PATIENT PERCEPTIONS OF THE FORMATION OF A THERAPEUTIC WORKING ALLIANCE WITH A REGISTERED DIETITIAN NUTRITIONIST DURING EATING DISORDER TREATMENT

By

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Abstract

The purpose of the research was to investigate patients' perception of the *facilitators* and *barriers* to forming a therapeutic working alliance with a Registered Dietitian Nutritionist during eating disorder treatment. Eight (expected) individuals whom had successfully completed an eating disorder treatment program were selected. Semi-structured interviews were conducted using researcher-developed questions. A thematic analysis of interview transcripts was performed. Descriptive statistics used included: simple counts and percentages of responses. Ninety-eight comments were recorded regarding facilitators and 75 comments were recorded regarding barriers. The percentages were ranked to identify the top 4 facilitators as Personality Characteristics (23%), Emotional Support (22%), Collaborative Decision Making (17%), and Client-Centered Approach (15%). The top 4 barriers were Disregard (20%), Personality Characteristics (16%), Nature of the Eating Disorder (13%) and Nature of the Dietitian's Role (13%). This study revealed that Personality Characteristics can be both a facilitator and barrier. Emphasis should be placed on displaying positive traits early. Emotional Support is highly valued. RDNs must strengthen their understanding of the connection between eating behaviors and emotions. The Nature of the Eating Disorder and Nature of the Dietitian's Role are intrinsic barriers. RDNs must minimize other potential barriers and strengthen facilitators to overcome these built-in barriers.

Keywords: Therapeutic alliance, working alliance, eating disorders

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Chapter I

Introduction

The collaborative relationship between patients and their clinicians; in which there are shared goals and a mutual willingness and agreement to participate in the necessary tasks to make progress in treatment, is known as the therapeutic working alliance (Turner, Bryant-Waugh, & Marshall, 2015). The formation of a strong therapeutic working alliance between a patient with an eating disorder (ED) and his or her clinicians has been shown to improve treatment outcomes (Elvins & Green, 2008). According to both the American Psychiatric Association (2006) and the Academy of Nutrition and Dietetics (Ozier & Henry, 2011), nutrition counseling is an essential component in the treatment of patients with EDs.

Eating disorders are more than simple nutritional intake issues; they require a Registered Dietitian Nutritionist (RDN) to serve a dual role of counselor and nutrition expert (Segool, 2011). High dropout rates, non-compliance, and refusal of treatment are common difficulties encountered by ED treatment providers (Geller, 2001). In order for RDNs to avoid encountering these pitfalls, one must develop an understanding of the factors patients believe facilitate or hinder the formation of a therapeutic working alliance with an RDN during treatment.

This study aimed to provide RDNs with insight into the ED patients' perspectives on the key factors to developing a strong therapeutic working alliance. When armed with such insight, RDNs may be able to better focus their efforts on specific areas in order to quickly form strong alliances with clients and anticipate improved treatment outcomes.

Statement of Purpose

The purpose of this study was to investigate the patient's perception of the facilitators and barriers to forming a therapeutic working alliance with the RDN during ED treatment.

Conceptual Framework

This research was based on the psychoanalytic concept of the therapeutic working alliance, also referred to as the helping alliance, working alliance, or therapeutic relationship. Introduced by Edward Bordin in 1979, four propositions provide the conceptual framework for this research:

1. All genres of psychotherapy have embedded working alliance and can be differentiated most meaningfully in terms of the kind of working alliance each requires.

2. The effectiveness of therapy is a function in part, if not entirely, of the strength of the working alliance.

3. Different approaches to psychotherapy are marked by the difference in the demands they make on patient and therapist.

4. The strength of the working alliance is a function of the closeness of fit between the demands of the particular kind of working alliance and the personal characteristics of patient and therapist (p. 253).

Bordin suggests that the concept of a working alliance can be applied outside of the psychotherapy setting and translated to any relationship where there is an individual seeking change and one that offers to be the change agent. In this research study, this framework was applied to the relationship between the ED patient seeking change and

the RDN as the change agent.

Bordin (as cited in Horvath & Greensburg, 1989) states that the working alliance "makes it possible for the patient to accept and follow treatment faithfully" (p. 224). Three components are used to assess the quality and strength of the alliance; those components are tasks, goals, and bonds. Tasks refer to the specific behaviors that make up the counseling process; both the counselor and client accept responsibility to complete these tasks to have a successful working alliance. Goals are the specific outcomes targeted by the counseling process and should be endorsed and valued by both parties involved. Bonds consider the complex nature of interpersonal relationships and attachments that form between client and their counselor. Bonds include constructs such as trust, acceptance, and confidence in the working alliance (Bordin,1979; Horvath & Greensburg, 1989).

This framework positions the strength of the working alliance as a critical factor in the success of treatment. This pivotal role of the alliance places a high value on insight into its formation. The aim of this study was to determine what factors patients believe are facilitators and barriers to the closeness of fit referred to in the framework. This is needed for the development of the strong therapeutic working alliance with an RDN (Bordin, 1979).

Significance and Justification

An estimated 20 million women and 10 million men in the United States suffer from a clinically recognized ED at some time in their life (Wade, Keski-Rahkonen, & Hudson, 2011). With EDs having the highest mortality rate of any mental illness,

researchers have many questions that still need answers. Ongoing efforts are aimed at developing and refining strategies for preventing and treating eating disorders (U. S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health, 2014). Successful nutrition counseling requires RDNs to form a therapeutic working alliance with clients (Herrin, & Larkin, 2013). The factors influencing the formation of a such an alliance in the areas of nursing and psychotherapy have been well researched (Ryan, Malson, Clarke, Anderson, & Kohn, 2006; Sly, Morgan, Mountford, Sawer, Evans, & Lacey, 2014). Despite extensive literature in the area of nutritional counseling, studies have focused on the effectiveness of counseling strategies rather than the relationship between the RDN and the patient (Cant & Aroni, 2008; Endevelt & Gesser-Edelsburg, 2014; Schwartz, 1981).

It is notoriously difficult to establish a therapeutic working alliance with ED patients for many reasons, including the complexity of the conditions and an individual's resistance to treatment (Kaplan & Garfinkel, 1999). Incorporation of patient values with evidence-based practice and clinical experience allows clinicians and patients to form a therapeutic working alliance that optimizes clinical outcomes. Therefore, research on patients' views of ED treatment is important (de la Rie, Noordenbos, Donker, & van Furth, 2006). The way in which a provider delivers care to a client with an ED may be as important as the intervention itself in terms of patient satisfaction and progress (Bell & Newns, 2004; Wright, 2010). Determining what ED patients perceive as important facilitators and barriers to forming a strong therapeutic working alliance with an RDN may help RDNs and researchers gain new insights into the successful development of a

therapeutic working alliance and new ways to connect with ED patients.

Assumptions

Assumptions made in this thesis include the following:

1. The researcher's interview questions will provoke accurate, complete, and thoughtful responses from the participants.

2. Participants in this study will provide honest responses to the interview questions.

Research Questions

This study was designed to address the following research questions:

1. What did the clients/patients view as facilitators to forming a therapeutic working alliance with an RDN?

2. What did the clients/patients view as barriers to forming a therapeutic working alliance with an RDN?

Definition of Terms

The terms used in this research were defined both theoretically and operationally:

Anorexia Nervosa (AN)

Theoretical definition: the eating disorder characterized by restriction of energy intake leading to significantly low body weight; intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain and disturbance in the perception of the shape of size of one's own body (American Psychiatric Association [APA], 2013). Operational definition: the individual's diagnosis as reported (Question 6, Appendix A).

Barriers

Theoretical definition: Something immaterial that impedes or separates (Aguero Esquivel, 2014; Venes & Taber, 2009). Operational definition: Any factor that prevents or hinders an individual from forming an alliance with their RDN. These factors were identified by thematic analysis of participant responses to interview questions (Questions 4, 6 ii, 7, 8, Appendix B).

Binge-eating Disorder (BED)

Theoretical definition: the eating disorder characterized by both eating in a discrete period of time the amount of food larger than most people would eat in a similar period of time under similar circumstances and a sense of lack of control over eating during such episodes, and such behavior is not associated with the recurrent use of inappropriate compensatory behaviors (APA, 2013). Operational definition: the individual's diagnosis as reported (Question 6, Appendix A).

Bulimia Nervosa (BN)

Theoretical definition: the eating disorder characterized by recurrent episodes of binge eating and recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting, fasting, and excessive exercise; and disturbance of perception of shape and size of body (APA, 2013). Operational definition: the individual's diagnosis as reported (Question 6, Appendix A).

Clients/Patients

Theoretical and operational definition: Individuals with eating disorders who are participating in eating disorder treatment that includes nutrition counseling (Herrin, &

Larkin, 2013; Segool, 2011).

Facilitators

Theoretical definition: Something that assists, helps to cause, or makes easier. Operational definition: Any factor which aids in forming an alliance with the RDN. These factors were identified by thematic analysis of participant responses to interview questions (Questions 3, 5, 8, Appendix B).

Nutrition Counseling

Theoretical and operational definition: A supportive process, characterized by a collaborative relationship between the RDN and client/patient intended to establish food, nutrition and physical activity priorities, goals, and individualized action plans that foster responsibility for self-care to treat an existing condition and promote health (Academy of Nutrition and Dietetics [Academy], 2014, p. 64).

Other Specified Feeding or Eating Disorder (OSFED)

Theoretical definition: the eating disorder characterized by the presence of a feeding or eating behavior that causes clinically significant distress and impairment but does not meet the full criteria of the other feeding and eating disorders (APA, 2013). Operational definition: the individual's reported condition (Question 6, Appendix A).

Successful Completion of Treatment

Theoretical and operational definition: advancing from a treatment program at the recommendation of the treatment team and does not include being discharged prematurely due to personal choice or lack of insurance coverage (Question 2, Appendix A).

Therapeutic Working Alliance

Theoretical definition: The collaborative relationship between patients and their clinicians; in which there are shared goals and a mutual willingness and agreement to participate in the necessary tasks to make progress in treatment. Also referred to as the therapeutic alliance, working alliance, helping alliance, and therapeutic relationship (Turner, Bryant-Waugh, & Marshall, 2015).

Unspecified Feeding or Eating Disorder (UFED)

Theoretical definition: the eating disorder characterized by behaviors causing clinically significant distress/impairment of functioning but does not meet the full criteria of any of the Feeding or Eating Disorder criteria (APA, 2013). Operational definition: the individual's reported condition (Question 6, Appendix A).

Variables

The variables of interest in this study were: (a) *facilitators* to forming a therapeutic working alliance and (b) *barriers* to forming a therapeutic working alliance.

Limitations

The following were some limitations of this study:

1. The small sample size used in this study may not be representative of the perceptions of all patients with eating disorders and therefore the results may not be generalizable to a larger population.

2. The study participants were recruited through a social media post using the snowball method. This recruitment method requires that individuals have access to the internet and therefore the results may not be representative of all patients with eating

disorders.

3. The study relies on the participants' memory of past experiences. This introduces the potential for recall bias, a type of information bias caused by differences in the accuracy or completeness of the recollections (Porta, 2014).

4. Subjects were self-selected do to their interest in the topic, this may bias the results.

Summary

This study attempted to determine the *facilitators* and *barriers* patients perceive as key factors in forming a therapeutic working alliance with the RDN during ED treatment. This chapter presented an introduction to the study. The therapeutic working alliance as proposed by Bordin (1979) served as the conceptual framework for this study due to its emphasis on the alliance as a critical factor for treatment success. The importance of developing an understanding of patient perceptions of the alliance with an RDN was discussed. Research questions addressed by this study served to provide insight into the *barriers* and *facilitators* involved in the formation of a therapeutic working alliance. All terms that may be unfamiliar to the readers were defined and limitations of this study were outlined. A review of the literature, specific methodology, and thematic analysis of the data are included in Chapter II.

Chapter II

Review of the Literature

Introduction

This literature review focused on the construct of the therapeutic working alliance including its value and formation. The facilitators and barriers involved in alliance development were reviewed. A brief overview of the characteristics of EDs and ED treatment was elaborated upon. The role of the RDN in the treatment process and common difficulties encountered in treating patients with EDs were discussed. Finally, the review examined the development of interview questions, use of Skype interviewing, and thematic analysis as well as their significance to this research.

Major sources consulted. The literature in this chapter was chosen from the following sources: (a) ScienceDirect, (b) Google Scholar, (c) EbscoHost, (d) D'Youville College Masters Theses, (e) CINAHL, and (f) PsychNET. Search terms used included: therapeutic alliance, working alliance, helping alliance, therapeutic relationship, helping relationship, patient-dietitian relationship, patient-provider relationship, patient-centered counseling, client-centered counseling, nutrition counseling, dietitian, nutritionist, patient perceptions, interpersonal relationship, eating disorders, eating disorder treatment, anorexia nervosa, bulimia nervosa, alliance development, alliance formation, barriers, and facilitators.

Therapeutic Working Alliance

Value. Several studies investigating the value of a therapeutic working alliance found that a strong alliance was associated with improvements in the client's overall

well-being, their mental health and a decrease in dropout rates (Escobar-Koch et al., 2010; Prestano, Lo Coco, Gullo, & Lo Verso, 2008; Swain-Campbell, Surgenor, & Snell, 2001). The results of the study by Swain-Campbell, Surgenor, and Snell (2001) suggest that the strength of the therapeutic working alliance had a greater effect on treatment outcomes than the type of intervention and services provided. The development of a therapeutic working alliance early on in the treatment process serves to facilitate early symptom reduction which is the strongest predictor of treatment outcomes (Turner, Bryant-Waugh, & Marshall, 2015). Bourion-Bedes et al. (2013) studied the prognostication value of the early therapeutic working alliance development in weight recovery. The results indicated that a better perception of the alliance early in treatment was linked to a shorter time for weight restoration in both outpatient and inpatient treatment settings. This study indicates that even if the patient and therapist viewed the alliance differently in the early stages they were still able to work together to achieve mutual goals (Bourion-Bedes et al. 2013). Wright and Hacking (2011) suggest however that recovery outcomes may be achieved based solely on the existence of the bond, without need for agreed upon tasks and goals.

Formation. "To establish a good therapeutic alliance it is important to negotiate treatment goals with an individual patient at different moments during the process of change" (De la Rie, Noordenbos, Donker, & van Furth, 2006, p. 675). In a 2013 systematic review of the psychological treatments for eating disorders, findings suggest a therapist's ability to understand a client's fears, and educate him or her on the repercussion of EDs were key factors in the establishment of a strong therapist-client

alliance (Antoniou & Cooper, 2013).

Facilitators. In a study conducted by Sly, Morgan, Montford, Sawer, Evans, and Lacey (2014), eight participants were interviewed to determine their experiences in developing a therapeutic working alliance with a nurse during treatment for an eating disorder. This research found the alliance was a key experience to the overall treatment experience. The participants of this study suggested the alliance should be active, allowing for the participant to be an equal partner. Clinicians whom allowed discussion of "treatment taboos" such as triggers or behaviors that were difficult to cease were able to develop more effective alliances. The results also indicated that clinicians should make a good first impression by allowing the patient to do most of the talking and take the time to understand the patients background. Several additional studies in nursing, including a systematic review of current understanding of the therapeutic relationship, found similar results to Sly et al. and further elucidated that trust, respect, genuineness and empathy are contributing factors to alliance development (Snell, Crowe, & Jorden, 2010; Wright, 2010).

One phenomenological study consisting of interviews with 38 women with anorexia nervosa (AN) indicated patients were satisfied when their health professional possessed certain desirable traits in the categories of acceptance, vitality, challenge, and expertise. The desirable characteristics in the area of acceptance were generosity (i.e. kindness, giving, and understanding), respect (i.e. active listening and nonjudgmental approach), and patience. Patients expressed feelings of the therapist "talking with me instead of just talking at me" and they "felt equal in the relationship" (Gulliksen et al.,

2012, p. 935). Health professionals who took an 'active interest' in the patient's personal qualities and were able to display a sense of humor were seen by patients as having positive vitality traits. Patients also identified positive challenge characteristics as a 'focus on the resources' and 'support through difficult times' as those qualities encourage clients to look towards their strengths and abilities to find solutions to challenges. The final area addressed in this study was expertise. The patients placed positive value on the providers displayed knowledge and authoritativeness. The patients made statements such as "all the things I tell her might not sound so stupid to her because she might have heard the same thing before" or "authoritative but at the same time humble…a secure person" (Gulliksen et al., 2012, p. 938).

Zaitsoff, Yiu, Pullmer, Geller and Menna (2015) examined factors adolescents with ED consider important towards therapeutic engagement. The following four constructs were examined as facilitators to therapeutic engagement: (a) Trust, (b) Agreement on therapeutic goals, (c) Confidence in ability to change, and (d) Feelings of inclusion in therapeutic decisions. These constructs were selected through a review of existing research on motivational interview and the therapeutic working alliance.

In semi-structured interviews of 34 adolescent females, each participant was asked questions related to each of the four constructs to identify factors impacting each of the four constructs. Trust was associated with factors that included "genuine concern, avoidance of assumptions, confidentiality, acceptance, personal disclosure/shared experiences, and synchrony (pushing only as hard as the patient was comfortable with)" (Zaitsoff et al., 2015, p. 599). Agreement on goals was also associated with synchrony as

well as "client input, judgement/assumptions, respect, information, trust, and formalization of long term goals" (p. 599). Confidence in ability to change consisted of "support, judgmental/assumptions, patience, examine consequences, nothing, providing alternative strategies, and regaining control" (p. 600). Feelings of inclusion arose from "control/power, caring, consideration of client readiness, and provides choices" (p. 600). These findings suggest that providers working with clients with EDs should be open-minded and pace interventions in accordance with the client's readiness to change by setting goals that are not overly ambitious (Zaitsoff et al., 2015).

The Wright and Hacking (2011) study had similar findings to the Zaitsoff et al. study (2015). Wright and Hacking (2011) identified six themes regarding the therapeutic relationship during interviews of both healthcare professionals and adults accessing services for anorexia. The themes were safety, externalization of the ED, use and acceptance of maternalism, authenticity of the relationship, recovery measured in kilos, and power of hope and optimism. Each theme was further described to elaborate on the factors contributing that aspect of the relationship. Safety was defined by patients as feeling supported as well as being in a "safe place". Externalization of the ED was seen as important to the relationship because it sets the ED as a separate entity from the "real" patient. Use and acceptance of maternalism was often identified as nurses take on a 'mothering' role and patients are inclined to behave in a dependent manner. Authenticity of the relationship is composed of genuineness and transparency. Recovery measured in kilos was a key factor as patients reported a sense of closeness and bond was often formed with the individual responsible for weighing them as that was a very difficult

experience and often triggered a hostile or emotional reaction (Wright & Hacking, 2011). Power of hope and optimism was something patients looked for in providers as they often found it difficult to see beyond the disorder; one nurse interviewed suggested that often time patients would "borrow [her] hope" (Wright & Hacking, 2011, p.112). A summary of facilitators to the formation of a therapeutic working alliance are shown in Table 1.

Barriers. Gulliksen et al. (2012) study discovered several undesirable traits patients with AN identified as leading to be dissatisfaction with their health professional. Characteristics such as disregard, prejudice, passivity (ex. inactive or unengaged), and pampering (ex. feeling sorry for patient) were seen by patients as negatively impacting their relationship with their health professional (Gulliksen et al., 2012).

In a study interviewing ten nurses that had worked with adolescents with ED, struggle for control, blaming the victim, labeling and stigmatizing, and favoritism were noted as barriers to developing a therapeutic relationship (Ramjan, 2004). The primary barrier discussed was the 'power struggle' as the nurses stated patients saw them as "bad people 'trying to make them fat'" or an 'army officer' enforcing the treatment program (p. 499). Because adolescents are not typically self-referring for treatment and often disagree with their authority figures on their need for treatment, it can be extremely difficult to develop a therapeutic working alliance with them as they lack readiness to change (Bourion-Bedes et al., 2013).

Endevelt and Gesser-Edelsburg (2014) studied adherence to treatment and barriers to long-term counseling with a RDN in a general patient population. This study identified that patients whom viewed the RDN as purely an "educator" and sessions as

Table 1. *Facilitators to Therapeutic Working Alliance Formation*

Study	Type of Clinician	Population	Facilitators
Sly et al., 2014	Nurses	Eating Disorders	Participant as equal partner, Discussion of "treatment taboos", Good first impression
Snell, Crowe, & Jorden, 2010; Wright, 2010	Nurses	Eating Disorders	Trust, Respect, Genuineness, Empathy
Gulliksen et al., 2012	Therapists	Anorexia Nervosa	Acceptance (generosity, respect, non-judgmental approach, patience), Vitality (active interest in patient, sense of humor), Challenge (focus on resources, support through difficult times), Expertise (knowledge, authoritativeness)
Zaitsoff et al., 2015	Therapists	Eating Disorders	Trust (genuine concern, avoidance of assumptions, confidentiality, acceptance, personal disclosure/shared experiences, synchrony), Agreement on therapeutic goals (synchrony, client input, judgement/assumptions, respect, information, trust, formalization of long term goals), Confidence in ability to change (support, judgmental/assumptions, patience, examine consequences, nothing, providing alternative strategies, regaining control), Feelings of inclusion in therapeutic decisions (control/power, caring, consideration of client readiness, provides choice)
Wright & Hacking, 2011	Healthcare Professionals	Anorexia Nervosa	Safety, Externalization of the eating disorder, Use and Acceptance of Maternalism, Authenticity of the Relationship (genuineness, transparency), Recovery Measured in Kilos, Power of Hope and Optimism

"informative" they expected to receive only minor interventions, tips or training, and no follow-up care. This mindset of a transactional relationship is a major barrier to adherence to nutritional treatment. A summary of barriers to the formation of a therapeutic working alliance are shown in Table 2.

Eating Disorders

Eating disorders are serious, life-threatening illnesses that impact millions of people in the U.S. annually (Wade, Keski-Rahkonen, & Hudson, 2011). ED is an umbrella term for a group of associated disorders such as anorexia nervosa, bulimia nervosa, and binge eating disorder. Each of these separate disorders is characterized by a different set of behavioral symptoms as well as a disturbance in emotions and attitudes surrounding weight and food (APA, 2013).

Anorexia Nervosa (AN) is characterized by an inadequate food intake that leads to a body weight that is significantly below normal. This weight loss is accompanied by an intense fear of weight gain, a preoccupation with weight and the persistent use of behaviors to lose weight. The health consequences of AN included abnormally slow heart rate and low blood pressure leading to heart failure, loss of muscle, reduction of bone mineral density, dehydration leading to kidney failure, generalized weakness and fatigue, dry hair and skin, and growth of lanugo (downy layer of hair). While AN only affects approximately 1% of Americans, it is the most common mental health diagnosis for young women (National Eating Disorders Association[NEDA], 2016).

Bulimia Nervosa (BN) is characterized by a cycle of bingeing (consuming very large amounts of food) followed by and compensatory behaviors such as self-induced

Table 2. *Barriers to Therapeutic Working Alliance Formation*

Study	Type of Clinician	Population	Barriers
Gulliksen et al., 2012	Therapists	Anorexia Nervosa	Disregard, Prejudice, Passivity (inactive, unengaged), Pampering (feeling sorry for patient)
Ramjan, 2004	Nurses	Eating Disorders	Struggle for control, Blaming the victim, Labeling and Stigmatizing, Favoritism
Endevelt & Gesser-Edelsburg, 2014	Registered Dietitian Nutritionists	General Population	Purely an Educator, Sessions Informative (minor intervention, tips or training, no follow-up required), Transactional Relationship

vomiting, laxative use, and/or excessive exercise. This cycle of behavior is accompanied with the feeling of being out of control during an episode of binge-eating. The health consequences of BN include electrolyte and chemical imbalances leading to irregular heartbeats, heart failure and eventually death, tooth decay, chronic irregular bowel movements, gastric rupture, and inflammation or rupture of the esophagus. Bulimia affects approximately 2% of the American population (NEDA, 2016).

Other Specified Feeding or Eating Disorder (OSFED) formerly called Eating Disorders Not Otherwise Specified (EDNOS), is an ED that causes a significant disruption or impairment without meeting the full criteria for existing ED diagnosis. The OSFED diagnosis is used for individuals presenting with atypical anorexia nervosa, purging disorder, night eating syndrome, as well as bulimia nervosa and binge-eating disorder with a lower frequency and/or limited duration of symptom use. These disorders while not meeting the criteria for the more commonly known diagnoses are not less serious conditions. OSFED conditions still carry the same severe emotional, psychological, and physiological disturbances and deserve the same level of concern from treatment professionals (NEDA, 2016).

Unspecified Feeding or Eating Disorder (UFED) is a diagnosis utilized when an individual has a clinically significant disturbance that does not meet the criteria for any of the other diagnoses. This is most often used in emergency situations where there is a lack of information available or the clinician is unable to assess the degree of symptoms (NEDA, 2016).

Treatment. ED treatment programs are most effective when they involve a

multidisciplinary team of skilled psychiatrists, RDNs, doctors and social workers with experience in eating disorders. The treatment programs that focus on symptomology and medical consequences of the disorders while addressing the underlying psychological and interpersonal factors involved in ED have been shown to be most effective (Ayzenberg, 2015). There are five established levels of care for eating disorder treatment (a) outpatient, (b) intensive outpatient, (c) partial hospitalization (full-day outpatient care), (d) residential treatment, and most intensive (e) inpatient hospitalization. Many individuals with ED are responsive to treatment at the one of outpatient levels (Ayzenberg, 2015). However, a pretreatment evaluation is essential to determine the level of care recommendation. Factors such as patient weight, rate of weight loss, organ system function particularly cardiac function, and metabolic status are the primary physical parameters used in determine the level of medical monitoring required for the patient and thus impacting the level of care selection (Yager et al., 2006). The length of stay and level of care selected for an individual can also be on based insurance coverage, the patient's ability to pay, severity of the disorder, and other co-morbidities (Ayzenberg, 2015).

Role of Registered Dietitian Nutritionist. "Dietetics combines the health and disease sciences with the understanding of food compositing and the various economic, social, psychological and physiological factors that influence nutritional behavior" (Endevelt & Gesser-Edelsbur, 2014). According to both the APA (2006) and the Academy (Ozier & Henry, 2011), nutrition counseling is an essential component in the treatment of patients with EDs. Eating disorders are more than simple nutritional intake

issues; they require a RDN to serve a dual role of counselor and nutrition expert (Segool, 2011). RDNs are responsible for nutrition assessments which are incorporated into patient treatment plans and often times a food history can more practically reflect the potential deficiencies that might not be seen during laboratory testing (Ozier & Henry, 2011). The RDN is responsible for developing a refeeding plan, monitoring weight stabilization, and helping patients regain healthy relationships with food and often physical activity (Mittnacht & Bulik, 2015). Insufficient attention has been paid to determining the optimal approaches for nutrition intervention as the disturbance in eating behavior is seen as the secondary feature for the eating disorders (Beumont, O'Connor, Touyz, & Williams, 1998; Bulik, Berkman, Brownley, Sedway, & Lohr, 2007; Hart, Russell, & Abraham, 2011).

The core role of the RDN is to assist the ED patients in understanding that the amount and variety of food consumed is linked with their health and energy as well as to aid in the separation of food and weight-related issues from the underlying emotional issues (Williams & O'Connor, 2000). A strong emphasis is placed on the need for RDNs to collaborate with other treatment providers and not be the sole practitioner treating a client (Thomas, 2000; Ozier & Henry, 2011; Wakefield & Williams, 2009). Another important role of the RDN is to provide education for other clinicians as medical nutrition therapy is a core skill of the RDN (Cordery & Waller, 2006).

In a Delphi study of 25 RDNs working in ED treatment, consensus was reached in support of using patient-centered counseling techniques to develop patient goals; goals should be based on what the patient feels is important. RDNs believed that goals should

be mutual and achievable so patients may develop a sense of success. RDNs reached unanimous consensus that part of their role was to make patients aware of the signs of malnutrition and encourage patients to consider achieving a "healthy state rather than a healthy weight" (Mittnacht & Bulik, 2015, p. 115). Participants also strongly agree that patients should follow an eating plan that starts at a manageable level and gradually increases overtime. Ninety-five percent of RDNs believed psychotherapy techniques consistent with those being used by the patient's primary therapist should be incorporated into the nutrition counseling sessions when the RDN is properly trained in the techniques to reinforce patient learning (Mittnacht & Bulik, 2015). "While RDNs are not therapists, it is a mistake to think [they] cannot work therapeutically" (Evans, 2016, p. 13). The incorporation of therapeutic language and techniques facilitates behavior change while establishing a sense of safety, minimizing judgement and shame, and maintaining a focus on client needs (Evans, 2016). RDNs in the study suggest that to engage a resistant patient utilizing discussion of what motivates the individual, the patient's passions, and the long-term effects of ED may help to encourage the patient to engage in treatment (Mittnacht & Bulik, 2015).

Whisenant and Smith (1995) conducted a cross-sectional correlation survey of U.S. RDNs to determine information on nutrition therapy practice with ED patients, and identify areas needing more attention. This study identified nutrition education and assessment of eating behaviors as well as a nutritional assessment as important components of their role in ED treatment.

Difficulties. According to several studies, the nature of clinical symptoms,

existing issues of trust, and the presence of comorbidity are the three major factors contributing to the difficulties clinicians often face when attempting to treat patients with EDs (Kaplan, & Garfinkel, 1999; Ramjan, 2004; Connan, Dhokia, Haslam, Mordant, Morgan, Pandya, & Waller, 2009). Clients are often seen as deceitful, untruthful and uncooperative as they attempt to maintain control over their environment (King & Turner, 2000; Ramjan, 2004). In a study of 304 current and former ED treatment patients, there was a reported 14% dropout rate due to a lack of motivation or readiness to engage in treatment (De la Rie, Noordenbos, Donker, & van Furth, 2006). Patients reported lack of trust, not seeing change in their symptoms and/or not feeling as their reasoning for dropping out of treatment. In order to successfully treat individuals with EDs, establishing a relationship of trust and understanding seems to be paramount.

Specific challenges RDNs encounter when working with patients are conducting meaningful sessions with individuals in a starved state. In order for clients to retain the knowledge being passed on by the RDN a certain level of refeeding must be done (Omizo & Oda, 1988). RDNs might also encounter defensive patients, that often protest, dispute, sabotage, or attempt to manipulate their way out of having to comply with the nutrition intervention (Krey, Palmer, & Porcelli, 1989). Issues of dietary noncompliance are often hard to address in the outpatient treatment setting as individuals are often living independently for all or part of the treatment period and may lack the supervision necessary to correct the behaviors (Woo, 1986). Whisenant and Smith (1995) found that denial of the condition, family issues, impulse control, patient manipulation, trust issues, power struggle between patient-family, misinformation, motivation, passive/aggressive,

power struggle with the dietitian, and communication were frequent difficulties reported by RDNs treating patients with eating disorders.

Tool

Developing interview questions. Semi-structured interviews should utilize open-ended questions to allow the interviewee to describe their viewpoint (Jacobsen, 2012). Researchers should look towards their experiences in the area of research, as well as stories and anecdotes told by individuals around them. Additionally, the researcher should conduct a literature review to see what previous research suggests (King & Horrocks, 2010). Questions should focus on the topics to be discussed and be organized in a logical manner, although the order may change based on participant responses to previous questions. Questions should be written in a clear, neutral, and sensitive manner (Doody & Noonan, 2012). It is best to start with questions that are easily answered and then move progressively into more sensitive topic areas. Patton (2002) suggests questions are based on behavior or experience, opinion or value, feeling, knowledge, sensory experience, and demographic or background details. Each question may be followed up with probing questions for elaboration, clarification, or completion of responses (King & Horrocks, 2010). Probing should be incorporated into the interview in order to gain greater understanding of key points raised by the previous question (Holloway & Wheeler, 2010). It is extremely important that probes and prompts are formulated so as not to "lead" participant's responses. Before conducting an interview, it is important that questions are carefully reviewed to be sure participants would feel able to freely answer and that there is not a particular answer the researchers is requiring (King & Horrocks,

2010). The development of interview questions is conducive in meeting the needs of this study as it allows the researcher freedom to construct an interview script that is tailored towards the patient-dietitian relationship.

Skype interviews. Skype offers researchers the opportunity to collect qualitative data using the free communication service (Deakin & Wakefield, 2013). Skype users are able to call, see, message, and share with people in different locations. Skype interviewing offered a synchronous (real-time) approach to interviewing and allows for interviewees with time or place limitations to participate in research (Janghorban, Roudsari, & Taghipour, 2014). Skype interviews allow for both nonverbal and social cues to be observed and are comparable to the authenticity of face-to-face onsite interviews (Janghorban, Roudsari, & Taghipour, 2014; Stewart & Williams, 2005; Sullivan, 2012). Interviews conducted utilizing Skype allow researchers to access key informants and increase participants that may not otherwise have been able to participate. This online interview process allows for participants to withdraw at any point in the process by simply clicking a button (Janghorban, Roudsari, & Taghipour, 2014). Despite the many benefits to Skype interviews, the need for internet access, digital literacy, and familiarity with online communication can be drawbacks to this method (Deakin & Wakefield, 2013). A study conducted by Hamilton found that participants seemed to prefer Skype interviews over phone or email interviewing. Participants valued being able to see the interviewer and found the experience more enjoyable and less demanding than e-mail interviews (Hamilton, 2014). Skype interviews were selected for this study as this method provided the researcher maximum access to subjects, and the method was not

limited by geographic proximity while still allowing for face to face communication.

Thematic Analysis

Thematic analysis is a widely used qualitative analytic method within psychology (Boyatzis, 1998; Roulston, 2001). Thematic analysis is used to identify patterns within qualitative data however there is no defined agreement on how to go about doing such an analysis (Attride-Stirling, 2001; Boyatzis, 1998; Braun & Clarke, 2006; Tuckett, 2005). Thematic analysis can be used within different theoretical frameworks to explore the reported experiences for patterns of events and meanings of participants. This method of analysis can reflect both the reality and the deeper meanings. Thematic analysis offers flexibility to have researcher defined themes which capture important patterns in the data relevant to the proposed research questions. An inductive approach to thematic analysis involves the process of coding the data without trying to fit it into a preexisting coding frame, or the researcher's analytic preconceptions. The benefits of thematic analysis include flexibility, easy to learn, generate unanticipated insights, accessible to researchers with less experience in qualitative research (Braun & Clarke, 2006).

Thematic analysis generally consists of three stages: descriptive coding, interpretive coding, and overarching themes. The descriptive coding stage consists of a thorough reading of the transcript, highlighting relevant material that may help to understand the participants view and begin to define descriptive codes. The interpretive coding stage is the second phase of the thematic analysis this is where the researcher will interpret clusters of descriptive codes and interpret the meaning of such clusters in relation to the research questions. Stage three is overarching themes where the

interpretive codes are utilized to generate key themes for the entire data set. This enables the researcher to construct diagrams/schematics to represent the levels of coding and identify the main themes of the data set. During each of the stages, quality checks should be conducted to recognize the need to rethink aspects of the coding while attempting to generate themes. It is recommended that researchers try to restrict the number of themes generated from the data as far as is allowable from the data set, usually down to two to five overarching themes (King & Horrocks, 2010).

Braun and Clarke (2006) assert that the aim of thematic analysis is to build a narrative that gives the reader insight into the topic of the research rather than just provide a summary of overarching themes. When reporting the results of a thematic analysis, the researcher should take care to tell an analytical narrative that makes "an argument in relation to your research questions" (p. 93). Quotes that illustrate the nature of the theme clearly and easily should be provided to provide readers a sense of the speaker (King & Horrocks, 2010).

Summary

The therapeutic working alliance is a critical component in improving treatment outcomes for patients in eating disorder treatment (Escobar-Koch et al. 2010; Prestano, Lo Coco, Gullo, & Lo Verso, 2008; Swain-Campbell, Surgenor, & Snell, 2001). Trust, respect, genuineness and empathy are contributing factors to alliance development (Snell, Crowe, & Jorden, 2010; Wright, 2010). Characteristics such as disregard, prejudice, passivity, and pampering were identified as negatively impacting the patient-provider relationship (Gulliksen et al., 2012).

Eating disorders are a group of conditions; each characterized by a different set of behavioral symptoms as well as disturbances in emotions and attitudes surrounding weight and food (APA, 2013). The core role of the RDN in treatment is to assist the ED patients in understanding that the amount and variety of food consumed is linked with their health and energy and to aid in the separation of food and weight-related issues from the underlying emotional issues (Williams & O'Connor, 2000). In order to successfully treat individuals with EDs, establishing a relationship of trust and understanding seems to be paramount (De la Rie, Noordenbos, Donker, & van Furth, 2006).

Semi-structured interviews utilize open-ended questions to allow the interviewee to fully describe their viewpoint (Jacobsen, 2012). Skype interviewing offered a synchronous (real-time) approach to interviewing and allows for interviewees with time or place limitations to participate in research (Janghorban, Roudsari, & Taghipour, 2014). Thematic analysis of interview transcripts offers flexibility to have researcher defined themes which capture important patterns in the data relevant to the proposed research questions (Braun & Clarke, 2006). This type of analysis allows the researcher to generate unanticipated insights into the facilitators and barriers to forming a therapeutic working alliance with an RDN during treatment for an ED. The insight generated from this study will help in the successful development of a therapeutic working alliance and identifying new ways to connect with ED patients.

Chapter III

Procedures

Introduction

The purpose of the research was to investigate patients' perception of the facilitators and barriers to forming a therapeutic working alliance with a Registered Dietitian Nutritionist during eating disorder treatment. Eight to ten individuals (expected) who had successfully completed an eating disorder treatment program were selected. Semi-structured interviews, using researcher developed interviews questions, were conducted via a Voice over Internet Protocol (VoIP) application (ex. Skype, WebEx). Interviews were recorded and notes were taken during each interview. The recordings were subsequently transcribed and coded. A thematic analysis of the interview transcripts was conducted to identify any commonalities in participant responses. Descriptive statistics were used to count, rank, and determine percentages of themes in participant responses.

Setting

This study was completed by adult individuals living in the United States (U.S.). Subjects participated in the interview via their personal computers in a location of their choosing.

Population and Sample

A purposive sample of participants was recruited from adult members of a social media group for former patients of an eating disorder treatment program (Appendix C). A snowball technique was then used to gather additional participants; the members of the

online community were asked to refer other alumni from the treatment program to participate in the study.

There were three criteria for participant eligibility: (a) Participants had to state they had successfully completed a treatment program, (b) Participants had to be a minimum of 18 years of age at the time of interview, and (c) Participants were treated by an RDN. The expected number of participants for this study was eight to ten provided the data collected was consistent. In the event that consistent data was not obtained, additional participants were interviewed.

Data Collection Methods

The researcher obtained approval from the Institutional Review Board (IRB) at D'Youville College before the study was conducted (Appendix D). Initial contact with the participants was made through a recruitment flyer posted to Facebook groups for recovering individuals (Appendix C). The flyer provided a link to Survey Monkey where individuals were able to electronically consent to the study, answer a brief survey of demographic information and provide his or her contact information to the researcher (Appendix A). After initial contact was made, the researcher then contacted all participants by email to provide more detailed information to the participants about the interview, answer any questions the participants may have about their role in the study and confirm their willingness to participate (Appendix E). Lastly, a date and time were set for the study interview to take place.

The interviews took place via a VoIP application (Skype, WebEx) and were either video or audio recorded at the discretion of the participant. The duration was anticipated

to vary from approximately 45 to 60 minutes based on the length of the participant's responses. During each interview notes were taken on any nonverbal cues perceived by the researcher and were included with interview transcripts. The semi-structured interview method was selected for this study because there appeared to be a gap in the literature on the factors facilitating and inhibiting the formation of a therapeutic working alliance with an RDN (Appendix B). The interview method allowed the participants to fully describe their perceptions of the formation of the therapeutic working alliance to develop a thematic analysis of the factors involved.

Protection of Human Subjects

The researcher obtained permission to conduct this research from the Institutional Review Board (IRB) of D'Youville College (Appendix D). The confidentiality of the participants was of a high level of importance. Participants filling out the online background/demographic questionnaire were immediately disqualified if they were under 18 years of age. A numeric coding system was used to identify participants on the video/audio recordings and transcripts. All names or specific identifiers of the treatment facility and/or the RDN were redacted in transcripts to further prevent identification of the subjects. Participants were made aware that their participation was voluntary and they could withdraw consent at any time during the background/demographic questionnaire, interview scheduling process or during the interview itself. Only individuals that had completed a treatment program were allowed to participate in the study to avoid selecting individuals that were in vulnerable states. The video/audio recordings were destroyed upon the successful completion of the thesis.

Tool

Semi-structured interview questions were developed by the researcher based on themes and elements of the therapeutic working alliance elicited from the literature review in Chapter II. The key topics addressed in the interview were: trust, honesty, impression of the therapeutic working alliance, and establishment of shared goals. The questions were administered over approximately 50 minutes with one question asked at a time. The researcher was able to ask additional probing questions or ask for clarification to participant responses before moving on to the next question (Aguero Esquivel, 2014; King & Horrocks, 2010) (Appendix B). The principal focus of the interview was to understand the participant's experience of developing the therapeutic working alliance while in treatment. The interview questions were pilot-tested on a convenience sample of staff members of an eating disorder treatment facility (n= 3) to ensure the questions were easy to understand and would elicit in-depth responses (Appendix F).

Treatment of Data

Thematic analysis was used to analyze the qualitative data obtained from the semi-structured participant interviews. A review of this methodology was included in chapter II. Thematic analysis was conducted by the researcher and a graduate dietetic student as described below. After both individuals completed independent analysis of the transcripts, the results were compared to assess for consistency of identified themes. Descriptive statistics were used to analyze the frequency and distribution of the identified themes in participant responses, as well as to assess the sample demographics. The purpose of the descriptive analysis was to determine what themes were most frequently

identified by the participants when describing their relationship with the RDN.

Thematic Analysis. An inductive approach to thematic analysis was utilized for this study. The inductive approach involved the process of coding the data without trying to fit it into a preexisting coding frame, or the researcher's analytic preconceptions (Braun & Clarke, 2006). Each transcript was read from start to finish to immerse the researcher into the perspective of the participant. Any notes taken during the interview on the nonverbal cues linked to a specific response were reviewed during the initial reading of each transcript. After the initial reading of the transcript the coding process began. In accordance with King and Horrocks (2010), the researcher utilized a three stages coding process consisting of descriptive coding, interpretive coding, and overarching theme identification. During a second reading of the transcript, the researcher highlighted relevant material that may help to understand the participant's view and began to define descriptive codes. The researcher then interpreted clusters of descriptive codes and elucidated the meaning of those clusters related to the research questions. Finally, an overarching theme name was assigned to groupings of interpretive codes to describe that understanding and identify the key themes for the entire data set (Braun & Clarke, 2006; King & Horrocks, 2010).

To assist in eliminating any potential bias in the researcher's analysis of the transcripts, a graduate dietetic student independently analyzed each transcript following the same process described above. The overarching themes identified in the two analyses were then compared to ensure accuracy and objectivity of the researcher's analysis. If the two analyses were not in agreement as to the themes being expressed, a third reviewer

was consulted to determine which of the analyses more accurately reflected the participant's perspective.

Research question 1. What did the clients/patients view as facilitators to forming a therapeutic working alliance with an RDN? The researcher designed questions to guide participants to describe the most significant facilitators to building a relationship with their RDN, as well as discuss topic areas of trust development, collaborative decision making, and potential improvements.

Upon the completion of each interview, the video/audio recordings were transcribed and all names or specific identifiers of the participant, treatment facility and/or the RDN were redacted in the transcripts to prevent identification of the subjects. Any notes taken during the interview on nonverbal cues perceived by the researcher were included with the transcript. A thematic analysis of the transcripts was conducted in the manner described above. The researcher then analyzed the coded data to identify any trends or related concepts between the subjects' responses and determine the frequency of the identified themes. The perceived facilitators were identified and ranked in order. Examples of the participants' comments were documented in conjunction with the identified facilitators.

Research question 2. What did the clients/patients view as barriers to forming a therapeutic working alliance with an RDN? The researcher designed questions to guide participants to describe the barriers to building a relationship with their RDN, as well as discuss any causes of dishonesty and mistrust in the relationship.

The same analysis method used for research question 1 was used for these data;

the perceived barriers were identified and ranked in order. Examples of the participants' comments were documented in conjunction with the identified barriers.

Summary

The purpose of this qualitative study was to assess patient perception of the formation of a therapeutic working alliance with an RDN during eating disorder treatment. This study took place using a semi-structured interview conducted via a free VoIP application. Interviews were completed using a computer with internet access in a location of the participants choosing. A purposive sample of subjects over 18 years old was used. The participants were alumni from eating disorder treatment facilities across the U.S. This study used a semi-structured interview guide consisting of open-ended questions developed by the researcher. The interview data were transcribed, coded, and a thematic analysis was performed to identify any trends in the qualitative data collected. Descriptive statistics were used to analyze the frequency and distribution of the identified themes in participant responses, as well as to assess the sample demographics.

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Chapter IV

Journal Article

Patient Perceptions of the Formation of a Therapeutic Working Alliance with a Registered Dietitian Nutritionist during Eating Disorder Treatment

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ABSTRACT

Background An estimated 20 million women and 10 million men in the United States suffer from a clinically recognized eating disorder (ED) at some time in their life.[1] The way in which a provider delivers care to a client with an ED is as important as the intervention itself in terms of patient satisfaction and progress.[2,3]

Objective This study investigated the patient's perceptions of the facilitators and barriers to forming a therapeutic working alliance with a Registered Dietitian Nutritionist (RDN) during eating disorder treatment.

Design The study used semi-structured interviews to identify perceived facilitators and barriers. Seven semi-structured interviews were conducted via Skype/WebEx.

Participants/Setting Subjects included 7 women over the age of 18. Participants completed the interview via their personal computers in a location of their choosing.

Statistical analysis Thematic analysis was used to analyze the qualitative data obtained during the interviews. Data were coded and segmented into common themes. Descriptive statistics including simple counts and percentages were used to analyze subjects' comments.

Results Analysis of the 7 interviews yielded 6 facilitators and 8 barriers. The number of comments regarding facilitators was 98. The number of comments regarding barriers was 75. The top 4 facilitators were Personality Characteristics (23%), Emotional Support (22%), Collaborative Decision Making (17%), and Client-Centered Approach (15%). The top 4 barriers were Disregard (20%), Personality Characteristics (16%), Nature of the Eating Disorder (13%) and Nature of the Dietitian's Role (13%).

Conclusion Personality Characteristics can be both a facilitator and barrier. Emphasis should be placed on displaying positive traits early. Emotional Support is highly valued. RDNs must understand the connection between eating behaviors and emotions. The Nature of the Eating Disorder and Nature of the Dietitian's Role are intrinsic barriers. RDNs must minimize other potential barriers and strengthen facilitators to overcome these built-in barriers.

Keywords: Therapeutic alliance, working alliance, eating disorders

INTRODUCTION

The collaborative relationship between patients and their clinicians; in which there are shared goals and a mutual willingness and agreement to participate in the necessary tasks to make progress in treatment, is known as the therapeutic working alliance.[4] The formation of a strong therapeutic working alliance between a patient with an eating disorder (ED) and his or her clinicians has been shown to improve treatment outcomes.[5] According to both the American Psychiatric Association[6] and the Academy of Nutrition and Dietetics, nutrition counseling is an essential component in the treatment of patients with EDs.[7]

Eating disorders are more than simple nutritional intake issues; they require a Registered Dietitian Nutritionist (RDN) to serve the dual roles of counselor and nutrition expert.[8] High dropout rates, non-compliance, and refusal of treatment are common difficulties encountered by ED treatment providers.[9] In order for RDNs to avoid encountering these pitfalls, one must develop an understanding of the factors patients believe facilitate or hinder the formation of a therapeutic working alliance with an RDN during treatment. This study attempted to provide RDNs with insight into the ED patients' perspectives on the key factors to developing a strong therapeutic working alliance.

An estimated 20 million women and 10 million men in the United States suffer from a clinically recognized ED at some time in their life.[1] With EDs having the highest mortality rate of any mental illness, researchers have many questions that still need answers. Ongoing efforts are aimed at developing and refining strategies for preventing and treating eating disorders.[10] Successful nutrition counseling requires RDNs to form a therapeutic working alliance with clients.[11] The factors influencing the formation of a such an alliance in the areas of nursing and psychotherapy have been well researched.[12,13] Despite extensive literature in the area of nutritional counseling, studies have focused on the effectiveness of counseling strategies rather than the relationship between the RDN and the patient.[14-16]

It is notoriously difficult to establish a therapeutic working alliance with ED patients for many reasons, including the complexity of the conditions and an individual's resistance to treatment.[17] Incorporation of patient values with evidence-based practice

and clinical experience allows clinicians and patients to form a therapeutic working alliance that optimizes clinical outcomes. Therefore, research on patients' views of ED treatment is important.[18] The way in which a provider delivers care to a client with an ED may be as important as the intervention itself in terms of patient satisfaction and progress.[2,3] Determining what ED patients perceive as important facilitators and barriers to forming a strong therapeutic working alliance with an RDN may help RDNs and researchers gain new insights into the successful development of a therapeutic working alliance and new ways to connect with ED patients.

METHOD

Setting

Subjects participated in the Skype/WebEx interview via their personal computers in a location of their choosing.

Population and Sample

The target population of this study were adult members of social media groups for former patients of eating disorder treatment programs. Participants had to have successfully completed a treatment program, be 18 years of age or older at the time of the interview, and have been treated by a RDN. The desired sample size for this research was 8 to 10 individuals.

Data Collection

The researcher obtained approval from the Institutional Review Board (IRB) at D'Youville College before the study was conducted (Appendix D). Initial contact with the participants was made through a recruitment flyer posted to Facebook groups for

recovering individuals (Appendix C). The flyer provided a link to Survey Monkey where individuals were able to electronically consent to the study, answer a brief survey of demographic information and provide his or her contact information to the researcher (Appendix A). After initial contact was made, the researcher then contacted all participants by email to provide more detailed information to the participants about the interview, answer any questions the participants may have about their role in the study and confirm their willingness to participate (Appendix E). Lastly, a date and time were set for the study interview to take place.

The interviews took place via a Voice over Internet Protocol (VoIP) application (Skype, WebEx) and were either video or audio recorded at the discretion of the participant. The duration was anticipated to vary from approximately 45 to 60 minutes, based on the length of the participant's responses. During each interview notes were taken on any nonverbal cues perceived by the researcher and were included with interview transcripts.

Tool

Semi-structured interview questions were developed by the researcher based on themes and elements of the therapeutic working alliance elicited from the literature review in Chapter II. The key topics addressed in the interview were: trust, honesty, impression of the therapeutic working alliance, and establishment of shared goals. The questions were administered over approximately 50 minutes with one question asked at a time. The researcher was able to ask additional probing questions or ask for clarification to participant responses before moving on to the next question (Appendix B).[19,20] The

principal focus of the interview was to understand the participant's experience of developing the therapeutic working alliance while in treatment. The interview questions were pilot-tested on a convenience sample of staff members from an eating disorder treatment facility (n= 3) to ensure the questions were easy to understand and would elicit in-depth responses (Appendix F).

Treatment of Data

An inductive approach to thematic analysis was utilized for this study. The inductive approach involved the process of coding the data without trying to fit it into a preexisting coding frame, or the researcher's analytic preconceptions.[21] Each transcript was read from start to finish to immerse the researcher into the perspective of the participant. Any notes taken during the interview on the nonverbal cues linked to a specific response were reviewed during the initial reading of each transcript. After the initial reading of the transcript the coding process began. In accordance with King and Horrocks,[20] the researcher utilized a three stages coding process consisting of descriptive coding, interpretive coding, and overarching theme identification. During a second reading of the transcript, the researcher highlighted relevant material that may help to understand the participant's view and began to define descriptive codes. The researcher then interpreted clusters of descriptive codes and elucidated the meaning of those clusters related to the research questions. Finally, an overarching theme name was assigned to groupings of interpretive codes to describe that understanding and identify the key themes for the entire data set.[20,21]

To assist in eliminating any potential bias in the researcher's analysis of the

transcripts, a graduate dietetic student independently analyzed each transcript following the same process described above. The overarching themes identified in the two analyses were then compared to ensure accuracy and objectivity of the researcher's analysis. If the two analyses were not in agreement as to the themes being expressed, a third reviewer was consulted to determine which of the analyses more accurately reflected the participant's perspective. Descriptive statistics were used to analyze the frequency and distribution of the identified themes in participant responses, as well as to assess the sample demographics. The purpose of the descriptive analysis was to determine what themes were most frequently identified by the participants when describing their relationship with the RDN.

RESULTS

Participant Characteristics

As shown in Table A-1, the study sample consisted of 7 women, the majority of whom identified as white non-Hispanic (85.7%). The length of time the participants had been treated by their RDN ranged from 3 to 12 months. The age at which a participant received treatment ranged from 15 to 51 years of age. A little more than half of the study sample were treated under the diagnosis of Anorexia Nervosa (57.1%), followed by the diagnosis of Bulimia Nervosa (42.8%). A more than half of participants reported being treated at the outpatient level of care (57.1%), followed closely by partial hospitalization/day treatment (42.8%). A full listing of reported demographic data can be found in Table A-1.

Semi-structured Interview Results

A total of 7 participants completed the interview portion of the study. Analysis of all the interview transcripts identified 6 perceived facilitators and 8 perceived barriers. The perceived facilitators and barriers with associated participant comments are listed, from highest to lowest frequency in Tables A-2 and A-3, respectively. Descriptive statistics of reported facilitators and barriers are listed from highest to lowest frequency in Table A-4. The total number of comments recorded across all 7 participants was 98 regarding facilitators and 75 regarding barriers.

Research Question 1 What did the clients/patients view as facilitators to forming a therapeutic working alliance with an RDN? The researcher designed questions to guide participants to describe the most significant facilitators to building a relationship with their RDN, as well as discuss topic areas of trust development, collaborative decision making, and potential improvements.

The four most common facilitators (n=98) that emerged from the interviews were *Personality Characteristics* (23%), *Emotional Support* (22%), *Collaborative Decision Making* (17%), and *Client-Centered Approach* (15%). Most participants referred to that the RDNs' ability to provide Personality Characteristics and Emotional Support as being the primary facilitators. The RDNs' Personality Characteristics included traits such as patience, non-judgmental, accepting, open, authentic, relatable, friendly, charismatic, and straightforward. Participant comments included statements such as *"[my dietitian] had a smile, she was much friendlier, she related to me"* and *"she was just such a happy, positive person."*

There area of Emotional Support included aspects such as providing reassurance and encouragement, support through difficult times, feeling understood, validation of feelings, and serving a dual role (part RDN, part therapist). For example, one participant stated,

> *"[my dietitian] took some time to just sit and talk with me about what was upsetting me and so in a lot of ways she functioned a little bit like a therapist and a dietitian…for eating disorders that's so important because the two [food and emotions] are interlinked, the stuff that is driving you to eat unhealthily are emotional things and the behaviors around the food trigger such an emotional response."*

The third perceived facilitator identified was Collaborative Decision Making. This area included taking client input, working with other providers, feelings of client inclusion in therapeutic decisions, and providing alternative strategies. One participant shared, *"I had lots of input into what [my meal plan] was, but of course there were rules around it, [my dietitian] would say you need to have this much or pick one from this category and one form that category, to fulfill your calorie intake"*

The perceived facilitator of Client-Centered Approach included factors such as showing an active interest in the client, emphasis on returning control to client, and recommendations aligned with client readiness. A full listing of perceived facilitators is found in Table A-2.

Research Question 2 What did the clients/patients view as barriers to forming a therapeutic working alliance with an RDN? The researcher designed questions to guide

participants to describe the barriers to building a relationship with their RDN, as well as discuss any causes of dishonesty and mistrust in the relationship.

The four most common barriers (n=75) that emerged from the interviews were *Disregard* (20%), *Personality Characteristics* (16%), *Nature of the Eating Disorder* (13%) and *Nature of the Dietitian's Role* (13%). Most participants described perceiving some degree of Disregard and reported that as the main barrier. Disregard was expressed through comments regarding a lack of utilizing client input and not feeling understood or heard, a perceived lack of care, and lack of sensitivity to client needs. For example, one participant stated that *"it felt like [my dietitian] didn't like me or even care about me"*

Personality Characteristics was also a frequently identified barrier which included traits such as judgement, unapproachable and a lack of sensitivity. Multiple participants made comments including *"[my dietitian] just wasn't the right personality for me"* or *"there was just something about her vibe."*

The Nature of the Eating Disorder and the Nature of the Dietitian's Role were both identified as equally contributing barriers. Several participants expressed feeling as if the eating disorder itself prevented them from connecting with their RDN. One participant stated, *"a lot of the time [my lying] had more to do with the nature of the eating disorder than the anything about the dietitian."* Another echoed that sentiment sharing about a time she lied that *"the eating disorder was just really loud at that time and I don't think it was anything that [my dietitian] did...if anyone had asked me if I had used behaviors while I was gone I would have said no."* Equally as often participants referenced the Nature of the Dietitian's Role as a barrier. One participant stated, *"a lot of*

what made it difficult was just that she was a dietitian…and I know that part of her job is to judge whether or not certain things were okay." A full listing of perceived barriers is found in Table A-3.

Serendipitous findings

Posting advertisements on social media was adequate for recruitment. Postings were made in 6 different Facebook groups within a combined membership totaling over 20,000. This method yielded 33 individuals to attempt the qualifying survey. However scheduling interviews and sending reminder emails did not always support participation. A total of three participants did not answer at their schedule interview time, nine did not reply to the scheduling email, one rescheduled their interview, and one formally withdrew their participation. As a result, the sample size was slightly smaller than anticipated, and the results may have been impacted.

When setting up interviews, the researchers noted that for participants without previous experience with VoIP applications, WebEx was a considerably easier application to use. The WebEx platform allowed the research to send an email invitation to the participant which contained a link to the scheduled meeting. Upon clicking the link participants were taken to the WebEx site where they were prompted through a few quick steps to configure their computer before joining the meeting. The process was simple and did not require the participant to seek out any additional instructions or sign up for an account prior to the scheduled interview.

Many participants initially struggled to identify facilitators and barriers when attempting to describe their relationship with just one RDN. Most participants had

worked with multiple RDNs at different times over the length of their eating disorder and were better able to identify facilitators and barriers when comparing the relationships then when attempting to speak exclusively about one relationship. In order to capture a more accurate description of the RDN-client therapeutic working alliance, the researcher utilized probing questions which encourage clients to provide comparison and further describe each relationship.

DISCUSSION

The value of a strong therapeutic working alliance has long been associated with improvements in the client's overall well-being, their mental health, and decreased treatment dropout rates.[22-24] The findings in this current study identified Personality Characteristics, Emotional Support, Collaborative Decision Making, Client-Centered Approach, Self-Disclosure, and Expertise/Knowledge as the primary facilitators to the formation of a therapeutic working alliance with a RDN, ranked in order highest to lowest. These facilitators are consistent with previous research on the alliance formed with other healthcare professionals, including nurses and therapists, when treating clients with eating disorders.

Research has shown that the ability to make a good first impression, approachability, patience and authenticity, allowing the patient to do most of the talking and provide input in decisions are frequently identified as facilitators to the therapeutic working alliance development.[13,25-29] Findings from this study support this. The researcher found that participants were generally more receptive to RDNs that were open to client input and worked with them to develop highly individualized plans. The

participants noted greater sense of connection to the RDN when the RDN shared a bit about him/herself and formed a more authentic relationship that wasn't purely clinical. These results are in agreement with three studies conducted in the field of nursing that identified participant as equal partner, genuineness, and good first impression as some of the facilitators to alliance formation.[13,25,26]

The barriers identified in the current study include Disregard, Personality Characteristics, Nature of the Eating Disorder, Nature of the Dietitian's Role, Assumptions, Poor Communication, Lack of Proper Support, and Power Struggle, ranked in order from highest to lowest. These barriers are consistent with the existing research in other disciplines working with eating disorder clients. A struggle for control, prejudice and stigmatizing, and disregard have been shown to negatively impact the relationship between eating disorder clients and their health professionals.[29,30]

Additionally, research conducted on the general patient population has suggested that the RDN is often perceived as purely an educator and a more transactional relationship in nature.[31] The results from this study are consistent with that research. Participants reported notions that the RDN was solely there to provide and change meal plans rather than counsel on behavioral changes. The Nature of the Dietitian's Role along with the Nature of the Eating Disorder are barriers intrinsic to the RDN-client relationship in the eating disorder treatment setting. The deceitful and uncooperative nature of eating disorders coupled with the cognitive difficulties from being in a starved state have been cited as primary difficulties in treating clients with eating disorder.[30,32,33] The findings of the current study support these identified difficulties.

Limitations

Although qualitative research has many strengths, there are also limitations to studies using qualitative methodology. In this study, there researcher focused on recruiting via social media, thus limiting the generalizability to patient with eating disorders whom do not have access to the internet or choose not to use social media. Additionally, there is a possibility of recall bias as the study relies on the participants' memory of past experiences.

CONCLUSIONS

Results revealed that participants had clear perceptions of the facilitators and barriers to the formation of a therapeutic working alliance with an RDN during eating disorder treatment. This study found that Personality Characteristics were viewed as both a major facilitator and barrier. Clients responded well to RDNs they perceive as friendly, empathetic, non-judgmental and open but struggle when approached with a cold, clinical, or overly authoritative demeanor. It is crucial for RDNs working with this population to focus on presenting the more positive personality traits early on in working with new clients to develop a strong therapeutic working alliance.

In this qualitative study, the researcher found that an important facilitator was Emotional Support. Understanding the intensity of the connection between eating behaviors and emotions when working with clients with eating disorders is imperative for RDNs as clients highly value the ability to talk about more than just the food itself with their RDN.

Results from this study indicate two major barriers, the Nature of the Eating Disorder and the Nature of the Dietitian's Role, that are intrinsic to all therapeutic working alliances between an RDN and a client with an eating disorder. These results demonstrate the need for an RDN working with this client population to minimizing the other six potential barriers and strengthen their ability to provide in the areas of the six perceived facilitators in order to overcome these inherent barriers and develop a strong therapeutic working alliance.

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Table A-1. Demographic Data (n=7)

	Count	Percentage
Length of time treated by Dietitian?		
3 months	1	14.3%
5 months	1	14.3%
6 months	1	14.3%
7 months	2	28.6%
12 months	1	14.3%
Unknown	1	14.3%
Level of care		
Inpatient/Residential	2	28.6%
Partial Hospitalization/Day treatment	3	42.8%
Intensive outpatient	1	14.3%
Outpatient	4	57.1%
Age when treatment was received		
15	2	28.6%
24	2	28.6%
26	1	14.3%
31	1	14.3%
51	1	14.3%
Eating Disorder Diagnosis		
Anorexia Nervosa	4	57.1%
Bulimia Nervosa	3	42.8%
Binge Eating Disorder	0	0.0%
EDNOS	2	28.6%
OSFED	1	14.3%
UFED	0	0.0%
Other	0	0.0%
Current situation		
I accept my body and no longer have thoughts, feelings or behaviors	0	0.0%
I am free from behaviors and thoughts and I am mostly OK in my body	0	0.0%
I am often free from behaviors and thoughts, but not all the time. Under times of stress I sometimes revert back to my unhealthy	2	28.6%

behaviors.		
I can stop the behaviors but not the thoughts.	2	28.6%
I can stop some of the behaviors, but not all of them.	2	28.6%
I tried to recover, but I couldn't I have relapsed since treatment and still struggle with my eating disorder.	1	14.3%
Gender		
Female	7	100.0%
Male	0	0.0%
Other (please specify)	0	
Ethnic Background/Race		
American Indian or Alaska Native	0	0.0%
Asian	0	0.0%
Black or African American	0	0.0%
Hispanic or Latino	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
White, non-Hispanic	6	85.7%
Other (please specify)		
White and Asian	1	14.3%

Table A-2. Perceived Facilitators to Therapeutic Working Alliance Formation

Theme	Count	Comments
Personality Characteristics	23	“she had a smile, she was much friendlier, she related to me" "she was just such a happy positive person” “recovery is not a linear path, so every time I come in and I've had a setback that week or haven't been doing as well, instead of trying to take me from where I was the week prior she's just like ok we can go from where you are now…she was very accepting in that way”
Emotional Support	22	“she took some time to just sit and talk with me about what was upsetting me and so in a lot of ways she functioned a little bit as a therapist and a dietitian" "she's not trained as a therapist but she was willing to do some of that because it is what I needed at that moment, if it got to be too much for her she would pick up the phone and call my therapist” “we have contact between appointments, she told me I could text her…it’s nice to have support when I get into stressful situations”
Collaborative Decision Making	17	“it was the dietitian and I working as a team” “she let me spread [snacks] out more so I wasn’t feeling that all at once I was eating more than I wanted to eat” “she shows you choices of things…and I’d get to pick the things that I thought I could handle”
Client-Centered Approach	15	“She would address my concerns specifically and would work around solutions for them specifically” “she just took the time to get to know me well” “she wanted to put me back in control of my life in the right way" "she would remind me that it was my meal plan, that it was my treatment and my recovery”
Self-Disclosure	11	“He shared a little bit about himself", "she opened up about her life, it made her more than a dietitian just analyzing me" "she disclosed to me that she was recovered from an eating disorder…I’ve definitely felt closer since then" "that openness for [my dietitian] to say hey I'm not really sure what to do about this…”
Expertise/ Knowledge	10	“I trusted that a dietitian is who really knew what I should be eating" "I needed somebody to really tell me what a normal relationship with food really looked like and she did that”

Table A-3. Perceived Barriers to Therapeutic Working Alliance Formation

Theme	Count	Comments
Disregard	15	“[my meal plan] was definitely more dictated to me”, "it made me frustrated that even when I was trying so hard to be honest about everything that I wasn't being believed” “I just felt like she didn’t like me and didn’t care about me”
Personality Characteristics	12	“something about her vibe…I kind of perceived it as cold" "she wasn't the right personality for me, she was too strong and mean for a kid like me”
Nature of the Eating Disorder	10	"the eating disorder was just strong enough to prevent me from being honest" “[the eating disorder] is a secretive sort of thing, so you don’t want to let too much out about it”
Nature of the Dietitian’s Role	10	“it was always more or less, just in and out of those appointments, get my meal plan and go” “the fact that she was a dietitian and the one who would raise my intake levels”
Assumptions	9	“there's the assumption that if you say you have an eating disorder then having food that doesn't make you feel very good, that you are just doing that because of the eating disorder…if you don't eat all foods then you're really not recovered", "she accused me of lying when I wasn't gaining weight, even though I was eating what she told me to…lying is very typical for people with eating disorders but I never lied to her" "she said 'well the weight graph shows that [purging] is what you've been doing' but I wasn't”
Lack of Proper Support	8	"she was trying to set unrealistic goals with me" "it was hard to keep any continuity between the visits where there was so much time to sort of be left to my own devices"
Poor Communication	6	“I thought she said I wasn’t going to get fat but I did get fat"
Power Struggle	5	"it made me feel like the dietitian and my mom were on a team against me" "the dietitian came to the appointment with a defensive stance, as if they had an agenda, when you sense that immediately barriers come up" "I had to turn over the control that I had to them"

Table A-4. Descriptive Statistics of Perceived Facilitators and Barriers

	Theme	**Frequency**	**%**
Rank	**Facilitators**		
1	Personality Characteristics	23	23%
2	Emotional Support	22	22%
3	Collaborative Decision Making	17	17%
4	Client-Centered Approach	15	15%
5	Self-Disclosure	11	11%
6	Expertise/Knowledge	10	10%
	Total	98	
	Barriers		
1	Disregard	15	20%
2	Personality Characteristics	12	16%
3*	Nature of the Eating Disorder	10	13%
3*	Nature of the Dietitian's Role	10	13%
5	Assumptions	9	12%
6	Lack of Proper Support	8	11%
7	Poor Communication	6	8%
8	Power Struggle	5	7%
	Total	75	

Appendix A

Implied Consent Form and Background/Demographic Questionnaire

Implied Consent Form

Dear Volunteer,

My name is Karen Darden and I am a 5th year dietetics student. You are invited to participate in a research study being conducted through D'Youville College. The purpose of my study is to determine what factors former patients believe were facilitators and barriers to forming a working relationship with a Dietitian during treatment for an eating disorder. This study will take place in 2 phases. Phase 1 is a brief online questionnaire consisting of 10 questions and that will take approximately 5-10 minutes to complete. If you qualify for phase 2 you will be asked to provide an email address at the end of the survey and will be contacted to schedule a Skype/WebEx interview that may take 45-60 minutes to complete.

Your participation in this research project is completely voluntary and confidential. Risks of participation are minimal. However, you may decide to stop participating in this research without penalty. If you decide to discontinue with the research during phase 1, do not click the submit button and you will be withdrawn. By completing and submitting this questionnaire, you agree to be contacted by the researcher for phase 2. If you decide to discontinue the research during phase 2, you may withdraw via email prior to your scheduled interview or at any time during your interview you may ask to be withdrawn from the study. After your interview has been completed you may not withdraw from the study.

Your participation is greatly appreciated. If you have any concerns or questions regarding this study, please email me at dardek11@dyc.edu. You may also contact my thesis advisor, Dr. Edward Weiss, at 716-829-7832. **Thank you for your time and participation.**

Sincerely,

Karen Darden

Background/Demographic Questionnaire

1) Are you currently 18 years of age or older?
   a. Yes
   b. No*

2) Have you successfully completed an eating disorder treatment program? Successful completion is defined as advancing from treatment at the recommendation of your treatment team and does not include being discharged prematurely due to personal choice or lack of insurance coverage
   a. Yes
   b. No*

3) During treatment for your eating disorder did you work with a dietitian?
   a. Yes
   b. No*

For the purposes of this study think only of the dietitian you worked with during your most recently completed treatment stay.

4) How long were you treated by this dietitian: _____

5) At what level(s) of care were you treated by this dietitian: (choose all that apply)
   - ☐ Inpatient/Residential
   - ☐ Partial Hospitalization/Day Treatment
   - ☐ Intensive Outpatient
   - ☐ Outpatient

6) At what age did you receive this treatment: _____

7) Eating Disorder Diagnosis:
   a. Anorexia Nervosa
   b. Bulimia Nervosa
   c. Binge Eating Disorder
   d. Eating disorder not otherwise specified (EDNOS)
   e. Other specified feeding or eating disorder (OSFED)
   f. Unspecified feeding or eating disorder (UFED)
   g. Other (please specify)_____

8) Which of the following statements most accurately reflects your current situation?**
   a. I accept my body and no longer have thoughts, feelings, or behaviors related to my eating disorder.
   b. I am free from behaviors and thoughts and mostly OK in my body.
   c. I am often free from behaviors and thoughts, but not all the time. Under stress I sometimes revert back to my unhealthy behaviors.
   d. I can stop the behaviors, but not the thoughts.
   e. I can stop some of the behaviors, but not all of them.
   f. I tried to recover, but I couldn't. I have relapsed since treatment and still struggle with my eating disorder.

9) Gender:
   a. Female
   b. Male
   c. Other (please specify)_____

10) Ethnic Background/Race: (choose all that apply)
   ☐ American Indian or Alaska Native
   ☐ Asian
   ☐ Black or African American
   ☐ Hispanic or Latino
   ☐ Native Hawaiian or Other Pacific Islander
   ☐ White, non-hispanic
   ☐ Other: _____

9) Please provide an email address where you can be reached by the researcher to schedule a Skype/WebEx interview. Email: _____

*Subjects selecting these answers were directed to a disqualification page. This page appeared as "Thank you for your time, unfortunately you are ineligible for the interview portion of this study." The "Skip Logic" function prevented ineligible subjects from spending unnecessary time to complete the survey.

**Reference: Costin, C., & Grabb, G. (2012). *8 keys to recovery from an eating disorder: effective strategies from therapeutic practice and personal experience.* New York: W. W. Norton & Company.

Appendix B

Semi-structured Interview Questions

Semi-Structured Interview Questions

1. Describe the relationship you had with your dietitian during treatment.

2. Do you feel you had a positive or negative relationship with your dietitian and why?
    a. **Note**: This question may be omitted if the nature of the relationship is discussed in response to question 1.

3. What was helpful in forming a relationship with your dietitian?

4. What made it difficult to form a relationship with your dietitian?

5. What would have improved your relationship with your dietitian?

6. In working with your dietitian to adjust your meal plan, did you feel like you had input in those decisions?

7. Is there a time when you were not honest with your dietitian? If so, what about your relationship with your dietitian prevented you from being truthful?

8. Did you trust your dietitian? What was helpful or not helpful in developing trust with your dietitian?

9. Were there any specific moments or interactions with your dietitian that stand out to you as having a major effect on the relationship you had with your dietitian?

Note: Each question may be followed up with probing questions for elaboration, clarification, or completion of responses (Aguero-Esquivel, 2014; King & Horrocks, 2010).

Examples:

- Would you say more about _____?
- Can you give me an example?
- Tell me what you meant by _____?
- Can you explain this further?
- Is there anything else?

Continuing Responses (reflective listening, p.72) summarize or reflect the content or feelings presented by the person being helped (get people talking, learning about pt./employee's situation, develop effective communication, uncover the problem) (D'Augelli, Danish, Hauer, & Conter, 1985).

1. **MmHm**- (head nod, "go on")
2. **Content**- Mirroring: repeat statements ("you seem to be saying…", it seems you are…", "it sounds like…")
3. **Affective**- Reflects the feeling: translates patient's feelings into words, use feeling word ("it sounds like you feel [add feeling word] …", "you seem [tired, sad, happy] …"

Appendix C

Facebook Recruitment Flyer

Facebook Recruitment Flyer

Appendix D

IRB Full Approval Letter

D'Youville COLLEGE
320 Porter Avenue
Buffalo, New York 14201-1084

TO: **Karen Darden**

FROM: Dr. Roger Fiedler RCF/EB
Institutional Review Board

DATE: February 13, 2017

SUBJECT: **IRB FULL APPROVAL**

I am pleased to inform you that your application to the D'Youville College Institutional Review Board entitled: *"Patient Perceptions of the Formation of a Therapeutic Working Alliance with a Registered Dietitian Nutritionist During Eating Disorder Treatment"* has been granted **FULL APPROVAL** with respect to the protection of human subjects. This means that you may now begin your research unless you must first apply to the IRB at the institution where you plan to conduct the research.

Please note that you are required to report back to this IRB for further review of your research should any of the following occur:

1. a major change in the method of data collection
2. unanticipated adverse effects on the human subjects
3. unanticipated difficulties in obtaining informed consent or maintaining confidentiality
4. the research has not been completed one year from the date of this letter

Congratulations and good luck on your research!

eb

cc: Director of Graduate Studies
Dr. Edward Weiss
file

(716) 829.8000
fax: (716) 829.7790

Appendix E

Interview Scheduling Email

Interview Scheduling Email

Dear _____,

Thank you for completing phase 1 of my research study on the working relationship with a Dietitian during treatment for an eating disorder!

I am contacting you because you have qualified for phase 2 and I would like to schedule a Skype/WebEx interview that may take 45-60 minutes to complete. Please suggest a day of the week and time that suits you and I will do my best to accommodate it.

Your participation in this research project is completely voluntary and confidential. Risks of participation are minimal. However, you may decide to stop participating in this research without penalty. If you decide to discontinue the research during phase 2, you may withdraw via email prior to your scheduled interview or at any time during your interview you may ask to be withdrawn from the study. After your interview has been completed, you may not withdraw from the study.

Your participation is greatly appreciated. If you have any concerns or questions regarding this study, please email me at dardek11@dyc.edu. You may also contact my thesis advisor, Dr. Edward Weiss, at 716-829-7832. **Thank you again for your time and participation.**

Sincerely,

Karen Darden

Appendix F

Pilot Test Feedback Form

Pilot Test Feedback Form

Please answer the following questions regarding the background/demographic questionnaire and interview you have just completed. Comments, critiques, and suggestions are welcome.

1. Was there any additional information that should have been provided to help aid in the completion of the background/demographic questionnaire?

2. Was the level of difficulty appropriate for a typical adult?

3. How did you feel about the length of the questionnaire and interview script?

- ☐ Too short
- ☐ Just right
- ☐ Too long

Comments/Suggestions:

_____
_____
_____

4. Were the questions and directions clear?

- ☐ Yes
- ☐ No

Comments/Suggestions:

_____
_____
_____

5. Do you have any additional comments/suggestions?

_____
_____
_____
_____

Survey adapted from Minarich, 2015