Instilling hope for a brighter future: A mixed-method mentoring support program for individuals with and recovered from Anorexia Nervosa

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Abstract

Aims and Objectives: To investigate the feasibility of a 13-week mentoring program in providing social support to promote hope for recovery in anorexia nervosa.

Background: With no clear first line psychological treatment for people with anorexia nervosa, mentoring support programs, as an adjunct to treatment, may provide the social support necessary to promote hope for recovery.

Design: A mixed method study; Participatory action research.

Methods: Women (n=11), recovering and who had recovered from anorexia nervosa, participated in the program and completed self-report questionnaires related to quality of life, distress and the mentoring relationship at different time points. Qualitative feedback from logbooks, workshop evaluation questionnaires, interviews and focus groups was also collected to assess the program’s acceptability.

Results: General compliance for completing most study outcome questionnaires was 90% however the mentoring relationship questionnaires were not completed to the same degree. Five key themes emerged from the focus group/interview data: 1) She understands me and could relate to me; 2) Re-connecting with the world - Asking questions and being challenged; 3) Mentors’ altruistic motivations and the transformation and discovery of self; 4) Instilling hope - Recovery is possible; and 5) Effective communication - The key to successful mentoring.

Conclusions: Further research is needed however the results provide preliminary support for the mentoring program’s feasibility as an adjunct to treatment. We found that having someone who understands, to talk and share with, met a clear need for people with anorexia nervosa.

Relevance to clinical practice: While further research is warranted mentoring support or recovered mentors may play a potentially valuable role in supporting those in community settings.
INTRODUCTION

Anorexia nervosa (AN) is a potentially life-threatening eating disorder. It is associated with a distorted perception of body image and fear of gaining weight (American Psychiatric Association, 2013). There is some evidence that the prevalence rate in Australia for DSM-5 eating disorders may be increasing (Hay, Girosi, & Mond, 2015) with the overall lifetime prevalence for AN estimated at 4.3% (Wade, Bergin, Tiggemann, Bulik, & Fairburn, 2006) and international estimates at 0.6% (Hudson, Hiripi, Pope, & Kessler, 2007). The seriousness of AN, is confirmed by the high mortality and morbidity rates, ranked one of the highest of all psychiatric disorder (Arcelus, Mitchell, Wales, & Nielsen, 2011; Keshaviah et al., 2014; Kostro, Lerman, & Attia, 2014). There is “no clear first-line psychological therapy” for adults with AN (Hay et al., 2014, p. 1001).

BACKGROUND

Social isolation and the withdrawal from social settings contribute to the entrenchment and chronicity of AN symptoms. Social interactions with others are important for ongoing support and hope for recovery (Leonidas & dos Santos, 2014). A mentoring support program for people with AN used as an adjunct to treatment, may provide the social support important to promote hope for recovery. While mentoring can take various forms, at the core lays the capacity for human relationships, a therapeutic alliance and goal setting (Australian Youth Mentoring Network, 2012). Despite recovery from AN being a unique and personal journey, it is rarely travelled alone (Australian Health Ministers’ Advisory Council, 2013). A mentor-mentee support program for people with AN may provide the impetus for recovery, and does so by enhancing hope, self-determination, self-management, empowerment and advocacy in the context of an authentic, therapeutic relationship.
AN is also an illness that isolates individuals and reaching a pre-determined target weight does not mark the end-point of recovery from AN (Jenkins & Ogden, 2012). Strong evidence suggests that empathetic and therapeutic relationships (with a health professional or other) are an intrinsic aspect for recovery and motivation to change (Bell, 2003; Colton & Pistrang, 2004; Espindola & Blay, 2009; Federici & Kaplan, 2008; Garrett, 1998; Ramjan, 2004; Ramjan & Gill, 2012; Wright, 2010). The development of a new healthy relationship with another promotes re-socialisation, reduces isolation and provides the strength needed to overcome challenges (D’Abundo & Chally, 2004). Mentor-mentee support programs can provide the foundation for these relationships to flourish and for mentees to re-connect with society, thus reducing their social isolation. Despite putative advantages of mentoring, to our knowledge there have been few published papers of people’s experiences with mentoring in the area of AN.

Mentoring in eating disorders has generally been preventative, assisting with self-esteem and body image (Lippi, 2000; McCarroll, 2012; McVey et al., 2010; Perez, Kroon Van Diest, & Cutts, 2014). This mentoring program set out to improve quality of life by treating individuals as more than a person with an eating disorder, listening respectively to their stories, avoiding judgment and providing a connection to a non-eating disorder treatment environment. The aim of this study was to assess the feasibility of the instilling hope for a brighter future mentoring program, and report preliminary outcomes of a mentoring support program for people diagnosed with and recovered from AN.

METHODS

Population, Sample and Procedure

The study was advertised to eating disorder practitioners, in eating disorder treatment facilities and online through eating disorder foundation websites such as The Butterfly Foundation. Twenty-eight individuals inquired about the project, see Figure 1. All the mentees were receiving treatment for their AN outside of the mentoring program and the mentoring program was adjunctive support only.
Five mentors (women recovered from AN) and six mentees (recovering women with AN) were recruited as active participants in the design, development and evaluation of a 13-week mentor-mentee support program. The mentee sample (N = 6 females) were those with AN, aged between 18 and 38 years (mean 26.83, SD 7.80) and the mentors were women recovered from AN (N = 5 females), aged between 20 and 44 (mean 30.4, SD 8.79) who had five years or greater recovery. See Table 1 for demographic details. Recovery was self-reported by the women and confirmed via an assessment by author PH. A psychiatrist (PH) assessed the mentors’ suitability to be a mentor via Skype; this included having a strong support system and resources for self-care. A maximum of six mentoring dyads were possible due to available funding.

The study was conducted in Sydney, Australia and all women were from the Sydney or greater Sydney area. The program ran from 14th March 2015 to 4th July 2015. The inclusion criteria for mentors were: 1) ≥ 18 years of age; 2) self-reported recovery from AN for at least five years; 3) assessed as eligible via interview with a psychiatrist experienced with AN; and 4) female. The inclusion criteria for mentees were: 1) ≥ 18 years of age; 2) not currently receiving in-patient care for AN; and 3) female. In order to match mentors and mentees most efficiently both groups were female. The study was approved by the University of Western Sydney Human Research Ethics Committee (H10825).

Mentoring program

The study used a Participatory Action Research (PAR) methodology. PAR “…is a form of action research that focuses on the participatory aspect of research in action” [Authors, 2016]. PAR aims to encapsulate the participants’ feelings, thoughts and viewpoints without manipulation from the researcher (MacDonald, 2012). A major theme of PAR is the promotion of people’s empowerment (Krimerman, 2001). Recognising empowerment and consumer involvement is crucial for treatment engagement and recovery from an eating disorder (Darcy et al., 2010; Espíndola & Blay, 2013), the use of PAR methodology is ideal. “…[Any] research aimed at developing the self-determination and resilience of mental health service users should be underpinned by PAR” [Authors, 2016]. See [Authors] for further details on the PAR framework utilised in this study.
Procedure

Participants met at an introductory workshop before commencement of the program. As per PAR principles, participants were actively engaged in the design, development and evaluation of the support program. During the workshop participants discussed matching with a partner, defining the program, roles and responsibilities, interaction and communication, support, dealing with relapse of a member, management of the partnership (ground rules and conflict resolution) and support required from the project team. This discussion provided the basic framework for the program. PAR research is a continuous process and thus aspects of the program were open to change, based on the groups’ needs and feedback, throughout the duration of the program.

While the participants had the opportunity to provide input into the support program, there were also agreed upon ‘non-negotiable’ items that formed part of the risk management protocol of the program. These included the program length, the program was not to replace existing treatment and the mentors were not counselors, and mandatory reporting requirements were outlined for abuse and self-harm.

During the program, participants completed quantitative self-report measures related to quality of life, distress and the mentoring relationship at different time points and completed qualitative weekly logbooks. Researchers monitored weekly logbooks to ensure safety. The logbooks recorded the type of contact and time each mentoring pair spent together, the topics of conversation and reported any program issues or additional support requirements. Based on content of the logbooks, the program organisers (SF & LMR) may have either telephoned or emailed mentors to provide ongoing support and supervision. Alternatively mentors contacted the program organisers directly by telephone and/or email when they required additional support or advice. The program organisers also checked in online with the mentors midway through the program (approximately six weeks). Pairs were reimbursed as needed for face-to-face meeting costs. Participants were invited to provide feedback at interviews/focus groups at the program end. There were six mentor-mentee pairs with one mentor pairing with two mentees. There was funding available to the pairs to reimburse them for costs for meeting face-to-face through the 13 weeks.
Measures

Study measures

The study was a mixed method study using qualitative and quantitative measures. Quality of Life was assessed with the validated self-report questionnaires; SF-12 (Ware, Kosinski, & Keller, 1996) and the Eating Disorder Quality of Life Scale (EDQoL) (Engel et al., 2005). The SF-12 is a 12-item self-report questionnaire that measures functional health and well-being, with two subscales; the Physical component summary and the Mental component summary (Ware et al., 1996). The EDQoL scale is a 25-item self-report measure assessing the degree to which an individual feels their eating disorder affects their quality of life (Engel et al., 2005). There are four subscales: Psychological, Physical/Cognitive, Work/School and Financial.

Distress was assessed with the Kessler Psychological Distress Scale (K10) (Kessler et al., 2002). The K10 is a 10-item self-report questionnaire that yields a global measure of distress based on questions about anxiety and depressive symptoms (Kessler et al., 2002).

Perception of the mentoring relationship was assessed using the Match Characteristic Questionnaire (MCQ) (Karcher, Nakkula, & Harris, 2005) and the Global Mentoring Relationship Questionnaire Scale (GMeRQS) (Ferro, DeWit, Wells, & Lipman, 2013). The MCQ is a 29 item, self-report instrument for measuring positive and negative perceptions of the mentoring relationship, the valuation of different purposes in the match, and the effects of external influences on the match (Karcher et al., 2005). The GMeRQS is a 5 item, self-report instrument assessing the mentoring relationship (Ferro et al., 2013). These measures are reliable and valid.

The SF-12, EDQoL, and K10 were completed at baseline (before the program started), and post the completion of the program, to provide study outcomes. The same measures were obtained at the study mid-point (at 7 weeks) to monitor health and safety. The MCQ was obtained post program completion only. The GMeRQS was completed at weeks 3 and 9 of the program to monitor the mentoring relationship only.
The qualitative methods employed collected feedback about the acceptability of the program through workshop evaluation questionnaires, the weekly logbooks and the end of program interviews/feedback. The qualitative methods included focus group sessions, phone interviews, written feedback and program logbooks. Logbooks collected data on topics discussed and activities undertaken by the pairs each week and provided feedback on the relationship and any issues encountered. The frequency of return of logbooks was reduced to fortnightly for the last half of the program based on feedback from participants.

Two focus groups, facilitated by an external facilitator, were held in a private room and the duration of the interviews ranged from 35 minutes to 50 minutes. The focus groups were guided by a semi-structured schedule with only mentors (n = 2) and mentees (n = 2) separately. An opportunity to participate in a phone interview with the external facilitator or to provide written feedback was provided to those participants who were unable to attend the focus group session on the day. Mentors (n = 3) participated in the 20-minute phone interviews and mentees (n = 2) provided written feedback.

Data Analysis

Quantitative Analysis

Medians and Interquartile ranges (IQR) for all the quantitative outcome data are reported. Analysing efficacy is not part of this feasibility study however ensuring health and safety was an aspect of the program. A paired t-test with two tails was used to analyze the data except for the MCQ, which was compared to population averages. Intent to treat was applied for the incomplete questionnaires by carrying baseline scores to mid-point scores and mid-point scores over to post-program scores. The results of the safety analysis are not reported in this paper.
Qualitative Analysis

The qualitative data were analysed using thematic analysis (Braun & Clarke, 2006). Qualitative data were digitally recorded, transcribed verbatim and then the first author (LMR) read and re-read the data to ensure familiarity and immersion in the depth and breadth of the content. Initial ideas were documented and data were organised into meaningful groups using line-by-line coding. After coding, data were sorted into potential themes that were reviewed and refined to capture the diversity and patterns of meaning (Braun & Clarke, 2006). Emerging themes were discussed with members of the research team (SF, DN, PH) until consensus was reached. For this paper, qualitative data related to acceptability/feasibility of the program has been included. Pseudonyms replaced participants’ ‘real’ names during the transcription and analysis phases.

Determining feasibility of the program

To measure feasibility the investigators evaluated recruitment capability, retention, compliance with completing study outcome measures and qualitative feedback from participants about program acceptability. According to Orsmond and Cohn (2015, 169), the key objectives in determining feasibility are assessment of the ability to recruit, evaluation of outcome measures, participant acceptability of the intervention and evaluation of the promise shown from preliminary results (Orsmond & Cohn, 2015).

RESULTS

Recruitment

Five mentors and six mentees were recruited (Figure 1). We were unable to include all interested participants due to funding restrictions and five individuals were not able to be included.
Retention

One mentor-mentee pair withdrew from the program at the midway point due to compatibility and health issues. This pair did not attend the first workshop due to illness on the day. All other pairs completed the program.

Quantitative Outcomes

Table 2 presents pre and post program values for mentors and mentees. No significant results were found. However, of note MCQ scores for the item: ‘How much do you value talking/sharing with the mentee/mentor?’ both mentors and mentees placed high value on the ‘Sharing Purpose Score’ post program (mentees: 77.5 (16.3)/mentors: 65.0 (15.0)). The ‘Closeness Score’ identified that the mentees felt close to the mentors (mentees: 72.5 (31.3)) but the mentors did not feel as close to the mentees post program (mentors: 47.5 (5.0)). The ‘Handle Issues Score’ identified that the mentees had confidence that their mentor could handle their issues (mentees: 76.7 (41.7)) however the mentors were less confident in their abilities post program (mentors: 66.7 (13.3)).

Compliance to completing questionnaires

The majority of the questionnaires were completed with 10 out of 11 participants completing the SF-12, EDQoL and the K-10 and with 7 of 11 participants completing the MCQ (3 mentees and 4 mentors). The GMeRQS questionnaire was completed by all participants at week 3 but only completed by 5 participants (2 mentees and 3 mentors) at Week 9 (45.45%). One mentor did not complete any of the post program questionnaires.

Qualitative Feedback – Program Acceptability

The post workshop questionnaires identified that participants found the first workshop positive and enhanced their understanding of expectations and elements of the program.

*I think it was important (to attend) because I had no idea of what to expect initially so it was good getting together—having an idea of what was expected, what it was all about, meeting everybody, and being able to put together our own ideas of the needs of this kind of program* (Melody - mentee).
Feedback received from both mentors and mentees, mid-program, identified that the frequency of completing the logbook weekly was onerous. Based on this feedback the logbook was completed fortnightly for the last half of the program.

*It was a little bit much when the logbooks were weekly. They seemed to come around quite a lot…but then they extended it out every few weeks…yeah, that was better* (Melody - mentee).

Feedback received about the program in general revealed acceptability of the program and a genuine need for mentoring support programs, as an adjunct to therapy, and “the lack of services available for people…who are recovering…and not being sick enough to be in hospital”. Participants questioned why this type of support service was not currently available and hoped that the concept would be implemented on a larger scale “because there is a lot of people out there that are quite interested in it…and that would find it helpful”.

*…it…is good to be able to offer people different types of treatment and support as opposed to just that kind of ‘one size fits all’* (Sharon - mentor).

*…I don’t know why there aren’t more mentoring programs – it seems really helpful* (Angie - mentee).

Overall the qualitative feedback received about the acceptability of the program was positive and showed promise in promoting hope that recovery was possible. However, mentees did raise concerns both in the first workshop and in the interviews that mentors might be ‘triggered’ (i.e. at risk for relapse) because of their role in the mentoring relationship.

*Recovery is possible but even mentors have to protect themselves or they relapse* (Belinda - mentee).
Qualitative Feedback - Focus Groups, Phone Interviews & Written Feedback

The focus of this section is to present the ‘voices’ of the nine participants who evaluated the program with an external facilitator and provided qualitative data either in a focus group session, a phone interview or as written feedback (if this was preferred). Two mentees did not provide feedback.

Five key themes emerged from the evaluation data: 1) She understands me and could relate to me; 2) Re-connecting with the world - Asking questions and being challenged; 3) Mentors’ altruistic motivations and the transformation and discovery of self; 4) Instilling hope - Recovery is possible and; 5) Effective communication - The key to successful mentoring.

She understands me and could relate to me

The mentees revealed that the mentoring support program had significant benefits for them. Primarily the program was not formal treatment and involved a mentor who was someone with ‘first-hand’ personal experience of the mental illness; hence was someone whom they considered credible, understood their situation and could relate to. This therapeutic relationship was distinctive in that mentees did not fear reprisal (e.g., being admitted involuntarily to hospital) on revealing their thoughts as they may with a therapist or fear triggering a relapse of eating disorder behaviours in a peer.

I found it quite helpful in...having someone to talk to that understands – like who’s been through a similar experience...um...things that I was struggling with at different times, she could relate to, and then give me some advice on what’s helped for her in the past and how she got through things... (Melody - mentee).

...a safe place to talk...without it being like...treatment. Like, sometimes when I’m with my therapist...I worry that things I say are going to impact...treatment, like, her decisions and recommendations...You feel, like, a bit, ‘I don’t know if I want to share this with you because...’ — But with this it was like, you know they’re going to understand and they’re not gonna judge... (Angie - mentee).
The mentors highlighted these same sentiments describing the mentoring partnership as special because their personal lived experience enabled them to be in a position to ‘normalise’ the experience, providing much needed reassurance and reducing the stigma and the isolation surrounding AN. Rose poignantly identified that the most important aspect of being a mentor was “being there for them…to get them to understand that there’s nothing wrong with them…there’s nothing to fix…they need to get better, which is different to fixing”. For this reason Sharon explained that a recovered individual “makes a better mentor” than someone without lived experience.

I think having somebody that understands, and, gets it, like…we’ve been through similar things…I know my mentee was like, “It’s just nice to have somebody that I can say these things, and they get it! You…understand and you can relate… (Mia - mentor).

Re-connecting with the world - Asking questions and being challenged

The participants (both mentors and mentees) revealed that another valuable outcome of this mentoring support program was that it allowed the mentees to start to slowly re-connect with the world by developing new relationships, connections and friendships with those who not only gave sound advice and provided motivational support but who “challenged [them] to change”. It was remarkable that all mentors mentioned communication and how ‘open’ and trusting their mentees were with asking questions of them and/or seeking advice on issues. Mentees identified and truly appreciated that their individual mentors reciprocated that same openness in discussions. The mentees felt comfortable expressing their feelings to their mentors without metaphorically needing to “wear a mask…and then presenting to the world something they’re not”.

…so she was at a stage where she obviously was ready to change… she was really open with me…and she seemed comfortable to ask questions, if she had questions and asked for my opinion on things and asked about my experience, which was good… (Sharon - mentor).

…We had a really open relationship…it was really helpful…we could just say…what we were thinking…you get more…if you can just be honest with each other…not fearing that kind of judgment (Melody - mentee).

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Each dyad flourished independently due to the flexibility ingrained in the mentoring program’s structure. Lived experience of AN enabled the mentors to tactfully confront their mentees on issues and ask difficult questions that other individuals may not have been able to ask. These mentors challenged their mentees on certain issues, including their current quality of life, which on the whole mentees responded to favorably. Sophie, a mentee, explained that she was “being challenged that there is more to life…that life is not an eating disorder”.

…she wasn’t afraid to ask questions that possibly other people kind of don’t want to go into… (Angie - mentee).

…I’m quite straight to the point, and I asked her a question which I don’t think anybody had really asked her, which was really what was going on for her and, no, she’d never discussed it, but then she was able to communicate that through text (Rose - mentor).

Mentors’ altruistic motivations and the transformation and discovery of self

For all the mentors, altruistic motivations prompted them to volunteer their time to take on the role as a mentor in this program. In essence the mentors were people who wanted to turn a past negative experience into a positive one by helping and supporting others. Like Carmen, a mentor, who explained “…it shows me how far I have come and I guess I like helping people. I like seeing that I could have a positive change on someone…”.

Participating in the mentorship program highlighted how far the mentors had come in their own recovery journey and while the eating disorder no longer defined who they were, it had played a positive part in shaping their resilience as women.

I learned a lot about myself, which often happens with mentoring, of course…I learnt some things about myself, and how far I’ve come on my own journey which was valuable for me…I also certainly initially found it highly beneficial to be able to support someone else (Louisa - mentor).

…it was a reminder of how far I’d come and what I had achieved…how have I been able to take the fact that I struggled from an eating disorder and use that in a positive way?…it doesn’t define who I am anymore but I suppose it has shaped me a little bit, in how I think and how I perceive the world (Mia - mentor).
Instilling hope - Recovery is possible

The key aim of the mentoring program was the intention that it may provide a glimmer of hope for those struggling with AN; that recovery is possible and a tangible, achievable outcome can emerge from an insidious illness. Belinda, a mentee, saw the mentoring program as providing hope that others had not given up on finding ‘the right help’ for people with AN: “Hope that people out there are searching for the right help for people who are suffering”. Mentees revealed that they valued the opportunity to be partnered with positive role models who instilled them with an aura of positivity and hope, by demonstrating their strength and resiliency as women who have overcome AN. These mentors showed them that recovery was worth the fight.

Mentees:

...just having someone recovered...gives you that hope that...it is possible...and through all the hard work...it’s worth going through it if you can get to that stage – and just like how life is for them now...being recovered...that was helpful (Melody – mentee).

...we bought "recovery" bracelets and this was a really nice process of looking together and buying them together and the meaning it will always hold for me about the hope of recovery...There is life without an ED...There is life after and outside of the ED (Sophie - mentee).

Mentors:

...she did say...to me a couple of times that it was really good for her to talk to someone who had actually been through it and come out the other end and it gave her...a bit of hope that you can get better and that things can return to a somewhat normal life (Sharon - mentor).

...in life there’s things that we all struggle with and we’re not perfect and it’s okay to make mistakes...and give them that hope and remind them...’cause I think that you can easily get stuck into thinking “this is just how it’s gonna be and I just have to deal with it”... (Mia – mentor).

Effective communication – The key to successful mentoring

The mentoring program’s success relied heavily on effective interpersonal communication. Mentors were cognizant that they were “working with...eating disorders...they’re complex...it’s something that takes time
It became apparent that the method of communication employed was influential in the time taken to build a successful therapeutic relationship. All the mentors were adamant that face-to-face communication was the optimal form of communication for a successful mentoring relationship and for a supportive friendship to develop.

I was somewhat disappointed...that I wasn’t able to have much face-to-face contact with my mentee...obviously when you are sitting face-to-face and talking with someone it is a lot easier to get a better idea of how they’re feeling (Sharon - mentor).

...there was a text message pretty much every day, but it was very much support, and so...over text message I find it hard to build up a friendship... (Rose - mentor).

Most mentees however preferred text-messaging via mobile phone, social media (i.e. FaceBook) or email communication instead of face-to-face contact. This may have been a generational issue or alternatively the least intimidating form of contact for mentees. While the mentors were happy to accommodate the needs of their mentees it did seem to have some implications for the relationship regarding misunderstanding. While text-based communication has its advantages, such as greater accessibility, it also had some perils for a vulnerable group where misunderstanding can easily and unintentionally occur and for one mentor “a certain amount of distance crept in”. This mentor, who had only one face-to-face conversation with her mentee, at the initial program workshop, felt strongly that she “didn’t feel as connected to her [mentee] as the program went on because we hadn’t spoken to each other face-to-face and that level of contact wasn’t there”. Mentors felt that messages and their intended meaning can easily be ‘lost in translation’ in a written form and it is crucial to structure statements and choose words wisely before sending or posting a message.

[the mentoring program] “…was a learning for me to be…far more mindful of perception with vulnerable people…” (Louisa – mentor).
DISCUSSION

The aim of the mixed method study was to assess the feasibility of a mentoring support program for a small cohort of women diagnosed with AN and those recovered from AN. Qualitative feedback from those who provided feedback via the workshop questionnaires, interviews, written feedback, and logbooks supported acceptability of the program and its role. Recruitment, retention and general compliance with completing the quantitative questionnaires provides preliminary evidence for the mentoring program’s feasibility, as an adjunct to treatment. Specifically we identified the importance of having someone who understands to talk and share with. This mentoring support program showed promising results as an option for continued support for those transitioning from inpatient care to the community or for those unable to access eating disorder (ED) services and is feasible with some minor changes.

We exceeded our expectations in recruitment for the study. We envisaged 5 participants in each group. We had significant interest in the program and increased our numbers to five mentors and six mentees based on our available funding but halted recruitment at this point. Our retention rate was high with all but one pair completing the 13-week program. While the study numbers are too small to analyze efficacy from the outcome questionnaires (related to QoL, distress, and the mentoring relationship), talking and sharing was valued highly amongst both parties. Being understood by others (particularly those that have been in a similar situation) strengthens hope for recovery and the development of trusting therapeutic relationships (Dawson et al., 2014; Hay & Cho, 2013). Mentors did not feel as close to mentees post program but given that many with AN struggle with developing relationships this was to be expected and may have also been related to preconceived expectations of what the relationship would be like. Another reason may have been that their experience of having anorexia nervosa and the factors involved in its onset may have differed from the mentee and may have affected the strength of the relationship. While mentees had confidence in mentors’ abilities to handle situations, mentors had lower confidence levels suggesting a need for pre-training support workshops for mentors in managing difficult conversations and situations.
Overall general compliance with most questionnaires was good except the mentoring questionnaires, which had mediocre completion rates. Both the short and long item mentoring questionnaires were involved in the poor completion rates so it appears unlikely that the length of the questionnaire was the decisive factor in non-completion. This may affect the ability of future studies to capture the mentoring experience from a quantitative perspective thereby a mixed method approach is suggested for future studies. The mentoring relationship is complex and it is possible that the mentees may have felt uncomfortable ranking statements about their mentors.

The mentees’ concerns that involvement in the program might ‘trigger’ relapse in mentors were not substantiated. The mentors in the program had no significant decreases in quality of life during the study based on study outcome questionnaires and there were no qualitative reports either. The program was viewed positively and was acceptable to participants who provided feedback however, there were some suggestions based on qualitative feedback that could be used to improve future AN mentoring programs (such as logbook frequency, program structure and communication methods).

Results in both the qualitative and quantitative questions found that talking and sharing were important. Within the program outlined in this paper, having a person who was able to relate to the mentee on a personal level and to the struggles they endured provided reassurance and a sense of ‘normalisation’, reducing the stigma associated with having AN. From consumer perspectives supportive positive relationships and being understood are rated highly as factors facilitating recovery (Hay & Cho, 2013; Lindgren, Enmark, Bohman, & Lundström, 2015; Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2003). While some health care professionals may struggle to understand AN and sometimes feel the condition is self-inflicted (Ramjan, 2004), mentors in this program identified that mentees needed to get better but “there’s nothing to fix”. This underscores the importance of mentors having lived personal experience of the illness because they do understand how AN can dominate and control one’s life; both mind and body.
Mistrust may persist between healthcare professionals and consumers with AN due to an incompatibility between the consumer’s desire for thinness and the healthcare professionals’ role in ensuring weight gain. This incongruity may limit the opportunities for the growth of trusting, therapeutic relationships. Some healthcare professionals believe that within behaviourist treatment environments the individual often mistrusts others and as such they “fear opening up” (Ramjan, 2004). With the aim of the mentoring program to not be treatment or a substitute, it was encouraging that all the mentees felt safe, had no reservations or trepidation in opening up and exploring their feelings with their mentors. Further the term ‘friendship’ was used to describe the relationship. This demonstrated how power was shared in the relationship, with open and candid communication. Mentees felt less threatened by mentors, as there was no perceived capacity or responsibility for mentors to enforce unwanted care.

As AN can sometimes present as a maladaptive attempt to communicate to the world through the use of one’s body to express feelings (Jenkins & Ogden, 2012), having the opportunity to be able to freely express emotions to someone who understood seemed to be in some ways cathartic for mentees. In essence the program identified how pivotal it was that the mentor was someone that ‘had walked in their shoes’, understood them and could share their personal experiences. Having these attributes seemed to decrease the stigma and isolation associated with having a mental illness (Boydell, Gladstone, & Crawford, 2002) and enhanced a sense of comfort in belonging (Fogarty, Ramjan, & Hay, 2016).

In accordance with the findings of others (Lippi, 2000; Perez et al., 2014), this mentoring program revealed the altruistic motivation of mentors to use their lived experience to help others and affirmed the transformation they have made in their own lives (Fogarty et al., 2016). Like Perez et al. (2014) our mentors described intrinsic rewards from the mentoring relationship and particularly that it confirmed their own recovery and healthy thought processes (Perez et al., 2014). Notwithstanding the
challenges involved with being a mentor, the benefits far outweighed these by validating their own recovery, their redefined thought processes, their repertoire of coping skills and practical advice as a recovered person, further enhancing their own self-worth.

Mentors instilled a sense of hope and optimism for recovery to their mentees as part of the therapeutic relationship. This was achieved through openness in sharing their personal stories, giving advice, providing practical strategies while showing empathy and validation of concerns. Evidence suggests that hearing others’ stories can increase hope and motivation to recover (Dawson, Rhodes, Mullan, Miskovic, & Touyz, 2014; Dawson, Rhodes, & Touyz, 2014; Lindgren et al., 2015). Ideally the mentees who volunteered for this program, and for any future program, needed to be at the stage Dawson, Rhodes and Touyz (2014) label the “the tipping point of change”. There needed to be some insight, externalisation of the AN, or motivation to recover. It is within this stage that someone may be more receptive to the offer of support and the development of new trusting relationships (Dawson, Rhodes, & Touyz, 2014). With greater understanding from others in our case mentors recovered from AN, it instilled hope in our mentees that the effort was worth the fight to achieve recovery. Mentors felt comfortable to challenge mentees and role modelled to them that their current quality of life could be greatly improved, that there was so much more to life than giving in to the illness and that they had the capacity to change their lives for the better. “Having hope and a belief in the possibility of life ‘beyond anorexia...’” (Hay & Cho, 2013, p. 737) has been reported as an important part of recovery.

Realising the personal and emotional investment being made by mentors in this type of relationship, there is always some danger for recovered mentors that work in close proximity with someone with AN, to be triggered by their mentee, with the re-surfacing of past emotions, negative experiences or thoughts. For the mentoring relationship to be successful personal self-care for mentors is critical. In addition, monitoring of mentors by program staff is imperative to ensure mentors’ health.
and safety. Self-preservation of one’s own health requires safety nets (external support mechanisms) to be in place and accessed as needed; this may include finding their own ways to debrief and reflect on circumstances with others to monitor their own emotional and mental health (Ramjan et al., 2016). Whilst the mentors in this study showed no decrease in quality of life or an increase in distress due to being involved in this program based on quantitative outcomes, any future programs should monitor the emotional and mental health and self-care resources of mentors.

Finally, interpersonal face-to-face communication was seen as a critical component for the development and maintenance of the supportive relationship. While studies show that a positive and stable therapeutic relationship, equivalent to face-to-face, can be established online or through text-based communication (Sucala et al., 2012), our mentors believed face-to-face contact was more personal. While the text-based or written communication was perhaps less intrusive on participants’ daily lives and less intimidating for the mentees, it can lead to miscommunication or misinterpretation by either party hindering trust. There are a number of stages involved in developing a relationship including building up trust, clarifying roles and boundary setting, and then enhancing the relationship to build a more open and comfortable relationship (LaPorta, 2012; Micevski & McCann, 2005; The Mentoring Partnership of Southwestern Pennsylvania, 2015) and taking into consideration the preferred method of communication for mentees was email or text, the development of a relationship might take longer to manifest than if there were more face-to-face meetings. Inclusion of a minimum number of face-to-face meetings or extending the program duration (to account for a possible delay in building a relationship) in future mentoring programs may enhance relationship development and mentoring program experiences.

Our mentors seemed to embody the key attributes necessary for successful communication within a therapeutic relationship, which included empathy, being there, providing reassurance, being non-judgmental, open and willing to share, honest, genuine, and trustworthy (Dziopa & Ahern, 2008;
Fogarty et al., 2013). Authenticity and being able to relate to the situation, being open, getting to know the individual, self-disclosure, and guiding them to find solutions have been identified as important for the success of interpersonal communication within the relationship (Shattell, Starr, & Thomas, 2007). The importance of effective communication cannot be underestimated in the relationship. It has been shown that there is a positive association with higher quality of life scores among people with eating disorders and greater communication in the mentoring relationship (Perez et al., 2014).

**LIMITATIONS AND CHANGES TO THE PROGRAM**

The limitations of this study include the small number of participants. A further limitation may have been the 13-week timeframe of the program, which may have limited the opportunity for the development of some relationships. Many of the questionnaires and logbooks were used to monitor the health and safety of the participants and initially there was good compliance however as the program progressed the compliance waned. This may have been because the participants a) did not understand that some of the questionnaires were for their safety and health, and/or b) the participants felt that nothing was changing regarding their health so they felt less motivated to complete the paperwork. It is important that a mentoring program monitors the health and safety of the participants (both mentors and mentees) and getting the balance between monitoring safety and paperwork is important. One way to address this balance between safety and paperwork is to inform the mentees’ medical health professionals of their involvement in the program. This then allows medical health professionals to communicate concerns to the program coordinators. It should also be acknowledged that inpatient consumers may not have the insight (be at “the tipping point of change”) to engage in such a program; the mentoring program described in this study may be better suited to those transitioning from inpatient settings to the community. Those providing this type of mentoring program may also need to manage participants’ expectations by clearly outlining that the program is not treatment per se and boundaries are set, however relationships can evolve in different ways. Further research is warranted to determine the viability of mentoring programs in adult inpatient and paediatric settings and whether differences in age between mentors and mentees may have implications for the overall nature of the relationship. Future research may possibly need to look at key aspects whereby mentor and mentee may need to be matched (not just by age but in relation to other
factors associated with the ED—e.g. type, duration) however this may need to be according to people’s preference as there can be pros and cons to such closer ‘matching’.

CONCLUSIONS

This mentoring support program supports further evaluation as an adjunctive resource with intrinsic rewards for both mentor and mentee. The development and maintenance of a non-judgmental, empathetic therapeutic relationship, with a mentor who understands the connection to anorexia and where the mentee is listened to and appreciated, may provide the social support necessary to sustain motivation for recovery and the genesis of a new identity separate from anorexia nervosa.

IMPLICATIONS FOR CLINICAL PRACTICE

While further research is warranted mentoring support or recovered mentors may play a potentially valuable role in supporting those in community settings. Healthcare professionals may be able to find ways to partner ‘recovered’ individuals with ‘recovering’ individuals, while monitoring health and safety, as it has shown potential benefits in instilling hope for recovery.

REFERENCES


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Sucala, M., Schnur, J. B., Constantino, M. J., Miller, S. J., Brackman, E. H., & Montgomery, G. H.


Table 1: Demographic profile of the participants.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Participants</th>
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<tbody>
<tr>
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<tr>
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</tr>
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<td>Age (years)</td>
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<tr>
<td>5 Mentors</td>
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<td>6 Mentees</td>
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<td>Country of Birth</td>
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<td>Children</td>
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<td>Years struggling with anorexia nervosa</td>
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<tr>
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<tr>
<td>Years recovered</td>
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<td>Mentors</td>
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<td>5-20</td>
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<td>SF-12 QoL</td>
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<td>Emotional</td>
<td>Psychological</td>
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</tr>
<tr>
<td>Baseline</td>
<td>49.3 (12.5)</td>
<td>24.7 (7.3)</td>
<td>29.0 (7.0)</td>
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<tr>
<td>Post-program</td>
<td>48.5 (4.9)</td>
<td>25.7 (8.5)</td>
<td>30.0 (6.5)</td>
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<td>Baseline</td>
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<td>51.1 (5.7)</td>
<td>1.0 (2.0)</td>
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<tr>
<td>Post-program</td>
<td>56.8 (4.9)</td>
<td>53.0 (14.4)</td>
<td>3.0 (6.5)</td>
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</table>

**Higher score = greater QoL**
| Population norms are not available for mentees or those with an eating disorder. Population average is for the general population not specific to mentors involved in AN mentoring. |

<table>
<thead>
<tr>
<th>Pre and post program values and results</th>
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<table>
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<tr>
<th></th>
<th>Pre (n=25)</th>
<th>Post (n=25)</th>
<th>95% CI</th>
<th>Z</th>
<th>Sig</th>
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<tr>
<td><strong>Satisfaction Score</strong></td>
<td>64.0 (25.0)</td>
<td>63.5 (41.0)</td>
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<tr>
<td><strong>Non-academic Support</strong></td>
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<td>0.48</td>
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<td><strong>Academic Support</strong></td>
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<tr>
<td><strong>Fun Purpose Score</strong></td>
<td>53.3 (5.0)</td>
<td>52.5 (12.8)</td>
<td></td>
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<tr>
<td><strong>Character Dev't Purpose</strong></td>
<td>45.0 (10.0)</td>
<td>45.0 (15.0)</td>
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<td><strong>Outlook Purpose Score</strong></td>
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<td>55.0 (11.3)</td>
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<td>0.47</td>
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<tr>
<td><strong>Programmatic Support Score</strong></td>
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<td>0.77</td>
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<tr>
<td><strong>Parental Engagement Score</strong></td>
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<td>85.0 (55.0)</td>
<td>1.42</td>
<td>0.15</td>
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</tbody>
</table>

Higher scores = greater satisfaction

N/A: Not applicable
Figure 1. CONSORT Flow Diagram

Enrollment

Assessed for eligibility (n= 28)

Excluded (n= 16)
- Not meeting inclusion criteria (n= 6)
- Declined to participate (n= 3)
- Spots full (n= 5)
- Too busy/busy workshop day (n= 2)

Consented (n= 12)

Mentors

Withdrew (n= 1)
- Too busy (n= 1)

Mentees

Mentors (n= 5)
- Attended Workshop (n= 4)
- Unwell on workshop day (n= 1)

Workshop

Mentees (n= 6)
- Attended workshop (n= 5)
- Unwell on workshop day (n= 1)

Program

Mentors (n= 5)
- Completed Program (n= 4)
- Did not complete program (mentee withdrew) (n= 1)

Mentee (n= 6)
- Completed Program (n= 5)
- Did not complete program (withdrew due to health and compatibility issues) (n= 1)

Analysis

Analysed (n= 5)

Analysed (n= 6)