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"You feel that you are stepping into a different world": Vulnerability and biases in the treatment of anorexia nervosa

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ABSTRACT

The treatment of anorexia nervosa has been marked by challenges, prompting scholars to establish therapeutic guidelines aimed at overcoming barriers, and enhancing the efficacy of treatment. Although previous studies have documented the difficulties that usually arise in anorexia treatment, the challenges and the vulnerabilities therapists face have not been fully illuminated. The objective of this study is to delve into therapists' experiences and explore the sense of vulnerability they encounter during the treatment of anorexia nervosa, thereby fostering a more profound comprehension of their perspectives. One-to-one interviews were carried out with a cohort of 7 Greek therapists, all of whom had a minimum of 5 years of professional experience. Data were analyzed using interpretative phenomenological analysis and two main themes were constructed: therapist-related factors and building communication. Therapists experienced moments of self-doubt wherein they questioned their capacity to provide an efficacious treatment plan. Aside from this sense of vulnerability, treatment was also thought to be hindered by personal biases while issues of mistrust and parental involvement were considered to be additional challenges. Lastly, the study raises doubts about the therapist's role as the confident and unbiased expert, emphasizing the criticality of addressing these challenges to enhance the overall treatment outcomes.

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"Man hat das Gefühl, in eine andere Welt einzutreten": Vulnerabilität und Vorurteile in der Behandlung von Anorexia nervosa

ABSTRAKT
Die Behandlung von Anorexia nervosa ist von Herausforderungen geprägt, die Wissenschaftler dazu veranlasst haben, Festlegung therapeutischer Leitlinien zur Überwindung von Barrieren und zur Steigerung der Wirksamkeit der Behandlung zu etablieren. Obwohl frühere Studien die Schwierigkeiten dokumentiert haben, die in der Regel auftreten bei der Behandlung von Magersucht wurden die Herausforderungen und Schwachstellen, mit denen Therapeuten konfrontiert sind, voll ausgeleuchtet.

Das Ziel dieser Studie ist es, die Erfahrungen von Therapeuten und Therapeuten zu untersuchen das Gefühl der Verletzlichkeit zu erforschen, dem sie während der Behandlung von Anorexia nervosa begegnen, dadurch wird ein tieferes Verständnis ihrer Perspektiven gefördert. Es wurden Einzelinterviews mit einer Kohorte von 7 griechischen Therapeuten durchgeführt, die alle ein Minimum von 5 Jahren Berufserfahrung mitbrachten.

Die Daten wurden mit Hilfe von interpretativen phänomenologische Analyse und zwei Hauptthemen wurden konstruiert: therapeutenbezogene Faktoren und Kommunikationsaufbaumechanismen. Therapeuten erlebten Momente des Selbstzweifels dabei stellten sie ihre Fähigkeit in Frage, einen wirksamen Behandlungsplan zu erstellen.

Neben dieses Gefühl der Verletzlichkeit wurde auch durch persönliche Vorurteile behindert während Fragen des Misstrauens und der Einbeziehung der Eltern als zusätzliche herausforderungen. Schließlich wirft die Studie Zweifel an der Rolle des Therapeuten als selbstbewusster und unvoreingenommenen Sachverständigen, der betont, wie wichtig es ist, diese Herausforderungen anzugehen, um die Gesamtergebnisse der Behandlung.

"Sientes que estás pisando un mundo diferente": Vulnerabilidad y sesgos en el tratamiento de la anorexia nerviosa

RESUMEN

El tratamiento de la anorexia nerviosa ha estado marcado por desafíos, lo que ha llevado a los estudiosos a establecer pautas terapéuticas dirigidas a superar las barreras y mejorar la eficacia de tratamiento. Aunque estudios previos han documentado las dificultades que suelen surgir En el tratamiento de la anorexia, los desafíos y las vulnerabilidades a las que se enfrentan los terapeutas no han sido totalmente iluminado. El objetivo de este estudio es profundizar en las experiencias de los terapeutas y explorar la sensación de vulnerabilidad que encuentran durante el tratamiento de la anorexia nerviosa, fomentando así una comprensión más profunda de sus perspectivas. Uno a uno se realizaron entrevistas con una cohorte de 7 terapeutas griegos, todos los cuales tenían un mínimo de 5 años de experiencia profesional. Los datos fueron analizados mediante métodos interpretativos análisis fenomenológico y se construyeron dos temas principales: factores y la construcción de la comunicación. Los terapeutas experimentaron momentos de duda sobre sí mismos en el que cuestionaron su capacidad para proporcionar un plan de tratamiento eficaz. Aparte de Esta sensación de vulnerabilidad, también se pensaba que el tratamiento se veía obstaculizado por sesgos personales mientras que los problemas de desconfianza y participación de los padres se consideraron desafíos. Por último, el estudio plantea dudas sobre el papel del terapeuta como imparcial, haciendo hincapié en la importancia de abordar estos desafíos para mejorar la resultados generales del tratamiento.

"Senti che stai entrando in un mondo diverso": vulnerabilità e pregiudizi nel trattamento dell'anoressia nervosa

RIASSUNTO

Il trattamento dell'anoressia nervosa è stato caratterizzato da sfide, spingendo gli studiosi a stabilire linee guida terapeutiche volte a superare le barriere e a migliorare l'efficacia di trattamento. Sebbene studi precedenti abbiano documentato le difficoltà che di solito sorgono nel trattamento dell'anoressia, le sfide e le vulnerabilità che i terapeuti devono affrontare non sono state completamente illuminate. L'obiettivo di questo studio è quello di approfondire le esperienze dei terapeuti ed esplorare il senso di vulnerabilità che incontrano durante il trattamento dell'anoressia nervosa, favorendo in tal modo una comprensione più profonda delle loro prospettive. Sono state effettuate interviste individuali con una coorte di 7 terapeuti greci, tutti con un minimo di 5 anni di esperienza professionale. I dati sono stati analizzati utilizzando l'analisi fenomenologica interpretativa e sono stati costruiti due temi principali: fattori relazionati ai terapeuti e l'instaurarsi della comunicazione. I terapeuti hanno vissuto momenti di insicurezza in cui hanno messo in dubbio la loro capacità di provvedere un piano di trattamento efficace. A prescindere da questo senso di vulnerabilità, si è pensato che il trattamento fosse ostacolato anche da pregiudizi personali, inquanto le questioni della sfiducia e del coinvolgimento dei genitori sono state considerate delle sfide addizionali. Infine, lo studio solleva dubbi sul ruolo del terapeuta come confidente ed esperto imparziale, sottolineando l'importanza di affrontare queste sfide per migliorare i risultati complessivi del trattamento.

«Vous avez l'impression d'entrer dans un monde différent » : Vulnérabilité et biais dans le traitement de l'anorexie mentale

ABSTRAIT

Le traitement de l'anorexie mentale a été marqué par des défis, ce qui a incité les chercheurs à établir des lignes directrices thérapeutiques visant à surmonter les obstacles et à améliorer l'efficacité de traitement. Bien que des études antérieures aient documenté les difficultés qui surviennent habituellement dans le traitement de l'anorexie, les défis et les vulnérabilités auxquels les thérapeutes sont confrontés n'ont pas été entiérement éclairé. L'objectif de cette étude est d'approfondir les expériences des thérapeutes et explorer le sentiment de vulnérabilité qu'ils rencontrent lors du traitement de l'anorexie mentale, favorisant ainsi une compréhension plus profonde de leurs perspectives. Un par un des entretiens ont été réalisés avec une cohorte de 7 thérapeutes grecs, ayant tous un minimum de 5 ans d'expérience professionnelle. Les données ont été analysées à l'aide d'interprétations phénoménologique et deux thémes principaux ont été construits : liés au thérapeute facteurs et l'établissement de la communication. Les thérapeutes ont vécu des moments de doute dans lequel ils remettaient en question leur capacité à fournir un plan de traitement efficace. À part ce sentiment de vulnérabilité, on pensait également que le traitement était entravé par des préjugés personnels tandis que les problémes de méfiance et d'implication des parents étaient considérés comme des facteurs supplémentaires défis. Enfin, l'étude souléve des doutes sur le rôle du thérapeute en tant qu'acteur confiant et expert impartial, soulignant l'importance de relever ces défis pour améliorer la résultats globaux du traitement.

“Αισθάνεσαι ότι εισέρχεσαι σε έναν διαφορετικό κόσμο”: Ευαλωτότητα και προκαταλήψεις στη θεραπεία της ψυχογενούς ανορεξίας

ΠΕΡΊΛΗΨΗ
Η θεραπεία της ψυχογενούς ανορεξίας χαρακτηρίζεται από προκλήσεις, ωθώντας τους μελετητές να καταρτίσουν θεραπευτικές κατευθυντήριες γραμμές με στόχο την υπέρβαση των εμποδίων και την ενίσχυση της αποτελεσματικότητας της θεραπείας. Αν και προηγούμενες μελέτες έχουν καταγράψει τις δυσκολίες που συνήθως προκύπτουν στη θεραπεία της ανορεξίας, δεν έχει ριχτεί αρκετό φως στις προκλήσεις και τα τρωτά σημεία που αντιμετωπίζουν οι θεραπευτές. Ο στόχος της παρούσας μελέτης είναι να εμβαθύνει στις εμπειρίες των θεραπευτών και στις

διερευνήσει το αίσθημα ευαλωτότητας που αντιμετωπίζουν κατά τη διάρκεια της θεραπείας της νευρικής ανορεξίας, προωθώντας έτσι μια βαθύτερη κατανόηση της εμπειρίας τους. Πραγματοποιήθηκαν ατομικές συνεντεύξεις με ένα δείγμα 7 Ελλήνων θεραπευτών, οι οποίοι είχαν επαγγελματική εμπειρία τουλάχιστον 5 ετών. Τα δεδομένα αναλύθηκαν με τη χρήση ερμηνευτικής φαινομενολογικής ανάλυσης και προέκυψαν δύο κύρια θέματα: παράγοντες που σχετίζονται με τον θεραπευτή και η οικοδόμηση της επικοινωνίας. Οι θεραπευτές βίωσαν στιγμές αυτοαμφισβήτησης κατά τις οποίες αμφισβητούσαν την ικανότητά τους να παρέχουν ένα αποτελεσματικό θεραπευτικό σχέδιο. Εκτός από αυτή την αίσθηση ευαλωτότητας, η θεραπεία θεωρήθηκε επίσης ότι παρεμποδίζεται από προσωπικές προκαταλήψεις, ενώ ζητήματα δυσπιστίας και γονεϊκής εμπλοκής θεωρήθηκαν επιπρόσθετες προκλήσεις. Τέλος, η μελέτη εγείρει αμφιβολίες σχετικά με το ρόλο του θεραπευτή ως του σίγουρου και αμερόληπτου ειδικού, τονίζοντας τη σημασία της αντιμετώπισης αυτών των προκλήσεων για την ενίσχυση της συνολικής θεραπευτικής έκβασης.

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SCHLÜSSELWÖRTER Anorexia nervosa; Behandlung; Herausforderungen; Therapeuten; persönliche Voreingenommenheit

PALABRAS CLAVE anorexia nerviosa; tratamiento; desafíos; terapeutas; sesga personal

PAROLE CHIAVE anoressia nervosa; trattamento; sfide; terapeuti; pregiudizi personali

MOTS-CLÉS anorexie mentale; traitement, défis; thérapeutes; préjugés personnels

ΛΈΞΕΙΣ-ΚΛΕΙΔΙΆ Ψυχογενής ανορεξία; θεραπεία; προκλήσεις; θεραπευτές; προσωπική προκατάληψη

Introduction

Anorexia nervosa (AN) is a severe mental disorder that is characterized by a problematic attitude toward food and body image followed by starvation and malnutrition (APA, 2013). Given the severity of the disorder, treatment, which is usually undertaken by medical and other professionals, is mandatory for a more favorable outcome than if left untreated. Across different countries and healthcare systems, medical and psychological treatment is

offered, either in outpatient or inpatient settings, with approximately one-third of the clinical population requiring intensive treatment (Herpertz-Dahlmann, 2021).

Numerous studies emphasize the formidable nature of achieving successful outcomes in the treatment of eating disorders (EDs), with many clinicians characterizing ED patients as difficult to treat (Geller et al., 2012; Halmi, 2013). Nonetheless, those working in medical and human service professions perceive labels as a valuable 'cultural capital' (Bourdieu, 1986). Cultural capital is defined as the accumulated cultural knowledge, education, and skills that individuals possess, which can be used to gain social and economic advantages (Bourdieu, 1986). This implies that these labels and patient categorizations hold authoritative recognition within institutions and empower therapists to exert influence over 'difficult' patients. For instance, in situations where patients are considered resistant, therapists have the capacity to employ legal mechanisms that allow for the imposition of highly coercive treatments, including the mandatory application of re-feeding techniques (Jutel, 2009). This highlights therapists' clinical authority over patients' bodies and treatment decisions, which is connected to discussions of bias (Foucault, 1979). Therapists assert their power and control over individuals by extending the discourse on categorizations and labels associated with ED patients (Foucault, 1978). According to Foucault, this can be seen as a form of biopower exercised by neoliberal governance to manage bodies and regulate behaviors.

Literature points to the challenges in treating ED patients, as therapists often experience intense emotions like rage and hopelessness (Colli et al., 2015). These emotions can have a considerable effect on the therapist's performance and the treatment process. Strober (2004), for instance, highlighted the strong negative emotions therapists experience which might even evoke a desire to free themselves from the patient's influence. As indicated by research, such feelings can lead therapists to opt out of treating individuals with EDs (Thompson-Brenner et al., 2005). However, therapists' reactions may vary with experience, with less experienced professionals showing more negative responses compared to experienced therapists (Sansone et al., 1998). Experienced therapists tend to have strong alliances and lower negative emotions (Satir et al., 2009), suggesting better preparation, either mentally or professionally, for ED treatment.

Additional challenges that may be associated with the therapists' level of experience are treatment adaptations. Clinicians that have worked with AN patients perceived treatment adaptations based on individual-specific elements as a challenging issue that is usually encountered in ED treatment (Kinnaird et al., 2018). Consistent with these findings, treatment decisions (i.e. interventions or management of co-occurring disorders) in intensive care settings have been found to contribute to therapist

vulnerability (Webb et al., 2022). In addition to decision-making challenges, clinicians trained in cognitive behavioral therapy (CBT) and cognitive analytical therapy recognized the importance of adapting communication styles, such as providing clear instructions and avoiding humor or metaphors, to better meet the unique needs of patients (Kinnaird et al., 2017). These observations were made within the context of treating individuals with AN and autism spectrum disorder (ASD) comorbidity, where the nuances of treatment decisions and communication play a pivotal role. Additional key challenges that have been raised by therapists are the patients' difficulty to be emotionally open and their tendency to hide their eating practices (Tragantzopoulou & Giannouli, 2020). Patients with AN frequently encounter difficulties expressing their emotions and are often reluctant to disclose their eating behaviors.

While acknowledging the demanding nature of treating AN, especially regarding severity and dropout rates, extensive research on therapists' vulnerabilities and challenges, particularly among Greek therapists, is lacking. Most of the existing studies on this topic have been conducted in the UK or Australia, and they often treat professionals' personal experiences and vulnerabilities as a peripheral issue. Therefore, the present study aims to bridge this gap by specifically exploring the vulnerabilities and challenges experienced by Greek therapists during the treatment of AN. We believe that amplifying therapists' voices around the challenges they usually encounter in treatment with AN patients may contribute to further understanding the barriers and mechanisms that interfere with the outcome of the therapeutic process.

Methods

Design

To uncover the experiences and the challenges Greek therapists face when treating individuals with AN, the study adopted a qualitative design. Qualitative research enables the exploration of personal experiences and perspectives based on the accounts of the individuals (Hammarberg et al., 2016). Using an interview-based exploration, the research question we sought to investigate was: What kinds of challenges and vulnerabilities do professionals working with AN face?

Participants

Eligible participants had to a) be licensed therapists, b) have at least five years of professional experience, and c) have experience in treating patients that had been diagnosed with AN. Following the ethics approval, a purposive

Table 1. Participant demographics.

Participants	Gender (M/F)	Age Range	Time in Profession (Years)	Therapeutic Approach
Participant 1	F	30–40	12	CBT
Participant 2	F	20–30	6	CBT
Participant 3	F	30–40	11	Person-centered
Participant 4	M	30–40	7	Family Therapy
Participant 5	F	50–60	15	CBT/Schema Therapy
Participant 6	F	40–50	9	CBT
Participant 7	F	20–30	5	Family Therapy

sampling design was used. The first group of participants was referred to the study through an outpatient therapeutic clinic that specializes in treating a range of mental health issues, including EDs. The first author met with the therapeutic clinic in Thessaloniki, Greece and gained their co-operation on the study. These first participants provided contacts for other psychotherapists who practice in private settings, hence snowball sampling occurred. In total, seven professionals volunteered to participate in the study. All participants were Greek and predominantly female (only 1 male psychotherapist participated), all of whom had experience in treating AN in both adolescents and adults (Table 1).

Data collection

Participants were invited to take part in one-to-one semi-structured interviews where their experiences of treating individuals diagnosed with AN were discussed. Interviews lasted around one hour on average, although the shortest was 31 minutes, and took place at the therapists' place of work, outside of their working hours. An interview guide informed by the literature was prepared ahead of the interviews. Prompts were also implemented to elicit more information. Prior to the interviews, participants were asked to sign an informed consent form and agree on recording the interviews. The interview dialogues were audio-recorded and transcribed verbatim by removing any identifiable information.

Ethical considerations

The study was approved by the researchers' university ethics committee. Participation in this research was voluntary and all individuals signed a written, informed consent. Therapists did not reveal the identity of their clients and no personal information was included. Participants were informed about their right to omit any question that could be perceived as violating the therapeutic confidentiality, and withdraw from the study at any stage.

Data analysis

The qualitative data were subject to interpretative phenomenological analysis (IPA). IPA is a method that enables the in-depth exploration of people's lived experiences and the conceptualization of the meanings of experiences as reported by the participants themselves (Smith et al., 2009). We felt this phenomenological approach was suitable for this study, given that the aim was to understand how therapists make sense of the challenges faced when treating individuals with AN, and of their own vulnerabilities. The following stages outlined by Smith et al. (2009) were followed:

Stage 1: After interview transcription, familiarization with the data was initiated. The first transcript was read and re-read a number of times while early reflections and ideas were noted down in the right-hand margin. Open reflective reading did not allow for any predetermined notions to intervene with the data and new insights could be attained.

Stage 2: Once a good level of familiarization had been achieved, coding was initiated. Codes were both descriptive and conceptual, aiming to capture the overarching understanding of the experience. Notes were also coded, searching for emergent themes and central features. Emerging themes were noted in the left-hand margin.

Stage 3: At this stage, connections among emerging themes were examined. Themes that presented similarity in terms of their conceptual meaning were grouped together to form clusters of themes whereas themes that were characterized by weak evidential base were dropped. Clusters were reviewed again and produced superordinate themes.

The same process was repeated for every transcript and the list of themes created from the first transcript informed the analysis of the rest of the data. In case new themes were emerging in subsequent transcripts, we compared them with previous findings. All transcripts were compared with each other to inform the final list of themes. Themes were considered concurrent only if more than half the participants had reported them. In the presentation of the results, the term 'some' refers to two or three participants whilst 'most/the majority' is five to six participants.

The first author conducted the primary analysis and in collaboration with the second author, who independently analyzed two of the transcripts, themes were compared. To ensure credibility and trustworthiness, we thoroughly discussed our interpretations, notes and themes at different stages throughout the analytic process. Analysis resulted in two themes (Table 2). We have selected representative excerpts that support the presentation of our findings and allow for transparency within our results.

Table 2. Summary of themes and subthemes.

Themes	Subthemes
Therapist-related Factors	The vulnerability of the therapist
	Therapeutic bias
Building Communication	Tests of trust
	Parents and therapy involvement

Results

Therapist-related factors

The vulnerability of the therapist

All participants reported that treating patients with AN is a demanding responsibility that requires several hours of preparation and careful management of each case. Some participants discussed their attempt to integrate various therapeutic interventions, such as CBT techniques and relational interventions in the context of family therapy, to enhance the therapeutic process. However, some of them reported feeling vulnerable in their position to implement different interventions or decide which responsive matching to client characteristics beyond diagnosis would be helpful. Three therapists reported '*questioning*' their own abilities as therapists when treatment needed to be adapted and interventions seemed to be inefficient. Although all participants had experience in treating AN, the pressure to provide help and alleviate the symptoms of the disorder provoked feelings of despair:

> I am always thinking . . . how much can I push her? What should I do now? I fear that I will not be able to handle the pressure or that the client will think that I don't care about her. (P3)

Many expressed that they had to prepare in advance or carefully think of the words they would use during sessions. The pressure to always be careful with their words was perceived as stemming from their own fear of leaving clients helpless. Participants were aware of the severity of the disorder and the urgent need for treatment. Hence, they reported feeling an elevated sense of responsibility to both the clients and their parents. In cases where therapy ended abruptly, participants reported experiencing a strong feeling of bafflement and anguish of the outcome of the case. Two participants perceived that the fear of not being able to help the clients escalated their anxiety of how each case should be handled:

> Sometimes you feel that you are stepping in a different world . . . that you have to be careful with the words you are using. In front of you . . . you have a person that needs help and if you say something disturbing, they will easily leave therapy and never return. (P2)

Therapeutic bias

Generally, all participants thought that personal biases were present at the beginning of the therapeutic relationship. However, the less experienced participants stated that they tended to generate several interpretations based on their own biases. The main bias that was mentioned by the less experienced therapists was that AN patients are difficult to treat. Patients were considered to be resistant and non-responsive to treatment. Some therapists interpreted clients' resistance during therapy as a form of control. Patients were framed as demanding control of the treatment to protect their disorder rather than seeking its treatment. Others perceived resistance as an aversion to maturity, however, some therapists stated that such interpretations had been stemmed from their own biases rather than the clients themselves:

> I thought that he wanted to control therapy because the process of rethinking and interpreting situations would mean that he grows up. I started making interpretations based on what I was assuming rather than what the client was presenting. (P4)

While all participants reported biases initially undermining their therapy attitude and client relations, some acknowledged these biases as negatively impacting their practice by marginalizing aspects of clients' experiences. For example, they might have '*minimized some symptoms*' or not '*paid full attention*' to specific details, which in turn could affect the appropriateness of their treatment approach. Initially, when some of them began working as psychotherapists, they did not consider the necessity of immediate or ongoing supervision meetings. Over time, they realized the value of supervision meetings, which aided in bias recognition and addressing. This process not only transformed their connection to the clients but also influenced their theoretical positions and approach to therapy:

> You come to therapy with all these subtle prejudgements about AN clients ... without even listening to their story. Supervision helped me to become aware of these biases and shift my perspective. (P7)

Building communication

Tests of trust

Most participants viewed AN clients as individuals that needed to '*feel connected to someone*'. Therapists stated that the clients' primary need was to establish a connection with them and a sense of alignment that would enable them to trust the therapeutic process. Nonetheless, clients were perceived as struggling to communicate their concerns or, more importantly, therapists thought that they were trying to conceal their symptoms and

thoughts. Clients were characterized by therapists as being '*cautious*' or '*hesitant*' in terms of how they would communicate with them, and which aspects of their AN trajectory would be revealed. Some of the therapists observed that patients were cautious towards them and hesitant to open up, even though they were trying to *'rely on'* someone:

> We started our sessions but I was feeling that he was trying to hide something . . . or maybe he didn't know how to say it . . . he was being very cautious. He was distant . . . he didn't open up. (P1)

Two participants experienced trust issues in the form of tests. Specifically, patients would sometimes resort to lying when reporting their homework assignments, such as maintaining food diaries, a common requirement in CBT as used in this study. Their intention was to gauge the therapists' reactions, assessing whether they could trust them. Therapists found that responding with empathy, avoiding judgment, and refraining from pressuring clients to complete tasks were key factors in establishing trust. Building a positive therapeutic alliance was seen as essential for effective treatment:

> There were times that she was lying . . . times that she'd say that she had forgotten to bring the diary or that she had forgotten to write her food diary . . . I feel that she wanted to see my reactions . . . or see if she can trust me. (P5)

Parents and therapy involvement

Most of the participants that had worked with adolescents stated that parental involvement in therapy was desirable and important for AN treatment. However, in the context of private practice and the outpatient treatment unit discussed in this study, parents seemed to be unwilling to participate in therapy, as described by some interviewees. Their unwillingness to participate in therapy was attributed to their belief that adolescents had to *'work the most'*. Most of the parents could not understand *'their part of responsibility'*. Other parents tended to minimize the symptoms. In male adolescents, for instance, fathers tended to misattribute extreme weight loss to the need to *'man up'*, disregarding the diagnosis. Therapists acknowledged that making the parents accept the fact that their children were suffering from an ED was a key challenge:

> The dad had an extreme denial and reluctance to understand that his child had a problem. I don't know what else he needed to see in order to understand it . . . a very tall and extremely skinny girl was fainting. (P6)

Aside from parents, most therapists experienced an unwillingness from the part of their clients to allow parental involvement. Although parents were requested to attend separate sessions, clients were '*negative*' and expressed their disagreement. The majority of the therapists reported that disagreement was originated from their clients' belief that confidentiality would be

breached and private information would be shared with their parents without '*their own permission*'. It was interesting how one therapist described one incident of denial in respect of parental involvement. The client, who was an adolescent, thought that having her parents attend separate sessions would mean that both parents and the therapist would secretly make their own arrangements aiming at making her eat more or be hospitalized:

> The child knew that her parents every 3 or 2 weeks would visit me. She didn't like it because she thought that we were plotting against her. Even though I'd explain to her that she needs her parents' support for this struggle, it became very difficult for her to understand it.

Discussion

We set out to explore the challenges therapists face when working with individuals that have been diagnosed with AN, such that their own vulnerabilities and the difficulties arising during the therapeutic process could be elucidated. Our study questions the perception of therapists as confident 'experts', which was documented in prior studies (Constantino et al., 2017; Olivera et al., 2013) and highlights the sense of vulnerability, characterized by uncertainty in treatment selection and self-doubt, experienced by therapists. While our sample acknowledged personal biases, it also framed the therapeutic process and relationship as influenced by these biases, raising questions about therapist power and its impact on treatment and interactions. Further, our findings indicate client hesitancy, often expressed as trust tests. Unlike other studies, we highlight that clients themselves, not just parents, are reluctant to involve their parents in treatment due to fear of 'betrayal' by both parents and the therapist.

Gaining trust and encouraging parental involvement

The importance of the therapeutic alliance in treatment outcomes for AN has long been stressed, with empathy, confidentiality, non-judgmental attitude and trust being proposed as the main components of a successful, therapeutic relationship (Zaitsoff et al., 2015). Yet, trust was seen in the present study as difficult to achieve. Therapists experienced mistrust in the form of tests on the part of their patients, who seemed to be both cautious and hesitant toward the therapeutic process. In previous qualitative studies, patients understood treatment as punishment, and trust was something that therapists had to earn (Holmes et al., 2021; Offord et al., 2006). The findings of our study suggest that patients found it difficult to trust therapists. As such, they tended to test therapists' reactions before committing to therapy and engaging with the therapeutic plan. The establishment of trust in the therapeutic relationship allows clients to gradually open up, leading to better communication and a deeper understanding

of their struggles. This connection is closely linked to addressing biases and cultural capital. A trusting relationship enables therapists to deliver individually sensitive care and helps clients overcome their biases towards therapy.

Trust issues were also found to be expanded on parental involvement. Therapists discussed their patients' reluctance to include parents in the therapeutic process, often stemming from a fear of being betrayed by the therapist. This reluctance and fear can be seen as a manifestation of vulnerability on the part of both patients and therapists. Patients may be vulnerable due to their struggles with AN, while therapists are vulnerable to the challenges of building trust and addressing biases. A key challenge, however, raised in this study was that of parental denial and involvement in therapy. During critical and transitional periods such as adolescence, parents play a pivotal role in detecting the initial signals of AN and seeking professional help (Treasure & Nazar, 2016). Clinicians have reported that parental involvement in therapy is desirable and appears to support treatment outcomes (Webb & Schmidt, 2021). In our study, therapists confirmed the importance of parental involvement, but most parents declined or minimized symptoms, possibly due to cultural influences. Greek society tends to underestimate ED severity, causing stigma for patients and families (Janicic & Bairaktari, 2014). This reluctance and minimization may also be a form of bias, as parents may not fully acknowledge their child's condition, or a form of vulnerability due to potential stigma. In summary, trust, vulnerability, and bias are interconnected in treating AN. Trust is crucial, impacting patient-therapist interactions and parental involvement. Vulnerability arises from trust challenges, while bias, linked to culture, can lead to the absence of parental involvement in treatment.

Vulnerability and power

Therapists' adaptability in interventions significantly impacts therapy effectiveness (Owen & Hilsenroth, 2014). While therapists learn to tailor their approach during training (Horne, 2013), it remains a challenging task. An important finding of this research is the increased sense of vulnerability experienced during AN treatment and the underlying reasons for it. Therapists reflected on their ability to be flexible, reporting feelings of inadequacy and despair when interventions proved inefficient, aligning with prior research on treatment adaptations and decision-making challenges (Kinnaird et al., 2017; Webb et al., 2022). However, the present study builds on these findings by emphasizing decision-making complexities and adaptability fears, especially the concern about leaving patients helpless. Therapists consistently worry that clients might discontinue therapy, knowing the potential harm this can cause to their lives, leading to feelings of responsibility and distress (Tragantzopoulou & Giannouli, 2020). These emotions, including inadequacy, fear, and vulnerability, may lead to

negative feelings like rage and hopelessness, potentially causing therapists to avoid treating AN patients.

The study also underscores that professionals are not immune to biases. Instead, they are susceptible to influences and biases that perceive AN treatment challenging. Personal biases such as AN patients are treatment resistant and difficult to treat were reported by the therapists with less experience. Although AN treatment is challenging, biases and the process of assigning labels to patients intensifies these difficulties. Given that clinicians are those that hold the knowledge and the skills, they are able to exert power on patients (Foucault, 1979) and create expectations that fall short in capturing the uniqueness and diverse encounters of patients. Holding the jurisdiction to deliver a psychiatric diagnosis and a treatment to patients establishes and bolsters the professional's affirmation of status, and power (Freidson, 1970). Such labels coming from professionals hold narrative power and, once established as 'truths', they infiltrate society and gain institutional endorsement before eventually being embraced by individuals. Therefore, further psychological pressure is placed on EDs patients and stigma, both self-stigma and social stigma, is perpetuated. This significantly impacts clinical practice. To address it, we must reconsider therapist training. Cultural competency and implicit bias training should be core components, helping therapists understand the backgrounds of their patients and recognize their unconscious biases. Finally, it is essential to advocate a social constructionist therapy approach. Therapists should avoid imposing labels and instead engage in collaborative dialogue, where both parties construct their therapeutic narrative through open communication (McNamee, 2003).

Conclusion and recommendations

The study comes with both strengths and limitations. It is the first study that explores the vulnerabilities and the biases therapists face and highlights the challenges AN treatment entails. To increase the credibility and trustworthiness of the results, many measures such as inter-rater reliability were taken (Williams & Morrow, 2009). One limitation of this study considers the socio-demographic characteristics of our sample. Most of the therapists had more than 5 years of experience in treating AN clients, however, the challenges and vulnerabilities novice therapists face may be different. A further limitation of our study considers the generalizability of the results. The study recruited only Greek participants and the experiences reported were referring to Greek patients. As such, our results may not be applicable to samples from other countries and may be limited to describing the challenges within the Greek population.

Involving therapists in research is vital in ED therapy to understand therapist-patient interactions. Our findings reveal biases and labels influenced by therapists' 'cultural capital' and clinical power, affecting treatment expectations and hindering therapy. We suggest that particularly novice therapists and those with

less experience should understand and map the factors that impede their professional practice. It is imperative for all therapists to engage in self-reflection to uncover and confront their biases. Moreover, a reflexive stance and a constructionist approach must be adopted, letting therapists and clients to co-create their therapeutic dialogue. Finally, the role of supervision cannot be overstated. Supervision offers a vital opportunity for therapists to enhance their self-awareness and refine their clinical judgment. Irrespective of the level of experience, it is crucial for all therapists to uncover their biases, by making clear distinctions between what the patients are presenting during therapy and what they assume patients will present.

Disclosure Statement

No potential conflict of interest was reported by the author(s).

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Data availability statement

Data will be made available upon reasonable request.

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