any incidents that got in the way of moving through shame?
4. What do you wish you had that would have helped you move through shame?
    a. Prompts:
        i. Resource? Person? Experience?

Prompt Option:

If stuck, you can prompt based on Brown's four factors:

1. The ability to recognize and accept personal vulnerability

2. The level of critical awareness regarding social/cultural expectations and the shame web
3. The ability to form mutually empathic relationships that facilitate reaching out to others
4. The ability to "speak shame" or possess the language and emotional competence to discuss and deconstruct shame

Closing:

Before ending the interview, the researcher will ask:

- How are you feeling after sharing these incidents and reflecting on your eating disorder in adolescence?
    - Researcher will respond appropriately if the participant is emotionally distressed (for example empathic reflection, taking a break, or using crisis management skills)
- Is there anything else you would like to add?

READ DEBRIEF SCRIPT

APPENDIX I: DEBRIEFING DOCUMENT

Thank you for your participation in this research project. I greatly appreciate your time and contribution.

If you have any questions or concerns, please do not hesitate to contact Hilary or her supervisor.

Principle Investigator: Hilary Evans: Hilary.Evans@mytwu.ca 604-786-8208

Supervisor: Dr. Mihaela Launeanu: Mihaela.Launeanu@twu.ca 605-513-2121 ex. 3351

If you have any questions about your treatment or rights as a research participant, you may contact Elizabeth Kreiter in the Office of Research, Trinity Western University at 604-513-2167 or researchethicsboard@twu.ca

If you are experiencing distress at a later time and are in need of resources, some local resources are listed below:

BC Crisis Line: 604-872-3311

Kelty Eating Disorder Crisis Line: 310-6789

Fraser River Counselling
604-513-2113
www.fraserrivercounselling.ca

Langley Community Services
604-534-7921
info@lcss.ca
https://www.lcss.ca/

If you are in need of resources and none of the above resources work for you, please do not hesitate to contact Hilary Evans at the contact information listed above, and she can direct you to alternative resources.

Thanks again!

Hilary Evans

APPENDIX J: PARTICIPANT FOLLOW UP EMAIL

Hi Participants,

I hope you are having a great week. I am excited to be able to share the results of the study with you, and I am looking forward to getting your feedback. It was such an honour for me to hear all of your stories, and I want to make sure that these results appropriately and correctly capture your experience.

I have attached the results in two forms: a one page overview visual, and a results summary overview that includes examples in the forms of quotes (with all descriptive information removed).

Please take a read through the results and consider the following questions:

1. Do the category headings make sense to you?
2. Do the category headings capture your experience and the meaning of the incidents you recalled?
3. Is there anything that does not seem to fit from your perspective? If so, what doesn't fit?

I am also interested if you have any other feedback that doesn't fit into these questions.

If you could respond via email, text, or a phone call within one week that would be fantastic. I have completed my first draft of my thesis, and am looking forward to incorporating your feedback into my revised copy before I move towards next steps.

If you'd like to have a conversation about the results, I would be more than happy to speak with you (or meet up!). Most of you have it, but my number is 604-786-8208 if you would like to text or call.

Thanks for your time,

Hilary Evans

APPENDIX K: SUMMARY OF RESULTS

- ***Incidence rate*** *refers to the percentage of incidents within the total incidents in each respective segment. For example, if the incidence rate for a helping category was 10%, that means that one tenth of all of the helpful incidents belong to that category.*
- ***Participation rate*** *refers to the percentage of participants contributing to the respective category. For example, if the participation rate for a category is 50%, half of the participants contributed to that category.*

HELPFUL INCIDENTS			
Category Name	**Incidence Rate**	**Participation Rate**	**Examples**
Social Support	20.87%	90%	*"It was at that community that I had, um, that was positive and kind of fighting the shame because even though they knew about it, they weren't like judging me, um, or like criticizing me. And they were, um, like more like concerned and, um, just still treated me like a friend, which is what I needed"* *[Talking about teachers] "They were thinking outside of just like the, the system and they were thinking like, I really care about this person. Like I want to help them, I want to spend extra time with them or I want to take them under my wing."*

Personal Connection with Healthcare Professionals	13.1%	60%	*“You know it was just like her, like speaking life over me and just being like this, you’re going to […]get better.”* *“She saw like my being… not just someone with an eating disorder. It was like ya, seeing me.”*
Psychological Counselling	11.65%	80%	*“There was like this kind of inward battle going on and how I was able to kind of separate yeah. The eating sort of for myself, she was very good at like separating those two things. Oh, for sure. And she did a lot of like, um, like externalizing I think”.*
Practical Support from Parents	9.22%	90%	*“There was no question whether I was allowed to eat or not. Like I, whatever she made, I had to eat. And, um, and so whenever I had like breakdowns or anything, like she was very comforting, very empathetic, um, and really like spoke to like the emotion I was feeling or the fear I had.”* *“She would try and distract me, but that's what I need to, like, she was in tune and aware of the struggle that was going on.”* *“My Mom bought me so many new clothes that fit me*

			throughout every stage of my eating disorder and recovery."
Humour & Celebrating Victories in Treatment	8.25%	40%	*"Joking about it in an appropriate way was really helpful."*
Spiritual Connection	6.3%	70%	*"And then [counsellor name] just was just very, very, um, wonderful. And I think the fact that she shared the same faith as me was huge. She didn't like, she was very good at, um, I was always the one to bring it up."* *"I had another counselor come in and I just connected because it was like she's a lot more like spiritual. Um, and just kind of understood it."* *"I was just at church and in the back and they were just like laying hands on me and praying and I just felt like I was crying and I just was like, like yeah, it was just like this, like my eyes are open."*
Positive Embodied Experience of	5.82%	40%	*"I think that was very positive because I was able to experience my body in a positive way. Um, and I do like*

Body and Eating			*when I dance, like there is a very fulfilling, um, like feeling that comes with it."* *"Dancing was a way, um, sort of to positively experienced my body and it was like a very like, inward experience"*
Knowledgeable Health Professionals	5.83%	40%	*"That's actually a helpful thing. Having a family physician who knew about eating disorders."*
Helping Others	4.85%	60%	*"I was helping this woman who like [...] with just some like food at like the cafeteria or whatever. And that was really helpful for me, feeling like I could help other people in the future."*
Freedom to Make Choices	3.88%	50%	*"If we were grocery shopping, she would make sure that I had some choice about like, um, foods that I wanted her to buy or to make that I really enjoyed eating."*
Education/Access to information -	3.88%	50%	*"I think it was helpful when [the doctor] explained things medically."*
Awareness of Other People with	3.40%	40%	*"At the time it was helpful because I was able to feel not alone and that she actually understood what I was going*

an Eating Disorder			*through and… she didn't think I was crazy for having the thoughts that I was so fat or anything, she understood." [Discussing her interaction with someone else who had an Eating Disorder]*
Supportive Significant Other	2.91%	40%	*"He just didn't' treat me differently when I was sick versus when I was healthy."* *"And he wanted to know more and he wanted to educate himself and then the next time we talked about it, I could tell that he went and did that because he was saying all these things and I'm like, okay. He obviously did some research."*

HINDERING CATEGORIES			
Category Name	**Incidence Rate**	**Participation Rate**	**Examples**
Perceived Inconsiderate Actions and Comments from Health Professionals	13.95%	70%	*"The counsellor encounter, um, probably did… well I don't know, maybe it did add a bit of shame because it was kind of like she was talking about it in a way like, why are you doing this to yourself? Like you're hurting yourself."* *"[My doctor] said I look like a survivor from the*

			Holocaust, which was a little extreme…"
Feeling watched or controlled by others	11.05%	60%	*"And I think I was just mad because I didn't, I truly, truly believed that I was fine. So to have someone diagnose you, even though they were right, yeah. It just took away all my voice. Yeah."* *"Just the feeling of like not being able to wheel the wheelchair to the washroom or shower without my mom. […] it was just like very humiliating to […] girl. Um, and so ya a lack of freedom. It made things worse. It was like, well, I need to, I, I can't control anything."* *"People were taking control from me in every single way. Like I couldn't even use like the washroom without someone going and following me into the washroom. So it was like, I felt like no one trusted me."*
Perceived Unhelpful Behaviour from Family	9.88%	70%	*"My dad would be like, what is wrong with you? Like why don't you eat like you're fucked up."* *"It was quite common for my mom to take away like sweets for me [as a punishment], which makes sense. But, um, also I don't think food should be a reward or punishment."*

General Comments from others about one’s body	9.3%	70%	*“I had quite enough [pressure] coming from myself and any other comments that people made about you look fit, you look good, you look slim you or anything like that. Right? Like even though they were compliments they weren't because they were telling me you your body is for other people to look at and it is only going to be okay if it looks like this”*
Comments about being Underweight	8.14%	70%	*“Let's say the change room before gym class. Yeah. Like girls would say, oh, like, wow, how are you so skinny?”*
Falling Short of Expectations of Self	6.40%	50%	*“I felt so ashamed after this. I thought I was just like such an idiot…I hated myself for it. It was a morning and um, I did my breakfast was like, I don't know, it could've been like five minutes for all I know. And I was like sitting in bed and I was like, where's my breakfast mom? She's like, it's coming. It's no problem. And I had a full blown like tantrum […] like a five year old kid would have. And my mom, that was the one time when she just was like, I can't deal with this right now.* *And she went home for the day. […]I felt like shit. I felt like I was like the worst person. Like how could I have a Tantrum like that? Um, I felt like it wasn't me. It wasn't me*

			at all.”
Comments about being Overweight	5.81%	50%	*“You left for [province] and like, you came back like twice as chunky or something like that as you were before.”*
Perceived Unhelpful Behaviour from Friends	5.81%	50%	*“She just kind of stopped talking to me and I would try to like connect when we were both in town or whatever and she would just always be busy and we just stopped talking”* *“Friends from school and stuff, when I told them so many of them withdrew and I feel like I lost a ton of friends through that time”*
Witnessing Mom’s concern about her own body and food intake	5.23%	40%	*“My mom is really like the, again, the foundation of like some of those main comments that were made going up about body image, what you look like status based on what you look like”* *“My mom would bake a bunch of cookies and she’d eat like four fresh cookies cause they're so amazing out of the oven. And then she'd say, oh I'm, I'm so bad. I have no self-control.”*

Dance Teacher's Comments & Behaviour Regarding Body	4.65%	50%	*"My dance teacher and like, um, instructor or director somehow, like they, um, take the liberty to weigh me and I don't know why. And they never told me what it was, but they would weigh me and I don't know why. And so like, but they would make comments about if I had gained or lost or if it was good or bad. And so that was like, that was really difficult for me too, cause that would happen like in the studio and like nobody else was around, but it still just felt really weird."*
Feeling Exposed by Others	4.65%	50%	*"My mom would disclose what I felt to be too much personal information to friends about my weight and recovery."*
Being Weighed and Discussing Weight	4.07%	40%	*"Going for weigh-in's and stuff like that. I found that kind of shame inducing."*
Abuse from Men	4.07%	40%	*"I was confused what had happened because I thought it was the shame that I felt for doing sexual acts I didn't want to do. And that's why I feel so guilty?"* *"I thought my whole worth or value was in my body."*

Unhelpful use of Social Media	3.49%	40%	*"But I hated what I looked like when I'd compare myself to the fitness models on Instagram or something."*
Specific Spiritual Practices	3.49%	30%	*"I know fasting is a spiritual practice in many different religions, but I don't think for myself that was helpful. Especially to be encouraged in that."*

WISH LIST CATEGORIES

Category Name	**Incidence Rate**	**Participation Rate**	**Examples**
More Support and Understanding from Family	19.48%	60%	*"In hindsight I think I wish they noticed cause I think I was crying out for help and none of them noticed until the collar bone or something was showing then they would just think, oh you, you lost a lot of weight and they would help me or for my behavior."*
More education for self on eating disorders	15.5%	50%	*"It would maybe just be helpful to talk to people who are fully recovered well or just like very much on the road to*

			recovery." *"I think it would've been helpful to have some sort of discussion or crash course about how social media and those influences affected like the view of what was healthy."*
Improved Support and Knowledge of Eating Disorders among Medical Professionals	14.29%	60%	*"I think that like, yeah, like more education for like certain care workers, especially people working in the industry. Like, for instance, like, yeah, that the women who were like social or support workers, like they're literally working with these people. So I like either I feel like they should have gone through it or they should have education on it."* *"I think having the medical professionals quite educated if they're working when people have eating disorders disorders...Yeah. Cause I*

			would hear from doctors like go eat a burger and stuff like that."
People and Society are better Educated on Eating Disorders	10.38%	50%	*"I think just for people to know more about eating disorders would have been helpful, you know, like for people, um, to know more about, okay these are warning signs."*
People would have reached out to me	10.38%	40%	*"I wished that like, you know, people who cared about me would have expressed their care and their concern."*
I had more accepting and safe environments	10.38%	40%	*"That there was an environment that was created where I felt safe enough to tell them without it being months."*
More social support	7.79%	30%	*"I feel like it would have been really helpful to have a solid group of friends."*
More access to eating disorder specific support	6.40%	40%	*"Um, maybe more accessibility? Like, because I'm a rural person, it was like an hour and a half drive to get to a*

			counselling appointment.” *“So I honestly wish there was more resources for people who are like over 25 yeah. That’s the biggest thing for me.”*
People didn’t make comments about the body	5.19%	30%	*“[I wish] people didn't make bloody comments about my body, but there's no way to stop that from happening. But that was extremely damaging.”* *“I wish people wouldn't have made shitty comments.”*

APPENDIX L: EMAIL TO EXPERTS

Hi _______,

I am nearing the end of my thesis, and am looking for experts in the field of eating disorders to complete a credibility check for my study.

My study is on adolescent eating disorders and shame resilience, and my research question is: ***What helps and hinders developing shame resilience for adolescents diagnosed with an eating disorder?*** Using ECIT, I interviewed 10 women (retroactive self-report) and the results show 13 helpful categories, 15 hindering categories, and 9 wish list categories. The time commitment for completing this credibility check would involve less than an hour, and can be done from home.

Here's some info about what I would need:

ECIT involves nine credibility checks, and as mentioned one of them is called "expert opinions". This involves having an expert read through my results summary, which I have attached, and answering three broad questions after reviewing:

1. Do you find the categories to be useful?
2. Are you surprised by any of the categories?
3. Do you think there is anything missing based on your experience?

The purpose of this credibility check is to make sure that the categories listed are congruent with your knowledge of the research and professional field.

I have attached the results in two formats: a one page overview visual, and a results summary that includes incidence rates, participation rates, and examples through the form of quotes.

Let me know if this makes sense and if you would be willing to do this. I'm also happy to send more information about the results if you'd like. If it's possible, it would be great if I got your feedback on those three questions in about a week.

Thank you for your time!

Best,
Hilary Evans

APPENDIX M: CATEGORIES WITH INCIDENT CODES

Having a Spiritual Connection (13)
Reading bible verses that I wrote in the toilet
Putting bible verses under my toilet
Writing apology letter to God for hating body and throwing it into fire with other people
Having a counsellor who was more spiritual helped me
Feeling like God was speaking to me through a nurse
Asking god for help in prayer
I had a spiritual dream about quicksand and sinking and it changed my outlook on life, and I started praying
Someone prophesying over her
A really helpful sermon on hurts and habits
Being prayed for at church and having a special connection with God
Getting a prophetic word that fit for me at a youth conference
Counsellor being willing to talk about faith if she brought it up
Having an encounter with God at a youth conference
Social Support (43)
Friend asking if she could come to therapy session
Friend breaking down in therapy session (out of care and concern)
A friend from high school saying something (noticing a change in appearance)

My Mom supported me when I didn't have a social life
My friend called my Mom when she noticed I was not doing well and that's what made Mom take me to the doctor
My brother came after visiting hours with a bag full of toys and gifts and I saw a lot of emotion in him
My sister made changes in her life to be close to me
My sister would come and paint my nails and do my hair
My grandmother saying I love you for the first time
My best friend and her Mom coming to visit me
Having support and knowing that my family would come together if someone was hurting
Seeing that my brother would support me no matter who he was dating
Watching planet earth together as a family
A friend saying that she was sorry she wasn't there for her and that she didn't notice back then
My Dad showing me love and not punishing me after he found out I disobeyed him
Friend's distracting her when she had an urge to purge
Friends would help me by getting me to leave my temptation place and go for a walk
Friends saying they could see a change in her and her relationship with food
Having family visit in the hospital
My friends showed me support when I gained a lot of weight
My best friend would come over and hangout with me when I was at my highest weight

My friends expressed wanting to spend time with me and accepted me for who I was
Friends applauding for me at a school fashion show
People showing me support when I was at different sizes
My friends and family being non-judgmental when we spent time together
Being invited on outings with friends
Showing up to a party and being welcomed
Care from other people without judgment
My Mom's articulating confidence about daughter's recovery
Parents recognizing it and casually bringing it up
Having a friend and sticking together
Teachers encouraging her
a friend telling me about how she coped with something difficult
Teacher's reaching out and expressing care for me
Friend made her a box of joy
Friend calmly expressed concern
Dad's presence was helpful
Seeing a strength in my mom when she was supporting me. She was diligent
Mom being empathetic and speaking to my feelings
Mom was aware of what I needed
Community of People at Dance who didn't withdraw from me

Mom didn't overshare and had boundaries (she tried to protect my privacy)
Teachers treated her normal during the hospital homebound program
Practical Support from Parents (19)
Mom offering to buy me new clothes
My Mom stayed with me in the hospital with me
My Mom ate with me
My Mom was willing to homeschool me
Mom would pick me up from school
My Mom was a constant in the hospital for me. She would go home and bring laundry etc.
My family bringing in A&W or Taco Bell and eating dinner with me
Parents being excited when she decided to go to counselling and offering to pay for it
Family bringing flowers
Parents deciding to keep her at home instead of hospital
Mom bringing her to counselling and paying for it and asking about it
Texting Mom to have her pick me up from school and we would go to the beach for coffee
Mom buying me new clothes was helpful
Dad coming to appointments with me
Dad would take her to appointments
My Dad would listen and then give me practical steps

Dad presented eating disorder programs to her
Parents encouraging her at dinner time
Mom would distract me during meals
Supportive Significant Other (6)
Boyfriend researching eating disorders
Boyfriend being there for me and telling me he was there for me during a tough time
An important conversation with her boyfriend that gave her stability in their relationship
Boyfriend not commenting on body
Boyfriend's support in sharing the little victories with her
Boyfriend not treating me differently when I was sick or when I was healthy
Having Personal Freedoms (8)
Dance teacher letting me have some time to choose when to tell my Mom (she gave me 4 months)
Space and privacy was really helpful for me
Mom giving me some choice regarding snacks
Specialist giving her a chance to change and choose before hospitalizing her
Dad showed me more trust with time
Dad would give me choices
My Dad was very patient with me and didn't rush me

My counsellor didn't rush treatment
Helping Others (10)
Being able to help others with Math
Being able to empathize really deeply and understand where others are coming from
Having peer be positively impacted by me being myself
Talking to another girl about God's truth about body image (to try to help her)
Realizing that my pain could be helpful for someone else's recovery story and that I don't have to live in this pain forever
Educating younger girls on eating disorders (at dance)
Being able to share my story with others to help them
Meeting with a young girl who was sturggling with an eating disorder (to help her)
Being able to share what helped me with other people
Helping woman in the cafeteria with her food (it made me realize I can help people)
Humour & Celebrations (17)
Doing well at school and celebrating my successes with my teacher (he told me good job)
My Mom's friend trying to make refeeding fun and funny
My friends taking me for wheelchair rides and trying to bring me joy
My Mom and I would take fun trips in my wheelchair
My sister's friend would take me on wheelchair wheely rides

My brother and I would go to bingo and try to win prizes and have fun
Being excited to share that she hadn't purged for multiple days with her dance teacher
Humour was really helpful
My Mom and I laughed about how the diet was out the window now
My Mom and I got ice cream cones and laughed together
My roommate and I laughing and joking about ordering a pizza
Joking and laughing with my family
Laughing about calling junk food fun food
Having secret dance parties and laughing with siblings
Boyfriend (who is now husband) seeing me at my worst and still loving me (showing me love)
Humour and appropriate joking with family was very helpful for me
Dad going to the mall and doing photobooth pictures with me to celebrate me reaching a food goal
Education on Eating Disorders for Self & Others (8)
Seeing someone in a higher weight clsas be fit
Reading the 8 Keys to Recovery
Working on a body image workbook
Looking at plus size models and reading about that movement
Learning about the variety of food healthy people eat was helpful for me

Doctor explaining things medically so I could learn
Learning you aren't a bad person for eating certain foods
Mom asking for advice from professionals and doing readings to learn
Hearing about Other People with an Eating Disorder (7)
Hearing about other people who had an ED and understand on the "something fishy" website
Having another friend with an eating disorder that could understand my experience
Mom (who had an eating disorder) emphathizing with my experience
having a friend who shared the same feelings about body as me (made me realize I'm not the only one that feels this way)
having a friend with an eating disorder made her feel not alone
Someone else with my hometown with an ED reaching out to offer her support and connect on what it's like
Meeting my best friend, and having her tell me about smoeone she knew who had an eating disorder
Positive Embodied Experience of Body and Eating (12)
Learning about the pleasure of eating food
Feeling strong and fit in my body
Being able to eat and enjoy an entire pizza in a social setting
Enjoying eating an entire box of pizza without any negative thoughts

Enjoying a second piece of cake at a birthday party with my sister
joining the worship dance team changed my vision of a negative dance world
Deleting all previous photos of body
Dance made me feel as though I was good at something
being able to see my body more accurately
looking back at photos of self and realizing she hadn't actually seeng what she had looked like
Realizing my body was trying to protect me and help me survive
Dancing and being able to feel my body in a more positive way
Counselling (24)
Writing a poem that got noticed
My counsellor teaching me that it's good to have a voice
My counsellor giving me a book called bringing out my inner bitch, and I loved it
My counsellor challenged me with gentle grace
My counsellor teaching me to say fuck off to the eating disorder voice
Being able to have self-compassion breaks the shame down a lot
My counsellor teaching me how to be compassionate with my thoughts
Counsellor giving me more power
Counselling helping her understand where everything had come from

(after counselling) Being able to address mom about her food comments and realizing they didn't hit deep anymore
Emphasis on family counselling
Psychiatrist helped me break down my beliefs in therapy
Counsellor letting me talk
My counsellor telling me that 100% recovery is possible
Counsellor helping me gain further insight into perfectionism
Counsellor did mindfulness visualizations with me
Counselling helped me separate my thoughts from who I am
Family therapist helped give me a voice and stand up to my Mom
Journaling at the eating disorder house
Expressive therapies
Counselling gently challenging me
My counsellor incorporating my learning style into counselling
Counsellor helped me externalize the ED
Counsellor eating fear foods with her
Personal Connection with Medical Professional (27)
Therapist's calm presence made me feel I didn't have to do it alone
Doctor's reassurance

Therapist using her name
Having a good fit with my therapist and her good tone of voice and nice office helped me
My counsellor really understood me
My counsellor told me that she had an eating disorder previously and I felt like I was understood
I looked up to my counsellor and thought she was strong
My counsellor being willing to keep in touch
Having a good connection with my counsellor
Having a counsellor who is a better fit for me
Reassurance from nurses that I could tell was genuine
Psychiatrist speaking highly of me
Having a nurse check in on me
Psychiatrist taking me for a walk and talking with me
Having an amazing doctor
One of my support workers in the hospital encouraging me that I'm going to get better
Having staff at the hospital be present and there with me
Having a nurse that affirmed me
The comforting presence of one of the nurses
A doctor telling me that I was smart
Being paired up with an approachable, friendly, pretty counsellor

Noticing through talking with friends that there are shared experiences gives her hope
Everytime I talked about it it gave me more power
Being able to share my story gave me more ownership
Appropriate self-disclosure from counsellor (made me feel like I was getting to know her)
Counsellor expressed confidence in her
Counsellor was calm and not alarmed
Having Knoweldgable Medical Professionals (12)
Therapist knowing what to do
Doctor taking an educated authoritarian stance (telling me the cold hard truth)
Doctor telling her next steps
Having a team of health professionals
Having a nurse that would carry the conversation
Having a nurse that would not ask inappropriate questions regarding my eating disorder
Having an involved GP
Having a GP who knows about eating disorders
The conversation jar we used helped me for meal support
Having a specialist that was no-nonsense and talked to me with my parent in the room
Dietician telling me my food intake doesn't have to be perfect it just has to be good enough
Doctor gave me an appropriate timeline and goal setting around food

Hindering Categories with Incidents

Specific Spiritual Practices (6)
a friend asked someone who used to have an ED at church to meet up with me, and they tricked me into going (church style mentoring)
Being prayed for on stage for my ED
spiritual practice of lent was not helpful for me (I would restrict too much)
I felt guilty because of the internalized standards of self-control I thought were from the Bible
spiritual practice of fasting was not helpful for me
things being explained as B+W during childhood was not helpful-- It caued me a lot of guilt
Dance Teacher's Comments & Behaviour Regarding Body (8)
Dance teacher commenting on my thigh gap
dance teacher forcing help on her
dance teacher threatening to tell my mom about my ED
felt shame when screwing up on my dance teacher's plan for my recovery
witnessing skinny girls getting praise from dance teachers
Dance teacher telling me to suck in my stomach and stand upstraight
Dance teacher commenting on mistakes and my outfit measurements
My dance teacher being startled by my weight gain
Feeling exposed by others? Other people talking about me behind my back? (8)

My family gossiped about my cousin who also had an eating disorder
Being called out in front of my dorm about skipping dinner after previous disclosure
dentist noticing my ED right away and thinking I wouldn't be able to hide it anymore
My Mom disclosed too much info to her friends that I wasn't comfortable with
Doctor shared info I told him with my Dad without asking
Dance teacher would talk to other Mom's about me
School counsellor overshared with my Mom
people touching my body at friend's house and dance
Being Weighed (7)
having to recall weight changes during intake
My Dad weighing us growing up
Weigh-in's at the hospital were shame inducing
Comments from the nurse during weigh-in's
weigh in's were really hard
My dance teacher weighed me (and seeing her expressions was not helpful)
Pediatrician for ED was too rough (pushed and pulled me on the scale)
Abuse from Men (7)
brother being verbally abusive (saying people wouldn't care if I died and people don't care what I'm talking about)

boyfriend breaking up with her after I told him I didn't want to be physically intimate anymore. I thought my whole worth or value was in my body
boyfriend called me digusting in front of all my friends when I tried to kiss him at the gym and was sweaty
my exboyfriend assulated me and I thought I was responsible
abuse from father
I asked my boyfriend if he would still date me if I gained weight and he said no
Abuse by my boyfriend
Feeling watched and controlled by others (19)
Inpatient program was not helpful because I was surrounded by so many people were struggling
In the hospital people were taking control from me
It was humiliating to not be allowed to go to the bathroom by myself
I felt like I was treated like a child in the hospital
My parents using food as a reward or taking it away as punishment
My parents not letting me get a treat when I was on vacation with them
Being controlled in the hospital and timed while eating
People assuming that all my behaviours were to do with an eating disorder
Being told she needed to make her personality more mild
My Dad disciplining me a lot

Getting spanked a lot growing up for letting out emotion
Having someone diagnose me when I thought I was fine took away all of my voice
being frustrated at friend acting like she was the doctor
Being watched in the eating area
I felt like I didn't have enough privacy
psychiatrists jumping to conclusions without talking to me and forcing medication on me
Dad would hide food from me and lock it up
My Dad would try to watch me
Dietician restricting her from going to dance
Unhelpful use of social media (6)
Proanorexia websites
comparing my body to photos
comparing myself to fitness models on instagram
feeling like I could never reach my body goal because her body wouldn't react that way
"thinspo" on pinterest (proanorexia)
Comparing myself to others on instagram
General Comments about Body (16)
Having a staff member at lululemon tell me I should work there due to my body type (she meant it as a compliment)

Compliments about weight loss
Family members making flippant remarks regarding my body and eating disorder
Mom making comments about my body
comments from people about my body and weight
People joking about my body
My friends joking about how I had multiple lines on my arm
People didn't understand and would make comments
Comments about being skinny and people wanting to look like me
comments from peers about body size
People making comments about how I was sick
At a fitting the staff were making comments about my boobs and butt
Modelling agent asked her to chane her clothing so she could be half nude
Dance Mom saying she should paint on cleavage on chest for recital
Peer saying that my body was the standard
my dance teacher commenting on my body
(3) Comments about being Overweight (10)
Someone called me fat at youth group
People commenting on weight gain
A guy at school called me a pig

Modelling agency making her face skinnier on photoshop and talking about it
While doing a photoshoot photographer said they'd edit her body parts smaller
Comments from others about being chunky
Modelling agent would talk about weight loss and appearance
Someone associating her sister with a bird and her with a pig
Friends calling me chubby cheeks
Sister borrowing her pants and yelling that her pants were too big
(4) Comments about being Underweight (14)
Someone using the word skeleton to describe her
People saying you're so skinny to me
I didn't like comments about being skinny because I didn't see myself that way
Finding out that people at work had a bet giong about how much I weighed
A coworker saying that I could use an extra 5-10 pounds
Coworker making comments about my small wrist size
Brother making comments about seeing my bones
People staring at me and saying I was so thin
Classmate grabbing her wrist and saying it was so skinny
People pointing out that I was really skinny
Mom commenting on how I look bony

Comments about her clothes not fitting properly
My friend's Mom made comments about thinking she would crush me when she hugged me
Someone telling me I would blow away with the wind
Perceived Inconsiderate Action and Comments from Medical Professionals (24)
Being humiliated by medical professionals doing a developmental assessment (they were looking for something wrong with me)
Getting kicked out of the eating disorder program because I couldn't gain enough weight
Dentist talked to my Mom about my eating disorder like I wasn't even in the room
A nurse said I had a strange eating disorder
The woman who was taking my EKG at the hospital said she looked like a model
Psychiatrist not treating me as significant
At the first meal in inpatient treatment a woman asked about her Mom's recipe for butter chicken
psychiatrist had a bad sense of humour and made inappropriate jokes
Having a nurse asking questions about ED during meal
having a sickly thin nurse that wasn't eating
having a counsellor I didn't connect with wasn't helpful
Counsellor saying that she was surprised that the participant hadn't killed herself yet
doctor implying that I chose to do this to myself
Specialist saying she looked like a survivor from the Holocaust

My guidance counsellor implied that I was doing this to myself
My doctor would assume random behaviours were due to an ED
having a school guidance counsellor try to scare me out of it
being paired with a counsellor who was obese made me feel uncomfortable
Support workers making naive/ insensitive comments
Social worker invalidating me for being in the hospital
Open talk in hospital
Doctor said to me "why are you doing this to yourself" during the referral process
Pediatrition who specialized in ED's did not show me empathy
doctor did not notice my ED at first
Witnessing Mom's concern about her own body and food intake (9)
Mom referring to eating less about being good (impact of morality)
witnessing my Mom throw a plate across the room because my Dad brought home fresh bread (she was mad because she knew it would be hard for her not to eat the bread)
Witnessing Mom have an outburst because of food
My Mom going on the Dr. Bernstein diet
My grandmother dieting
hearing my Mom say "I'm so bad" after eating multiple cookies
My mom talking about dieting

My Mom bought fat free food for herself and us
Mom talking about getting a facelift in the car
Perceived unhelpful behaviour from family (17)
My Dad saying that I was hurting my Mom
One of my parents telling me that I could get myself out of the hospital and some of the other kids can't
My Mom left the house for an extended period of time because she was so mad at me
Dad yelling at me when I was vomitting
Dad said I'd be better off dead
Dad saying what is wrong with you
Fights at family dinner over dinner
Dad not understanding and forcing me to eat a cookie
Mom treating me like a child
My Mom wouldn't visit me
Mom told me I was going to have a heart attack
Dad would yell at me asking how to help
Mom told me I was hurting her
Mom calling my sister a pimple face
My sister refused to come to therapy

Mom saying that it'll get better in a couple months. She didn't understand
Mom not saying anything after depression diagnosis
Perceived unhelpful behaviour from friends (10)
working in a superficial environment
People being mean to me on my first day of school
Friends comparing their muffin top size with me
a friend asked someone who used to have an ED to meet up with me, and they tricked me into going
An untrue rumour being spread about me
A friend argued with me about my ED
Friendship stress in highschool
Disclosing vulnerable information to a friend and having her stop talking to me
during modelling walking into a room of girls who want to be better than you
friends pulling away and withdrawing from me
Falling Short of Expectation for self (11)
Binging
Cutting myself
trying on old clothes
Seeing hurt and fear in my family

I felt so ashamed after I had a full meltdown because my breakfast was late
I felt ashamed that I treated my Mom poorly
Comparing myself to others at dance
Feeling like a failure at piano
sharing a story of healing while still relapsing "I felt like I was lying"
Lying about reasons for weight loss (saying it was due to medication)
Looking back at old photos of self and feeling like I was fat

Wish list Categories with Incidents

People didn't make comments regarding my body (4)
People didn't make positive comments regarding her body
people didn't make comments about other people's bodies
People wouldn't comment on my body
Staff being more aware of words/ actions (and not commenting on my body)
People would have reached out and asked (8)
Someone would have said something to me
Wish that my friend would have nicely pointed out behaviours and asked about it while showing concern for me
People querying the beginning behaviours of the ED
Wish that friends or parents would have noticed ED behaviours and going to the gym before I had substantial weight loss
somebody saying that she was working out too much
I wish old friends would have reached out to me
Friends would have reached out
People wouldn't have been afraid to reach out
My environments were more accepting and safe (8)
I wish I had more freedom while I was in the hospital

I wish there was more personal freedom and acceptance in treatment
Psychoeducation on how dance impacts body image
wish for a safe home environment to tell parents about ED (to feel safe to confess mess ups without punishment)
having a safe/ christian environment
Safe places where my ED doesn't have to be a secret
Wish that there was more acceptance of my body in dance
I wish that there was a lack of critique and the standard of perfection wasn't there in dance
More education for self on ED's (12)
Someone recommended sport as a healthy means of exercise
Someone would have helped her learn how to exercise normally
I wish for more education on the nutrients in food
I wish for more education on the pleasure of food
I wish that there was more education about social media so that there was less focus on the body
Learning about eating disorders soon
Psychoeducation on cognitive disorders and ability to challenge thoughts
Psychoeducation regarding disordered eating and body image
having the resources to come to a conclusion myself
Someone who had an ED to come and share with her. Someone who understood

Wish I could have heard more stories of people who had eating disorders and their recovery
more info on how social media influences us
More access to eating disorder specific support (5)
After hours professional support
ED program hadn't changed and there was still more 1 on 1 support
more resources for people over 25
more accessiblity for people in rural settings
I wish I wasn't cut off from services once I was doing better
More social support (6)
that a friend would have said that she was sorry and that she was there for her earlier
I wish that a friend would have privately talked to me instead of calling me out in front of everyone
I wish my friends wouldn't be so intrusive
I wish people would have been friendlier in high school
a solid group of friends
I wish I was able to talk to other people who were recovered
Improved support and knowledge of eating disorders among medical professionals (11)
I wish I had more understanding from doctors and nurses

I wish there was more knowledge about how to treat people with eating disorders
I wish health care professionals would know that it's not just about weight, and we need more of a
I wish there was more support in focusing on feelings as opposed to body
Medical professionals were educated on ED's (doctors shouldn't tell me to eat burgers)
I wish I had a better experience with my doctor and counsellor
I wish my therapist would give me her full attention
More education for support and care workers in medical settings
I wish doctors knew more about EDs
More integration of why and purpose in treatment
I wish my ED specialist cared and was warm
More support and understanding from family (15)
Mom had thrown away our scale or taken a stance
I wish my Mom had spoken up more.
I wish that my Mom stood up for me.
I wish I had more understanding from family
Parents not punishing me or grounding her as much
Better communication between parents
I wish my parents created a plan for re-entry into life after the hospital

I wish my parents were more involved in working with me
My parents understood why I was nervous to go to school
I wish Dad was mroe assertive and confident and emotionally attuned
Wish Mom came to counselling
I wish that my Mom undrestood depression and my eating disorder
Sister would have come to therapy
Wished sister would have cared more
Brothers would have been more involved
People and society was better educated on EDs (8)
People had more knowledge about EDs
People would have been more interested in EDs
I wish I had more understanding from everyone
I wish society wasn't as body focused
People would stop using the terms good and bad associated with food
Wish they would let me come up with the conclusion that I had a problem
that people and society would understand people with eating disorders are not attention seeking or shallow
That people in society would be more aware of eating disorders