Client Experiences of Transitioning from Adolescent to Adult Mental Health Services While Battling Anorexia Nervosa

by

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Abstract

Objective: This study aimed to conduct qualitative research on the perspectives of service users regarding the transition from adolescent mental health to adult mental health services while battling anorexia nervosa.

Method: Critical Incident Technique was employed in this study. Interviews were conducted with women who were actively battling anorexia, or had struggled with it in the past, and who have either fully completed, or were in the process, of completing a service transition from adolescent mental health services to adult mental health services.

Results: There were seven participants in this study. From the seven interviews 285 critical incidents to transition services were identified and extracted. Eighty-one incidents were found to be helpful, 121 were found to hinder, and 83 were wish list items that participants would have liked to have seen happen during their transition to adult mental health services for eating disorders. Incidents were placed in categories using inductive reasoning. There were eight helpful categories, nine hindering categories, and six wish list categories. Credibility checks were completed to ensure trustworthiness.

Discussion: The helpful, hindering, and wish list results were discussed within the themes of identity processes, relationship construction, and navigating a complex mental health system. Benefits and limitations of the research were also discussed. The significance and implication of these results have an impact on eating disorders services and service providers in British Columbia.

Keywords: Eating disorders; anorexia nervosa; service transition; emerging adults; adolescent mental health; adult mental health

Dedication

For Oreste & my family. Thank you for being the most stellar supports throughout this entire chaotic process. I actually could not have completed this without all your encouragement, advice, patience, and good humour. Love you all.

Acknowledgements

I would like to acknowledge the contributions of a few key people, without their assistance this project would never have made it to completion.

First and foremost, to the participants who shared their stories with me, I have a tremendous amount of respect for all of you and feel very honoured and privileged to have shared this experience with you. Thank you for your time, thoughts, and ideas.

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List of Acronyms

ADHD	Attention deficit hyperactivity disorder
AMH	Adult Mental Health
Anorexia	Anorexia Nervosa
B.C.	British Columbia
BC ED CoP	British Columbia Eating Disorders Community of Practice
BCMHAS	B.C. Mental Health and Addictions Services
BMI	Body Mass Index
CAP	Child and Adolescent Program, Vancouver Coastal Health, North Shore
CAT	Cognitive Analytic Therapy
CBT	Cognitive Behaviour Therapy
CI	Critical Incident
CIT	Critical Incident Technique
CPS	Community Psychiatric Program, Vancouver Coastal Health, North Shore
CYMHA	Child and Youth Mental Health and Addictions, Vancouver Coastal Health, North Shore
CYMH	Child and Youth Mental Health
CBT	Cognitive Behaviour Therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
EDAC	Eating Disorder Association of Canada
MCFD	Ministry of Children and Family Development
NICE	National Institute for Clinical Excellence
OAMH	Older Adult Mental Health, Vancouver Coastal Health, North Shore
PHSA	Provincial Health Services Authority
SMART	Socio-ecological model of readiness for transition
VCH	Vancouver Coastal Health

Glossary

Adult Mental Health Services	In British Columbia, public mental health services that provide services for adults ages 19+.
Anorexia	Eating disorder characterized by extreme emaciation, intense fear of gaining weight, persistent behaviours that interfere with weight gain, and disturbed body perception.
Child and Youth Mental Health Services	In British Columbia, public mental health services that provide services for children and youth. Infant mental health ages 0-5, child and youth mental health ages 6-18 (often these services are delivered together in one program).
Emerging Adulthood	The developmental stage between adolescence and adulthood (ages 18-25). This stage is characterized by relative independence from normative expectations (in regards to partnerships, employment, housing, and worldviews). There is much variability during this developmental stage.
Service Transition	When people who receive CYMH services move to/are referred to AMH services. The process of moving from one organization to another.

1. Introduction: Research Question and Rationale

Anorexia nervosa (anorexia) has the highest mortality rate of all psychiatric disorders with an estimated mortality rate of 4.9-9.6% (Fichter, Quadflieg, & Hedlund, 2006). Frighteningly, the prevalence of anorexia nervosa is not on the decline despite research and treatment efforts (Hoek & van Hoeken, 2003; Palmer, 2008). The steady prevalence of anorexia nervosa coupled with the high rate of mortality suggests that this disorder requires solutions regarding care pathways and treatment services.

Anorexia nervosa is generally diagnosed in adolescence, but often requires treatment through adulthood. Incidence rates are highest among females aged fifteen to nineteen (Arcelus, Bouman, & Morgan, 2008). The average duration of anorexia nervosa lasts approximately six years (Treasure, Schmidt, & Hugo, 2005). As such, anorexia nervosa frequently spans both Child and Youth Mental Health Services (CYMH) and Adult Mental Health Services (AMH).

Transition to adulthood (ages 18 – 25) is a critical and unique time for many people: we are no longer dependent adolescents, yet not fully independent adults. This time of "emerging adulthood" has been shown to affect economic, social, and health outcomes across the lifespan (Arnett, 2007).

This transition period for emerging adults with eating disorders may be even more difficult than for their "healthy" counterparts. There are many other simultaneous life changes that are occurring, and often "there is little that is normative... [It] is very much a transitional period" (Arnett, 2000). For those emerging adults with eating disorders who are receiving eating disorder treatment services from the public health care system in British Columbia, this time of change may be more complex due to transitioning from CYMH to AMH programs (and therefore also changing healthcare

providers), which may create an additional stressor at a time when stability may be more beneficial.

Services for those with eating disorders in British Columbia change from CYMH services to AMH services at the end of age of eighteen (with some variability). During this time, emerging adults are often facing expected developmental transitions; such as school (secondary to post-secondary), employment (perhaps moving from part-time to full-time status), and living arrangements (sometimes moving away from the family home). In addition to these changes, emerging adults who use mental health services are tasked with finding adult services and changing their support team, often having to change their primary clinician/counsellor as well. Existing research on these types of transitions suggests that this can lead to service disruption, waitlists, and an increased likelihood of mental health service dropout (Pottick, Bilder, Vander Stoep, Warner, & Alvarez, 2008).

Because of the high mortality rate, guidelines for monitoring and treating anorexia nervosa have been outlined by the UK-based National Institute for Clinical Excellence (NICE). Their recommendations included "that the level of risk to the patient's mental health and physical health should be monitored as treatment progresses because it may increase – for example following weight change or at times of transition between services in cases of anorexia nervosa" (NICE, 2004, p.36). This emphasizes the possibility of increased risk at times of service transition, which many people with anorexia nervosa would undergo.

The NICE guidelines include recommended treatment options for anorexia nervosa, none of which is classed as a Grade A recommendation (at least one randomized controlled trial and overall quality and consistency as substantiated by research), but rather Grade B (clinical studies, no randomized clinical trials). They assert that "family interventions that directly address the eating disorder should be offered to children and adolescents with anorexia nervosa" (NICE, 2004, p.60). The guidelines for adult treatment are more vague, seeming to focus on group counselling interventions rather than family-based treatments, suggesting that, from adolescence to adulthood, treatment philosophies may vary greatly. These variations may increase the risks for emerging adults at the time of service transition from CYMH to AMH services.

CYMH and AMH services in British Columbia differ in important ways. Within CYMH services, the recommended treatment is family based-interventions with the responsibility for recovery shared by both family and client. Services are often offered by a multi-disciplinary team. Conversely, adult eating disorder services vary across programs, and treatment methods are inconsistent. There is some availability of multi-disciplinary treatment for adults but many programs do not have the financial resources. Some adult services do not offer individual counselling, and instead offer a group therapy treatment format. Other locations provide some individual counselling along with some group counselling. There is less emphasis on family involvement and more of a demand on emerging adults to be responsible for their own care (Treasure et al., 2005). At the time of transitioning services, many individuals with anorexia nervosa do not continue with clinical care for numerous reasons, most of which seem to stem from a lack of seamless care pathways (Dimitropoulos, Tran, Agarwal, Sheffield, & Woodside, 2012). Viner (2003) described barriers to transitioning service such as an inconsistent referral process, poor communication, lack of continuity and coordination, conflict between treatment philosophies, and disengagement of emerging adults.

Given these concerns, moving emerging adults into an adult system only when a transition is absolutely necessary may be more appropriate than requiring all emerging adults to automatically transition to an adult system based solely on an age requirement. This approach also fits with my therapeutic framework where each individual may require different interventions for a similar clinical issue. From my perspective, there is no "one size fits all" in mental health work.

There has been little research on the topic, including that we do not know the individuals' own perspective of this transition. The goal of this study was to explore the impact of the transition from CYMH to AMH services in British Columbia for emerging adults who are battling anorexia nervosa. The study aimed to address gaps in the literature by exploring and attempting to understand the experience of being an emerging adult, navigating a complex mental health care system, and also fighting a difficult battle against anorexia.

This study aimed to understand the experience of transitioning from CYMH to AMH eating disorders services, as an emerging adult with anorexia, from a holistic

perspective. Few studies have explored this topic, and the scant research that does exist has indicated that future studies should continue to increase the knowledge base in this area. For example, contextual factors affecting service transition have not been taken into account. Therefore, exploring the transitions holistically to identify possible strengths and barriers to continuing clinical care (i.e., what helps and hinders clients' transitions) was warranted. In much of the limited research, there has been a focus on healthcare providers such as nurses and dieticians. In contrast, this study has focused on therapeutic aspects and the experience of disruption when transitioning from CYMH to AMH services from the perspectives of the service users themselves, thus addressing an important gap. Lastly, this study explored how service users would conceptualize an ideal experience of transition that is needs-led versus service-led.

To explore the aforementioned aims of the study, the research question was: "What are the helpful and hindering experiences for emerging adults with anorexia when transitioning from CYMH to AMH eating disorder treatment services?" To answer this question, the Critical Incident Technique (CIT) was employed, in order to identify what helps and hinders this transition experience as well as explore what might be an ideal transition. The answers to these questions will be important to British Columbian organizations that service this population because they can: (a) increase understanding of the best way to work with people with anorexia experiencing service transitions, (b) influence mental health service policies and procedures related to eating disorder service transitions, and (c) foreground the voices of people experiencing eating disorder service transitions.

In the following chapter, I explore these ideas in more depth, focusing on anorexia and development, interventions for this clinical issue, the theory for emerging adulthood, service transitions in general, and service transition for emerging adults with anorexia.

2. Literature Review

In this chapter, I give an overview of Anorexia Nervosa (anorexia) describing its history, symptoms and associated features, diagnostic criteria, comorbidities, etiology, treatment, course, and outcomes. Following this will be a brief overview of treatment service options available for eating disorders in British Columbia. I then provide a description of the difficulties of service transition. Lastly, I review the relevant literature that explores anorexia and development, service transition, service transition and anorexia, and highlight gaps in the research literature.

2.1. Anorexia Nervosa

2.1.1. Brief Historical Overview

Throughout history, there have been accounts of self-imposed starvation, often in the context of religious rituals (Bemporad, 1996). Sir William Gull (1874) and Dr. Ernest Charles Lasegue (1873) were among the first to create a clinical description of anorexia. These first descriptions focused on physical symptomology (such as heart rate and amenorrhoea) and described it as an affliction that was gender specific to women. Near the end of the 19th century, there was an increased awareness of the psychological symptoms of anorexia, such as fear of gaining weight and body image issues (Shorter, 1987). Diagnostic criteria for anorexia were first included in the Diagnostic and Statistical Manual for Mental Disorders-III (DSM III) in the 1980s (Sunday et al., 2001).

2.1.2. Symptoms and Associated Features

The typical features and symptoms of anorexia include: extreme emaciation, intense fear of gaining weight, persistent behaviours that interfere with weight gain, disturbed body perception, and for women, cessation of menstruation (though in most recent Diagnostic and Statistical Manual of Mental Disorders-V, cessation of

menstruation is no longer a criterion). Other problems that arise and that are commonly associated with the disorder include preoccupations with food, sexual difficulties, problems secondary to weight loss, struggles for control, and impulsivity (Oltmanns, Emery, & Taylor, 2006).

Secondary medical complications associated with anorexia can cause severe health problems. These include constipation, intolerance to cold, lethargy, abdominal pain, dry/cracked skin, lanugo (growth of very fine hair), anemia, infertility, cardiovascular difficulties, dental erosion (due to purging), impaired kidney functioning, osteopenia, and electrolyte imbalances. Some of these symptoms are serious and can lead to death.

2.1.3.   Diagnostic Criteria for Anorexia Nervosa

In the Diagnostic and Statistical Manual of Mental Disorders IV-TR (DSM IV-TR), anorexia nervosa is broadly defined as a disorder affecting primarily adolescent girls and young women. Anorexia is characterized by distorted body image and excessive dieting that leads to severe weight loss, with a pathological fear of becoming fat. The specific criteria in the DSM IV-TR are as follows:

307.1 Anorexia Nervosa

* Refusal to maintain body weight at or above a minimally normal weight for age and height, for example, weight loss leading to maintenance of body weight less than 85% of that expected or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected.

 * Intense fear of gaining weight or becoming fat, even though underweight.

 * Disturbance in the way one's body weight or shape is experienced, undue influence of body weight or shape on self evaluation, or denial of the seriousness of the current low body weight.

 * In postmenarcheal females, amenorrhea, i.e., the absence of at least 3 consecutive menstrual cycles. A woman having periods only while on hormone medication (e.g. estrogen) still qualifies as having amenorrhea.

The criteria in the new Diagnostic and Statistic Manual of Mental Disorders V (DSM-V) include several minor but important changes:

> "Criterion A focuses on behaviors, like restricting calorie intake, and no longer includes the word "refusal" in terms of weight maintenance since that implies intention on the part of the patient and can be difficult to assess. The DSM-IV Criterion D requiring amenorrhea, or the absence of at least three menstrual cycles, will be deleted. This criterion cannot be applied to males, pre-menarchal females, females taking oral contraceptives and post-menopausal females. In some cases, individuals exhibit all other symptoms and signs of anorexia nervosa but still report some menstrual activity."

> There are two subtypes of anorexia described in the DSM IV-TR as follows:

Restricting Type: During the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behavior (self-induced vomiting or misuse of laxatives, diuretics, or enemas).

Binge Eating/Purging Type: During the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behavior.

2.1.4.   Comorbidity

Anorexia is associated with other psychological disorders, such as obsessive-compulsive disorder, obsessive-compulsive personality disorder, and major depressive disorder (Oltmanns, Emery, & Taylor, 2006). The following is a description of features of each of the aforementioned disorders from the DSM IV-TR:

- Obsessive-Compulsive Disorder: recurrent obsessions (intrusively persistent ideas, thoughts, impulses, or images) or compulsions (repetitive behaviours or mental acts to reduce anxiety/distress) which are severe enough to be time consuming or cause marked distress or significant impairment. At a point, the person recognizes that the obsessions/compulsions are excessive or unreasonable.
- Obsessive-Compulsive Personality Disorder: preoccupation with orderliness, perfectionism, and mental and interpersonal control. This is at the expense of flexibility, openness, and efficiency.
- Major Depressive Disorder: Depressed mood most of the day, nearly every day. Diminished interest/pleasure in activities, significant weight loss/gain,

insomnia or hypersomnia, psychomotor agitation or retardation, loss of energy or fatigue, feeling worthless, difficulty with attention, and recurrent thoughts of death. Five or more of these symptoms need to be persistently present for a two week period.

These comorbid disorders may be reactions to starvation rather than pre-existing disorders that cause anorexia (Oltmanns, Emery, & Taylor, 2006).

2.1.5. Etiology Of Anorexia Nervosa

There is no single cause of anorexia. Instead, researchers have posited that anorexia arises from a complex interaction of psychological, biological, and sociocultural risk factors (Oltmanns, Emery, & Taylor, 2006). Following is a description of several elements that have been suggested to contribute to the development of anorexia, including social, psychological, genetic, and physical factors.

Social Factors

Some researchers propose that social factors contribute to the onset of anorexia (Oltmanns, Emery, & Taylor, 2006). Prevalence of eating disorders has risen in recent decades alongside the rise of the "thin ideal" and North America's interest in body image (Hoek, 1995; Kendler et al., 1991; Lucas et al., 1999, as cited in Oltmanns et al., 2006). Work in fields that emphasize weight (models, ballet dancers, gymnasts) have higher reports of anorexia. Evidence for social factors effecting anorexia includes that anorexia is more common among young people who report greater exposure to social media. It has also been hypothesized that troubled family relationships and child sexual abuse may contribute to the occurrence of anorexia (Oltmanns et al., 2006).

Psychological Factors

It has been suggested that psychological factors contribute to the onset of anorexia, including: a struggle for perfection and control, depression or low self-esteem, dysphoria, negative body image, and dietary restraint (Oltmanns et al., 2006).

Genetic Factors

Genetic factors have also been hypothesized to contribute to the onset of anorexia (NICE, 2004). The majority of family studies indicate that eating disorders run

in families. In a study by Strober and colleagues (1997) it was found that female relatives of those with anorexia are 11.4 times more likely to have anorexia compared to control participants. Heritability estimates are broad; therefore the relative contribution of genetics is not entirely clear.

Physical Factors

There are several physical factors that may contribute to the onset of anorexia, such as early menarche (understood to increase body dissatisfaction), early feeding difficulties (documented, but unclear as to why it constitutes as a risk factor), and physical constitution (history of premorbid obesity) (NICE, 2004).

2.1.6.   Interventions in Anorexia Nervosa

Treatment of anorexia varies from adolescence to adulthood. Available research defining what qualifies as "best practice" is "small and inconsistent in methodological quality" (NICE, 2004, p.81) for both adolescents and adults in treatment.

Psychological interventions for anorexia vary in availability and include (but are not limited to) the following: family therapy, cognitive behaviour therapy (CBT), cognitive analytic therapy (CAT), focal analytic therapy, interpersonal therapy, and motivational interviewing (NICE, 2004).

When working with children and youth with anorexia it is often family interventions that are offered, for example, the Maudsley Approach (Treasure et al., 2005). With adults, there is no uniform approach to treatment: where it occurs, for how long, the intensity, or which interventions are offered.

The following are general guidelines for treating adults or youth with anorexia from the National Clinical Practice Guideline (NICE, 2004):

Treatment Guidelines for Adults

- Most adults with anorexia nervosa should be managed on an outpatient basis with psychological treatment provided by a service that is

competent in giving that treatment and assessing the physical risk of people with eating disorders.

- People with anorexia nervosa requiring inpatient treatment should normally be admitted to a setting that can provide the skilled implementation of refeeding with careful physical monitoring (particularly in the first few days of refeeding) and in combination with psychosocial interventions.

Treatment Guidelines for Children and Youth

- Family interventions that directly address the eating disorder should be offered to children and adolescents with anorexia nervosa.

- Family members including siblings should normally be included in the treatment of children and adolescents with eating disorders. Interventions may include sharing of information, advice on behavioural management and facilitating communication.

- In children and adolescents with eating disorders, growth and development should be closely monitored. Where development is delayed or growth is stunted despite adequate nutrition, paediatric advice should be sought.

- Health care professionals assessing children and adolescents with eating disorders should be alert to indicators of abuse (emotional, physical and sexual) and should remain so throughout treatment.

- The right to confidentiality of children and adolescents with eating disorders should be respected.

- Health care professionals working with children and adolescents with eating disorders should familiarise themselves with national guidelines and their employers' policies in the area of confidentiality.

- Children and adolescents with anorexia nervosa should be offered individual appointments with a health care professional separate from those with their family members or carers.

- The therapeutic involvement of siblings and other family members should be considered in all cases because of the effects of anorexia nervosa on other family members.

- In children and adolescents with anorexia nervosa the need for inpatient treatment and the need for urgent weight restoration should be balanced alongside the educational and social needs of the young person.

2.1.7.   Course and Outcome of Anorexia Nervosa

The course and outcome of anorexia is variable. There are many factors that affect the course and outcome of anorexia, such as age of onset, weight during illness, comorbidity, psychological and social stressors, and the number of episodes.

Course and outcome for children and adolescents varies. Some will recover completely after a first episode, whereas others will follow a more chronic course. Adolescents who do recover are more likely to have healthy early physical and psychosocial development and no negative precipitating events (such as bereavement) (North, Gowers, & Byram, 1997). When these factors have not been a part of a youth's experience and when there have been social difficulties or abnormal personality development, anorexia may have a more chronic course (Gowers, Crisp, Joughin, & Bhat, 1991).

In the emerging adult population, Steinhausen, Rauss-Mason, and Seidel (1991) researched and summarized 68 treatment studies before 1989 with a length of follow up of one to thirty-three years. Their findings indicated that 43% of people recover completely, 36% improve, 20% develop a chronic eating disorder and 5% die from anorexia or complications associated with the disorder. In a more recent study, Steinhausen (2002) asserted that there is no evidence that the outcome of anorexia has improved over the second half of the past century.

2.2. Treatment Services in British Columbia

In British Columbia, there are several different levels of care available for treating anorexia. The British Columbia Ministry of Health Services, in collaboration with the Ministry of Children and Family Development (2010), has described our system as consisting of primary, secondary and tertiary care programs. In B.C., these care levels are defined as follows:

- Primary care: provided by physicians, dieticians, and other community service providers. Includes services such as assessment, diagnosis, monitoring, and counselling.
- Secondary care: community based mental health centres. Care is provided by mental health clinicians, psychiatrists, and other contracted agencies. Access to specialized services is sometimes available. Collaboration with local physicians and health authority dieticians is also encouraged. This care can is provided in hospital units in varying degrees.
- Tertiary care: provided by the Provincial Health Services Authority (PHSA) through B.C. Mental Health and Addictions Services (BCMHAS). The child and youth program is located at B.C. Children's Hospital and it is called the Provincial Specialized Eating Disorders Program. Adult tertiary services are located at St. Paul's Hospital. (p.4)

A new definition and way of classifying eating disorder services is currently in development. In the yet-to-be published 2014 Eating Disorder Association of Canada Clinical Practice Guidelines (EDAC, 2014), the levels of care are distributed into four categories;

- Low intensity outpatient programs (focus on engagement and recovery)
- High intensity day, residential, and inpatient programs (focus on recovery)
- Outpatient with inpatient support programs (focus on quality of life)
- High intensity inpatient (focus on medical stabilization)

Each category represents a service that may be more suitable for certain people, at certain points in their recovery, at certain times. The primary goal is to refer individuals to programs that are best suited to their individual needs (rather than fitting all the individuals into a one-size-fits-all program). This new action plan is being promoted as an improved way for people to receive eating disorders treatment, versus current practices. At this time, services operate fairly independently from one another. EDAC proposes a collaborative and needs-led way of providing quality treatment services in

B.C. Service delivery is an important focus of the present research because how it is administered directly affects how people transition between services in our province.

(See Appendix A for a complete listing of B.C. eating disorder services).

2.3. Emerging Adulthood and Anorexia

"Emerging adulthood" was coined by Jeffrey Arnett (2000) to address the developmental stage between adolescence and adulthood. It was used in this study to describe people between the ages of eighteen and twenty-five, and was considered an appropriate frame from which to explore the experience that participants in this study faced. During this developmental stage, emerging adults receiving services for anorexia are also often transitioning between CYMH and AMH counselling services.

Arnett (2000, 2007) describes "emerging adulthood" as neither adolescence nor adulthood but a distinct period from both – demographically, subjectively, and in regards to identity exploration. This period is characterized by relative independence from normative expectations; love, work, and worldviews are frequently explored and changed. Arnett (2000) applies developmental theories from Erik Erikson (1950, 1968), Daniel Levinson (1978), and Kenneth Keniston (1971) all of whom conceptualize and distinguish the period between adolescence and adulthood as different (having different tasks and continued role experimentation).

Emerging adulthood is distinct demographically, Arnett (2000) has argued. It is the only period in life where absolutely nothing is normative demographically. Whether one lives with parents or alone, is married or unmarried, has children or not, goes to school or is employed, all vary considerably during emerging adulthood compared to any other age group. Arnett (2000) described the period of emerging adulthood as diverse and unpredictable: "a reflection of the experimental and exploratory quality of the period" (p.471).

Arnett (2000) also stipulated that emerging adulthood is distinctly subjective. Emerging adults do not see themselves as either adolescents or adults. When asked if they perceive themselves as adults, they often reply: "in some respects yes, in some

respects no" (p. 471). Attaining adulthood is equated to attaining certain qualities of character, such as accepting responsibility for one's self, making independent decisions, and becoming financially independent. These characteristics are generally not accomplished until one is in their late twenties.

Identity explorations during the time of emerging adulthood are distinct from other life periods (Arnett, 2000). This period, because of variability, is often an opportunity for exploration in love, work, and worldviews. Often, identity formation is not completed in adolescence and spills over into the period of emerging adulthood. During this time, love becomes more intimate and serious. Work becomes less about supporting lifestyle and more about creating career. Finally, the absence of enduring role commitments makes it possible in emerging adulthood to experiment and explore more than during any other life period.

Emerging adulthood is limited to certain cultures and certain times (Arnett, 2000). It is not universal and is found in cultures that postpone entry into adult roles and responsibilities. Emerging adulthood can be typically found in highly industrialized or post-industrial countries. These countries often require high levels of education and training for employment and marriage, and parenthood is typically postponed until after education is complete. Emerging adulthood is not even universal in the aforementioned types of countries but instead is more of a cultural characteristic. Social class also impacts the availability of emerging adulthood, as often those people from middle class and above have more opportunity for exploration than those in the working class or below. Arnett (2000) does note that emerging adulthood is likely to become more inclusive worldwide as the world economy becomes increasingly globalized. With regards to the present research, it is noted that Canada is a highly industrialized country and, in British Columbia in particular, it would seem that many people would fit within the emerging adulthood framework.

Bynner (2005) suggested that looking at the structural factors influencing emerging adulthood is equally as important as exploring cultural factors. Gender, parents' social class, own social class, qualification level, family structure, and family economic status are seen as instrumental in dictating whether there is an opportunity to experience emerging adulthood, meaning that often the most advantaged people are

those who fall into an emerging adult category. Bynner (2005) proposed that although Arnett's emerging adult theory is strong, looking at it through a "developmental" lens fails to recognize the importance of social structures. In this study, social structures and cultural factors that may help or hinder the service transition process were attended to as possible critical incidents of transition (i.e., contextual and developmental changes, versus solely an organizational change).

Developmental factors that co-occur during the transition process were also attended to in the present research. These factors are often neglected when examining successful transitions, and it is therefore important to include them in a holistic conceptualization of the experience of service transition. A developmental perspective regarding what helps and hinders service transition from CYMH to AMH for individuals with an eating disorder has not yet been researched to date.

2.4. Service Transition: Not Specific to Anorexia

Research studies have investigated the transition from youth services to adult services for those emerging adults with special health care needs, in foster care, and for those with other psychiatric disorders. Studies have also addressed the understanding of the experience of service transition from the perspective of health care providers (such as nurses and paediatricians) and caregivers (i.e. parents, guardians). There is no extant research that has explored the experience of transitioning services for emerging adults specifically with anorexia nervosa. Generally speaking, research in this area is scant and does not necessarily reflect the voices of all key stakeholders. However, the limited research suggests that transitioning services is a high risk time for numerous emerging adults, and is not viewed by them as a positive experience as they work through various difficulties.

The following sections contain a review of key points from service transition literature not specific to anorexia: (a) service transition is not viewed as a positive experience for many emerging adults; (b) service transition can be difficult, because as an adult, there is often less service availability and different eligibility criteria; (c) service transition is treated as an event rather than a process that requires time and preparation;

(d) service utilization declines in emerging adulthood (during emancipation); (e) therapeutic interventions and philosophies change during transition (often from a more family centered model to individualized treatment); (f) family centered care can be beneficial if continued into emerging adulthood despite transitioning to AMH services; (g) the complexity of multiple service usage and developmental changes need to be acknowledged; and (h) that there are tools available to assess transition readiness, and factors that can facilitate a positive transition experience.

2.4.1. Transition: Experiences of Problems

Disruption of mental health care during times of transition adversely affects the health, well-being, and potential of emerging adults (Lamb, Hill, Kelvin, & Van Beinum, 2008 as cited in Singh et al., 2010). In a qualitative study in the U.K., Singh et al. (2010) found that the vast majority of mental health service users transitioning from CYMH to AMH services experienced the transition as poorly planned, poorly executed, and poorly experienced. An optimal transition was experienced by less than 4% of those in their study. The study highlighted important aspects of transition such as transfer planning meetings, joint working, and information transfer between CYMH and AMH services. Caregivers and emerging adults were also at odds regarding parental involvement in care once transferred to AMH (emerging adults preferred less parental involvement, while caregivers hoped not to be "left in the dark"). Singh et al. (2010) noted that having a "paediatric-adult split [in] mental health services introduce[s] discontinuities in care provision where the system should be more robust" (p. 309). One of the important suggestions emerging from the study was that "age windows" rather than strict age cut-offs could be used to decide optimal transition times for emerging adults. Although this tactic may disrupt the long-standing way of working in CYMH and AMH, it may be an important and helpful improvement that is congruent with providing individualized service.

2.4.2. Service Transition and Healthcare Providers

Marcer, Finlay, and Baverstock (2008) were more specific in their service transition study than Singh et al. (2010). Rather than looking at all CYMH/AMH service users, they focused specifically on those with attention deficit hyperactivity disorder

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(ADHD). The study asked CYMH paediatricians about their experience of transitioning clients to adult services. A quarter of respondents reported that at least 40% of their clients would require ongoing services (such as adult psychiatry, psychology, or general practitioner), suggesting that the services needed would span CYMH and AMH services, similar to anorexia. In regards to referrals, 90% of respondents indicated that there was a clinical need for dedicated services, but none was available. This study indicated a gap in service provision for emerging adults with ADHD who were moving from CYMH to AMH services.

2.4.3.   *Transition and Utilization Rates*

Service transition in general, as described above, is variable and a difficult experience for many service users. This is perhaps why Pottick, Bilder, Vander Stoep, Warner, and Alvarez (2008) found a precipitous decline in mental health service utilization rates at the age of emancipation (18-21 years of age – the time of emerging adulthood). Their research supports that emerging adults have the greatest challenges and that emerging adulthood is when many disorders have peak rates of incidence. Continuity of care is also threatened at the time of service transition because emerging adults must change services and meet new service criteria to continue care. Similar to Singh et al. (2010), Pottick et al. (2008) suggested service improvements that focused on effectively designing developmentally appropriate services that keep emerging adults engaged in mental health treatment. Service eligibility criteria, developmental readiness factors, and shared planning were all factors thought to improve counselling service transition, with a focus on individual care.

2.4.4.   *Service Transition: Adolescents vs. Adults*

In a guest editorial for the *Psychiatric Rehabilitation Journal*, Davis, Koroloff, and Ellison (2012) questioned the efficacy and improvement of services for emerging adults with serious mental health conditions. They reported that the needs of emerging adults differ in important ways from those of more mature adults. They cited brain research showing the areas involving executive functioning as maturing last. These delays can be associated with difficulty handling emotion and risks, responding to relationships, and engaging in complex academics or employments. The authors further suggested that, in

future research, interventions established in older and younger populations could be adapted for emerging adults. For emerging adults, a balance of tailored child and adult interventions may improve the efficacy of interventions (Davis, Koroloff, & Ellison, 2012).

2.4.5. Service Transition and Families

In their 2011 research focusing on youth with special health care needs, Duke and Scal examined the pivotal role for continued family centered care when emerging adults transition to AMH services. The purpose of the study was to evaluate the impact of family centered care on the likelihood that a parent would report their child was receiving health care transition services. The secondary purpose was to examine the extent to which family centered care as a process (of relationship building, response to family needs, builds on strengths, understands cultural context, and necessity of long-term continuity of care takes precedence) mediates the relationship between having a usual source of care and receipt of health care transition counselling services. The researchers hypothesized that having family centered care would be associated with all aspects of transition services and would produce more positive outcomes. Their study indicated that having a usual source of care and having family centered care was optimal. The authors suggested that, rather than diminishing the role of caregivers in emerging adulthood, there should be input from caregivers and shared decision making because family can be vital to the health and well-being of emerging adults with chronic conditions (Duke & Scal, 2011).

Jivanjee, Kruzich, and Gordon (2009) investigated the transition from adolescence to adulthood (the time of "emerging adulthood"), noting predictable and unpredictable changes. Because of these changes, families were seen to commonly experience anxiety, uncertainty, frustration, and turbulent relationships. This qualitative study, using focus group methods, reported the experiences and perceptions of family members whose children where transitioning counselling services. Families reported that, during the time of transition, they often found themselves excluded from care planning. Caregivers noted that, although they wanted their children to attain independence, they also felt it was a realistic goal to increase autonomy gradually, because of their child's persistent mental health difficulties. Caregivers were also aware of the legal restrictions around service confidentiality, but believed that continued

support and shared decision making would be beneficial. It was emphasized that strong family relationships were associated with better outcomes for emerging adults with mental health concerns (Lyons & Melton, 2005; Orlowska, 1995; Podmostko, 2007).

CYMH service users and their parents, as well as professionals were interviewed in a 2012 study by Hovish and colleagues. Similar to the previously described studies, these researchers reported that young people were jeopardized during the transition from CYMH to AMH services. Notably, a picture emerged of complex service interactions. Emerging adults were regularly involved in multiple services (such as social services, housing services, legal services, and counselling services). The multitude of services and co-occurring developmental changes was complex and potentially influential to their health outcomes. The authors found that gradual preparation, continuity of therapeutic relationship, joint working (between CYMH and AMH), and no waitlists helped when transitioning between mental health services. In this study participant's views about transition were varied, which may speak to the need for tailored individualized transition service plans (Hovish, Weaver, Islam, Paul, & Singh, 2012).

2.4.6.   Ideal Service Transitions

Although there is well-documented general research on service transition in mental health, there is still a great deal of variation in terms of how it is experienced by those transitioning. Service providers may have knowledge to create positive care pathways; however, their application in practice is not yet universally demonstrated. Munoz-Solomando, Townley, and Williams (2010) reviewed existing literature, and their findings suggested that service transition is often seen as an event rather than a process, and that more preparation for transition is warranted. They also conceptualized service transition as happening in context – occurring alongside biological, educational, psychological, and social development. They defined "transition" as:

> A person's journey between services that should be shaped by awareness of the narrative of their past history, evolving needs, values and preferences, and present circumstances as well as by services that are involved recognizing the culture, capabilities, and capacities that are required of them (p.316).

This definition of transition encompasses the multiple pathways of health, is holistic in nature, and addresses contextual and developmental factors affecting those emerging adults at times of transition. This client-centered approach highlights mental health services based on client needs. The authors also suggested that future research documenting the personal experience of emerging adults and their families, and models for successful transition, would be a worthwhile endeavour.

Well-planned transitions from CYMH to AMH services are optimal and can help create continuity of care and better mental health outcomes. Sound planning is also cited by Schwartz, Tuchman, Hobbie, and Ginsberg (2011) as reducing high-cost emergency health care utilization and disability. They described a socio-ecological model of readiness for transition to adult-oriented care for emerging adults with chronic health conditions (the SMART model). Special attention was paid to transition as a multi-systemic process that takes into account systemic and ecological factors of transition. Other factors incorporated into the SMART model included assessing socio-demographics, culture, healthcare access, patient characteristics, and inter-related components of knowledge, skills/self-efficacy, beliefs/expectations, goals, relationships, and psychosocial functioning (clients, parents, and providers). The SMART model provides measureable socio-ecological components that assesses readiness to transition from a systems approach. The authors invited future researchers to continue to develop psychometric tools that can aid in developing clinical guidelines and interventions to enhance transition readiness. This model suggests there may be key factors to creating a positive experience of transition from CYMH to AMH services, but it remains unclear if these tools or any others are being used to facilitate the process in healthcare settings.

2.5. Anorexia, Service Transition, and Development

Service transitions from CYMH to AMH services for emerging adults with anorexia nervosa have not been studied closely. After a thorough review of the literature, only five studies were found that specifically addressed anorexia and service transition (one located in Canada). These studies superficially addressed the developmental needs of emerging adults and the contextual factors involved in the transition period.

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Additionally, the studies accessed the perspectives of the care providers (such as occupational therapists, nurses, and psychiatrists, but not counsellors). The voices of emerging adults with anorexia have not been included in the literature to this point.

Treasure and colleagues (2005) were among the first researchers to address the difficulties that many emerging adults with anorexia face when transitioning from CYMH to AMH services. Their research addressed how the reports and guidelines from the National Institute for Clinical Excellence (NICE) impacted the management and care for people with anorexia, as well as how the guidelines were integrated into current healthcare. Their focus was on how different organizational structures provide care for emerging adults who are transitioning from one service to another. For example, when an emerging adult has been receiving care with CYMH service, does their referral transfer to general practice, secondary or tertiary services, AMH services, or student services? In particular, the researchers questioned what skills are needed (and by whom) to provide appropriate services to emerging adults with eating disorders. This research suggested that many AMH teams feel they lack the skills to manage eating disorders. Thus, the question remained: what services should emerging adults with anorexia access? The authors asserted that this gap in services requires an answer.

The perspectives of healthcare professionals on eating disorders and services have also been explored. Reid, Williams, and Burr (2010) examined how healthcare workers such as psychiatrists, psychologists, occupational therapists, and general practitioners understood treatment and service provision for people with eating disorders. They found two themes. The first centered on the practical issues of meeting the complex needs of those with eating disorders, and the second was the recognition of patient diversity and the need for individually tailored interventions. Many of the concerns in the first theme centered on experiencing too many referrals and not enough time, not having appropriate skills and training, and the differences in treatment setting (i.e., inpatient, specialized, and community) as well as how the environment can be considered a treatment factor. Participants in this study also recognized a need for more specialized services to meet the increase in people presenting with eating disorders. These healthcare service providers also expressed that the funding was not available, which was seen as a barrier to creating appropriate services. These barriers resulted in understaffing and strict referral criteria.

The second theme in the study by Reid, Williams, and Burr (2010) addressed that staff believed treatment should be individually tailored to fit the individual rather than a uniform treatment approach. Holistic approaches were viewed as imperative (in the context of using a multi-disciplinary team, and having a trusting therapeutic relationship). This article highlighted what healthcare professionals viewed as their needs for being able to provide treatment and service provision to those emerging adults with eating disorders. It did not address the explicit needs of emerging adults with anorexia and, as such, it still lacks the perspective of the individuals' experience.

Dimitripolous, Tran, Agarwal, Sheffield, and Woodside (2012) conducted qualitative research about the perspectives of service providers regarding the transition process from CYMH to AMH services in Toronto, Canada. In this study, "clinicians" (occupational therapists, social workers, dieticians, nurses, psychiatrists, and youth workers) were interviewed to explore their understanding of the transition process. Analysis of the interviews produced three emerging themes. The first theme was focused on factors that relate to illness, such as denial and ambivalence. The participants in the study agreed that parents are a key to involving emerging adult clients in treatment, as many emerging adults refused to participate in adult treatment services because their parents were no longer a determining factor. The second theme was a concern that anorexia interrupts normative adolescent developmental processes. Participants believed that emerging adults with anorexia functioned at a lower chronological age, had cognitive deficiencies compared to their healthy counterparts, and were not as psychologically mature. Participants also noted that many emerging adults with anorexia were isolated and disconnected from their peers. The final theme addressed participants' understanding of parental involvement during the transition process. It was reported that caregivers felt families were more involved in CYMH services, and that, during the transition to AMH services, the changes regarding confidentiality and involvement in treatment were challenging. Participants understood parental involvement as very important in treatment regardless of the emerging adults' age. Participants also argued against legally imposed requirements that force emerging adults to organize, navigate, and manage their treatment alone.

There is little research that focuses solely on the transition experience of emerging adults with anorexia and their service providers. The aforementioned studies

provide a glimpse into service transition from the perspective of other service providers (nurses, occupational therapists, psychiatrists, social workers, etc.), but fail to provide insight into therapeutic relationships and the disruption that takes place during transition. The counselling experience may also be a factor that can be explored alongside the other service transitions that take place.

Research that addressed both service transition and eating disorders together is the 2008 study by Arcelus, Bouman, and Morgan. Instead of looking at organizational structures or skills, they examined characteristics of those people with eating disorders who have made the service transition. The study found that CYMH service users who moved to AMH services had lower self-esteem and more maturity fears compared to users who had not accessed these services before. This is important to further our understanding of the experience of not only service transition, but perhaps how the longevity of the disorder affects the individual. The practical application could be an opportunity to focus on self-esteem and maturity in the initial stages of AMH services. This finding also exemplifies yet again the risk involved during service transition for emerging adults with anorexia.

Arcelus and colleagues (2008) also found that, of the 887 participants utilizing AMH services, 27.7% had received CYMH services beforehand. Nearly half of the 27.7% of people transitioning from CYMH had been referred by their general practitioner rather than by their previous CYMH service providers. This may speak to the variable and erratic nature of service transition. The authors suggested a few guiding principles that could help emerging adults with the service transition. These included a gradual introduction to more individually oriented services (versus family oriented services), using interventions that target low self-esteem, early identification of individuals who may need service transition, early planning, and that transition not occur during crisis. The authors emphasized the need for "needs-led and not service-led" protocols that are flexible and in the client's best interest.

Lastly, it is important to look at research that indicates how to conduct a "good" transition. Winston, Paul, and Juanola-Borrat (2011) studied how CYMH and AMH services in the United Kingdom can work more closely to create smooth transitions for people with anorexia. They identified a purposeful and planned transition to have some

of the following elements: early identification of those needing to transition, preparation of both client and family, gradual transition, close collaboration, flexible protocols, and delayed transition during times of instability. Winston et al. (2011) suggested that, to improve transitions, there needs to be explicit transparency with emerging adults as well as with their families, so that all parties involved have the same expectations and understanding of the changes to come.

3.   Methods

A qualitative research design, Critical Incident Technique (CIT), was chosen as a method appropriate to best answer the research question: what are the helpful and hindering experiences for emerging adults with anorexia when transitioning from CYMH to AMH eating disorder treatment services? It was selected for its utility in investigating helpful and hindering factors, effective and ineffective procedures, successes and failures, collecting observations, and identifying the characteristics that are critical to events (Butterfield, Borgen, Amundson, & Maglio, 2005). In this study, it was used to elicit participants' experiences of helpful and hindering transitioning service incidents. In this chapter, I will describe the history and evolution of CIT. CIT methodology, procedures, participant recruitment, data collection and analysis, and validity and reliability checks will also be discussed.

3.1. Design

A qualitative research design using the Critical Incident Technique is consistent with the goals of this research study. The design of this study aims to facilitate exploration and understanding of participants' experiences that were critical in either helping or hindering their transition as they moved from CYMH to AMH eating disorder services.

The philosophy of qualitative research also fits well with me. Ontologically, in qualitative research, the nature of reality is seen as subjective and multiple (Creswell, 2007). Accordingly, participants' quotations and themes, drawn from their words, representing all the different participant perspectives, are incorporated. Epistemologically, the relationship between the researcher and participant is close (Creswell, 2007). As such, I will situate myself within the research, rather than as a distant and objective observer. The role of values and biases are also understood being

a part of qualitative research. As such, the axiology of qualitative research fits with my understanding of how my personal experience cannot be separated from my research. The language of qualitative research also fits my personal and preferred writing style. Creswell (2007) describes qualitative rhetoric as informal, using a personal voice ("I"), and having limited definitions. Lastly, the methodological styles of qualitative research fit my philosophies in that the process of qualitative research does not use generalizations, attends to context (holistic in understanding), and uses an emergent design (Creswell, 2007).

3.1.1. *Critical Incident Technique (CIT)*

Critical Incident Technique (CIT) was first described by Flanagan (1954). Originally, it was used in the Aviation Psychology program for the U.S. Army Air Force in World War II to analyze critical job requirements. Flanagan (1954) described CIT as a flexible set of principles, rather than a rigid technique, that was able to be modified and adapted to meet the needs of the research. It has been used in nursing, counselling, psychology, education and teaching, medicine, marketing, job analysis, organization learning, performance appraisal, and social work (Woolsey, 1986). In the field of counselling psychology in particular, CIT is viewed as a respectable, reliable, and valid method of research (Butterfield et al., 2005).

CIT has evolved since its' inception in 1954. Butterfield et al. (2005) note four major departures from the original method. The first departure is the method's evolution from a positivist, objective method to study behaviour to a more constructivist method that can also explore psychology and experiences. The second change has seen CIT shift from an emphasis on conducting research by observation to, instead, having multiple methods that include retrospective self-reports. The third methodological departure involves data analysis. Flanagan originally conceptualized a subjective process of categorization resulting in the formation of categories. However, researchers now do not necessarily keep strictly to this form of data analysis as it could be deemed as "reductionistic" and lacking in context; therefore, other methods of data analysis may also be applied. The fourth departure in current CIT methods is the establishment of various credibility and trustworthiness checks.

A critical incident (CI) is described by Wong (2000) as:

An event which has significant positive or negative impact on the individual. This may involve three components which are: (a) antecedent conditions, (b) the event, and (c) the consequence. Each of these components may include thoughts, feelings, behaviours and relationships. (p.56)

Rather than only looking at incidents, researchers are encouraged by Wong to look at "meaning units" that are more indicative of a holistic and complex understanding of the critical incident. Using this framework, participants are able to place value and importance on the aspects of the critical incident that they choose because they weave their own narratives.

To study a critical incident, CIT uses five major steps (Flanagan, 1954, as cited in Butterfield et al., 2005). The first step involves ascertaining the general aims of the activity being studied (what is the objective of the activity and what is the person trying to accomplish?). The second step is setting plans and specifications. This step involves making decisions around defining the type of situations to be observed, determining the situations' relevance to the general aim, understanding the effect the incident has on the general aim, and deciding who will do the observations. This step was set up to create objectivity for observations. The third step of CIT is collecting data, which can be undertaken in various ways, including individual or group interviews, questionnaires, observations, or record forms. The fourth step involves analyzing the data. The aim of analysis is to create a categorization scheme that summarizes and describes the data. The final step is interpreting and reporting the data. This step involves reflection on the process of research, wherein the researcher searches to understand how personal values and biases have influenced the study. It is also in this step that limitations and degree of credibility are discussed.

Sample size in CIT research is determined by the number of critical incidents rather than the number of participants. Woosley (1986) suggests that incidents should be collected until redundancy in participant responses occurs. Redundancy is achieved when only two or three incidents out of a hundred have new content (see Appendix F for CI Log).

CIT, in particular, is particularly appropriate for this study because it will permit the identification of specific incidents around transition experiences for people with anorexia, and exploration of what helps or hinders these experiences. Thus, it helps in understanding a specific experience (service transition) for a certain group of people (emerging adults with anorexia). In using CIT, I wanted to contribute to the sparse research on this particular topic by using participant's own words, and create a collaborative meaning-making experience with these key stakeholders. CIT is also advantageous because its purpose is to explore turning points and provide insight. By employing this research method, I endeavored to understand the service transition experience. With an improved understanding of the service transition based on the perspective of those who experience them, there may be an opportunity to develop recommendations for smoother service transition for emerging adults, particularly around arbitrary age service designations.

3.1.2. *Situating the Researcher*

I will situate myself within this study so the reader may have a more transparent understanding of my subjective experiences and motivations for doing this work. In qualitative research, the emphasis is on the researcher as a subjective component of the analytical work. As such, I cannot separate myself objectively from what I am studying. Instead I will provide an opportunity for the reader to learn about my experience, biases, assumptions, and motivations for choosing this avenue of research.

I am a thirty-one year old female of mixed ethnicity. I have been working with the North Shore Child and Adolescent Program (CAP) for approximately six years. This program is funded mainly by Vancouver Coastal Health (VCH) and partly by the Ministry of Children and Family Development (MCFD). This is a Child and Youth Mental Health and Addictions (CYMHA) Program. I have had many different positions in the program – starting as an administrative assistant and currently as a Child Behaviour Worker. I have worked in both the Social Skills program and the Eating Disorders program (Be Real). During my years at VCH, I also had the opportunity to work at Community Psychiatric Services (CPS), Stepping Stones (a substance use program), and Older Adult Mental Health (OAMH) in differing clerical positions. My experience has spanned both CYMH and AMH programs.

It was my time at Be Real eating disorders program that was of particular relevance to this research study. I worked as a Behaviour Support Worker at the day treatment program for one year (occupying a temporary leave position). During this time I had the privilege of working with many inspiring young women who were fighting eating disorders. I was also very lucky to work with a skilled multi-disciplinary team that consisted of psychiatrists, paediatricians, nurses, clinicians/counsellors, dieticians, administrative staff, volunteers, and practicum students.

As a Behaviour Support Worker, I had an array of responsibilities. I made the overall weekly schedule. I planned groups – these consisted of a cooking or restaurant group, a lifeskills group, an open talk group, dialectical behaviour therapy skills group, and a recreational outing. I also delivered meal support services thrice daily (lunch, snack, and dinner).

Spending the majority of my day with the emerging adults that our program served helped me to gain an understanding of how difficult battling an eating disorder can be. It is a difficult struggle at the best of times. Not only do people have to first figure out how to enter the mental health system, they then need to learn to navigate it and advocate for their own care. During times of change and struggle, this becomes a major task. I think that part of the responsibility as healthcare professionals is to ensure continuity of care for those emerging adults who are bridging services.

My interest in exploring service transition from CYMH to AMH services stems from issues that I have heard discussed in the Vancouver eating disorders community. I am a member of the B.C. Eating Disorders Community of Practice (BC ED CoP). This organization helps to facilitate knowledge exchange between various practitioners working in the eating disorder field. The focus is on health promotion, prevention, treatment, and recovery. Each year, BC ED CoP hosts a two day workshop, which I have attended for the past three years. Practitioners attend from all over the province. Each year, I have participated in what is called "open space". During this part of the workshop, themes are discussed in small groups and are often reflective of areas in which improvements can be made. Each year the topic of service transition has risen; sometimes in regards to transitioning between different care levels (primary care, secondary care, and tertiary care) and sometimes between agencies (CYMH and AMH).

Often, themes include not having enough information, poor communication, or a lack of seamless care pathway processes. Because of my interest in both CYMH and AMH, this organizational topic has always been a fascination for me. I am particularly curious about counselling for people with eating disorders, as they often span both CYMH and AMH services (while other disorders may not).

As a professional in the eating disorders field, I have seen people grapple with transitions. Often, during the later adolescent years, the complexity of people's situations can grow. As examples, I would see a struggle for autonomy that late adolescents/emerging adults engaged in with their families; there seemed to be a rule change in confidentiality (which finds parents uninvolved in care); having to navigate a new mental health system (CYMH to AMH); and changes in therapeutic philosophies (from very individualized, multi-faceted services to more group-based care). All of these and more seemed to make it increasingly difficult for emerging adults to successfully receive services. To me, it seems as though the structure of the Canadian health care system tends to fit everyone into the same round hole when there are many square pegs that the structure does not accommodate.

My biases, assumptions, and theoretical allegiances that I brought to the research were: (1) Biases: I did not believe that service transitions are a smooth event for people with anorexia who move from CYMH to AMH services. As "emerging adults" rather than "adults", I believe that adult counselling services may not always be the best fit for this developmental stage. (2) Assumptions: I assumed that many individuals will report having experienced service disruption while transitioning and that these disruptions compromised their eating disorder treatment. I also carried the assumption that, because of the organizational difficulties of service transition, many people drop out of services. (3) Theoretical/Conceptual allegiances: my theoretical and conceptual allegiances can be understood through a holistic and narrative lens that takes into account developmental and contextual factors. In conducting this research, I aligned with needs-based (and not service-led) care. I believe that needs-based care can lead to successful and individualized care pathways.

3.1.3. Ethical Considerations

All participants were asked to sign a consent form. This form contained information about the study, including: purpose of the study, the participant's rights and the nature of their participation in the study, anonymity, confidentiality and its limits, where data would be kept and safeguarded, debriefing, and the potential risks that could arise from participating in the study. A copy of the consent form can be found in Appendix B. This study was reviewed by the Simon Fraser University Office of Research Ethics to ensure minimum harm to participants involved in the study, and that ethical research guidelines were followed.

3.2. Procedures

In this section, how the general aims of the activity were ascertained is described, plans and specifications are set, and data collection and analysis are reviewed. Reliability and validity procedures are also discussed. The procedures will follow those set out by Butterfield, Borgen, Maglio, and Amundson (2009). These procedures are a good match for this study as they align closely with the original steps outlined by Flanagan (1954), with variations in criteria for reliability and validity. Specifically, Butterfield et al. (2009) developed more checks to establish trustworthiness, and outlined procedures for conducting CIT that are specific to psychological research.

3.2.1. Ascertaining the General Aims of the Activity

To ascertain the general aims of the study it was important to define the objective of the activity. From this objective, an understanding of what the person is expecting to accomplish by engaging in the activity can be deduced (Butterfield et al., 2009). In this particular study, the objective of the activity was to investigate the experience of the transition from CYMH services and AMH services in B.C., for emerging adults with anorexia transitioning between eating disorders services. People who make the transition from CYMH service are expected to navigate and set up a new AMH service. Ideally, the transition should allow them to flow easily into a new treatment program.

3.2.2. Making Plans and Setting Specifications

In CIT research, it is important to make plans and set specifications. This was accomplished by answering and defining four key aspects (Butterfield et al., 2009). The type of situation to be observed or reviewed must be defined, the relevance of the situation to the general aim must be defined, the extent of the effect the incident has on the general aim needs to be understood, and, lastly, the decision about who will make the observations is made.

The type of situation that will be observed or reviewed is the experience of transition from CYMH services to AMH services and what helped or hindered this process. The relevance to the general aim is that, by finding out what incidents helped or hindered the process of transition, programs can work to create a better transition experience for emerging adults who are already facing many simultaneous life changes. The expectation is to understand the extent of the effect service transition can have on continuity of care, development, and overall functioning for emerging adults with anorexia. There were no observations of participants in CYMH or AMH service settings; instead in-person interviews were conducted.

3.2.3. Data Collection

Data was collected by recruiting participants who met the study criteria (which will be defined in full below – also see Appendix D). I will also describe recruitment and interview protocol. Seven people participated in this study.

Participant Recruitment

I recruited participants for this study by using a recruiting announcement (see Appendix C). I emailed and mailed the announcement to various B.C. eating disorder services (mainly in Vancouver and the Lower Mainland), asking both the programs and individuals working within the programs to assist in finding people who had transitioned from youth eating disorder services to adult eating disorder services. I posted the recruiting announcement in the Tri-Cities community at various locations, with the permission of the establishments. As I am a member of the B.C. Eating Disorders Community of Practice (BC ED CoP), I also connected with professionals on the private

website and posted a recruiting announcement in the monthly newsletter. The recruitment announcement was also posted at Douglas Colleges and on The Looking Glass website and Facebook page.

All participants were asked to complete a brief phone screening questionnaire to determine their suitability for the study (see Appendix D). At that time, the purpose of the study was explained to participants. The questionnaire then asked about their history of receiving treatment from eating disorders services (if they had transitioned from youth to adult services) and asked briefly about their history of anorexia. Anorexia was defined using the following DSM-V criteria as a general guideline:

1. Below minimal normal body weight for age and height, or while working in youth counselling services, this can be defined as a failure to meet expected weight gains instead of weight loss.

2. Intense fear of gaining weight or becoming fat, persistent behaviours that interfere with weight gain.

3. Body dysmorphia (experience and significance of body weight and shape are distorted).

Participants needed to have been actively using eating disorder services or had reached a place where services were no longer required. Participants were people who were currently struggling with anorexia, or who had struggled with it in the past. Participants were not restricted because of marital status, ethnicity, gender, sexual orientation, or socioeconomic status. I conducted all interviews in English. Exclusion criteria consisted of the following two criteria: (1) being under the age of nineteen; and (2) having any physical, cognitive, or emotional reasons to not participate (this was a subjective definition that the participant could define and was left to their discretion).

Interview Protocol

After the initial phone screening, participants were asked to meet for an in-person interview. Data collection occurred during these in-person interviews. These interviews took place at community parks or coffee shops (whichever was more easily accessible and comfortable to participants). Confidentiality was ensured in these public places by

spacing ourselves far away from others. Participants were asked throughout the interview if they were still comfortable talking in the space. The interviews lasted approximately one hour.

The interview began with a reminder of the research purpose, explaining consent-to-participate procedures, answering any questions participants posed, and obtaining a signature confirming the participant understands consent perimeters (see Appendix B). Once signed, participants received a copy of the consent form.

I used a semi-structured interview format with room for flexibility if clarification was needed (see Appendix E for a copy of Interview Protocol and Questionnaire). Interviews contained questions about general, non-identifying demographic information, and about critical incidents that either helped or hindered the experience of eating disorder treatment service transition. Participants were also asked about "wish list" items that they would have recommended during the transition. Flexibility during the interviews allowed for follow-up questions and probes that provided richer data. Once the interview was complete, participants received written communication about the research project and contact information should there be any further questions or concerns.

It was hoped that a second interview would be conducted at a later date via phone or in-person to cross check participant answers and check credibility, unfortunately these did not occur due to time constraints.

All interviews were taped and transcribed by this researcher in their natural language.

3.2.4. Data Analysis

Woolsey (1986) describes the objective of data analysis in CIT research as "provid[ing] a detailed, comprehensive and valid description of the activity studied" (p.248).

Thus, to begin, the formulation of categories was derived from thematic content; grouping similar themes about transitioning between eating disorder services (the Critical Incident or "CI"). This occurred in three steps: first, incidents were extracted from

the interviews and placed in a computer Word format table, with one CI per row; secondly, the CIs were sorted into similar categories and subcategories; and, finally, data analysis included seven credibility checks to maximize validity and reliability.

The CIs were extracted from the interviews based on a frame of reference related to what helped or hindered the participants' transition from CYMH services to AMH services. This data is most important in this study because the principle use of the findings will be to provide professionals with a better understanding of ways to support individuals making a transition. CIs described the transition event and then expressed how the incident impacted participants in either a positive or negative way.

Using inductive reasoning, categories were formed by identifying a small number of CIs in the first interview and by defining certain categories and placing the CIs in them. Inductive reasoning stipulates that the categories are probably "right" but that there is no absolute "truth" to them (which would be deductive reasoning). Interviews were then reviewed and CIs were extracted from the interviews by searching for "helping" factors and "hindering" factors in each interview. Once found, these factors were extracted from the interview transcripts and placed in the computer Word-format table. This was a flexible process, as new categories were created with each new interview, and old categories were also modified until all CIs from all interviews were categorized.

To maximize the richness and distinctiveness of the categories, Woolsey (1986) has suggested that choosing a level of specificity is important. To this end, in the present research, categories and subcategories were used. Specificity makes all categories more particular. It involves reflecting on categories in a critical way to ensure that each category is the appropriate size and that it does not need to be readjusted or reworked. This process helped to determine the correct fit for each CI in each category and subcategory. Interviews were revisited to add more context to increase specificity in some cases.

Reliability and Validation Procedures

Credibility checks are not necessarily required in qualitative research; historically, they are associated more with quantitative research philosophies and methods.

Credibility checks are employed to help ensure that research is reliable and valid. In quantitative philosophy and methods, having credibility checks ensures research is closer to the absolute truth. Qualitative research, on the other hand, does not necessarily prescribe a "truth", but rather a description of an experience true to those participants in that time and place.

Although credibility checks are not a requirement, I think that they will create a research process that is well-documented, credible, and trustworthy. Because of these factors, and based on the recommendation of Butterfield et al., 2009, I have decided to include reliability and validation procedures in this thesis. In the following section I introduce and describe the nine credibility checks I used in this study. See Appendix H for a summary of the credibility checks employed.

Audio taping interviews

As qualitative research is descriptive in nature, audio taping interviews is a means to capture participant's words verbatim (Butterfield et al, 2005). Having a very accurate account of participant's narratives was crucial in creating a rich and meaningful account of what helped or hindered service transition. Thus, this research was conducted using audio tape to accurately represent participants' views.

Interview Fidelity

Creswell (1998) highlighted the importance of following an interview protocol. The protocol is in place to ensure that the CIT method is being followed, the interviewer is not asking leading or prompting questions, and the interview guide is being followed. This was checked by the thesis supervisor, who asked questions about the interview process and the interview protocol over the course of the data collection phase. Feedback from this credibility check increased interview fidelity.

Independent Extraction of CIs

It is customary for a person who is familiar with CIT methods to listen to the audiotapes independently from the researcher and to extract CIs (Alfonso, 1997: Novotny, 1993, as cited in Butterfield et al., 2005). The purpose of this process is to evaluate the level of agreement between the study's researcher and the independent

person. It is assumed that more agreement means more credibility and that the CIs are of importance to the event/aim of the activity.

In the present research, due to time constraints, I was not able to enlist another person to independently extract the CIs. This has been identified as a limiting factor in this research (see discussion).

Exhaustiveness

In compliance with CIT research methodology, it is imperative to track when exhaustiveness or redundancy is achieved. Butterfield et al. (2009) suggest using a tracking system or log that is filled out for each participant. In the log, CIs were placed into categories (see Appendix F). Each time a participant was interviewed, the log shows whether CIs were placed into existing categories or whether there was a need for a new category to be created. Once there were no new categories being created, exhaustiveness was achieved. Exhaustiveness was achieved in this study after the fifth participant, with no new categories emerging.

Participation Rates

Participation rates are important to ensuring that the CI is important to the aim of the study. Butterfield et al. (2009) established that a participation rate of twenty-five percent for a category is needed for it to be considered valid and strong. Participation rates are calculated by counting the number of participants that contributed to a certain category and by dividing that number by the total number of study participants. For example, if there was a category called "Communication between CYMH and AMH services", and 15 of the 20 participants reported this as a helpful item, the participation rate would be calculated at 75% (Butterfield et al., 2009).

Participation rates were calculated in this study. Because of the small number of participants, all CIs were considered important and included in this study. Participation rates are indicated in the helpful, hindering, and wish list results section.

Placing Incidents into Categories by an Independent Judge

Butterfield et al. (2009) state that, to further establish reliability and validity, an independent person should be asked to place twenty-five percent of randomly chosen

CIs into categories that have been formed by the researcher. The higher the rate of agreement, the more sound the categories are thought to be (Butterfield et al., 2009). In the event of a discrepancy, Butterfield et al. (2009) suggest clarifying the information and categorization with the participants during the participant cross check (below). In the present study, the thesis supervisor placed all incidents into categories in collaboration with this researcher. Categories were created, defined, redefined, and dismissed based on inductive reasoning. This is not exactly the method established by Butterfield et al. (2009), but was used to enhance validity.

Cross Checking by Participants

In CIT research, once the first interviews have been collected, analyzed, and placed into categories, a second interview is typically conducted to cross-check CIs and categories. This is an important step in validity and reliability checks as it allows participants to confirm interpretations, review the categories, make sure that the CIs have been placed in the appropriate categories, and it is an opportunity to honor the participants and accurately report their experiences (Butterfield et al., 2009).

Butterfield et al. (2009) suggest cross checking be completed in the following manner. An email can be sent to the participant that includes information about the CIs and the categories that have arisen from them. Included in the email can be the following questions in regards to the CIs: (a) Are the helping/hindering CIs correct? (b) Is anything missing? (c) Is there anything that needs revising? and (d) Do you have any other comments? In regards to the categories, the following questions can be emailed as well: (a) Do the category headings make sense to you? (b) Do the category headings capture your experience and the meaning that the incident had for you? and (c) Are there any incidents in the categories that do not appear to fit from your perspective? If so, where do you think they belong? Rather than having the participant reply via email, a telephone interview time can be arranged. This simplifies the process, and decisions can be made with the participant as to any changes to be made. This is also an opportunity for to ask any follow up questions from the first interview.

In the present study, this very important validity check was not completed due to time constraints. However, each participant asked for a completed copy of the thesis;

therefore, opportunity for feedback will be possible in the future. This is a central limitation to the research, which will be discussed further in the Discussion.

Expert Opinions

This reliability and validity check is completed by sending the categories to experts in the eating disorders field. This occurs after the categories are finalized and after cross-checking with participants. Butterfield et al. (2009) suggest asking the experts the following questions: (a) Do you find the categories to be useful? (b) Are you surprised by any of the categories? and (c) Do you think there is anything missing based on your experience?

In the present study, the categories and critical incidents were checked for reliability and validity by an expert in the eating disorders treatment field. With that feedback, the names of the categories were changed to become more descriptive of the incidents within them.

Theoretical Agreement

In CIT, there are two parts to completing the theoretical agreement check. In the first part, the researcher explores the underlying assumptions of the study. The second part looks at how the categories compare with current research literature (Butterfield et al., 2009). Theoretical agreement was checked in this study by exploring the underlying themes and assumptions of the study. Research literature was reviewed to compare the categories that were found in this study with what others have found in the currently or in the past.

4.   Results

Interviews were conducted with seven participants. Participants became aware of the study from facebook recruitment announcements, through mutual acquaintances, and through academic poster presentations. All participants were female and ranged from ages nineteen to thirty-one, with an average age of twenty-six. Five of the participants described themselves as Caucasian, one participant described herself as Metis and Caucasian, and the remaining participant described herself as Mexican and Caucasian (see Appendix I for details). During the telephone screen, participants indicated that they met, or had met the criteria for anorexia while accessing eating disorder services. At the time of the interview, participants were not asked to indicate whether they were currently battling anorexia or if they were recovered (as self-defined). Names of participants have been changed to protect their identities.

From the seven interviews, a total of 285 critical incidents were extracted. Of the 285 critical incidents, 81 were identified by the participants as helpful to creating a good transition from adolescent to adult mental health services while battling anorexia, 121 critical incidents were identified as hindering the process of transitioning, and 83 critical incidents were identified by participants as wish list items to create better transitions. The 285 critical incidents were sorted into different categories depending on if they were deemed helpful, hindering, or as a wish list item. The helpful incidents were categorized into eight separate categories, the hindering incidents were categorized into nine separate categories, and the wish list incidents were categorized into six separate categories. The categories were labelled to comprehensively describe the meaning of each category. This chapter will describe each of these categories in further detail.

4.1. Categories that Described What Helps the Transition from Adolescent to Adult Mental Health Services while Battling Anorexia

There were eight categories describing incidents that helped create a good transition from adolescent to adult mental health services while battling anorexia. Embedded within the eight categories were twelve subcategories. The categories are presented here by frequency of incidents (i.e., the category with the most incidents is presented first, carrying on in decreasing order). The presentation of the categories in this fashion is not an indication of the importance of each category, but instead suggests that these higher frequency categories may be more common among people going through this experience.

The following table summarizes the categories, number of participants who endorsed each category, the participation rate, and the number of helpful incidents indicated in each category.

Table 1.   *Incidents that Help the Transition from Adolescent to Adult Mental Health Services while Battling Anorexia*

Helpful Categories (N = 81 total CIs)	Number of Participants (N=7)	Participation Rate (%)	Number of Helpful Incidents
Central or Familiar Professionals	6	86%	26 (32%)
Smooth transitions	6	86%	17 (21%)
Support	6	86%	11 (14%)
Triaging	4	57%	5 (6%)
Counselling	4	57%	9 (11%)
Transition Motivation	3	43%	6 (7%)
Managing Treatment	3	43%	4 (<1%)
Perspective Taking	2	29%	3 (<1%)

4.1.1. Category 1: Central or Familiar Professionals

This category contained incidents that describe how it was helpful to have one or more professional people who continued to work with participants before, during, and sometimes after, the transition to adult mental health services. Professionals in this category were seen as central figures in their healthcare, and familiar people participants had known for a longer period of time. This was a large category and incidents were divided into two subcategories to facilitate a deeper understanding of the topic. The two subcategories were: (a) Professionals who prolonged care, and (b) Characteristics of caring professionals.

Category 1a: Professionals Who Prolonged Care

Incidents in this category related to helpful professionals who continued to work with participants after they were no longer necessarily mandated (i.e., participants had aged-out of service and/or were not yet connected with adult mental health services). Participants identified the importance of having continued care as it was seen as helpful to their continued recovery. The incidents were seen as particularly helpful because they spoke to the nature of a caring therapeutic relationship, which was important to participants because it meant having a familiar person, not having to repeat their history to new people or teams, and feeling cared for and supported. Melissa described it as:

> Nice — just to have that continuity, not having to repeat your story, like, a million times...I would go just to [counselling] to touch base. And having that person that I'd known for ten years was huge. I mean, huge because it was just you kind of leave off and you start up again, and they already know you.

Participants were also quick to point out how professionals went above and beyond their call of duty by performing tasks not generally inside the normal scopes of practice. These included continued email support and making arrangements for people to stay in touch with them. For example, Shelby recalled:

> The doctor that I had from [the city], she came over to [the city] a few weekends. Not specifically to see me, but she continued to see me even though she was a paediatrician. That was really amazing because they wouldn't let me into the [adult program] if I didn't have my own doctor.

Diana also noted similar above and beyond acts from her team that helped her to remain in treatment and transition into adult services, saying "I would come down back and forth every month and stayed with my psychiatrist, stayed with the dietician, stayed with everyone who worked with me there." Having professionals who prolonged care, even though participants may have aged-out of adolescent services, was important to continued therapeutic involvement and seemed to decrease the treatment dropout rate among these participants.

Category 1b: Characteristics of Caring Professionals

In this category, caring professionals were seen as those who provided support, were knowledgeable about services, were consistent, understanding, skilled in the eating disorder field, and who were familiar from adolescent services through to the time of transition to adult services. Participants seemed to feel, on a deeper level, that they were known by these professionals and had developed an attachment with them. One of these people was described by Kristina as:

> [Child psychiatrist] was my life saver. He is the reason that I am still here. I can credit him for a lot of things. He was absolutely amazing. He knows what he's doing and he's on top of it. And he actually takes the time to make sure things are being done the way they are supposed to be done. I have no doubt whatsoever that if he had been still working at the [hospital] during my transition things would have gone differently because he actually puts that time in and puts that effort in. He makes sure that things are okay and that people don't get left behind. Because that is one of the huge problems – that is that people fall through the cracks.

Professionals who helped during the transition process were also described as trustworthy, passionate, laidback, funny, honest, and caring. Having these caring professionals involved in participant treatment allowed participants to create strong and secure relationships that helped with recovery from their eating disorders. Shelby put it this way: "[Recovery was about] accountability mainly; knowing that there were other people who were invested in my recovery, and knowing that I didn't have to start from scratch with all entirely new relationships, with new health practitioners." Professionals who, through various characteristics, created a sense of belonging and knowing with the participants made transitioning services less of an individual, isolating process.

4.1.2. Category 2: Smooth Transitions

Incidents in this category describe how adolescent and adult services helped to create a smooth transition into adult mental health services. This category was split into two subcategories to clarify and hone in on important features of the incidents. The subcategories are as follows: (a) The transition was planned, and (b) Adult programs are helpful. It is important to highlight that transitions were not difficult in all cases, and that programs were seen as worthwhile and helpful after the transition process was complete.

Category 2a: The Transition was Planned

Two participants indicated that the transition from adolescent to adult mental health services was collaboratively planned with them. The collaboration seemed to have empowered participants to take charge of their own care and feel more comfortable with the transition. Diana noted that it did not seem "forced," and she felt that there were choices involved in the transition process.

> They brought [transitioning] up in a really delicate way I think, because I don't remember being scared about it. And it was sort of—or maybe even I brought it up and I said, you know, I know that I'm getting to that age. I don't remember. And that they gave me options. Do you want to be referred to [adult hospital]? It wasn't an automatic thing.

Kristina had a similar experience and also found that the adult services were "really accommodating and they make the transition easier." It was important to include these instances of smooth transitions to emphasize that each person has a different transition experience and they are not all negative.

Category 2b: Adult Programs are Helpful

Adult programs, in and of themselves, were seen as helpful by many participants once they had adapted to the new program. Although participants noted that navigating the transition into adult programs was often difficult, once that process felt complete, adult programs were a good support. Gaining familiarity and establishing rapport with the adult program and the professionals who worked there were seen as helpful to becoming comfortable with the new program. The differences in how the programs were

run compared to the adolescent programs made it easier for some people to continue treatment once the transition process was complete. Shelby stated:

> [The adult program] didn't disrupt my life. I was still able to go to school. And I find the more my life is disrupted by the eating disorder and dealing with the eating disorder, the worse it gets because I'm cut off from friends and having to explain it to people. So just giving me more of a chance to work things out on my own.

Some participants noted that adult programs seemed more flexible, especially in terms of what the focus of treatment would be, who would deliver it, and when it would happen. As adults, Diana noted, people were "electing" to be a part of the program and thus she found herself and others more motivated to engage in treatment. A few participants found adult programs to be very accommodating and to tailor treatment to the individual. As an example of this, Liv said that "[The adult program] was willing to tailor that sort of thing for me [her weight gain and re-feeding plan]. I mean, other people did it too, but instead of doing just a one size fits all for everyone."

Also of note was a focus in the adult program on what people were going to do moving forward with their lives. Planning for the future and setting goals was helpful to Melissa in particular. She noted that "eventually when I started transitioning to adult services, they wanted me to start looking at what do you want to do next?"

4.1.3. Category 3: Support

This category contained incidents that described the importance of family, partners, and friends who remained supportive during the transition from adolescent to adult services while battling an eating disorder. There were no subcategories in this section.

Many participants noted that, while struggling with the transition from adolescent to adult mental health services, having support was paramount to continued treatment. Having a family member, partner, or friend help with advocating for appropriate treatment was seen as very helpful. Participants noted that, often while battling an eating disorder, they may not necessarily be in a place of awareness of what is needed for

treatment, so having someone who cared for them to help with this aspect was important. Shelby explained how having the support of others was helpful to her:

> I wasn't really in a place where I could sort of look for all that stuff on my own. So my mum found the [adult program] here, which was not super helpful for me, but it was something. And she also got me into counselling services at [the university].

Other participants also noted that having support was helpful to the transition because the supporting people were very proactive in accessing services for them. Kelly and Kristina noted that their families were often advocating on their behalf. These families were ready to help with the transition and prepared to work to make sure their children received appropriate services in a timely manner. Participants explained that, even though they were battling the eating disorder, their families were no less involved in the struggle, and their support was important to continued treatment.

It seemed that participants found family, friends, and partners support to be helpful in advocating for services, but also as an indication that they were not alone in the battle against the eating disorder. Having positive things going on in one's life apart from the eating disorder, such as being friends with other people, was also seen to affect a positive outcome. Diana noted that these things were also an "external motivation that gave me a glimpse of real life." Having these experiences and supports helped participants to feel hopeful about having a life without an eating disorder. Melissa shared similar incidents of developing an eating disorder free identity that helped propel her during her transition:

> [Being in a relationship, having friends, and continuing to post secondary school] were positive...because I was [at the adolescent eating disorders program] for such a long time, my social life had kind of revolved around the people that I met there...Everything became about that safety space. And I was there Monday to Friday. And so yeah, I mean, starting to build a life outside of treatment was huge for me. Whether I was ready for that or not, I think it was very beneficial.

Not only were family, friends, and partners seen as excellent supports during the time of transition, they were seen as excellent supports through the course of recovery.

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4.1.4.   Category 4: Triaging

In many B.C. hospitals and programs, a triage system is used during the referral process to assess who should be admitted to services fastest, and who can wait to receive services at a later date. Participants reported that, during the transition from adolescent to adult mental health services, a triage system was used to delineate wait times into the adult programs. Programs may have different triaging criteria, which are based on an understanding of the severity of the eating disorder (which often prioritizes physical symptoms). Some participants found triaging to be helpful as it made for quicker admittance into programs when they critically needed it. Piper remarked that:

> I didn't have to really wait because I was urgent so they were able to move me along pretty quickly...[it was] helpful that you don't have to wait, because I know people who had to wait four months to get in to see [paediatrician] and by the time they see her they are really sick. I was really fortunate to have good people on my side who were like "no she has to be seen right now.

One problem that was noted in this triaging system is that the referred person needed to let people know that they were in crisis and needed services quickly, which can be difficult. Shelby clarified that this is also why it is important to have the support of family, friends, and partners because:

> [Programs] are really good about getting people in if you tell them that you're in crisis, but you have to say it. And so that was what my mom did when she called in. She was, like, "My daughter needs to see somebody now, now.

Often, participants found themselves not wanting to reach out for services, or not wanting to stress how dire their situations were, which led to triaging that was not necessarily responsive to the urgent care that was needed. Triaging was seen as helpful by the participants who were able to verbally express how much they needed help during the referral process.

4.1.5.   Category 5: Counselling

Many participants described the helpfulness of seeing a counsellor before, during, and after transitioning to adult eating disorders services. There were no

subcategories in this category. Therapy was seen as an avenue for open conversations about things concerning the transition, as well as a safe place to discuss any issues that participants were working through. Trust and openness were important for engagement in therapy.

Individual counselling was seen as extremely helpful. Piper noted that having therapeutic interventions that focused on the eating disorder specifically, as well as having space for other therapeutic topics was seen as very helpful. It was also noted that a focus on emotional awareness helped to clarify the reason for certain eating disorder behaviours.

Counselling was also described as being helpful when it fit with one's personal philosophies and ideas. For example, Diana observed that having a goal-oriented counsellor helped her and that: "it was only when I found the program that actually believed in full recovery without living at risk, that I could engage." Others noted that a goodness of fit with a counsellor was important – really connecting with a counsellor, feeling a trust, and feeling comfortable. Melissa stated:

> Finding a good fit is important because I've seen psychiatrists or other psychologists and it's been—not worked for me. So yeah, I mean, trust is a huge thing, that familiarity. But yeah, just the goodness of fit I guess is—has been huge for me.

These aspects of counselling: having an avenue for discussion, being open to examining all issues, having a shared philosophy of what is helpful in counselling, and feeling a goodness of fit, all seemed to help participants stay connected with services and continue treatment into adulthood.

4.1.6.   Category 6: Transition Motivation

Incidents in this category related to the idea that transition, in and of itself, is a motivation for recovery. This category had two subcategories: (a) Fear of chronicity, and (b) Recovery without disruption.

Category 6a: Fear of Chronicity

While engaging in adolescent services, some participants found the idea of transitioning to adult services so daunting that they felt more motivated to work towards recovery and complete services before even making the transition. These incidents were viewed as helpful, motivating factors. Participants in this category spoke of a fear of "becoming like those people" that engaged in adult services and that recovery would be more difficult if they continued with services rather than improving right away.

Participants in this category used the word "chronic" to describe eating disorders that last into adulthood. I would like to disclaim that the word "chronic" for me alludes to the inability to change or recover and describes a certain hopelessness. I think that the possibility of change and recovery is possible, so I would not necessarily use this word, but I do want to stay with participants original wordings.

Participants noted that, for them, it was helpful to have fear about the transition into adult services because it motivated them to recover. Many participants had either visited friends in the adult facilities or had visited to gain an understanding of their possible new program. Piper described adolescent services as "cushy", and that adult services "almost scares you out of being sick" because, at the time of transition, it does not seem to be a safe place. Diana shared the same feelings as Piper when she noted that "there was no way I was going to be that adult" and that the transition to adult services spurred her motivation to recover. Melissa expressed that the fear, for her, was about identifying into adulthood as someone with an eating disorder; she wanted to break free from that part of herself. She said:

> I think picturing myself in that position, not wanting to identify with the possibility that that could be me or that there was a commonality in the way we thought about things because we all had eating disorders. So just not wanting to identify with that piece of myself anymore.

Seeing other people, at an older age, still struggling with the battle against an eating disorder, seemed to motivate some participants toward a recovery before leaving adolescent services. It seems as though participants did not want to imagine themselves as having an eating disorder in the future, which affected their present drive to recover.

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Category 6b: Recovery Without Disruption

Also of note was one participant's experience of being so close to the end of treatment, and finding that transition was not in her best interest at that particular point in time. Diana commented that "the biggest [helpful factor] was the fact that I didn't have to transition really because that could have just disrupted the whole purpose because I was so close to being done". For her, a transition may have caused a step back; as such, her care team let her stay a little longer to complete treatment. Their flexibility in allowing her treatment to continue without disruption was very important to her battle against her eating disorder.

4.1.7.   Category 7: Managing Treatment

In this category, participants described incidents of how they managed their treatment during the time of transition. Throughout this time of treatment management, they were also developing as emerging adults. Treatment management was seen as a step towards adulthood, requiring responsibility and autonomy. This helpful category consisted of two subcategories: (a) Managing independently without family involvement, and (b) Growth and independence. Managing independently was expressed by such things as taking care of one's own healthcare and treatment choices (such as booking own appointments, getting to appointments independently, deciding about referral and care pathways, and seeing professionals without family involvement).

Category 7a: Managing Independently Without Family Involvement

For adolescents receiving treatment for an eating disorder, family based therapies are often recommended (Treasure et al., 2005). But for some of the participants in this research, it was more difficult and less conducive to recovery to have family involved in treatment. Transitioning into the adult services was helpful as it allowed for more independence and less family involvement. Some participants explained that, for them, they had already begun the process of becoming independent from their families before adolescence, so that moving into an adult program where this was an expectation was easier and normalized. Kristina observed that:

> There was a lot less family involvement for me then I think there is for
> a lot of people. So for me, it helped that I was already sorta doing all

these things for myself. I was already the one making all of my appointments, doing all of these things cause that's the way it worked for me, that's the way it worked out…So it was actually really helpful going to [adult program] and for them to not expect me to have my parents involved.

Kristina's adolescent experience was that of already being independent and participating in a program that required family involvement. Moving to the adult program and not having that expectation worked better for her treatment. Melissa seems to have had a similar positive experience of transitioning into a program where family involvement was not necessary. Melissa explained it as follows: "I felt like I was ready, whether I was or I wasn't, you know. Yeah, so it was good. It was good to have a little bit more autonomy in that way."

For some participants, a lack of family involvement was helpful, whereas for others it was a hindrance. This speaks to the philosophy of individualized care pathways, as each person has their own best way of making treatment work. The present findings suggest that there may not be a one-size-fits-all regarding family involvement.

Category 7b: Growth and Independence

Diana found that it was helpful in the adolescent program to begin fostering independence at an earlier stage, rather than being unprepared for the expectation of independence in the adult programs. Preparation, practice, and planning autonomously made the transition easier from adolescent to adult services. She stated that, for her, "[Adolescent services] also really help with networking, to find your support, understandably because most 16 year olds don't know necessarily how to reach the support that they need."

4.1.8.   Category 8: Perspective Taking

Incidents in this category related to the experience of transitioning into treatment with people who are not battling an eating disorder (i.e. who are struggling with another psychiatric disorder). Participants in this category found treatment within a mixed population to be helpful because of the impact it had on their perspectives of health and wellness. There were no subcategories.

Two participants had the experience of transitioning into eating disorder treatment on adolescent and adult psychiatric wards that were not specific to eating disorders. They found this experience helpful because it increased their understanding of shared and similar underlying issues that affect all people (not only those with eating disorders). These experiences also emphasized a focus on emotional or mental aspects of health and wellness, rather than solely focusing on weight or eating behaviours. Kelly recalls:

> I ended up in the hospital. I was in an eating disorder bed on the psych ward. It was one of three beds on the psych ward and there were a lot of other people there with different problems who were all adults. And I found that really helpful. They were, instead of completely being, all being eating disorders it was helpful sort of meeting other people with different problems. But realizing we all kind of have similar issues.

For Kelly, sharing the experience with a mixed population, rather than only people battling eating disorders made her feel connected with others and allowed her to see problems from many perspectives. She also observed that being on a mixed ward was a helpful experience because she was not "triggered in the same way that [she] had been in adolescent treatment".

Liv reflected that, for her, being on a mixed ward enabled her to focus on the emotional parts of the eating disorder. Not focusing on the eating disorder and working on her strengths empowered her experience. Liv said:

> I actually found being in the hospital this time around was a lot more conducive to sort of my emotional state because I was not just around people with eating disorders...So I kind of felt like, okay, the focus isn't just on me having this eating disorder. Like, I can actually do something.

Building on strengths, noting that everyone has similar issues to work on, and focusing on mental health and wellness seemed to be easier for some participants in a mixed population treatment environment. These participants emphasized the importance of creating meaning and gaining an understanding of their eating disorders: how it came to be, how it functioned, how it is maintained, and how to battle it through self-reflection and self-awareness.

This completes the eight categories of helpful critical incidents that aided in transitioning from adolescent to adult mental health services while battling an eating disorder. In the following section, hindering critical incidents are described and discussed.

4.2. Categories that Described What Hindered the Transition from Adolescent to Adult Mental Health Services while Battling Anorexia

The following nine main categories were observed to be hindering incidents to transitioning from adolescent to adult mental health services while battling anorexia. The hindering categories will be organized by frequency of incidents, with the categories with a higher degree of frequency being described first (again, not as a reflection of their importance but of possible common factors).

The following table summarizes the categories, number of participants who endorsed each category, the participation rate, and the number of hindering incidents in each category.

Table 2.   ***Incidents that Hindered the Transition from Adolescent to Adult Mental Health Services while Battling Anorexia Nervosa***

Hindering Categories (N = 121 total CIs)	Number of Participants (N=7)	Participation Rate (%)	Number of Hindering Incidents
Administration	6	86%	31 (26%)
Service Availability	6	86%	12 (1%)
Competency	5	71%	11 (<1%)
Communication	5	71%	11 (<1%)
Managing Treatment	5	71%	7 (<1%)
Loneliness and Lack of Safety	5	71%	7 (<1%)
Counselling	4	57%	23 (19%)

Bridging Services	4	57%	11 (<1%)
Development and Context	4	57%	8 (<1%)

4.2.1.　Category 1: Administration

This category described the hindering effects that administrative and/or organizational policies and procedures have on the transition from adolescent to adult mental health services for people battling eating disorders. Five subcategories were identified: (a) Waitlists, (b) Referral process, (c) Program requirements, (d) Funding, and (e) Transition gaps.

Category 1a: Waitlists

Participants described how long waitlists often affected their transition to adult services. Many participants did not experience a seamless transition from one program to another; instead participants often found themselves waiting to engage in services whilst the adolescent services had already discharged them from their services. Participants declined to access certain services because of the length of the waitlists (e.g., Piper and Kelly). Shelby noted that she often felt that during the referral process there were a lot of "hoops" to jump through that made it difficult to engage in services, and the waitlist was a very large one.

Waitlists seemed to function as a barrier to continuing services in adult treatment. Participants felt that services that were not delivered in a timely manner led to negative effects on their eating disorders. Liv described it as:

> It was just really disheartening because I just couldn't imagine spending six months trying to figure out what am I dealing with, the binging and purging, starving myself. I mean, I was just spiralling so badly. I just—I didn't—I could not see myself going for another month, let alone six months.

Long waitlists seemed to lead participants to feeling more hopeless about recovery and the possibility of life without an eating disorder. Because of the lack of funding and service availability in B.C. for mental health and eating disorders, people

may not be able to access services in a timely manner, which could increase the chances of a longer duration of the disorder and the risk of mortality.

Category 1b: Referral Process

This subcategory described the process of being referred to a program. Often, a referral is an administrative task that requires different criteria and paperwork depending on each organization. Different organizations require different types of referrals (e.g., a doctor's referral, self-referral, or referral from another program). As an adolescent in treatment, ideally the adolescent treatment program would refer to an adult program to provide continuity of care. Adolescent services would ideally continue until the person became connected with their new adult eating disorder program. Unfortunately, for many participants, the transition was not smooth. Piper remembered the complicated process:

> [There are] huge organizational difficulties. I've heard my paediatrician yelling on the phone at people because it is just so frustrating. When [adult program #1] opened they took the referring privileges away from GPs and other specialists in referring to [adult program #2] and [adult program #3]. So anybody who needed services to those places, their doctor had to refer them to [adult program #1] who then decided if they needed to go to [adult program #2] or [adult program #3].

Although the referral process seemed straightforward in theory, participants (and sometimes even their healthcare providers) found it complicated and difficult. Questions of who has the right to refer, and to where, aggravated participants because it added an extra challenge to gaining admittance into the programs that they believed were most suitable for them. The already difficult task of changing care providers was made even more daunting by the difficulty in accessing the programs.

Category 1c: Program Requirements

Participants described having difficulties with meeting program requirements, all of which led to a difficulty with transitioning into adult services. Inflexible rules, not meeting Body Mass Index (BMI) standards to access programs, being too healthy or not unhealthy enough, and not allowing for people to see psychiatrists outside the program, were some of the program requirements that were difficult to meet.

For some participants, programs required a certain number of days in attendance. Because of the unavailability of programs in more rural areas, some participants, such as Piper, found it difficult to meet this requirement because of the transportation difficulties. In her experience, the adult program was not flexible to her needs and this made it difficult for her to transition into this service.

Age requirements also made the transition difficult for some participants. In these cases, participants were discharged from the adolescent programs during their grade twelve year but could not access adult services until they had turned eighteen. Unfortunately for these people, if they could no longer access adolescent services, and had to wait to reach an age to access adult services, they felt as though there were no options open to them.

Of interest were some participant's beliefs about how unhealthy one needs to be in order to access services for eating disorders in British Columbia. Program requirements that were concerned about participants meeting certain weight requirements were seen as being detrimental to transitioning into adult services. Liv explained this program requirement and how the triaging that is more weight-based was hindering to her:

> Definitely to get into a program the issue with weight is definitely an issue. I mean, basically to get into a hospital setting, right now you have to be very ill, very ill. Because most of the hospital setting situations are obviously public programs. So that's very difficult. And if you're hovering sort of between, you're ill, but you're not critically, medically ill, then you're in a weird position because public health wise there's a very low chance you're going to get into a day treatment program right away. Or within a three month window let's say.

Being physically ill appeared to be prioritized over being mentally ill, perhaps because it is more easily measured. Participants found this difficult because it underemphasized the importance of mental wellness. Liv also noted that, to access services, one has to be "unhealthy enough." But, Kelly notes, one must also not be too unhealthy, otherwise a person does not meet the criteria for program participation. Participants agreed that minimum and maximum BMI requirements focus entirely too much on the physical aspects of eating disorders and nowhere near enough on the mental aspects.

Category 1d: Funding

Adolescent and adult mental health services in B.C. are funded by the health authorities. In this category Liv, in particular, spoke about how public programs are difficult to access because of program admission requirements. She also had this to say about funding: "[there are] systemic problems of not enough funding". Participants noted that not enough funding equals not enough services or professionals working at the services, leading to longer waitlists and creating a longer, more drawn out road to recovery.

Category 1e: Transition Gaps

Participants used the word "gaps" to describe how adolescent services end before adult services begin. This was seen as hindering the process of transitioning to adult services, increasing stress, increasing the likelihood of dropout, and leading to feelings of being unsupported. Many participants noted that there seemed to be a promise that services would be provided in the interim between adolescent and adult services, but no participants noted actually being able to access these unknown services. Some participants thought that these services were provided in the community, but were not told by their adolescent or adult programs about how to access or find these services. As such, they were not able to fill the gap between adolescent and adult. Diana put it as follows: "[There were] few outpatient services, but particularly while you're waiting for one of the few services, I received less [service]."

4.2.2.   Category 2: Service Availability

A lack of local services and resources were seen as a hindering factor to transitioning into adult mental health services for eating disorders. This category had three subcategories: (a) Comprehensive services, (b) General eating disorders services, and (c) Private services.

Category 2a: Comprehensive Services

Often in adolescent eating disorders services there are multi-disciplinary teams that provide many services for people in their care. Adolescent care users can have teams that consist of psychiatrists, psychologists, paediatricians, counsellors, dieticians,

nurses, recreational therapists, behaviour support workers, and other health care professionals. Participants stated that they felt adult services were not as robust as the services they had received in adolescent care. Participants strongly stated that there was a lack of comprehensive services available when transitioning to adult mental health for eating disorders. This was a barrier to transitioning as it made it difficult to adapt to a less comprehensive service. Not having access to these services made continued treatment more difficult.

Kelly noted that, for her, adult eating disorders services lacked many of the things that made adolescent services so supportive and helpful. She felt that the adult programs were "designed" for only acute eating disorders. Kristina seemed to share similar feelings about the adult programs and also explained that her experience at the adult program only offered her the possibility of working with a doctor, but not with an entire team. Participants described adult programs in lacking some of the fundamental elements that help with recovery; such as individual counselling and recreational programming.

Category 2b: General Eating Disorders Services

Eating disorders services in B.C. are slowly growing and becoming more comprehensive (e.g., the VCH Secondary Eating Disorders Program has been added as a community resource). Unfortunately, for many participants, their experiences of eating disorders programs were more limited in terms of available services and service availability for people with differing levels of care. Kelly observed that:

> [There was] probably an overall lack of resources. Like what I was saying about adult services kind of the same thing with youth services. If you're really sick, there's all this support. But if you're not as sick, then there's less support. And so for me, because I was transitioning to adult services at the time when I was doing well at that point, there wasn't much support for me because I was doing better. So it really felt like looking back, what would have been really helpful was kind of a more intermediate level of support. Where it's not so intensive, but it's not nothing either.

Participants expressed wanting to continue to access services, even if they were doing moderately well, but that there were no services available for people at that level of care. Melissa understood this as "the service at [the adult program] at that point was

very geared towards people with a high level of severity." This was seen to leave many people who were still struggling without program support.

Category 2c: Private Services

The lack of local services and resources caused some participants to look elsewhere for service. Some looked outside of the province, while others received care outside of the country. The inaccessibility of local healthcare seemed to make participants feel that the only way to receive appropriate care was to pay for it. Shelby concluded that "it seems like that's the only way to get help is to pay for it yourself." Having to pay for eating disorder treatment was a financial difficulty for participants with far reaching consequences, such as large debts. Melissa noted the cost, at that time in her emerging adulthood, ended up ultimately being too expensive and she needed to seek counselling sporadically rather than regularly, she said "it was very expensive for someone in their early twenties to be paying, you know, hundred and sixty dollars or whatever per session. I mean, that's—it's expensive." The lack of local services and resources hindered transitioning into public mental health services for eating disorders, creating a need for people to seek private care.

4.2.3.   Category 3: Competency

Participants described hindering incidents in this category related to the competency of healthcare professionals in the eating disorders field. The ability of professionals to work with eating disorders efficiently and successfully was questioned by participants because of their experiences with professionals who were not familiar, or who had no training, with eating disorders. This category was divided into two subcategories: (a) Experience with eating disorder treatment, and (b) Professional support.

Category 3a: Experience with Eating Disorder Treatment

Participants described the importance of working with professionals who have experience and knowledge of treating eating disorders. These professionals were described as someone who is competent in the field. It was viewed as an important aspect of transitioning to adult services because, if the professional was not viewed as

skilled in working with eating disorders, participants felt less hopeful of achieving recovery. Participants also explained that professionals who were perceived as not competent with eating disorders were hard to engage with, and they felt they may not receive appropriate care and wondered if they should discontinue care. The more perceived skill a professional had, the more participants seemed to trust and believe in their abilities to help them overcome their eating disorders. Kristina described her experience with a professional, new to the eating disorders field, as follows:

> My psychiatrist at [the hospital] was not at all helpful, she was not very helpful at all...she was really nice, but she is also very new to being a psychiatrist. It's not that I didn't like her, I really liked her, but she was very nervous. So it's nice, especially when you're transitioning, to have people who really know the process and can tell you exactly what's happening. Because if someone is uncertain – that's really anxiety provoking.

Participants expanded that, the uncertainties that some professionals who are not familiar with eating disorders may face as they begin gaining experience in the field had the unfortunate consequence of making them not feel confident in the professional's abilities. Talking about weight, in particular, seemed difficult for some professionals. This was difficult for participants because it is something that seemed central to discussing eating disorders and treatment. Kelly recalled talking with professionals about weight and how they would often bring it up in a way that was "degrading and uncomfortable." Others, like Liv, had a doctor who referred to her eating disorder as "the situation" rather than as an eating disorder. She made note that not being able to openly discuss, in a frank manner, what was going on for her made it difficult to ask for a referral to transition into an adult program.

Questionable professional competence in eating disorders treatment, also led participants to feel as though they could get away with continued eating disorders behaviours, which would escape the notice of the professional. Piper explained her experience with a professional not trained in eating disorder treatment:

> I was transferred to somebody who wasn't very, like I was transferred to the [city] to another doctor who didn't actually seem to know much about eating disorders, even though she called herself an eating disorder doctor. Like she would forget to weigh me, and I'm not gonna remind her [laughter]. And she would forget to take my blood

pressure, and once again I'm not gonna remind her of that either. So, that was really unfortunate and yah, I mean that's a really big problem if you are someone who has been in and out of hospital a lot. Right? 'Cause there is a good chance you might be transferred back in again and if you are with someone who isn't really competent, I don't like saying it that way, but it is what it is.

Having skilled, educated, and trained eating disorders professionals was seen as highly important to staying connected with programs and transitioning into adult eating disorder services. Participants wanted healthcare professionals who were at ease with talking about eating disorder issues and behaviours, and who were clear about treatment plans and expectations. Participants felt that they did not always have this level of professionalism and it hindered transitioning into adult services.

Category 3b: Professional Support

Participants found that some professionals they had met on their treatment journeys were not kind, supportive, or a good fit to work with. Participants noted it was very important to recovery to connect with the professionals they were working with and to feel supported and cared for; unfortunately many participants found professional support lacking.

Participants wanted to feel engaged with their healthcare providers in meaningful ways to create therapeutic and helpful relationships. Unfortunately, many participants noted that this was not their experience and that the lack of professional support made it difficult to transition into adult mental health programs. Kelly recalled how her adult program doctor was "patronizing" and difficult to work with. Piper noted that, during her transition to adult services she found her case worker to be "super unhelpful", "condescending", "unflexible", and "disrespectful to her psychiatrist". In an effort to better her care, she contacted the program coordinator to switch case managers, but the request was denied even though she knew it was not a good fit for her treatment. Because participants did not feel connected with their eating disorder professionals, they found it difficult to engage in treatment in a helpful and successful way. Shelby remembered her experience of transitioning into the adult program as follows:

The [adult program] was not a great experience for me. First when I saw it wasn't a great rapport, they switched me to somebody else who was actually a doctor not a counsellor. And I'm just not really sure

what his qualifications were for counselling. He'd basically just tell me "oh, stop worrying about it. It's, like, not important." By that time I was starting to get some basic counselling training and I was, like, "hmm, that's not what you're supposed to say."

Participants who experienced working with unsupportive healthcare providers often felt frustrated, stuck, and hopeless about their chances of really being able to engage in services and beat their eating disorders. Rapport and goodness of fit with eating disorder professionals were seen as essential components to positive treatment outcomes.

4.2.4.   Category 4: Communication

Communication was a hindering factor for participants transitioning from adolescent to adult mental health services while battling an eating disorder. Participants described a lack of communication between services during the transition, and also a lack of communication between themselves and their care providers. To provide more clarity and depth, this category has been divided into two subcategories: (a) Program communication, and (b) Service user and provider communication.

Category 4a: Program Communication

Participants spoke of experiencing difficulties in completing the transition process because of a lack of communication between their adolescent programs and the adult programs. This breakdown in communication seems to have led to barriers in transitioning; such as incomplete referrals, unscheduled appointments, incorrect information, and confusion.

Piper was unsure as to what information was given to her new adult team and "[she didn't] know if they had all the information or they just choose not to read it". Melissa shared her understanding of how agencies communicate between adolescent and adult programs about transitioning and treatment plans:

> It was a lot like starting from square one again in regards to having to repeat a lot of things and—even though obviously they would have had all the files and paperwork. But being aware that there are breakdowns in communication and new teams don't fully review files when they receive them. I mean, I'm aware of that, you know,

working in the industry. When you come with eight files, they're not reading every single piece of paper. So you're repeating things a lot.

It was Kristina's experience that her adolescent and adult programs were not aware of treatment and transition plans, and that she had to advocate and organize herself, saying:

> I think the main thing is that there is a huge lack of communication between the two services a lot of the time. So people can be on different pages...at least that was the case for me...The other issue is they weren't communicating with each other so I was the back and forth, which in any situation is stressful, but when you have all of this other stuff going on that's really hard to do as well...a lot of the time they seemed to have different ideas of what should be happening with me, like they just weren't communicating at all and I had to fill in the blanks for each of them...Lack of communication between services that's the big one, cause they don't really prepare you for how different the other service is going to be.

Participants struggled with upholding the line of communication between programs. It was found to be a hindrance when participants were unaware of what information was changing hands and having to figure out if any information was even changing hands at all. What should be an issue of inter-program communication became a stressor for these emerging adults with eating disorders.

Category 4b: Service User and Provider Communication

There were many different instances when participants felt that programs did not communicate well with them, either about the transition process, the expectations of adult programs, or about their own treatment. A lack of communication about the transition process and the adult mental health programs made participants feel in the dark about their future course and treatment. This made the transition a difficult and stressful experience for participants, and one that seemed filled with some unwelcome surprises.

Communication between herself and her service provider broke down for Piper when she found that her service provider had written a report about a supposed suicide attempt – "I have never attempted suicide in my entire life." She was shocked when she learned that this information had been given to adult services during her transition.

Because her service provider did not share the information that she was sending to adult services, her new program had misinformation about her mental health.

Other participants noted that their health care providers were not very forthcoming with information about how treatment would proceed in the adult program, as opposed to how it had been in the adolescent program. Participants felt that the adult programs were not as transparent and clear about the course of treatment and expectations of participation in the program. Some participants noted that communication about the referral process was unclear in terms of what was needed once someone was on the waitlist. Melissa was not made aware of follow up expectations, leading to discharge from a program she wanted to engage in:

> What they didn't tell me was that if you do not have a follow-up appointment for six months, you actually lapsed out of the system. And if that happens, they're not just going to be like, "Oh we saw you before, yeah, we'll take you back." No. Then you have to go on the wait list.

Participants felt as though communication with their service providers did not happen around important events that would affect their treatment. Miscommunications led to surprise, anxiety, and shock, often disrupting the transition process.

4.2.5. Category 5: Managing Treatment

Managing treatment independently as an emerging adult was identified as a hindering aspect of transitioning from adolescent to adult mental health services while battling an eating disorder. There were no subcategories in this category. Participants noted difficulties when transitioning to adult programs as there was a different expectation of responsibility for their own care that, in the adolescent programs, was not the same. Having the adult system place full adult responsibility on participants was difficult to manage as it was often the first time this responsibility was given to participants. Participants observed that, in hindsight, they did not feel like adults cognitively at the time of transition.

Participants noted that, although they had turned nineteen years of age, they did not quite feel like adults. Participants related to people of adolescent age rather than

adults. This made transitioning difficult because treatment ages range from nineteen onwards; therefore the mix of people participants received treatment with became older. Piper stated this as follows:

> My case worker at [adult program], she treated me like I was...like I was nineteen when I was transferred over, so I mean you are just kinda technically considered an adult, but she treated me like I was a full, like forty year old adult. And I'm like – I'm actually currently hospitalized at [the hospital] in the paediatric unit and I'm over here for an appointment and she was treating me like I was a full adult and I'm having to go to these adult programs and I'm like, I'm not a kid anymore, but I'm not really like an adult. I went to some of the adult groups and there are people there talking about their mortgage and their kids and I was by far the youngest person there. Like young adults, eighteen to twenty-four, is such a different subgroup, like it's like a full adult and you're not like a kid anymore and that was something that was really, really frustrating for me because I felt so weird being in the adult groups. Like you are definitely closer to around nineteen, eighteen even twenty, twenty-one, kinda more I related more to all the youth groups that we did rather than the adult groups. I felt like I was in the wrong place.

The change in onus of responsibility was difficult for many participants during the transition to adult services because it was the first time that they had to manage their healthcare independently, without the involvement of their families. Participants noted the change being very abrupt and difficult to handle all at once. There seemed to be a feeling of being left alone completely to fend for oneself, no matter what the outcome. Along these lines participants wished that they had additional support through the time of transition rather than no involvement.

This change in onus of responsibility for managing one's own treatment was also difficult because participants had been in adolescent programs, sometimes for long periods of time, where professionals had instructed them clearly on what to do. If hospitalization was required during adolescence, it was done with or without the adolescent's permission. As emerging adults in an adult system, participants found it difficult to adapt to not having people telling them what to do. This is how Shelby described it: "when I was living at home, it was, "okay, you're going to go to the hospital now because you're too sick". When I'm there, it was, "we think you should go to the hospital but we can't make you".

In an explanation of the difficulty of moving from an adolescent to an adult program and managing one's own treatment, Kelly recalled that in the adolescent programs there is a "framework" that consists of a "broader rubric of your parents dictating and deciding what you do and don't do to some extent". During the sudden transition to the adult program Kelly observed that the adolescent program had not prepared her to "make certain decisions for yourself when you become an adult."

Diana noted that, emotionally, she did not feel that as soon as she turned eighteen, she was an adult. She continued to feel, emotionally, like a child. Managing her own treatment was difficult as she transitioned into the adult program because of the change in onus of responsibility. In her words:

> At [the adult program] there's—they put a lot of responsibility on the patient. Where at [the adolescent program] you're technically a child, so you're treated as a child. And, like, going back to talking about emotional self, accessing [the adult program], I was still very much an emotional child. And they, I felt, were putting all this responsibility on me, and I assume just because—I thought well, like, you're 23,24,25,26,27,28 whatever. You should be able to do this, and then that causes such a conflict in me because I couldn't do it, or something about me that was too reluctant or immature to do what they wanted me to do. And they would go back—and I felt really blamed for not being able to do what they wanted me to do.

Because programs do not individually assess a person's capacity to manage their own care, participants felt like failures in their inability to do so. Being thrown in the deep end of managing one's own care was a significant stressor to participants and hindered the process of transitioning into the adult mental health programs for eating disorders.

4.2.6. Category 6: Loneliness and Lack of Safety

In this category, participants identified how loneliness and lack of safety discouraged and made transitioning difficult from adolescent to adult mental health services. This category had two subcategories: (a) Loneliness, and (b) Lack of safety.

Category 6a: Loneliness

Participants described loneliness as a hindering factor when transitioning from adolescent to adult mental health services. During the time of transition some

participants were moving to different cities, having to make an entirely new support group. Some participants were leaving behind programs and friends that they had been with for years. Other participants found it difficult to connect with new services. In addition, there were many contextual and developmental changes happening at the same time. All these experiences seemed to leave participants feeling isolated or alienated during the time of transition, making it more difficult to continue treatment and to continue battling their eating disorders.

Liv observed that "an eating disorder is not like being an alcoholic and going to AA. I mean, there isn't a lot of just support groups you can walk into." It was difficult, in her experience, to find support and be among others who were going through the same thing. Not having access to resources, such as support groups, during the time of transition made it difficult for her to feel in touch with others. Shelby recalled feeling similarly, in her experience of moving to a new city and trying to access adult services. The isolation of being alone and without friends gave her eating disorder an inroad and "it just spiralled out of control really fast, and [she] was doing really badly." Once she started feeling less lonely, had new friends, and a partner, she felt more in control over her eating disorder.

During the transition into adult services, participants felt lonely as well. Adult services were new and there were not many familiar faces. In the adolescent programs, many participants felt as though they had made friends, some lifelong. Participants did not feel that the same camaraderie existed in the adult programs (at least during the time of transition). Piper described her experience in an adult residential program: "I was having a bad day, like I think I had cried for the entire day for the first two days and I had never felt like that at any program. I felt so, I don't know, like I felt so alone." Loneliness was difficult for many participants to deal with during the time of transitioning from adolescent to adult mental health services because it gave their eating disorders a foothold.

Category 6b: Lack of Safety

Participants described how not feeling safe hindered their transition into adult programs. In some instances, it was due to how particular situations had been addressed in the adult programs. At other times, it seemed to be a feeling of leaving a

secure, familiar environment behind (adolescent programs) and moving towards something different and potentially unsafe.

In terms of unsafe situations, Piper experienced the following during her move into adult services. Unfortunately this unsafe incident was detrimental to her continued treatment in the adult program and she no longer felt safe to continue her transition:

> They sent me home in the worst possible way – they literally dropped me off...without anyone coming...with me. They were worried that I wasn't safe and so they didn't even send me...with my medications, but they let me [go] by myself, as I'm bawling. They gave me ten minutes...I didn't even have time to pack all of my stuff. They said...we could drive up and pick up the rest of my things. I was just not okay. If there was just any time that I had not been okay it was on that...ride home

Other participants noted that the safety of the adolescent program was a stark contrast to adult programs. Transitioning into the adult programs and becoming a part of that system was intimidating. Diana described adolescent services as having "an element of safety where children are still protected. And they create an environment that is that safe. Like, I felt safe at [the adolescent program]." For Diana, the adult program felt very unsafe. The example she used to describe the feeling of being unsafe in the adult program was that "there was no admission where I didn't wet the bed at least once." Melissa seemed to share a very similar experience of transitioning into adult services:

> It was way too intimidating [to transition to adult services] because the client base obviously was considerably older, and I had found treatment in the youth stream to be a lot more – I guess, I don't know, supportive I guess, just in so far as being a teenager and still being quite immature. I felt safe and comfortable at [adolescent program]. I think it was just way too intimidating to go to [adult program]. And so I stopped going. [It was intimidating because of] the age of the client base, the severity of their illness. Obviously people in their forties with chronic, long-term eating disorders, it was scary for a nineteen year old.

Feelings of safety within the adolescent program enabled participants to focus on their recovery and affect change in positive ways, whereas many felt that, at the adult programs, it was too difficult to focus on mental and physical wellness when there was little or no sense of safety at a basic level.

4.2.7.   *Category 7: Counselling*

Changes to counselling and how it was delivered was a hindering factor in transitioning from adolescent to adult mental health services while battling an eating disorder. This category was divided into three subcategories for clarity and understanding: (a) Individual counselling, (b) Group and family counselling, and (c) Adjustment to counselling deliveries.

Category 7a: Individual Counselling

Participants reported finding it difficult transitioning from adolescent to adult mental health services because of differences in individual counselling service delivery. At the adolescent program, many participants experienced being able to access unlimited individual counselling sessions. In contrast, some found adult programs to be lacking in counselling services completely, or to have a limited number of sessions available. In terms of having individual treatment services, Melissa commented "it's not a one-size-fits-all, that's for sure".

Participants were very adamant about the importance of individual counselling continuing through adulthood. Piper found it "mind blowing" that the adult program only provided three counselling sessions maximum. Kristina found the counselling in the adult program that she went to very "inconsistent." It was a difficult adjustment during the transition time for these emerging adults as they felt that they were limited in counselling access. Talking about the transition and working through the process was difficult because there was not enough individual counselling provided by adult services.

During the transition to adult mental health services for eating disorders, participants also found that their individual counselling service had gone from a full sixty minutes of therapeutic time, to a fifteen minute appointment for basic psychiatric medication monitoring. Melissa expanded on this, explaining:

> I didn't get any sort of emotional support from [the adult program] whatsoever. I still needed to pay a private therapist when I needed counselling. There wasn't counselling available through [the adult program] unless you did the [residential adult] program.

Participants also noted the difficulty that they had in changing counsellors. Many participants had connected with their adolescent counsellors and had developed a relationship with that person. Moving into the adult program and having to change counsellors was a struggle because trust needed to be rebuilt with someone new and that they had never met before. Establishing a new relationship took time and was difficult, adding stress to the already stressful transition. Diana noted how:

> In treatment, I felt that I became very vulnerable. And so after opening myself up like that to people, which is not easy for me to do, it was extremely hard for me to face a whole new team and have to relive my whole everything that I had just told this other team.

The transition process from adolescent to adult mental health services was difficult for participants because it involved a change in individual counselling (i.e., putting trust in a new counsellor and building an entirely new relationship).

Category 7b: Group and Family Counselling

In this subcategory, participants reported finding that, while transitioning to adult services, differences in counselling formats were difficult to adapt to. For some, family counselling was seen as important to continue into adult services, while others had more success with less family involvement. In B.C., group counselling is often offered in adult treatment services rather than individual counselling, and participants found this difficult.

Some participants wanted to continue family counselling into adulthood because they thought it would be helpful to their treatment. Piper noted that, at age 18, she still felt very much like an adolescent, not an adult, and wanted the support of her family. Once she transitioned to adult mental health for eating disorders, and no longer had to have her family involved, she found that her eating disorder took over and manipulated her into keeping her parents in the dark. She noted that she got "more sick...without having my family involved because they didn't really know everything that was happening."

Participants did take into consideration the helpfulness of groups, but wanted to emphasize that groups were not enough on their own and that continued individual counselling was paramount to recovery. Kristina had this to say:

[The adolescent and adult programs] are so, so different. Like if you go from the tertiary treatment program like [the adolescent hospital] to the secondary treatment programs like [the adult program], everything is run differently. Everything is so different – you go from fully individually focused to all of a sudden group focused... Like I think the groups can be very helpful especially once you're at this age range but there, when there's no individual focus, and you're so used to just the individual focus, it can be really overwhelming.

A group counselling format was not always seen as helpful by some participants. When in used in conjunction with regular individual counselling, group was seen as a worthwhile therapeutic element. When regular individual counselling was not stressed and group counselling was the only option, participants often felt that they were missing out on an important aspect of treatment. Some participants, after completing adolescent services and transitioning into adult services, just felt "grouped out," as Piper termed it.

Category 7c: Adjustment to Counselling Deliveries

In this subcategory, participants described how it is difficult to transition to adult services due to the adjustment required to different forms of treatment services. In B.C., adolescent and adult programs typically have differing treatment philosophies, and participants reported often feeling unprepared for the change.

Participants described a difference in treatment philosophy in terms of understanding "recovery." In the adolescent programs, it was noted that treatment philosophy generally incorporated full recovery from an eating disorder as a possibility. Participants reported that, in the adult programs, there was more attention to relapse and relapse prevention, indicating what they felt was a philosophy that understands eating disorders as never really going away. Participants felt this philosophy was "hopeless" in its view of one's ability to live eating disorder-free. Diana stated:

In my experience with the adult system, where there was more of a constant discussion of relapse. Like, basically you're admitted and your first group is about relapse. And it's, like, well, what am I doing here? I'm just going to get sick again.

Participants found that transitioning to adult services was also difficult in regards to counselling delivery because there seemed to be an attention to physical symptoms more so than psychological issues. The lack of significance placed on the emotional

needs of the participants was difficult because it did not focus on what that person needed at that particular time. Diana observed that talking about weight and eating disorder behaviours was not helpful to her in the adult program, because she had moved on from those issues. Rehashing things that she had worked through hindered her transition, because she had worked past that saying "that's really hard when you're sort of in that transition period for sure, between acute treatment and carrying on with your life." This also speaks to the need of providing varying levels of care that encompass the entire continuum of an eating disorder. Melissa found the treatment to not focus on mental wellness at all. She described it as "very much like harm reduction sort of— mentality [at the adult program]. Come and get weighed. Let's do your blood pressure. Where are things at? Do this blood work. We'll see you in three months, type thing." Focusing on the physical and behavioural aspects of the eating disorder, while disregarding the mental and emotional aspects, not only seemed to hinder the transition into adult services, but also seemed to hinder the transition into recovery.

One participant also noted changes from adolescent to adult programming, in how eating disorders were understood, and that more attention in adult services could be used to look at underlying issues. She also noted that services and service providers needed to have a more complex, comprehensive, and holistic understanding of eating disorders and eating disorder treatment. Melissa said:

> I continued to have — rely on other coping mechanisms that now I understand are symptoms of my eating disorder but would be more innocuous. Like perfectionism and work—being type A and a workaholic and needing to deal with—make sure everything's perfect for everybody else. All symptoms of an eating disorder that's not what kind of the average person would think of... there's a lot of talk about just recognizing the reasons behind eating disorders and what purpose they function or whatever. But I think at the end of the day, it's still very focused on symptoms... I think there's still a lot to be done in that way. So just even behind theory and—it's—I mean, there's been a lot of work that I've read around just looking at anorexia for sure as a brain based mental illness. And I think that really—I still find that lacking at [adult program], that understanding. I think the clinicians know how much of a role that plays. But I don't think that—still there is this kind of archaic idea that it's a family issue or it came from— always just comes from trauma or whatever. Really still missing the boat or missing communicating, especially with clients and the family we choose to have involved, how much of a perfect storm it takes. It's a brain based mental illness and then any sort of genetics or, like, family issues and trauma and—you know, it's so many things.

While transitioning into adult programs, participants felt there was a lack of understanding of the complexity of eating disorders and an unwillingness to understand the eating disorder within a larger, holistic context that was equal parts physical, behavioural, cognitive, and emotional.

4.2.8.   Category 8: Bridging Services

Bridging services was described by participants as the function of adolescent and adult mental health services in providing support throughout the transition, rather than having one service stop completely and then another service start. This could be having one particular, specific "bridging" professional involved in the interim between services, or a professional from adult services who begins contact early and continues with a person until they are attached with adult services, or a professional from adolescent services continuing treatment until a person is fully involved in the adult program. One participant described the bridging process as two countries with a lake in between. Building a bridge wouldn't start in the lake; it would start a bit back in the one country (the adolescent program), go over the bridge and then land a bit into the other country (the adult program). This category was divided into two subcategories to provide a clear understanding of the difficulties involved in bridging services: (a) Bridging, and (b) Planning.

Category 8a: Bridging

"[The adolescent and adult programs] talk about doing things like an overlap but for me that didn't really happen". That is how Kristina, along with other participants, explained how programs often talked about transitioning or bridging services, but did not follow through with it. Participants reported that often adolescent services were pulling out before adult services were fully in place, leaving participants feeling unsupported during that time.

Participants described not experiencing any bridging between programs. One would end and the other would begin at a later time. Participants found themselves without any support during a crucial period of their lives when many other simultaneous changes were happening (e.g., graduating high school, starting post secondary school,

beginning full-time employment, moving away from the family home, etc.). Kristina remarked upon her experience as:

> It's more like there's just no overlap, like they are pulling out and there's no one picking up. They are pulling away and they are expecting me to cling on to the other place but that other place isn't there yet, I'm still associated with them. That's why the overlap is really important but also making it around a time, like, maybe don't do the transition when so many other transitions are happening, even if it was starting that transition and doing that overlap over a longer period of time, I think that would be good. I don't think they should have one program pulling out without the other program coming in.

Participants described the lack of overlap as a time when they felt at greater risk for reoccurrence or an increase in eating disorder symptoms. Liv noted that because there was no one to help her bridge into adult services, she developed bulimia for the first time during this gap in services. Melissa also noted that even though transition was discussed, the abruptness of it caught her off guard. She did not have any help to bridge between services as her adolescent program closed her file before she began at the adult program, leaving her without support.

Category 8b: Planning

Some participants found that there was no planning for transition at all, which hindered the transition from adolescent services to adult services. Participants found that little time was spent talking about what the process would be like (what next steps to take, how the adult program works, what to do if the program doesn't work out, etc.). Instead, care providers seemed to view transition as a one-time event that did not require any organization or planning. Treating transition as an event rather than a process diminished the importance of the experience for participants. Kelly recalled:

> I think just, like, planning in general. Like, the reality is, it's a big step from going from having a lot of support, assuming you have a lot of support at [the adolescent program] or whatever you're involved in. To having, like, less support and an adult program is inherently less supportive than a children's program. So I feel like the planning is required.

Participants also noted that, in general, they found that adolescent and adult services did not encourage transitioning. When in adolescent services, care providers

were counselling participants to not continue with services. Participants did not know if this was because adult services were not appropriate, were not good, or they were well enough to be without services. Kelly described her experience of planning transition as "[the adolescent program] really discouraged transitioning to [the adult] health services almost. They were all—"you don't want to unless it's absolutely essential." You really want to avoid it." Other participants noted that the adult program was not "conducive to transition at all." These factors all hindered participants from transitioning to adult mental health services for eating disorders, even when the participants themselves felt it may have been helpful.

4.2.9.   *Category 9: Development and Context*

This category describes how participants understood different developmental and contextual factors that hindered the transition into adult mental health services while battling an eating disorder. These factors were also seen to exacerbate eating disorder symptomology. There were two subcategories: (a) Development, and (b) Context.

Category 9a: Development

Developmental factors that occurred around the same time as the process of service transition made transition even more difficult to deal with. These factors included leaving high school, starting university or college, joining the workforce, and moving away from home. These already stressful events, when combined with the stress of changing services, often gave eating disorders an opportunity to take control. Kristina explained:

> I mean, the transition that I had, they started doing all the stuff at the same time that I was graduating from high school. So it's like – not only am I graduating from high school and doing that transition, that was a huge hinder thing factor – was that too many things were happening all at once. Like I'm already so stressed out about leaving high school and oh but also my treatment services are entirely switched over now…It's like all of the confusion, and for anyone with an eating disorder, every single person I've met they have problems with transitions, change, those things are extremely anxiety provoking and extremely stressful…it [stress] heightens it [eating disorder] more than anything. Like it's gonna heighten the effect. So that in itself is stressful but knowing that it's happening at the same time is stressful. But by the time that I was actually starting to transition over my

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mother wanted me back in treatment and at that point [adolescent program] is pulling out and they won't take you back. There are just no options. And because you're not totally associated with [adult program] you can't get into [adult program] or anything like that either...It [eating disorder] so wants to take advantage of this really vulnerable time when like all of a sudden there's not really that much support. It's one of the worst times because there's all of these other things happening so you're already stressed out and the supports disappearing and it's just sort of slowly vanishing to an extent

Other participants, such as Melissa, noted similar incidents of experiencing too much change all at one time, saying, "at that point in my life, I had a relationship and friends and all that stuff you're doing in your late teens, early 20s. And I just was done with treatment." The time of emerging adulthood was not ideal for participants to make multiple changes all at one time; oftentimes, this served to exacerbate their eating disorders.

Category 9b: Context

Participants also felt that there were contextual factors of participating in the programs that hindered their transition into adult services for eating disorders. The nature of the programs seemed to unintentionally lead to, what participants called, a competition to be "the sickest". Liv mentioned, in regards to competitive nature of the program, that "using laxatives, purging, all those things. I had no idea about until I started in that program". Diana shared a similar experience and noted that:

The actual programs can be really competitive I guess and just generally unhealthy. Which is exacerbated by the medicalization of it because you are ranked on the priority list for treatment based on your medical needs. And—yeah, but I can't say I saw anybody with an eating disorder NOS in the [adult program] because [people with anorexia] always needed it. So even very few bulimics...people with bulimia

The context within which participants battled their eating disorders was seen as something that could hinder their recovery progress. Life circumstances and program circumstances played crucial parts in creating a more difficult transition process.

4.3. Categories that Described Recommendations for the Transition from Adolescent to Adult Mental Health Services while Battling Anorexia

The following six main categories were of the "wish list" variety (i.e., items that participants wished to have had during their transition from adolescent to adult mental health services while battling anorexia). The wish list categories are organized by frequency of incidents, with the categories with a higher degree of frequency being described first (again, not as a reflection of their importance but of possible common factors).

The following table summarizes the categories, number of participants who endorsed each category, the participation rate, and the number of hindering incidents in each category.

Table 3.   *Incidents that were Recommended (or "Wish listed") to Create a Smoother Transition from Adolescent to Adult Mental Health Services while Battling Anorexia Nervosa*

Wishlist Categories (N=83 Total CIs)	Number of Participants (N=7)	Participation Rate (%)	Number of Wish List Incidents
Transition Needs	5	71%	30 (36%)
Administrative Needs	5	71%	10 (12%)
Counselling Needs	5	71%	12 (15%)
Service Needs	5	71%	12 (15%)
Healthcare Management Needs	4	57%	8 (9%)
Planning Needs	4	57%	11 (13%)

4.3.1.   *Category 1: Transition Needs*

This category described the transition needs specifically for emerging adults moving from adolescent to adult mental health services, specifically around suggestions

for how to bridge the gap between adolescent and adult services. The category was divided into six subcategories of incidents relating to transition needs: (a) Elements of successful transitions, (b) Emerging adult groups, (c) Emerging adult programs, (d) Bridging professionals, (e) Transition information, and (f) Carry over.

Category 1a: Elements of Successful Transitions

Incidents in this category described what an ideal transition would look like for participants. It included elements of a successful transition, such as creating an individual transition plan, early preparation around transition, communication, planning, organization, bridging, and co-management between service users and service providers. Kristina explained it as:

> It's like if switching services was entirely 1:1, fully focused on all of these different things, like the rules are different, everything is different, completely different elements apply, they bring in all of these different things and then all of a sudden you're responsible when you're in the adult services. It is like polar opposite services. So I think that if someone was there, or even if they had that transition time frame, where it's like "this is how it's going to work during this time frame" but they also explain the process to you as you're going into this transitioning time frame, I think that would be ideal if they had that. Even if it was from seventeen to twenty-four. But before you're being thrown off into nothing. Then you're already starting that transition earlier and then there's like that transition time frame and then you go off into adult after that because then you're more prepared, prepared for the adult program, you know what's going to happen, you understand more what it's about.

Participants reported hoping that having more focus on how to create successful transitions would have an impact for future service users going through this process. For participants, talking about the transition and how it would be a progression was seen as an important element to transition. Advanced planning and organization were also seen to improve the process.

Category 1b: Emerging Adult Groups

Incidents in this subcategory centered around having more available emerging adult resources within existing adult mental health services. Specifically, participants recommended having emerging adult groups available for ages eighteen to twenty-four

inclusively. Participants suggested these groups may feel more comfortable and safe as the age group is more relatable if everyone is in the same range. Piper proposed:

> What would make the transition easier, like a wish list thing, would be to have a specific young adult group or program...like a subprogram, that's not specifically child and youth and that's not just adult. Because it is so different – I can't even explain how different it is when you're in there.

Category 1c: Emerging Adult Programs

Participants suggested having specific emerging adult programs to help with transitioning. This was conceptualized by participants as being a separate program that service users would transition into after their adolescent programs and before the adult programs. The aims of the program would be to help emerging adults to transition into the roles and responsibilities of adulthood. In this program, the process of emerging adulthood would be understood by program administration and service providers. Many participants understood the difficulty of achieving funding for a new program, but still emphasized the importance of developmentally appropriate services. Some participants called this a "young adult program," like Piper. Others called it a "transition program," like Kristina. The concept of a developmentally appropriate service that respects and understands the experience of being an emerging adult is described below by Melissa:

> Nineteen is—it's an adult, but it's very young still. And so having youth services that run up to an older age is probably a bit more appropriate now. Like, it's kind of—where is that middle ground, because when you're 11, 12, 13 with an eating disorder, being with someone who's 24, is maybe not super appropriate either. So I mean, I understand kind of they get stuck with that grey area. But yeah, for sure, I mean, I've always thought that youth services should run until you're a bit older...Developmental appropriateness as well. I mean, since I've been back at treatment through [the adult program], I've been in a program with people that are 19, 20. And at 31, you know, we don't—we're at completely different stages in life. Whereas there's people that are 21, 22, 23 that I was in the program with that are developmentally maybe, like, farther along or in the same space as me. So yeah, just developmentally where are people at too.

One participant acknowledged a residential program that was filling some of these needs in B.C. right now. However, because the program was in its early years, it was not available while she was transitioning services. Diana noted that:

[The residential program] would have been on my wish list and I'm glad it's there because it's that specific age group where there's tons of transition going on. So that's kind of cool that someone at [the adolescent program] who may need extra services can go there and to expect this discharge rather than the ongoing in-the-system scenario at [the adult program].

Participants seemed to feel heard and understood when they found out there are new services being provided in B.C. that hope to address the needs of emerging adults, but they nonetheless recommend that more be done for this specific age group.

Category 1d: Bridging Professionals

Having specific bridging or transition professionals was identified as a recommendation for creating a smoother transition from adolescent to adult mental health services while battling an eating disorder. Kristina recommended that having a specific "go-to person" in the adult program would help with the transition. She recommended specific "transition workers" that would help with making sure that people are settled into the adult program, and would be the person that could answer any questions and concerns. Kristina stressed the importance of the transition time, saying "[the programs] need more in between. I feel like they need someone to be there with people to do that transition because it's so different." Diana had a similar idea – wanting a specific professional to work at transitioning people from one program to another to create a more personalized process:

Imagine if they could have people who worked at both sites who were specific to that transition age...Hopefully it would be more than one because you don't necessarily connect with one person, and if your bridging person sucks or if you can't connect and you don't want to see her anyway, right. I think just having someone familiar, who would be able to more readily smile at you as a familiar face, rather than a newbie or another person in the waiting room. And maybe aware of specifics, like, you got a job last week and today you're coming for your assessment at [adult program] and she's going to ask you about your—how your job is. Just that little bit more personalization I think, rather than being a number. That would be my hope for that person, people, whoever. [They would] also prepare the other team too, because say you're done all your weight restoration and they start asking all about your physical stuff. Well, there's no point in that, so can we just move on to the assessment, right.

Participants felt that having a specific bridging professional would help personalize the process of transitioning between services. This would lead to more positive perceptions of the adult programs and lessen the dropout rates.

Category 1e: Transition Information

Participants recommended having more information about transitioning available to them before, during, and after the transition. Having access to a professional familiar with the transition process to discuss it, in either an individual or group setting, was reported as something that could be helpful, as was having someone available to answer questions, voice concerns to, and plan with. Liv even had the idea that programs should produce transition packages for clients with information on referrals, programs, and how to stay connected.

Participants wished for concise and clear information about how the moving from adolescent to adult mental health would work. They wanted someone to sit down with them and talk them through it. Liv recommended "step by step" planning around how to admit oneself into the adult eating disorders program. Melissa found that the planning was there, but she felt it would have been even more helpful to her transition if she had been able to sit down with both adolescent and adult teams to create mutual understanding of her situation. In that way, all teams would have had all the available information and everyone would be on the same page.

Category 1f: Carry Over

Wish list incidents in this subcategory described ways in which follow-up from adolescent services would have been helpful. Participants suggested that follow-up would have made them feel more supported and more able to solve any arising transition issues. Kristina suggested the following in terms of follow up:

> It would be really helpful, and that would be one of my wishes, if the child program would sort of not pull out until you are about 19, like they are still involved while you're transitioning into the adult program...the programs are helpful, there are always things about the programs that have room to improve but the programs themselves are very helpful when they are sort of...I just feel like there probably needs to be more follow up from the adolescent programs...I think the main thing would be overlapping and just having the younger services carry over...Like at the end of the first month like [following up] "[are

you] okay?" and then calling back the next month and being like "are you still involved cause that would be good". Making sure that things are still on track.

Other participants had similar recommendations, suggested that continued involvement after discharge from adolescent services would be helpful. Liv proposed:

> I, in fact, actually wish that even if you were an adult, say a year from after you were discharged you were really struggling, you could call or contact the people at the adolescent unit and be like, look, can you please help me get in touch? Or tell me how I can start doing that process to transition... this is a horrible analogy, but kind of like when you're just released from jail and you're on parole and you can meet with your parole officer every—not in a punitive way. But in a way that there might be here's the things you can look at for trying to get a job and stuff. Let me help you with these practical tools that will carry you along.

A continued relationship with the adolescent eating disorder team seemed as though it might have made participants feel more comfortable and supported as they moved through various life transitions (not only the program transition, but also developmental and contextual changes as well).

4.3.2. Category 2: Administrative Needs

Wish list incidents in this category were described as changes that could be made to the administrative and organizational structures to make transitioning from adolescent to adult mental health services for eating disorders more accommodating to service users. There were three subcategories: (a) Shorter waitlists, (b) Changes to the referral process, (c) Flexibility.

Category 2a: Shorter Waitlists

Participants cited long wait times to accessing adult services, which hindered their transitions into adult programs. Participants wished for generally shorter waitlists. Kelly recommended "just making sure someone's still supported in a timely way." Participants acknowledged that shorter waitlists would increase engagement in adult programs, decrease the length of time battling eating disorders, decrease the amount of time without support, and decrease dropout rates.

Category 2b: Changes to the Referral Process

The referral process was noted above as a hindering factor in transitioning to adult mental health services. Participants reported that changes in who can refer and to where would be helpful, especially having a more open referral process. Other participants wished that referral criteria could be re-evaluated, as some participants reported finding it difficult to gain access to programs, either because of not being sick enough or being too sick to participate.

Participants suggested that having a more open referral process would help people connect with services in a more appropriate and timely way. Many programs in B.C. have gatekeepers, meaning that access to programs is limited depending on what program a person is attending. Piper suggested that it would be helpful to simply have one program refer straight to another rather than having a middle party. She noted that it would, in her opinion, create a more "seamless" transition process.

Other participants reported finding the referral process difficult due to admission requirements perceived as too weight-based. Participants thought that some programs focused solely on whether a person was sick enough or too sick to participate. Liv proposed that:

> I think it's if you're already able and willing to follow a meal plan and do those things, with the support of a program, then you should be able to participate in the program. Maybe they have to limit certain things around physical activity and stuff, but I mean there's no reason why you can't do the other non-physical activity related things...I think in an ideal world, you should at least be able to go and have the interview or the meeting with them [during the referral process], and they can at least assess it from there. Like usually—whatever that first meeting was. To be able to have the admission meeting at least and not—that way you're not just—like a checklist or something.

Participants noted that, in this category, the referral process can often feel very impersonal as it focuses more on numbers, weight, and other physical aspects, rather than the emotional and cognitive aspects of eating disorders.

Category 2c: Flexibility

Participants recommended that it would be helpful to have a more individualized and flexible transition process overall. Wish list incidents included: not having specific, set, arbitrary age requirements for transition, having transitions happen during stable periods of time (e.g., not when other simultaneous life changes are happening), and being flexible with program rules (such as number of group sessions attended) during the time of transition. Participants stated that programs should have an understanding that transitioning to adult services is a difficult experience and time for emerging adults. Participants noted that transitions need to be different for each individual and needs-led, not service-led. Kristina explained her hope for improvements to the transition process as:

> Even if [the transition to adult services] was an option more than anything, at least to give you the option, because I'm sure for some people it's like "okay I'm done" and let me out. But a lot of people don't transition into adult services, they just drop off...During that transition period when you're transitioning and depending on what's going on, I think policies need to be looked at a bit differently.

Participants remarked that allowing for some flexibility during the time of transition would help create a better relationship with the adult program for emerging adults with eating disorders.

4.3.3.   Category 3: Counselling Needs

In this category, wish list incidents described how certain changes in counselling delivery would optimize the transition experience for emerging adults moving from adolescent to adult mental health services while battling an eating disorder. There were three subcategories: (a) Increased individual counselling, (b) Deepened understanding, and (c) Generalized counselling.

Category 3a: Increased Individual Counselling

Incidents in this wish list category described participants' recommendations for individual counselling services. Many participants felt that counselling was paramount to recovery and that transitioning into adult services was difficult because there was no longer an emphasis on individual counselling work. Participants noted that group

counselling was helpful, but that, as Kristina stated, there needed to be "the chance to have an individual processing point." Participants suggested that increasing the amount of individual counselling sessions in adult services would help with transitioning because it would keep treatment more consistent. Liv conveyed her understanding of the need for individual counselling from this perspective:

> I would say that the one thing that the private health system really gets right is that you're seeing your individual therapist at minimum three times a week. It's so key. I think groups and everything are also really helpful, but I mean, really the individual therapy is really key.

Participants also stressed the importance of not just having individual sessions, but of having more individual sessions available. Participants noted reasons as to why sometimes even counselling several times a week was beneficial to their recovery. Advocating for continuity of care, Liv explained:

> A lot of things happen on an hour by hour, day by day basis, especially when you're in a treatment program and a lot of those emotions are a lot more—as fresh, the closer they are to experiencing them. And it's hard to really convey it. Say you—something happened to you on Monday and you're seeing a therapist a week Monday. I mean, it's really hard to recapture what you were feeling at the time when that happened...You have more time to talk about things and there's more continuity. If you were talking about something for an hour and you didn't finish, well, if you're following up in a day or two then you can pick that up a lot more easily than a week from now. It's like—I feel sometimes when you're seeing a therapist once a week in the program, you're constantly putting out fires of something that's happening. And you're not really moving past that and into—delving into the other sort of more—other more deeper issues. Or if you have a really bad day, you could blow the whole session, and then you're not going to see them again for a week.

Hearing that participants were looking for adult treatment that continued to have individual counselling may be something that programs could be conscientious about when allocating resources and funding.

Category 3b: Deepened Understanding

Incidents in this subcategory reflected participants' wishes to have counselling professionals and programs form a more holistic and complex understanding of eating disorders. In particular, participants wanted to have counselling focus on the

psychological implications of having a long term eating disorder, focus on future planning, sharing "change" philosophies (rather than imposing the counsellor's own views), relapse prevention that includes more than just eating disorder symptoms, and counselling that is tailored to each individual.

All participants reported ideas for how counselling could have been more helpful to their recovery, and had several recommendations about how counsellors can improve. Kelly suggested that taking time in counselling to reflect on the future – what are the "psychological implications of what you're doing when you're young" and really "mapping out in [the] mind, okay, so if I'm not going to have that problem when I'm older, what am I going to have to do to get better?"

Other participants felt that counselling needed to go deeper, really searching for mental wellness and figuring out what that is for each person, even though that is a complicated task. Diana described her need to go deeper into her understanding of her eating disorder as a way to combat it:

> Here it's tricky for me to even—these are all really good things, but I look back at it now as, yeah, people assessing the rationalism and the logic and not seeing the part of me that hadn't healed – that could have used something else. And I don't know what it is. I can't know. But I don't know, yeah. So it's hard to put that as kind of a—what hindered it because in many ways I was successful after that transition. The only thing that proved that something that didn't work out, was that I relapsed.

Some of the concepts of relapse and relapse prevention in counselling were difficult for some participants as well. These participants wished that there was a more holistic understanding of symptoms that placed equal emphasis on physical and mental aspects of the disorder. Future planning and healthy living were also seen as key components that could be discussed in counselling. Melissa explained this recommendation as follows:

> I wonder too how much thought goes into relapse prevention that doesn't include only looking at symptoms. So include more than that. Like, include building a life outside eating disorder...It's, like, what is the signs of relapse? And then also, what are the signs of recovery? And maybe part of relapse prevention should be, you know, building a life...Yeah, not just oh, "well, you're throwing up, so now you need to reach out for support". But more like, "okay, aside from that stuff—or

even in spite of it, if you're still doing it, like, what do you—what else is going on for you other than treatment?"...How important it is to have treatment that fits each individual because of that. And I mean; I know that's difficult in our system. But it's so important, right, to start looking at that stuff more.

Participants agreed that an eating disorder was not just about food or weight. Participants noted, over and over again, that this was a complex disorder that had many different facets, all of which were different for different people. Looking at the disorder from a holistic perspective and really diving deep in understanding were participant-identified recommendations to improve counselling delivery.

Category 3c: Generalized Counselling

In this subcategory, wish list incidents were described as making counselling treatment not just eating disorders focused, and instead providing a broader based treatment. There was a wish for varying treatments for varying issues. Participants wished for treatment for issues such as anxiety or depression that they might also be struggling with. Or as one participant described it: addressing the problems underlying the eating disorder. Participants wished for other treatments that had a focus on coping, problem solving, and living skills (such as Dialectical Behavior Therapy, DBT). Kelly stated this wish as follows:

> If I had an opportunity to go back in time, it would be to get more support but maybe of a more generalized nature, you know what I mean. Like, I have another example for that. I took a DBT program as an adult. It was a generalized DBT program for people with anxiety and depression and eating disorders and borderline personality disorder and all these different things were in this group. And it was really helpful just about, how do you manage your life better? And cope better, but it wasn't about talking about your problems necessarily.

Providing participants with counselling not limited to eating disorder symptoms may allow for them to have the opportunity to discuss other issues in their world and potentially look at some of the underlying issues that are maintaining the disorder.

4.3.4.   *Category 4: Service Needs*

Wish list incidents included participant's descriptions of an ideal service transition that included more available service resources with varying levels of care. This category had five subcategories: (a) Levels of support, (b) Comprehensive services, (c) Other resources, (d) Integration of services, and (e) Developmentally appropriate services.

Category 4a: Levels of Support

Incidents in this subcategory described participant's wishes that more levels of care were available during the time of their transitions. Participants found that many adult programs could only be accessed if a person was sick enough, and treatment was more intensive because of the severity of illness admitted. Participants wished that more care levels, like intermediate care programs, had been available. Participants spoke to the importance of treatment at all levels, for fear that the non-physically compromised group of service users may be forgotten. Kelly remembered that "looking back, what would have been really helpful was kind of like a more intermediate level of support. Where it's not so intensive, but it's not nothing either."

Participants also noted, in regards to varying levels of support, that there was a lack of service opportunities available to them in the community sector. Participants wished that there had been more of an "in-between." Melissa recalled that her "opportunities [at the time of transition] were to see the doctor...and to go into [the adult program]—which is a very intensive program. So I kind of needed something in between." This in-between service that participants were describing follows the Eating Disorder Association of Canada Clinical Practice Guidelines (EDAC, 2014) recommendations for increasing the varying levels of care provided by programs to effectively match people with the program most suited to their needs (see literature review).

Category 4b: Comprehensive Services

Participants described a difficult transition because they were moving from having many available services through their adolescent programs, to fewer services available through their adult programs. Wish list incidents included having more

comprehensive services available in adult programs to facilitate a smoother transition and to provide more extensive treatment options.

Participants suggested that it may be worthwhile for services to include other healthcare disciplines, or to make referrals to other healthcare disciplines. One participant suggested occupational therapy as something that could have been helpful to her recovery in conjunction with existing services. As Shelby remarked, "not every adult's going to want or need [a comprehensive service] structure. But maybe just having all that available." Liv suggested having more groups available that were based on peer support and connecting with others in positive ways. It was suggested that these groups could also provide meal support. Participants suggested that more comprehensive services could provide more avenues of self-exploration, which could be important to gaining an understanding and mastery over one's eating disorder. Having robust services may also be an opportunity for participants to take part in activities they enjoy. Diana shared how allowing for a holistic approach is "building on hope. I know that there are things you look forward to doing and [other disciplines] can help with those things like building support systems and finding resources and stuff like that, differently than, say social work or nursing or psychiatry, and medicine." Participants reported that looking at treatment from a more holistic perspective opened up more possibilities for recovery.

Category 4c: Other Resources

Participants described that working with professionals who had knowledge of the broader services available for eating disorders would have been helpful to their transition from adolescent to adult mental health services. Some participants received services out of city, out of province, or out of country. Having professional support that understood other services (how to access them and how they may be a good fit) was seen as something useful. Participants thought it might be helpful to try other services to "think outside the box". Diana described her experience with referrals outside the regular realm of service:

> The openness of practitioners to more readily refer outside of their services, because I found a lot of resistance with that. Like, I was referred through my GP to the program in [the city] for eating disorders. But they—[the adult program] really wants you to use their

programs. And had I stayed in their program, I probably wouldn't be here right now.

Participants did note that referring outside of community resources was "tricky." It was helpful to have service providers think outside the box and be open minded about treatment options. For example, it would not be helpful to refer a participant to another eating disorder hospital if they had just completed an eating disorder hospital program; practitioners in this circumstance would hopefully refer to an altogether different type of service. The "tricky" part was not referring to too many services in too many places, as participants often felt that recovery was hopeless if they had been to so many places and had not seen any positive change. Accessing too many services left participants, like Diana, thinking "nothing can help me now because I've been everywhere." So a fine balance was thought to be important when making referrals, but participants overall wanted to have a greater knowledge of the availability of services that were outside the obvious scope.

Category 4d: Integration of Services

Participants recommended having adolescent and adult programs existing in the same space, which they perceived would be helpful to transitioning (i.e., this would ease the transition to adult services because it would remain in the same familiar space). The programs would still be split into adolescent and adult, but there would be more continuity of care as everything would reside in the same place, creating a safe and familiar environment. Shelby said that this integration would be like "people from the same organization that were just passing you off to the adult side of things. Rather than two separate organizations that don't know each other and work in different ways and have different policies and all that."

Category 4e: Developmentally Appropriate Services

Lastly, in terms of wish list critical incidents involving service needs, participants suggested that services take into consideration developmental appropriateness during the transition from adolescent to adult mental health services. This speaks to the ideal of needs-led and not service-led transitions also. Participants wanted programs to individually assess readiness to transition. If people were developmentally ready to transition to an adult program, then they would do so. If they were not ready, they would

not be forced to move. Kelly advocated that transition should "depend on your maturity level. I think that some eighteen year olds...it wouldn't be a good thing for them to go into an adult program. They're not mature enough really, but I know some who are." Participants reported believing that being ready to move to adult services in a developmentally appropriate way was not only helpful to transition, but helpful to engaging in treatment and recovery.

4.3.5. *Category 5: Healthcare Management Needs*

This category described wish list incidents of healthcare management and communication that participants thought would have helped their transition from adolescent to adult mental health services while battling an eating disorder. These needs are not necessarily something that healthcare providers could simply have provided to participants, but instead things that could have been discussed in adolescent services as important life skills. There were four subcategories: (a) Self advocacy, (b) Outside support, and (c) Communication and interpersonal skills

Category 5a: Self Advocacy

Incidents in this subcategory described participants' recommendations and their promotion of self advocacy in managing one's own healthcare, especially during the transition from adolescent to adult mental health. Participants described the difference between being in the adolescent programs (where professionals may tell someone what to do) to going into the adult programs (where service users will need to tell providers what they want to do) as a very big and difficult change. Advocating for oneself was seen as important to receiving appropriate care.

Participants noted that the change in responsibility was abrupt, so one needs to prepare to take charge of one's own treatment. Participants suggested that before leaving adolescent care, people should begin practicing how to advocate for themselves. Liv recalled that she found the transition and changing of healthcare management to be a "really big gap too, between people telling you what to do when you're a youth, versus you deciding what you want to do to manage your own health as an adult. You have to be really proactive in our healthcare system in general." Participants hoped that service providers would arm future service users with more knowledge about the differences in

healthcare management and self-advocacy, leading to a better ability to adapt to these changes.

Category 5b: Outside Support

Having family and friends involved in your healthcare was a suggestion made by participants to improve the transition process. Kristina noted it was helpful in terms of general treatment, but also to have support during appointments if necessary. Having the support of others was recommended to future service users going through the transition from adolescent to adult mental health services because it was helpful in terms of keeping appointments, listening to information during appointments, being held accountable, and for encouragement in attaining treatment goals.

Category 5c: Communication and Interpersonal Skills

Participants recommended that future service users use their communication and interpersonal skills to advocate for communication between service users and providers, as well as between agencies. This was another recommendation requiring knowledge and practice that could be a part of an adolescent program's goals.

In terms of creating transparency between service users and service providers, especially in regards to the files that are being transferred from adolescent to adult mental health services, participants recommended establishing open communication. Participants proposed that service providers let service users review the information that is sent to adult services during the transition process to make sure that it is representative of their experiences. Piper stated she had wished that her service provider had done so before sending misinformation to the adult program that she had attempted suicide in the past. Her reasoning was as follows:

> When you are transferring to an adult setting I think you should have the right to know what they're saying because I mean, what other differences are there? You should be able to see. You are technically an adult now and they are treating you like an adult so they might as well.

Participants also described in this category their beliefs that service users sometimes will need to advocate for communication between programs to ensure quality care and continuity of care in treatment. They urged future service users, who are

beginning to transition, to ask questions, advocate for communication, check in that all services are working together and have the same plans, and learn more about available resources. Kristina advocated for communication as follows:

> That's the main thing – ask the questions and make sure that everyone is on the same page. They won't actually be on the same page [laughter] but get it as close as possible. Make sure the communication is happening. As much as it would be great if they could do some of it between the services, you're probably going to have to do a lot more of it yourself...it's getting done and you also have a bit more of a say in what's happening and you can correct them if things are not happening that should be happening.

Participants thought that taking control of communication was helpful in making sure that there was clarity for both adolescent and adult programs, but also because it allowed service users to have a say in how their healthcare would proceed. Participants felt that, having choice in these circumstances and being open to communicating with their services, was a move toward gaining a greater degree of autonomy.

4.3.6.   Category 6: Planning Needs

This category contained incidents describing participants' wishes for a planned, ideal transition from adolescent to adult mental health services while battling an eating disorder. This category had two subcategories: (a) Planning and preparation, and (b) Prepping expectations.

Category 6a: Planning and Preparation

Participants wished that, during their time of transition, several different planning steps had been executed by their mental health service providers. These steps included things such as, planning in advance. This involved letting service users know up to a year in advance about the transition and beginning early stages of planning, even if it was not ultimately needed. Participants also wanted planning to happen often, as part of a process rather than a one-time conversation. Piper explained how she wished planning for transition had been different and what she would recommend to future service users:

My paediatrician would bring up transitioning and I didn't want to talk about it. I always kind of delayed the conversation, and I sort of wish that I had done it earlier so that I had been more prepared. I think it wouldn't have been so sudden. So I would say just have things prepared a bit earlier so that it's not such a [shock to the system]...And have a backup plan. While I was seeing my paediatrician I did have an appointment. Like seeing that doctor while I was still seeing my paediatrician, like see her for a couple of appointments to make sure it's working, which it wasn't, then make sure we have a backup plan...[and] test out your new doctor.

Participants stated they wished they had been more involved in the transition planning, even if they had been reluctant to do so in the beginning. Participants also recommended that, to have a smooth transition, one may need a backup plan in the instance that the new services are not a good fit. Some participants experienced this challenge and were left with nowhere to go and with no other plans, so they strongly suggested at least knowing what other treatment options were available. Also, having both adolescent and adult services involved in planning for the transition was seen as key to a successful transition for Shelby:

I think definitely communication between the youth services providers and the adult service providers. I guess it can be pretty tricky when they're in different places, but technology, email, phones. More preparation I think, even if the person is in a good place, because then it's—it was kind of—when I left, it was, "okay, we think you're going to be all right. So we're closing"— we had—I had some plans. I knew that that program existed. I didn't know it was going to take so long to get in. I think just having really solid plans for—then when things do go wrong, it's really important.

Lastly, having transition information was noted as a wish list incident. Participants reported often perceiving that they were discharged from the adolescent treatment services without knowing what steps they would need to take to seek out adult services. Having the information in advance and knowing what steps would need to be taken was important to be able to readily engage in treatment in a timely fashion. Having a plan that was individually tailored and not generic was also something participants recommended. Kelly stated:

It would have been really good to kind of have, I don't know, just a plan of what I was going to do...So maybe some people that is, the seamless transition to [the adult program]. Like, maybe for some people it's a seamless transition into community and then to adult

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mental health services. So it's individually tailored to what you need at the time. But I think it needs to happen in advance. You need to start thinking, okay, you've turned eighteen. Or you're seventeen, when you're in grade twelve would be a good time probably. Beginning in grade twelve. Say, okay, you basically have a school year to plan what your continuity of care is going to look like. We need to start planning it. And I think that having a safety net is important.

Adult services were described as a "black hole;" participants highly recommended that service users understand everything about how to gain access to those services before they begin making the transition so that they have all the information readily available and can plan in advance and adjust their plans if necessary.

Category 6b: Prepping Expectations

Wish list incidents concerned having adolescent mental health eating disorders services prepare them for the expectations of the adult mental health eating disorders services. Participants wished that their adolescent service providers had spoken with them more about the adult program, what the programs offered, what other services were available, how rules or treatment changes in adult services, and to talk about those differences. Participants noted that having conversations about those expectations would have been helpful and would have made the transition to adult mental health services easier. Shelby reported having hopes that teams could speak with their clients, who are about to transition, about how the adult program would be: "talking about it candidly with the team that you already have in place to—you know, this is how they work there, and this is what you're going to have to do." Having a working knowledge of the expectations of the adult program could dampen the surprise and shock that participants felt when they made the transition. Kelly described her experience as follows and her wish that adolescent programs better prepare service users who are transitioning for the change:

I think just planning in general. The reality is it's a big step from going from having a lot of support, assuming you have a lot of support at [the adolescent program] or whatever you're involved in. To having less support and an adult program is inherently less supportive than a children's program. So I feel like the planning is required...I guess I also felt that it would have been nice to have more focus on planning with me to help me with how it would look like too during that time. Because it is a really big transition in general for anyone, to go from

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being—having a curfew and having all these rules to govern your life and then all of a sudden you make all your own decisions.

For participants, the changes in expectations from the adolescent to the adult program were significant. Planning in advance and knowing about the change that is about to take place would help ensure the best possible transition process.

4.4. Summary

From seven interviews, 285 critical incidents were identified and extracted. Eighty-one incidents were found to be helpful, 121 were found to hinder, and 83 were wish list items that participants would have liked to have seen happen in their transition from adolescent to adult eating disorder treatment services. Incidents were placed in categories using inductive reasoning. Credibility checks were completed to ensure trustworthiness.

The results appear to be congruent with the literature on transitioning services and emerging adulthood. Some specific findings for eating disorders were identified in this study. The discussion chapter will focus on elaborating these findings, cross-validating the research, and synthesizing what has been learned from this study.

5.   Discussion

CIT was used to explore what helped and hindered the process of transitioning from adolescent to adult mental health services while battling an eating disorder. Participants also had the opportunity to present recommendations for the future, in terms of what would facilitate smoother transitions. Interviews were conducted in a semi-structured format, allowing participants to expand on their experiences, in their own words.

In this chapter, the results will be examined comparatively with existing research. This is also a measure of "cross-validation", or a "theoretical agreement" credibility check. In the first part of the cross-validation process, the researcher explores the underlying assumptions of the study. The second part of the cross-validation process looks at how the categories compare with current research literature. This chapter will also review new findings, practical implications of the research, limitations, benefits, and implications for future research.

5.1. Literature Cross Validation

An analysis of the existing literature can determine if the CIT was successful in exploring all aspects of the research question, creating a higher degree of validity (Andersson & Nilsson, 1964). Many of the emergent themes and categories from this research are congruent with current literature on emerging adulthood and mental health service transition. The literature cross validation will address three themes to provide clarity and cohesiveness. These themes have emerged from the twenty-three categories: (a) Transition processes and identity formation, (b) Transition processes and relationship construction, and (c) Transition processes in navigating a complex mental health system. The following table details which categories were sorted into each theme for helpful, hindering, and wish list items.

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Table 4. ***Helpful, Hindering, and Wish List Categories Sorted into Themes***

Theme	Categories Helpful = Blue Hindering = Green Wish List = Purple	Meaning
Transition Processes and Identity Formation	Transition Motivation	Participants no longer wanted to have an identity as someone with an eating disorder so they were motivated to achieve a faster recovery before the service transition disrupted their treatment.
	Counselling/Counselling Needs	Individual counselling was helpful when they worked on their own goals and aspirations in a safe and trusting place where changes in behavioural, emotional, and cognitive aspects of the eating disorder increased their emotional awareness and ability to self-reflect.
		Adult services lacked individually focused counselling and had different treatment philosophies (physical aspects of eating disorders versus emotional issues).
		Participants wished for more individual counselling sessions as they transitioned into adult programs. Counselling would also include a more robust treatment to eating disorders that did not only focus on weight.
	Managing Treatment	Outside of their families in adolescence, transition processes were helpful with a greater level of autonomy, choice, and responsibility in deciding on their own about their healthcare treatment.
		In adult programs, the total absence of their families in their healthcare management made it difficult for them to adapt.
	Loneliness and Lack of Safety	Participants felt isolated and lonely in transition processes to adult programs because they did not fit in with older adults and felt less safe.
	Development and Context	Many simultaneous life changes were viewed as stressors for participants, creating a negative transition experience.
	Transition Needs	Participants wished for programs and groups aimed towards emerging adults and their specific treatment needs in a developmentally appropriate way. Bridging and carry over from adolescent programs was also suggested.
Transition Processes and Relationship Construction	Central or Familiar Professional	Continuing a relationship with a central or familiar professional from adolescence, whom participants trusted, helped during the transition to adult services.
	Support	Proactive friends, families, and partners, were helpful to the transition process because of the support they gave participants.
	Perspective Taking	Receiving treatment in adult services with a mixed group of people (not only eating disorders) was seen as helpful to transitioning because it opened participants up to new perspectives.
	Competency	Some service providers were viewed as not competent in working with eating disorders, and not supportive of participants; making engaging with them for treatment difficult during transition.
	Communication	Participants experienced both a lack of communication between adolescent and adult programs during the transition process, as well as a lack of communication between themselves and their service providers.
	Healthcare Management Needs	Participants encouraged self-advocacy, facilitating communication between programs, growing one's support network and involving loved ones in one's healthcare.
Transition Processes in Navigating a Complex Mental Health System	Triaging	When participants were physically compromised, triaging was helpful because they were able to access services quickly.
	Smooth Transitions	Transitions were smooth for participants who collaboratively planned, in advance, the transition with their healthcare professional. Adult programs were helpful once settled into.
	Administration/ Administrative Needs	Waitlists, the referral process, program requirements, funding, and the gap between adolescent and adult services all hindered the transition process.
		Participants recommended that work be done by program administrations to decrease waitlist times, make changes to the referral process that take into account more than just physical aspects of an eating disorder, and for programs to be more flexible in terms of policies and procedures during the transition process.
	Service Availability/Service Needs	Participants found adult services less comprehensive, without varying levels of care, and difficult to access.
		Participants recommended that services need to become developmentally appropriate, comprehensive in adulthood, and have varying levels of support to meet the needs of all people with eating disorders.
	Bridging Services	Participants experienced no overlap between the adolescent and adult programs during the transition process; leaving them feeling unsupported as they waited to engage in adult services.
	Planning Needs	Participants wished that there was more planning and preparation for the transition process while they were still accessing adolescent services.

5.1.1.   Transition Processes and Identity Formation

The questioning and development of one's identity as an emerging adult was a common theme across several categories. The categories included in this theme were: transition motivation, counselling, and managing treatment (of the helpful categories), managing treatment, loneliness and lack of safety, counselling, and development and context (of the hindering categories), transition needs, and counselling needs (of the wish list categories). These categories have been grouped together because of the connections that they all share with development, growth, and identity formation. For emerging adult participants in this study, the process of identity formation seems important because it was co-occurring with the process of transitioning services.

Beginning in adolescence, people begin to question, "Who am I?", "What do I want in life?", "What am I going to be?" and many other life-defining questions (Archer, 1982). Archer (1982) believed these questions begin in adolescence, as adolescents develop the ability to think in abstracts and consider possibilities for their future selves. Emerging adulthood theory ascertains that there is a developmental period distinctly different from adolescence and adulthood; this variable period is characterized by autonomy, but not yet having adult commitments (Arnett, 2000, 2007). It is theorized that, in Western contexts, the search for identity continues during emerging adulthood (a prolonged period of time; longer than early developmental theorists ascertained) (Schwartz, Côté, & Arnett, 2005). The search for identity is seen to subside when socially defined, adult commitments are in place; for many people, this occurs in the late twenties. These commitments include career employment, permanent partnership, and parenthood (not necessarily in that order) (Luyckx, Schwartz, Goossens, & Pollock, 2008). This process of identity formation happens simultaneously with the process of transition from adolescent to adult mental health services for eating disorders.

For the purposes of this study, identity will be described using a narrative identity lens. Narrative identity is a qualitative definition, and it is focused on a person's life story (McAdams, 2011). A narrative identity focuses on the events and experiences that people use to explain how they came to be as they are (McAdams, 2011). These interpretations connect to one's current understanding of self (Habermas & Bluck, 2000). Narratives have been shown to predict health and psychosocial outcomes: promoting

healthy life choices and deterring risky decision making (Bauer & McAdams, 2004a, 2004b). For example, those who use narrative identity styles that frame experiences in terms of self-direction, personal growth, and overcoming obstacles tend towards higher levels of psychological well-being.

For the emerging adult, through a narrative identity perspective, transitioning into adulthood is a developmental task. In mental health care, transitioning into adult services is also a part of treatment for many emerging adults with an eating disorder. Participants in this study noted that transitioning, in and of itself, was a motivation to recover from their eating disorder. Participants no longer wished their narrative identity to be that of someone with an eating disorder. Looking into the future and seeing other people who continue to battle an eating disorder in adult services discouraged participants from wanting to identify with their eating disorder into adulthood. Participants noted that imagining themselves with a "chronic" eating disorder in adulthood motivated their current recovery. Editing out the eating disorder from life narratives became an important part of the transition process. This coincides with eating disorder and identity literature. For some people, the eating disorder can become incorporated into their sense of identity, making it difficult to change (Bulik & Kendler, 2000). Wade, Frayne, Edwards, Robertson, and Gilchrist (2009), have noted that motivation is an important predictor of change for those with anorexia, and that different treatment options, such as motivational interviewing can be used to increase motivation in this population. But in a review of the literature of motivational themes in recovery, a fear of chronicity was not found. However, Nordbo et al. (2008) has suggested that motivations to change are autonomous and different for each person, and that to increase the therapeutic alliance, counsellors need to understand the subjective content that drives people's wishes to recover. The findings here suggest that fear of chronicity and a continued eating disorder identity are two of those motivating factors for change, and that helped with their transition process.

Counselling was also connected with identity and was represented in the helpful, hinder, and wish list categories. Working on personal goals and aspirations in a safe and trusting environment led to an increase in emotional awareness and self-reflection for participants. As the search for identity often continues into adulthood, counselling is a chance to continue identity formation and create a meaningful life story (Schwartz, Côté,

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& Arnett, 2005). Not having individual counselling service in adulthood made it difficult for participants because they did not think they had the opportunity to explore themselves in the same way that they had in adolescence. Participants noted that adult services lacked the emotional and psychological support that participants were looking for, instead focusing on the physical aspects. Similar to what the present participants reported, Bezance and Holliday (2013) cited five studies reporting on the distinction between psychological and physical symptoms of anorexia. This difference led participants to experience a loss of identity when there was a focus on physical recovery rather than psychological recovery.

Managing treatment in the process of transition is thematically connected with identity formation. During the transition from adolescent to adult services, emerging adults are expected to begin managing their own treatment (e.g., booking appointments, deciding treatment plans). For some participants, this increase in autonomy had already occurred in adolescence as a result of their growing independence. For other participants, this shift was difficult to suddenly adapt to and the absence of family involvement in treatment made them more vulnerable to their eating disorders. This demonstrates the heterogeneity of emerging adulthood, and how accepting responsibilities of oneself and making independent decisions, are developed at different times for different people (Arnett, 2000). This variability is even found in people during their twenties. Growing and creating an autonomous identity for oneself is part of the emerging adult process as well as part of the transition process from adolescent to adult mental health services. Identity development continues in emerging adulthood, and as the story changes, autonomy changes as well.

Participants reported differences in how their autonomous identities shaped their treatment management and the transition process from adolescent to adult mental health services for eating disorders. Participants also mentioned that a hindering part of transitioning to adult services was that they did not yet feel like an adult; thus, there was a sense of loneliness and a lack of safety. Arnett (2000), in his theory of emerging adulthood, described this sense of self as subjectively no longer an adolescent, but not yet an adult. In adult programs, older adults are more likely to have formed identities and created life narratives. For emerging adults in adult programs, they are still exploring identity in the areas of love, work, and worldviews (Arnett, 2000). There is not a sense of

commonality between emerging adults and adults, leading emerging adults to feel as though they do not fit in. In an evaluation of an emerging adult program in Connecticut, Styron et al. (2006) noted that, in particular for emerging adults, strength- and community-focused components of their program were associated with less loneliness for participants. These findings, along with the results of the present study, suggest that creating strengths and a sense of community helps people to story an identity of togetherness with others. In a study by Goosby, Bellatorre, Walsemann, and Cheadle (2013), researchers noted how loneliness in adolescence can lead to poorer health outcome during adulthood, describing a correlation between adolescent loneliness and diagnosed depression, poorer adult self-rated health, and risk of cardiovascular disease. Furthermore, lonely adolescent girls were more vulnerable to these effects. Not only is the formation of singular identity important, but forming that identity as connected to others is very important to all health outcomes.

In the present study, development and context were seen as important to transition processes, as well as to identity formation, when participants experienced simultaneous life changes. Participants felt overwhelmed and anxious by so many co-occurring changes. Changes in school, work, love, and worldviews are part of the identity formation process – a normative process of change that young people succeed in achieving. The identity formation process became problematic for participants in this study when service transition was also thrown into the mix, as a key support was ending. The process of transitioning in mental health care is a disruption that adversely affects the health, well-being, and potential of emerging adults (Singh et al., 2010). Development and context influence identity formation, and with so many life changes, it adds a dimension of difficulty to the process by creating an existential anxiety. Existential anxiety is anxiety about creating a meaningful life and a heightened fear about what to do with one's life in a larger sense. Weems, Costa, Dehon, and Berman (2004) reported that it is common for emerging adults to experience existential anxiety concerns that are related to psychological distress and identity problems. Similarly, Berman, Weems, and Stickle (2006) found that emerging adults in the active stage of identity exploration reported the highest levels of existential anxiety.

In terms of identity processes, participants in this study wanted to be identified as emerging adults – not adolescents, yet not adults. Their transition needs included

specific "emerging adult" groups or programs that focused on specific emerging adult needs, such as identity formation, growth, and development. Participants were aware of their motivations to avoid transitioning to adult services, how counselling could help with their self-exploration, and how managing treatment was changing as they continued to emerge as adults. Identity development and transitioning into adulthood were hindered not only by the change in services and service providers, but by loneliness and other development and contextual factors associated with these changes.

5.1.2.   *Transition Processes and Relationship Construction*

Relationship construction and the transition process were common themes across several categories. The categories included in this theme were: helpful – having a central or familiar professional, support, and perspective taking; hindering – competency and communication; and wish list – healthcare management needs. These categories were grouped together because of the connections they share with relationship construction and transition processes. This theme is connected to identity processes as well because creating the "I" also has to do with connection to others.

Participants viewed the relationships they built with others as extremely important to the transition process. They noted that having a central or familiar person who continued to work with them, sometimes despite the fact that they had aged out of adolescent care, was very helpful in their continued battle against their eating disorders and continued engagement in treatment. Feeling deeply known by the professionals who supported them, meant that participants felt comfort and care, even during the transition process. Luborsky (1976) describes this type of alliance as characteristic of the later phases of treatment where therapy is a collaborative struggle of people's obstacles. Horvath & Symonds (1991) extrapolated that these quality alliances have been empirically associated with better outcomes in psychotherapy. The quality of relationships formed between people facing difficulties and their professionals is a strong determinant of continued engagement in treatment. Further to that, constructing strong therapeutic relationships facilitates engagement, lessens dropout and resistance to treatment by creating a supportive, stable, and accepting counselling environment (de Hann, Boon, de Jong, Geluk, & Vermeiren, 2014).

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In contrast to the helpful professionals mentioned, participants also encountered professionals who were identified by them as incompetent and unsupportive. Professionals whom participants viewed as incompetent in their knowledge about eating disorders had an adverse effect, with participants lessening their engagement in treatment and having a more difficult time with the transition process. These professionals did not build relationships that were helpful. Instead, participants viewed these professionals as working outside their competencies. Williams and Haverkamp (2010) explicitly stressed the importance of competence when working with vulnerable individuals, such as those with eating disorders. Their key concern was the complex psychological nature of eating disorders, physiological complications, and high mortality rates of anorexia. The authors further suggest that "it is reasonable to imagine that incompetent [treatment] could be life threatening in some cases (p.93)." Through their research, the authors generated a list of core competencies. Among these was the ability of professionals to establish a therapeutic relationship of trust and safety. Their participants (professionals who were experts in eating disorders treatment) saw this relationship skill as the most critical for even minimal ethical practice.

Participants in this study deemed relationship construction with professionals as important, but the relationship that participants created with significant others was also influential to transition processes. Participants noted that their proactive families, friends, and partners helped support them to manage the difficult transition to adult services. In this study, relationships participants constructed with their significant others helped with their continued treatment and with storying a meaning of life that did not revolve around having an eating disorder. Research by Dindinger (2013) explored youth perceptions of social support, and his findings suggested that, for his participants, an increase in perceived social support correlated to an overall decrease in symptomology. This research on perceived social support lends credibility to the present findings that family, friends, and partners play a crucial support role for participants during the time of transition from adolescent to adult mental health services for eating disorders.

Of interest was the role that perspective-taking played in helping the participants transition from adolescent to adult mental health services. Family, friends, and partners were seen as supportive, but so were other people without eating disorders whom participants met while receiving treatment. Some participants had the experience of

being on a mixed ward for treatment (a hospital ward for all pediatric or adult mental health patients). In the mixed ward, participants connected with many different emerging adults all undergoing some sort of struggle. Building relationships with other people and learning from them was helpful to the transition process because it helped participants to see their problems through a different perspective. Often participants noted that many of the underlying issues were the same, even for those without eating disorders. Creating relationships based on shared struggles and similar issues was important to participants because it brought focus to the core emotional problems and not only the physical aspects of the eating disorder. Research on mixed population wards and perspective-taking appears to be scant, but this issue can perhaps be framed through empathy and self-compassion. Sharing a treatment experience with people who do not have eating disorders seems to have opened participants up to a better understanding of themselves through their relationship with another. Self-compassion is explained by Neff (2003a, 2003b, 2004, as cited in Ferreira, Pinto-Gouveia, & Duarte, 2013, p. 207) as the ability to clearly understand one's thoughts and emotions with kindness and a "sense of shared humanity." Neff also found that feelings of self-compassion promoted change and proactive actions, and importantly, enhanced feelings of connectedness with others, recognizing shared experiences. Perspective-taking in a mixed population may have increased self-compassion and -empathy in the participants of this study.

Participants found that a greater understanding of self and other, through perspective taking and self-compassion, helped with the transition process. Communication with others was also an important factor in transitioning services. Participants experienced both a lack of communication between adolescent and adult programs during the transition process, as well as a lack of communication between themselves and their service providers. Communication in the delivery of health care is critical. In healthcare literature, not specific to mental health, Epstein and Street (as cited in Sherrill & Harris, 2013) found that strong service provider and service user communication led to improved treatment and even improved physiological outcomes. Strong communication was described as empathic, with the client involved in the decision-making process. Similarly, Nurjannah, Mills, Usher, and Park (2013) researched discharge planning specifically in mental health care and found that communication between service providers and service users is critical. Their results

confirmed that, during the transition process, it is important to acknowledge "the importance of communication between health professionals, consumers, and their families to maximize the effectiveness of this process" (p. 1175). An open relationship, coupled with communication, seems key to creating smooth transitions for emerging adults who are moving from adolescent to adult mental health services for eating disorders.

Constructing relationships with others was an important aspect of the transition process. Close relationships with care providers, family, friends, and partners were all helpful to the transition process. Difficulties that arose for participants in the relationship construction process derived from working with professionals who were not competent in eating disorders treatment. Self-compassion and communication were also emphasized by participants as helpful to relationship construction and transition processes. Participants in this study further encouraged self-advocacy, facilitating communication between programs, growing one's support network and involving loved ones in an individual's healthcare.

5.1.3. *Transition Processes in Navigating a Complex Mental Health System*

To understand the transition processes in navigating a complex mental health system, it may help to look at it through a larger systems framework. The previously mentioned themes of identity processes and relationship construction can exist within a larger framework, alongside the theme of navigating a complex mental health system. Using Bronfenbrenner's (as cited in Lau & Ng, 2014) ecological systems framework fits this purpose as it demonstrates how identity, relationships, and navigating complex mental health systems are interdependent and affect each other in different ways. This framework also draws attention to the element of context, which is very in line with the philosophy of the present research.

Bronfenbrenner (1979, 1992, as cited in Lau & Ng, 2014) theorized a systemic framework wherein an overall ecological environment contained embedded sub-environments; all the sub-environments are interdependent and affect each other in different ways. These sub-environments were labelled as (a) microsystem, (b)

mesosystem, (c) exosystem, (d) macrosystem, and (e) chronosystem. In the present study, Bronfenbrenner's framework can be used to understand the thematic contents of the findings. At the microsystems level, patterns of activities, interpersonal relationships, and roles are experienced by the developing person. Transition processes and identity formation and relationships fall into this sub-environment. The mesosystem exists for each individual, wherein the mental health system, a person is an active participant in their program. And the exosystem is what this thematic section encompasses – transition process in navigating a complex mental health system. In this sub-environment, the setting does not involve the active participant, but events that occur in this sub-environment can impact an active participant. The macrosystem is the larger overall picture of a person's sub-environments. Lastly, the chronosystem accounts for changes to sub-environments over time, such as during the transition process (Bronfenbrenner, 1979, 1992, as cited in Lau & Ng, 2014). The term "process" is used in this research because it indicates that, like the chronosystem, something is taking place over time and is not a consolidated single event.

In the exosystem of mental health services, participants found that certain policies were helpful in gaining quick and efficient access to service. Triaging was found to be helpful, but was not without complications. Priority of care is based on triaging categorizations that seem to differ from agency to agency. Consistent and appropriate triaging decision-making is needed to ensure that people are assessed accurately (Maldonado & Avner, 2004). Their study highlighted the importance of triaging, but also the tendency for variation between service providers (in a general hospital triaging system). Undertriaging and overtriaging were both a delay to service provision. In addition, they found that variability in triaging practices can affect resource allocation, health care costs, and patient outcomes. Participants also noted, that as adults, assessments required self-reports and often these emerging adults felt the need to under report their symptoms and difficulties.

Some participants also found, in the exosystem of mental health services for eating disorders, that there was a degree of planning to their service transition and that it was very helpful. These participants found that the transition was smooth when they collaboratively planned in advance with their healthcare professional what the transition process would look like. This communication and planning process (as noted) is

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essential to building good relationships and to improving mental health services and transition processes in a complex mental health system. Participants found the adult programs helpful once they felt settled in, after the transition process. This settling in, or stabilization process, is part of transitioning. There is little research on the phase of stabilizing oneself in a new program. Digby, Moss, and Bloomer (2012) researched transitioning for older adults with dementia and the stabilization period, finding that transferring services created feelings of disorientation, anxiety, and there was not a feeling of being settled until there were personal connections and a familiar routine. The process of transitioning encompasses settling into the adult program as much as being discharged from the adolescent program.

The process of transition from adolescent to adult mental health services for eating disorders is complicated by having to navigate a complex mental health system. Participants found that there was no overlap between services – meaning that once adolescent services stepped out, there was no support until participants accessed adult care (which they were often waitlisted for). Having no overlap in services left participants feeling unsupported. Participants wished that there had been more planning and preparation in adolescent services so that they would have been made aware of the possibility of a lack of bridging, or so that bridging could have been implemented. Research suggests that having a bridging or transitioning program that offers supports to people as they move from either one level of care to another, or one program to another, is beneficial to "maintaining and extending the gains" that people have achieved already (Houpt, Astrachan, Lipsitch, & Anderson, 1972). Planning for a carry-over from adolescent programs until engagement with adult services is achieved is helpful for people as they negotiate moving between two different systems.

Transition processes in navigating a complex mental health system can be improved. Administrative policies and procedures were listed by participants as a hindering factor. Waitlist, the referral process, program requirements, and the gap between adolescent and adult services, all hindered the transition process. Existing literature supports these findings and suggests that these barriers can be detrimental to health outcomes (La et al., 2014). Arcelus, Bouman, and Morgan (2008) also found that an inconsistent referral process was a barrier to accessing adult services as well as lack of continuity, poor communication, poor planning, and difficulties with the changes from

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individual to group based formats; all of which were also found in this study. Recommendations from Arcelus et al. (2008) included flexibility of policies and procedures during the transition process, early planning (up to six months prior), and the elimination of protocols that impede transition, such as age boundaries and referral criteria. In this study, participants also recommended that assessment be more holistic and not only focused on the physical aspects of eating disorders, but on the emotional and cognitive aspects as well. The findings from this research further validate existing literature in terms of administrative elements that hinder transition processes.

Lastly, in terms of transition processes in navigating a complex mental health system for eating disorders, service availability and needs were discussed by participants. Participants found adult services to be less comprehensive, without varying levels of care, and difficult to access. The literature of British- and American-based studies support the unavailability of services for eating disorders, research that explored this topic from a Canadian standpoint was unavailable. Escobar-Koch et al. (2010) also found that poor availability and accessibility of care was a very real problem for people with eating disorders in the U.K. and the U.S., noting that financial accessibility was also problematic for their service users. Service availability and accessibility needs to be further studied in a Canadian context to draw firmer conclusions about this issue in our mental health systems. Participants hoped that future service needs could be met with more developmentally appropriate services, comprehensive services in adulthood, and providing more varying levels of support to meet the needs of all service users with eating disorders.

5.1.4. Summary

Viewing the findings from this research from narrative and qualitative lenses, it can be seen how identity formation, relationship construction, and mental health systems influence, and are influenced by, the transition process.

People battling anorexia nervosa share the same struggles with transition processes as others without eating disorders, who have undergone a mental health service transition. These findings also suggest that the complexity of individual development, context, and eating disorder pathology mean that individual care pathways

must be shaped for each person experiencing the transition. The role of individual motivation to change in the context of identity formation and the role of perspective-taking in the context of relationship construction were unexpected findings in my research. Lastly, participants continuously highlighted the need for developmentally appropriate services that meet the specific needs of emerging adults.

The cross validation of the research supports the findings that there are many factors specific to emerging adults that contribute to the experience of transitions from adolescent to adult mental health services for eating disorders. There appears to be no single "right" way of planning a transition. However, an overall understanding is required that, to achieve quality care throughout the transition process, each individual requires a personal care pathway. Care pathways need to be built collaboratively with the service user and service providers. The present research also highlights the notion that transition is a process and not a one-time event. The CIT method was useful in exploring all aspects of the research question because it answered what the helpful, hindering, and recommended experiences were for emerging adults with anorexia when transitioning from adolescent to adult eating disorder treatment services.

5.2. Practical Applications

This research has many practical implications and different implications for practitioners. The findings from this study can provide information about the experience of transitioning from adolescent to adult mental health services, specifically for those with anorexia. The information obtained explores both the benefits and barriers to transitioning services and also includes recommendations made by service users to improve transitioning. The purpose of this research was to: (a) create a deeper understanding of the best ways to work with individuals with anorexia in service transitions, (b) influence mental health service policies and procedures related to service transitions, and (c) highlight the voices of people experiencing service transitions. The practical implications for counselling psychology practitioners will also be discussed.

This research has created a deeper understanding of the best ways to work with people in service transitions, specifically those battling eating disorders. The categorical

findings highlighted the different helpful and hindering incidents that are important to emerging adults. It is a holistic understanding that sheds light on the individual, relationships, and systems associated with the transition process. Counselling, motivation to change, treatment management, professional competency, social support, empathy, self-compassion, planning, administration, safety, development, context, collaboration, comprehensive services, communication, and bridging are some of the many ideas that have been discussed with participants about their transition processes.

This research can also serve to influence mental health service policies and procedures related to service transitions at an administrative level. Participants encouraged program administrations to be flexible during the transition process to allow for an adjustment to adult services to take place. Expectations of adult programs may need to be adjusted accordingly to meet the needs of emerging adults during the time of transition. Analyzing the policies and procedures at adult programs (such as waitlists, referral processes, program requirements, funding, and programming specific to emerging adults) may improve transition processes. These changes can hopefully lead to service providers being able to improve dropout rates, continuity of care, and service engagement. Administrative and organizational policies could be negotiated and treated more flexibly during the time of emerging adulthood, as individuals battling eating disorders manage the transition to adult services, helping them to settle into adult programs.

The present research has highlighted the voices of people experiencing service transitions. It was very much the intention of this research to offer client stakeholders the opportunity to share their thoughts and ideas about how to best support them through the transition process. This is key because the service users are the people most affected when transitioning services.

From this research there are also practical implications for counselling psychology practitioners. From participants, we have heard that a deeper understanding of eating disorders and the transition experience is needed to better service this population. Counselling psychology practitioners can use this research as a guide to facilitating smooth transitions. Key factors for counsellors to reflect on during this process are:

1. Process: Keep in mind that transition is a process, not an event, and will require checking in with your clients intermittently about how it is going for them – what struggles they are facing, what is helping, and what could be better.

2. Educate: Let clients know what transition is, when it will happen, what it will look like, and what will change, specifically in terms of new expectations and adult counselling service delivery. Help clients with navigating the complex mental health system by increasing their understanding of the system and by also personally being an advocate for system change.

3. Organize, Plan, and Prepare: Get ready for the transition well in advance through careful planning and preparation. Planning and preparation should be collaborative; involving both service users and providers. Communication should be clear and concise; with all parties having a shared understanding of how the transition will take place. Have solid plans in place but allow for flexibility during the time of transition. Do everything possible to create little to no gap between services.

4. Personal Growth: Encourage self-advocacy, decision making, and problem solving; especially in regards to personal healthcare management. Work together to increase self-compassion and -empathy through perspective taking. Delve into motivations to change, identity formation, and relationship construction. It would also be helpful to promote the formation of positive social support networks to increase feelings of belongingness.

5. Focus on Overall Wellness, not Weight: Create a therapeutic environment that has a holistic understanding of health and wellness that is not entirely weight focused. Also create space for understanding of developmental, contextual, and other factors that affect people battling an eating disorder.

6. Emerging adulthood: Keep in mind that during the transition process, developmentally, clients may not subjectively feel like adults yet, and may have needs specific to their experience as an emerging adult.

7. Evaluate: Ask clients about their transition experiences throughout the process. Find out what worked, what didn't work, and what could be improved upon.

Counselling psychology practitioners can reflect on any, or all, of these recommendations as ways to open and bridge the conversation with their service users about the transition experience.

This research adds to the literature of emerging adulthood, transition processes, and eating disorders. It also serves to build awareness of the complexity of eating disorders and the need for individualized care pathways. It highlights important barriers to engaging people in continued services and recommendations for better service provision.

5.3. Limitations and Benefits of Research

As with all research, there are limitations to the findings. First, the number of participants in this study was small. The number of participants may have limited saturation of incidents, which may have impacted the comprehensiveness of the understanding of the issues. It also means that this research cannot be generalized to a larger population. Second, with the exception of two people, participants' recall of the transition experience was retrospective. Memories can change over time. Some of the critical incidents may have been forgotten, faded, or changed. A benefit to this however, may be that, over time, participants had an opportunity to reflect and story their experiences in ways that made them clear. Lastly, all nine validity checks could not be completed, which is a limit to the research, especially because cross-checking by participants was not accomplished.

The benefits of this research have been to gain a more comprehensive understanding of the transition experience, specifically for people battling eating disorders. It has illuminated a topic that has not been researched thus far in the literature. These findings have provided information for counselling psychology practitioners regarding how to create smoother transitions for emerging adults with eating disorders. At a recent conference for the Eating Disorders Association of Canada,

wherein this research was presented in a poster session, practitioners noted that this information is helpful to their practice as it raises awareness and highlights important transition needs for people specifically with eating disorders. Participants reported that their participation in this study was helpful in creating space for them to voice their concerns about this issue, and in validating their feelings and experiences. It may be that sharing these experiences and reflecting on them, has provided them with further clarity and insight into their own personal process of transitioning from adolescent to adult mental health services for eating disorders.

5.4. Implications for Future Research

There are a number of implications for future research that have arisen from this study. Any of the categories identified in this research could be extrapolated and refined into their own research questions. For example, the perspective-taking category was a new finding from this research that could be further explored, looking at exactly how it is helpful to gain perspective during treatment.

This research could also be extended to include participants with other eating disorders such as bulimia, eating disorder not otherwise specified, and binge eating disorder. The exclusion of these, in this research, is by no means meant to diminish the importance of other eating disorders. Many people share the same eating disorders services and likely have the same strengths and struggles with transitions. This would be an important avenue for future research because, for services that work with all eating disorders, it would provide information on the transition experience for all service users (not only individuals battling anorexia). There may be differences between eating disorders that could be occurring and different support that is needed.

Future research could also focus more on the developmental and contextual aspects that help and hinder transitioning from adolescent to adult mental health services. In doing so, it may highlight important developmental and contextual events that are happening during the time of transition and perhaps map out when an appropriate or ideal time for transition should take place considering those events.

5.5. Conclusion

Anorexia nervosa has the highest mortality rate of all psychiatric disorders (Fichter, Quadflieg, & Hedlund, 2006). Anorexia is generally diagnosed in adolescence but often continues into adulthood – spanning both adolescent and adult mental health services. In this study, the framework of "emerging adulthood" was used to describe the transition phase between adolescence and adulthood (ages 18 – 25). During this transitional phase, people battling anorexia are making the change from adolescent to adult mental health services for eating disorders. These developmental and contextual changes can affect economic, social, and health outcomes (Arnett, 2007). Existing research on service transition suggests that difficulties with transitioning can lead to service disruption and increased service dropout (Pottick et al., 2008). Because of the complexity of this developmental period, and the high rate of mortality for anorexia nervosa, this time of transition requires complex ideas about care pathways and eating disorders treatment services to help with increasing engagement and decreasing attrition rates.

The goal of this CIT study was to identify what helps and hinders in transitioning from adolescent to adult mental health services while battling anorexia. Recommendations from service users were also sought. Using CIT worked well as it was the most suited research method to answer the research question. In evaluating the method, CIT was most appropriate to this research because it allowed for participant's voices to be heard, it had a flexible interview format that captured helpful, hindering, and recommended incidents, and the format allowed for a holistic questioning of the research question. The purpose of this research was to facilitate a deeper understanding of the transition experience and work toward changes that can be made in the service field to effectively support emerging adults with anorexia in their transition to adult eating disorders services. During this transition process, individuals leave the relative safety of adolescent programs and move towards increased independence in the adult system. Although transitions were viewed as difficult, what also emerged from the findings was that there were many programs, professionals, and people along the way who helped and cared.

Results from this research have provided information on helping and hindering factors of transitioning services, as well as recommendations for change. Seven female participants were interviewed. From the interviews, 285 critical incidents were identified and extracted. Eighty-one incidents were found to be helpful, 121 were found to hinder, and 83 were wish list items that participants would have liked to have seen happen. Credibility checks were conducted to improve trustworthiness.

The results indicated that participants were helped in the process of transitioning services through the following: having a continued relationship with a central or familiar professional throughout the transition, planning and preparing for the transition in advance, building a social support network, having a system that uses triaging to assess wait time to services, participating in counselling, having a motivation to recover, no longer wanting to have the eating disorder as part of their identity, being able to manage their own treatment, and opening up to new perspectives of what the underlying issues of the eating disorder may be, rather than focusing on weight and eating disorder symptomology.

The results also indicated that participants were hindered in their transition from adolescent to adult mental health services for eating disorders because of: difficulties with administrative policies and procedures (such as waitlists, program requirements, and referral processes), too few services to access, problems with professional competencies, lack of communication between service users and providers, lack of communication between services, difficulties which arose because of the changes in responsibility of treatment management, feelings of loneliness and lack of safety, changes to counselling delivery (having too few counselling sessions), lack of bridging between services, and other co-occurring developmental and contextual factors.

This research was validated by existing literature in the thematic context of the processes of identity formation, relationship construction, and the navigation of mental health systems. Practical implications, limits of the research, and avenues for future research were explored. Client experiences of transitioning from adolescent to adult mental health services while battling an eating disorder were difficult and complicated, but also sometimes positive. Regardless of the difficulties of transitioning, participants in

this study either continue their battle against anorexia, or had achieved recovery from anorexia. Despite barriers, these emerging adults persevered in their individual battles.

Throughout the course of this research, I was very fortunate to meet very intelligent, strong, and brave women who were willing to share their stories with me. I was able to learn a lot about how each individual worked through, not only their service transition, but their transition to adulthood while battling an eating disorder. What I take away from this research is the awareness that each person has an individual story that is slightly different from anyone else's, especially during the time of emerging adulthood where there is little that is normative. In my practice it has made me think more of individualized care pathways and the need for transitions that are conducive to continued care. I am taking away the idea that transition is a process, not an event, just as counselling is a process. It needs to be treated collaboratively and carefully with respect to each individual's experience. Lastly, I would like to end with a quote from one of the participants about the process of recovery from an eating disorder and the complexity of an eating disorder, because life is intrinsically complex and transitional. I think she sums it up nicely and in a hopeful manner:

"Transition is hard for anybody, for many people, sorry, and makes it something that's still multifaceted. Of course there's risk in there, but it doesn't have to be ongoing, lifelong risk, in my opinion. I just—I want—I had no idea [recovery] was possible, and I want everybody to have that."

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Appendices

Appendix A.

Eating Disorders Services Available in Vancouver

Below are resources available in Vancouver. The Kelty Mental Health Resource Website has resources available for all of British Columbia. Made available by Kelty Eating Disorders: Information from the Kelty Mental Health Resource Center (2014) http://keltyeatingdisorders.ca/maps/list/export.xls?eid=906

Program	Address	Ages	Service Level
Provincial Specialized Eating Disorders Program for Children and Adolescents - BC Children's Hospital	BCCH P3 – Mental Health Bldg., 4500 Oak Street, Vancouver, BC V6H 3N1 Phone: 604-8752200	Up to 18 and in school	Tertiary
Provincial Adult Tertiary Specialized Eating Disorders Program	Providence Health Care, St.Paul's Hospital 4 North - 1081 Burrard Street Vancouver, BC V6Z 1Y6 Phone: 604-806-8347	17+ out of high school	Tertiary
Centre for Healthy Weights: Shapedown BC	Shapedown BC, BC Children's Hospital 948 West 28th Avenue V2-207 Clinical Support Vancouver, BC V5Z 4H4 Phone: 604-875-2345 ext 5984	6-16 with Body Mass Index >95%	Secondary
Looking Glass Foundation for Eating Disorders	Looking Glass Foundation Mailing Address PO Box 16052, 1199 Lynn Valley Road North Vancouver, BC V7J 3S9 Phone: 604-314-0548	All ages including families and caregivers	Primary
Jessie's Legacy Eating Disorders Prevention Program at Family Services of the North Shore	Director, Community & Provincial Programs Suite 101 - 255 West 1st Street North Vancouver, BC V7M 3G8 Phone: 604-988-5281 (ext. 204)	All ages	Primary
Kelty Mental Health Resource	Mental Health Building, Entrance 85, P3-302	All ages	Primary

Centre	4500 Oak Street The Vancouver, BC V6H 3N1 Phone: 604-875-2084 Fax: 604-988-3961		
Woodstone Residence	743 Georgeson Bay Road Galiano Island, BC V0N 1P0 Phone: 250-539-2633 Fax: 250-539-5687	17-24	Secondary
Vista House	3360 Fleming Street Vancouver, BC V5N 3V5 Phone: 604-736-9931 Fax: 604-734-2756	18+	Tertiary
Community Outreach Partnership Program (Providence Health care and VCH)	COPP Case Manager 3360 Fleming Street Vancouver, BC V5N 3V5 Phone: 604-736-9983	18+	Tertiary
Child and Youth Mental Health	All locations: http://www.mcf.gov.bc.ca/ mental_health/pdf/offices_ services.pdf	18 and younger	Secondary
North Shore Youth Eating Disorders Program (North Shore & Sea to Sky)	6th floor – 132 West Esplanade North Vancouver, BC V7M 1A2 Phone: 604-992-4814 or 604-983-6883	19 and younger	Secondary
Vancouver Costal Health Eating Disorder Program	VCH Eating Disorders Program #333 - 2750 East Hastings 3rd floor Vancouver, BC V5K 2A1 Phone: 604-675-2531	All ages	Secondary
North Fraser Eating Disorders Program	#300 - 3003 St. John's St. Port Moody, BC V3H 2C4 Phone: 604-469-7600 Fax: 604-469-7601	All ages (under 12 with paediatric referral)	Primary
Fraser South Eating Disorders Program	Delta Mental Health Centre #129 - 6345 120th Street Delta, BC V4E 2A6 Phone: 604-592-3700 Fax: 604-591-2302	All ages	Secondary

Appendix B.

Informed Consent

.

INFORMED CONSENT FORM

Client Experiences of Transitioning from Adolescent to Adult Mental Health Services while Battling Anorexia Nervosa

Simon Fraser University

Principal Investigator
Carrie Bove, MA Counselling Psychology Student

███████████████

Faculty Supervisor
Dr. Patrice Keats, Associate Professor, Academic Coordinator

███████████████

This consent form outlines the purposes and procedures of this research project. This research is a partial requirement for the Counselling Psychology Graduate Program.

Purpose and Benefits

The purpose of this study is to deepen our understanding of helpful and hindering factors involved in transitioning from adolescent to adult mental health services for people struggling with anorexia. We hope to gain a better understanding of helpful and hindering factors in counselling service transition so that the best possible transition plans can be put in place to optimize the experience.

For the purpose of this study you must have been participating in adolescent mental health services for the treatment of anorexia and later have transitioned into adult mental health services.

Participants may or may not benefit from their participation in this study. Participants must be 19 years of age or older to participate.

Procedures

You are invited to participate in the following procedures:

1. An initial telephone conversation to be asked questions regarding your transition experience and your diagnosis that will check that you meet criteria for this study (no more than 15 minutes). A few non-identifying demographic questions will be asked as well. We will setup a date, time, and place for an in-person interview.

2. An in-person interview will take place. This will last no longer than 120 minutes. In this interview questions will be asked about your service transition experience and what helped and hindered it. The interview will be audiotaped; recordings will be destroyed after transcription and de-identified.

3. You will receive an email at a later date that will share the information that has been categorized by the researcher. A few follow up questions will be included in the email for you to think about but <u>do not</u> need to be replied to. Instead the researcher will telephone you for a quick follow up conversation (no more than 30 minutes). This is also an opportunity to ask any questions or find out about how to see the results of the research project.

*Overall participation in the study should take no more than three hours total.

Confidentiality

All identifying data will be kept strictly confidential within the limits of the law. All data will be coded so that your personal information is not associated to any of your data responses; personal information will be kept in a secondary secured location for contact purposes only. Access to non-identifying information will be restricted to the principal investigator and faculty supervisor. All data will be kept in a secure location for safeguarding. All identifying information will be removed from transcripts and drafts. Following the end of the study identifying information will be destroyed and the de-identified data will be kept indefinitely for research and educational purposes.

Limits to confidentiality include the following: (1) threat to harm yourself or others, (2) information of child abuse, and (3) if information is court ordered. This is a collaborative process and will involve active communication if confidentiality needs to be breached.

Risks, Stress, or Discomfort

If you are a first time participant, or if you have participated in many research studies, there is always a chance of experiencing some minor anxiety or stress from participation. The principal researcher will aim to minimize stress and discomfort. Questions from participants are encouraged during all stages of the research process.

This study hopes to deepen our understanding of helpful and hindering factors during service transition for people struggling with anorexia. Although every effort has been made to ensure that the questions will not be emotionally charged for you, it still may be possible that some questions could be difficult to answer, or that they bring up memories or thoughts that are uncomfortable. At any time if you are having strong feelings or a strong emotional response, please inform the researcher/interviewer so that steps can be taken to help you to return to a more comfortable emotional state.

You are under no obligation to answer any questions that you consider to be invasive at any time during your participation. Your participation is voluntary and you can withdraw at any time, for any reason. If you should choose to withdraw, your information will not be included in the study and will be destroyed.

Contact

If you have any questions, concerns, or if you require any further information about this study you are welcome to contact:
- Carrie Bove ███████████████
- Dr. Patrice Keats ███████████████

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, you may contact:
- Dr. Jeffrey Toward, Director, Office of Research Ethics at ███████████ ███████████

Participant's Statement

Your signature below indicates that the research study has been explained to you, that you have been given adequate opportunity to ask questions, and that you understand that any future questions that you may have about the research will be answered by the principal investigator listed above.

Your signature below indicates that you voluntarily consent to participate in this study; you understand that you are free to refuse or withdraw participation at any time without consequence.

Your signature below indicates that you have received a copy of this consent form for your own records. Your signature also indicates that you consent to participate in this study and that your responses will be kept in de-identified form and potentially for further use after this study for future research and educational purposes.

Participant's Signature	_____
Print Name	_____
Date	_____
Researcher's Signature	_____
Print Name	_____
Date	_____

Appendix C.

Recruitment Announcement

Recruitment Announcement

Have you struggled with Anorexia?
Have you moved from Adolescent services to Adult services?

If so, I am looking for people who are interested in telling their story.

What has been <u>helpful</u> and what has <u>hindered</u> transitioning from adolescent to adult counselling services while struggling with anorexia?

This unique research project focuses on your story of counselling service transition based on your descriptions; the people who have actually experienced it. We need your expertise.

Research consists of a quick screening call, an initial interview, and when possible a brief follow up. During these times you will recount what was helpful and what was unhelpful.

Your insight may assist others who have yet to go through this experience. This information will be used to inform services and professionals to effectively support people with anorexia.

If you are interested, or if you would like more information, please contact:
Carrie Bove – Email: █████████
Principal researcher and SFU graduate student in Counselling Psychology

V.03.03.2014
SFU Study#2014s0117

Appendix D.

Telephone Recruiting Script and Screening Questionnaire

Client Experiences of Transitioning from Adolescent to Adult Mental Health Services while Battling Anorexia Nervosa

Simon Fraser University

Principal Investigator
Carrie Bove, MA Counselling Psychology Student
████████

Faculty Supervisor
Dr. Patrice Keats, Associate Professor, Academic Coordinator
████████

Telephone Recruiting Script and Screening Questionnaire

Recruiting Script

Hi this is Carrie Bove. I'm an SFU Graduate student in counselling psychology. Thank you for calling or contacting me with an interest in participating in my study on what is helpful and what is hindering in counselling service transition from adolescent to adult services for people who struggle with anorexia. Your participation consists of this screening call, an in-person interview, and if possible, a quick follow up phone call for feedback.

There are certain criteria you would need to meet in order to participate in this research study. I will go over that now:

1. Are you nineteen or older? (Must be aged 19 or over to participate in this research project).

2. Do you have any medical, cognitive, or physical reasons that you feel would make it difficult for you to participate in this study?

3. Have you ever used an adolescent mental health service for eating disorders?

4. Have you had to transition from the adolescent mental health service for eating disorder to an adult mental health service for eating disorders?

5. Do you have a diagnosis of anorexia from a counsellor or psychiatrist at the aforementioned services?

6. Have you ever experienced any of the following: Below minimal normal body weight or a failure to meet expected weight gains? Intense fear of gaining weight or becoming overweight? Persistent behaviours that interfere with weight gain? Feeling your body weight and shape are larger than they may actually be? Loss of your period?

The interview will be taped but your identity will be anonymized. Interview tapes will be destroyed after transcription. Before the interview starts we will go over a consent form and it will need to be signed. The form goes over the purpose of the study, what participation looks like, confidentiality, risks and benefits, and contact information. During the interview and at the end you can ask any questions. At a later date after the interview I will contact you by email to show you the resulting categories and then call you by phone to see if you have any feedback. This is a collaborative process and I want to make sure that I am getting your story right.

You <u>are</u> eligible to participate in the study. Would you like to participate? If so, would it be possible for you to answer the following demographic questions?

1. Age

2. Gender

3. Ethnicity

4. City of Residence

5. Contact information (email and telephone)

Can we setup a time for an interview? Do you have any other questions? Thanks!

Or conversely should the volunteer not meet criteria: unfortunately you <u>are not</u> eligible for the study. Thank you so much for your time and your interest in my research. Do you have any other questions? Thanks!

Appendix E.

Interview Protocol and Questionnaire

Client Experiences of Transitioning from Adolescent to Adult Mental Health Services while Battling Anorexia Nervosa

Simon Fraser University

Principal Investigator
Carrie Bove, MA Counselling Psychology Student
█████████████

Co-Investigator
Dr. Patrice Keats, Associate Professor, Academic Coordinator
█████████████

Interview Protocol and Questionnaire

This protocol will be used with each participant in the study. Exact wording may change and there will be room for flexibility in terms of asking follow up questions.

Interview Protocol

First participants will be greeted and asked to read over the consent form (appendix B). After reading it I will ask them if they have any questions and if they understand the content. They will then be asked to sign the consent form.

Participants will then be oriented to the interview using the following script: Thanks so much again for agreeing to participate in this study. I really appreciate your time and thoughts and I am really interested in what you have to say. The purpose of this study is to find out what helps or hinders the process of transitioning from adolescent counselling services to adult counselling services. I'll be asking you questions around your experience of the transition to get a better picture; such as things that made you feel great about the transition or things that made the transition difficult to cope with. It could also be people that helped you, protocol that was in place that shaped your transition, etc.

My hope is this research will help create better transitioning plans for future service users. Your personal information will be anonymous and confidential. The non-identifying data will be reported in conjunction with the other participant's data. The results of this study will be available to you upon your request.

I just want to recap as well; although we talked about it during the informed consent, I did just want to repeat that if at any time you are feeling uncomfortable or emotionally charged,

please let me know and we can pause and take time to make sure you return to a comfortable emotional state. Do you have any questions so far?

Starting Questions: Establishing the Aim

1. Think back on the counselling service transition time – can you remember a specific event (person, place, or thing) that helped you in the transition or made the transition more difficult for you?

Critical Incident

1. Please describe a particular incident that significantly helped or hindered your process of counselling service transition. What happened?

Follow up Questions for Clarifying the Incident

1. How was the incident helpful (unhelpful)?

2. What meaning did this particular incident have for you?

3. What led up to it?

4. How did it turn out for you?

5. How did you feel about this incident?

6. Exactly what do you think it was that was helpful or hindering?

7. How did you know whether it was helpful or hindering?

8. What went on before and after the incident?

9. Can you tell me a bit more about that?

Continue to search for new incidents until there are no more and the topic has been exhausted.

Debriefing

To sum up the interviews and close with an opportunity to include a "wish list" of what would be an ideal solution or process of counselling services two questions will be asked of the participant.

1. Based on your personal experiences, can you tell me what you would recommend for other people who are going through this process?

2. If you were able to create the ideal or perfect counselling service transition, what would it look like?

3. What services would you ideally like to access? What would these services look like?

After the above questions are answered the following debriefing will take place following this script: That ends the formal part of our interview. Do you have any questions or thoughts that popped up that you would like to add in or clarify? How are you feeling at this time? (note* should there be any issue around the person's ability to cope should they experience emotional distress during or after the interview, I will take time to ensure the person is back to an emotionally secure place before they leave and provide them with resource information should they require further support). I will be analyzing and categorizing your responses as well as the other participants in the coming month, would it be okay if I call you with some follow up questions just to make sure I got it right? Also, at the end of the research study I am more than happy to provide the thesis to you; you would just need to let me know if that is something you would be interested in. Thank you so much again. (END)

Appendix F.

Participant Interview Log

Derived from Butterfield et al. (2009)

Date of CI Extraction	Participant #	Date Categorized	New Categories Emerged?
May 20th, 2014	1	May 20th and 21st, 2014	All new categories
July 23rd, 2014	2	August 21st, 2014	10 new categories
July 23rd, 2014	3	August 25th, 2014	1 new category
July 30th, 2014	4	August 25th, 2014	1 new category
August 19th, 2014	5	August 26th, 2014	1 new category
August 20th, 2014	6	August 26th, 2014	0 new categories
September 1st, 2014	7	September 2nd, 2014	0 new categories

New Categories Emerged?	Participant #	Total Hindering Categories	Total Helpful Categories	Total Wishlist Categories
May 20th, 2014	1	5 new = 5	8 new = 8	4 new = 4
July 23rd, 2014	2	3 new = 8	3 new = 11	4 new = 8
July 23rd, 2014	3	0 new = 8	0 new = 11	1 new = 9
July 30th, 2014	4	1 new = 9	0 new = 11	1 new = 10
August 19th, 2014	5	1 new = 10	0 new = 11	0 new = 10
August 20th, 2014	6	0 new = 10	0 new = 11	0 new = 10
September 1st, 2014	7	0 new = 10	0 new = 11	0 new = 10

Appendix G.

Resource List

Client Experiences of Transitioning from Adolescent to Adult Mental Health Services while Battling Anorexia Nervosa

Simon Fraser University

Principal Investigator
Carrie Bove, MA Counselling Psychology Student
█████████

Co-Investigator
Dr. Patrice Keats, Associate Professor, Academic Coordinator
█████████

Resource List

The following is a list of resources available should you need to reach out and speak with someone about this experience or any other that you may be struggling with (obtained from HealthLinkBC). Please feel free to also contact the principal investigator or the co-investigator should you have any further questions or concerns.

- 24/7 Distress Phone Services

  Provides confidential, non-judgmental, free emotional support for people experiencing feelings of distress, despair, anxiety, or depression and may be at risk of suicide. Contact: (604) 872-3311 or toll free (800) 784-2433

- Family Services of Greater Vancouver

  Community-based, not-for-profit organization providing social services to children, youth, adults, and families across the lower mainland. Services range from prevention to intervention, addiction services and more. Contact: (604) 731-4951

- VCH Eating Disorders Program

  The program offers a community based outpatient multidisciplinary team dealing with eating disorders that includes therapists, outreach counsellors, dietitian, nurse, family therapist, physicians, and psychiatrists. The program works with individuals at various stages in the recovery process in collaboration with their primary care providers (Family physician, nurse practitioner, etc).Treatment options include group work, family and friends support group, individual/family therapy, and outreach, nutritional, specialized medical and psychiatric support. Consultation and education are also available to community agencies and professionals to promote awareness and early intervention. As part of a larger continuum of care, the program liaises with the Eating Disorders Programs at BC Children's and St. Paul's Hospitals should clients require more intensive support. The program's vision is to establish client-centered care that empowers individuals and families to take responsibility for the recovery process and enhances their quality of life. Contact: (604) 675-2531

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SFU Study#2014s0117

- Kelty Mental Health Resource Center

  Provides a provincial resource centre working to link children, youth and their families with appropriate resources in all areas of mental health and addictions. Also provides resources for adults with an eating disorder. Offers information, advice, navigation, and peer support to parents and families, in person, over the phone, and by email exchange. Covers a wide range of mental health and substance abuse issues affecting children and youth in BC including, but not limited to, depression, anxiety, attention deficit and behavioural problems, child/youth eating disorders, and substance use. Parent peer support workers are available on Mondays and Fridays. Contact: (604) 875-2084 or toll free (800) 665-1822

- Additional or more specific resources can be found at:

  http://www.healthlinkbc.ca/servicesresources/

Appendix H.

Credibility Checks

Credibility Checks	Description	Incomplete/Complete
Audio taping interviews	Captures words verbatim	Complete
Interview Fidelity	Following an interview protocol	Complete
Independent Extraction of CIs	Independent person listens to interviews or reads transcripts and extracts CIs	Incomplete*
Exhaustiveness	Using tracking system to check new categories	Complete
Participation Rates	25% must endorse category for it to be considered valid and strong	Complete
Placing Incidents into Categories by an Independent Judge	Randomly place 25% of CIs into categories	Complete
Cross Checking by Participants	Follow up email to participants with data to be checked and asking for feedback	Incomplete*
Expert Opinions	Send categories to experts and ask for feedback	Complete
Theoretical Agreement	Explore underlying assumptions and look at how results compare to current research	Complete

Appendix I.

Demographics

	Age	Gender	Ethnicity
Participant #1	21 yrs	Female	Mexican/Caucasian
Participant #2	19 yrs	Female	Caucasian
Participant #3	22 yrs	Female	Caucasian
Participant #4	30 yrs	Female	Caucasian/Metis
Participant #5	30 yrs	Female	Caucasian
Participant #6	30 yrs	Female	Caucasian
Participant #7	31 yrs	Female	Caucasian