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Therapeutic Bond: Challenges of a Multidisciplinary Team Specialized in Eating Disorders

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Abstract

Establishing a good therapeutic alliance is essential in the treatment of people with anorexia or bulimia nervosa. However, healthcare providers consider sustaining the professional-patient bond challenging, as many patients do not acknowledge their illnesses and need for professional help. This study aimed to understand the meanings the team specialized in eating disorders (ED) assigned to the professional-patient bond. This descriptive-exploratory study adopted the Clinical-Qualitative Method and Bonding Psychoanalysis as the theoretical framework. Twenty-three professionals participated in this study. They were members of a healthcare team at a specialized ED outpatient clinic at a university hospital. Data were collected through semi-directed interviews applied online and submitted to Reflexive Thematic Analysis organized into three categories: (1) the centrality of the therapeutic relationship and how to enhance it to favor the treatment; (2) Difficulty in maintaining the professional-patient bond: an exhausting and demanding exercise; (3) Responding to the challenges imposed on the therapeutic relationship: perseverance and tolerance to frustration. Even though the participants recognize difficulties in maintaining a therapeutic relationship, they value it as a structuring axis of care and a factor that determines a successful therapeutic process. Empathy appears as a catalyzing vector of the therapeutic relationship, and the professionals perceive that they are also transformed in the patient's treatment journey. Additionally, the healthcare providers need to improve their resources to strengthen the therapeutic potential of the bond and overcome the challenges.

Keywords: feeding and eating disorders, health personnel, patient care team, therapeutic alliance, professional-patient relations

VÍNCULO TERAPÊUTICO: DESAFIOS DE UMA EQUIPE MULTIDISCIPLINAR ESPECIALIZADA EM TRANSTORNOS ALIMENTARES

Resumo

Estabelecer uma boa aliança terapêutica é requisito essencial no tratamento de pessoas com anorexia e bulimia nervosas. No entanto, a sustentação do vínculo profissional-paciente é percebida pela equipe como uma tarefa desafiadora, uma vez que muitas pacientes não reconhecem seu sofrimento e, consequentemente, a necessidade de ajuda profissional. O objetivo deste estudo foi compreender os significados atribuídos por uma equipe especializada em transtornos alimentares (ED) ao vínculo profissional-paciente. Trata-se de um estudo descritivo-exploratório, que utilizou o Método Clínico-Qualitativo e teve como referencial teórico a Psicanálise Vincular. Participaram 23 profissionais que integram a equipe de um ambulatório especializado em ED localizado em um hospital-escola. A coleta de dados foi realizada por meio de entrevistas semidirigidas aplicadas online. Os dados foram submetidos à Análise Temática Reflexiva e organizados em três categorias: (1) Centralidade do vínculo terapêutico e como potencializá-lo em benefício do tratamento; (2) Dificuldade em sustentar o vínculo profissional-paciente: um exercício exaustivo e exigente; (3) Respondendo aos desafios do vínculo terapêutico: perseverança e tolerância à frustração. Os participantes valorizam o vínculo como eixo estruturante do cuidado e fator determinante para o sucesso do processo terapêutico, embora reconheçam dificuldades na sua manutenção. A empatia aparece como vetor catalisador da relação terapêutica e os profissionais sentem que também são transformados no curso do tratamento. Diante dos desafios vivenciados, os membros da equipe necessitam aprimorar seus recursos para fortalecer o potencial terapêutico do vínculo.

Palavras-chave: transtornos da alimentação e da ingestão de alimentos, pessoal de saúde, equipe de assistência ao paciente, aliança terapêutica, relações profissional-paciente

VÍNCULO TERAPÉUTICO: DESAFÍOS DE UN EQUIPO MULTIDISCIPLINARIO ESPECIALIZADO EN TRASTORNOS ALIMENTARIOS

Resumen

Establecer una buena alianza terapéutica es un requisito esencial en el tratamiento de personas con anorexia y bulimia nerviosas. Sin embargo, la sustentación del vínculo profesional-paciente es percibida por el equipo como una tarea desafiante, una vez que muchas pacientes no reconocen su sufrimiento y, consecuentemente, la necesidad de ayuda profesional. El objetivo de este estudio fue comprender los

significados atribuidos por un equipo especializado en trastornos alimentarios (TA) al vínculo profesional-paciente. Se trata de un estudio descriptivo-exploratorio, que utilizó el Método Clínico-Cualitativo y tuvo como referencial teórico el Psicoanálisis Vincular. Participaron 23 profesionales que integran el equipo de un ambulatorio especializado en TA ubicado en un hospital-escuela. La recolección de datos fue realizada por medio de entrevistas semidirigidas aplicadas online. Los datos fueron sometidos al Análisis Temático Reflexivo y organizados en tres categorías: (1) Centralidad del vínculo terapéutico y cómo potenciarlo en beneficio del tratamiento; (2) Dificultad en sostener el vínculo profesional-paciente: un ejercicio exhaustivo y exigente; (3) Respondiendo a los desafíos del vínculo terapéutico: perseverancia y tolerancia a la frustración. Los participantes valoran el vínculo como eje estructurador de la atención y factor determinante para el éxito del proceso terapéutico, aunque reconocen dificultades para su mantenimiento. La empatía aparece como vector catalizador de la relación terapéutica y los profesionales también se transforman en el transcurso del tratamiento. Frente a los retos experimentados en el trabajo, los miembros del equipo necesitan mejorar sus recursos para fortalecer el potencial terapéutico del vínculo.

Palabras clave: trastornos de alimentación y de la ingestión de alimentos, personal de salud, grupo de atención al paciente, alianza terapéutica, relaciones profesional-paciente

Anorexia nervosa (AN) and Bulimia nervosa (BN) are eating disorders (ED) characterized by the tenacity with which patients maintain their symptoms active and health problems that commonly lead to severe physical, psychological, and social impairments (American Psychiatric Association - APA, 2014; Leonidas & Santos, 2020a, 2020b). While rigid and restrictive eating behaviors prevail in AN, binge eating followed by compensatory behaviors are more prominent in BN, such as self-induced vomiting, strenuous physical exercise, and the use of laxatives for purgative purposes (APA, 2014). Despite specificities, some symptoms are common to both conditions, such as critical distortion of body image, low self-esteem, and difficulties managing affective and social bonds (Leonidas & Santos, 2020a, 2020b).

The literature shows that health professionals face difficulties establishing and maintaining a therapeutic bond with patients diagnosed with AN/BN. They often complain of fatigue and hopelessness when faced with their patients' resistance to change; studies indicate that patients with ED are usually refractory to treatment (Fleming et al., 2021; Graham et al., 2020; Thompson-Brenner et al., 2012). The teams claim that, in addition to having self-destructive behaviors, patients with AN/BN are suspicious, reluctant, or ambivalent toward treatment (Manochio et al., 2018).

The literature often associates a lack of awareness or denying such disorders with patients' skepticism and ambivalence toward treatment (Souza et al., 2019). Individuals with ED tend to be reluctant and even refractory to treatment due to a failure to understand the disorder's severity, which is also associated with how patients relate to their emotional conflicts. Patients are affected by ego-syntonic symptoms, i.e., they often fail to acknowledge their disturbed and problematic eating behavior patterns, which results in low motivation to engage in the process of change (Treasure et al., 2020; Santos & Pessa, 2022; Souza et al., 2019). Personality factors such as immaturity, rigidity, and inflexibility, in addition to an "all or nothing" thinking pattern, contribute to denying their illness (Oliveira-Cardoso & Santos, 2019). If chances are not appropriately managed, difficulties in adhering to the therapeutic plan may become more pronounced, resulting in high rates of treatment discontinuation and abandonment (Graves et al., 2017; Manochio et al., 2018; McDonald et al., 2021; Souza & Santos, 2015; Souza et al., 2019). Treatment non-adherence rates are estimated at more than 70% (López-Gil et al., 2023).

More recently, in the contemporary context of care provided to ED, difficulties in treatment adherence have been considered according to the bond formation model, especially from the perspective of object relations theory and attachment theory (Leonidas & Santos, 2020b). The psychoanalytic model emphasizes the importance of addressing current difficulties experienced in the therapeutic relationship established with patients with ED based on the emotional understanding of the vicissitudes of their first significant bonds. This assumption suggests that patients suffer from early self-development failures, understood as the matrix of one's ability to relate (Bruch, 1978; Ferreira et al., 2021; Leonidas & Santos, 2020b).

Psychotherapy creates an environment of controlled regression, which enables an individual to access repressed affects of early experiences, updating them in the analytical scene

through transference, that is, a sort of "stage" on which the psychotherapist handles ideational and affective elements until they gain symbolic representation (Santos et al., 2020b). The underlying assumption is that archaic affective experiences, which have not yet acquired psychic inscription, may interfere with forming and maintaining bonds in the later period of growth and emotional development. Severe psychological disorders, such as those present in the symptomatic manifestations of anorexia and bulimia, are distortions in the maturation process preventing the achievement of emotional health (Granieri & Schimmenti, 2014; Leonidas & Santos, 2020a).

This study is grounded on the theoretical-conceptual framework of Bonding Psychoanalysis (Berenstein & Puget, 2008), in which a bond is established between subjects of the unconscious (Levisky, 2021; Maia et al., 2023b; Santos et al., 2020a). From the perspective of Bonding Psychoanalysis, such a bond is constitutive of the intersubjective space, which encompasses the web woven between the presences of two or more subjectivities, as well as the psychological mechanisms that keep them connected (Berenstein & Puget, 2008). A bond is defined as the link encompassing distance proximity between the presence of two or more subjects and the mechanisms that maintain them connected, i.e., which sustain a relatively stable bond over time. Therefore, the intermediate space between one subject and another demarcates the boundaries of the intersubjective dimension (Puget, 2003; Berenstein & Puget, 2008). The authors above consider that the mechanisms maintaining a cohesive bond constitute a "working alliance."

Presence is defined as being in front of someone recognized as not self, reaffirming the essential nature of the encounter with another individual to compose the bonding web (Maia et al., 2023b; Santos et al., 2020b). Therefore, the concept of presence presupposes the existence of a radical and irreducible difference, which goes hand in hand with another, which Puget (2003) calls *ajenidad*, situated outside the symbolic field. In other words, it is a difference for which there is no accessible representation in the psyche. Consequently, *ajenidad* is a differentiating requirement of the self-other pair and the founding landmark of the boundaries of the self. On this inescapable and unassimilable difference, the "working alliance" takes place so that the bond established between two subjects of the unconscious can remain alive and operative. Thus, based on how they experience and symbolize otherness as a radical difference (*ajenidad*), each subject constitutes his/her own bonding web throughout life (Puget, 2003; Maia et al., 2023b; Santos et al., 2020b).

The psychoanalytic notion of bonding can be transposed to the professional-patient context of AN/BN, in wich a specific type of bond, a therapeutic relationship, is configured and supports transference and guides the treatment (Oliveira-Cardoso et al., 2018; Ramos & Pedrão, 2013). This construct has been commonly defined as a device that allows maintaining a bond of psychological intimacy, which is established between a health professional and a patient. The quality and type of such a bond determines the effectiveness of the intervention; the more comfortable and understood a patient feels, the more receptive and accessible he/she will be to work with his/her thoughts, emotions, and behaviors (Santos & Pessa, 2022). In this health

model, which is based on a connection between subjects of the unconscious, establishing a good therapeutic relationship leads to a greater chance of improving a patient's symptoms and using the potential of the analytical encounter to the best.

A working alliance is a fundamental element for consolidating a solid therapeutic relationship, also referred to in the literature as the therapeutic alliance. The therapeutic alliance is defined as a relationship established between a professional and a patient in favor of the therapeutic process, based on ego functions, but also referring to the organization of childhood object relations (Zetzel, 1956). The therapeutic alliance is the first step toward establishing transference neurosis (Peres, 2009), driving the treatment dynamics. It is when the patient includes the professional as a fantasy figure with whom he/she will reenact his/her primary bonds with parental figures, using the therapeutic function to express unconscious conflicts and, thus, reconnect with repressed ideational and affective content. Thus, the bonds between a patient and health professional and the treatment are considered catalytic and driving forces toward change and a particular case in which a social bond is established. Like any bond, the links go back to the gratifications and frustrations experienced in the primary relationships established with parental figures during childhood, especially with the maternal figure (Leonidas & Santos, 2020a). The particularity of the psychoanalytic intervention consists of instrumentalizing the bond, establishing it as the backbone of the treatment (Peres, 2009), and making it operate in the service of the patient's emotional maturation.

If the contact with the *ajenidad* can be supported within a permissive emotional atmosphere, the bond that the patient establishes with the psychotherapist is strengthened and can support and lead to a therapeutic alliance. The quality of this bond depends on the personality resources each individual can acquire throughout their development, including the degree of maturity of their ego defense mechanisms. Thus, an individual's ability to bond depends on the peculiar way in which he/she can relate to himself/herself and his/her own body in the incessant search for the gratification of basic needs, which are coupled with instinctual experiences and re-enacted in the transference (Ferreira et al., 2021; Leonidas & Santos, 2020b).

One matter that researchers rarely consider is that treatment implies bonding, and bonding involves the participation of other actors (health professionals) who have the potential to strongly influence the (low) treatment adherence of individuals with ED. Based on a previous study, ED are considered psychopathologies with a complex and multifactorial etiology linked to a primary and multifaceted deficit in the early development of the psychological apparatus. This deficit affects one's ability to bond (Leonidas & Santos, 2020a); thus, health professionals providing healthcare to this population must be prepared and aware of the need to thoroughly examine how they relate to their patients during consultations.

The professionals must have a flexible and welcoming attitude, and the treatment must be implemented *with* and *through* bonding. As these patients are notoriously prone to regressions in their relationship patterns (Leonidas & Santos, 2020a), an attentive look at how bonds develop and evolve is an essential resource in the therapeutic arsenal. The quality of the bond established

in the treatment of ED directly influences how smoothly the process occurs, especially in the management of chronic conditions (Ramos & Pedrão, 2013; Souza & Santos, 2013a, 2015; Weeb et al., 2022; Werz et al., 2022).

As noted by Zetzel (1956), the therapeutic alliance from a psychoanalytic perspective is not only central to the therapeutic process but also a predictive factor of its evolution (Peres, 2009). Furthermore, international studies show that a professional's availability to care for the bond facilitates such an alliance, as it fosters trust and encourages patients to be emotionally open and candid, strengthening treatment adherence (Johns et al., 2019; Sibeoni et al., 2017).

However, the literature shows that health professionals attending patients with anorexia or bulimia tend to see their resistance to treatment and susceptibility to chronic symptoms (Seah et al., 2017). Literature reviews (Graham et al., 2020; Graves et al., 2017; Seah et al., 2017) emphasize that clinicians commonly experience negative responses when caring for patients with ED, including frustration, hopelessness, feelings of incompetence to manage care, and concerns about the patients' poor clinical evolution. The reason is that these patients tend to sustain an unchanged clinical condition for months or years, alternating with brief periods of stability. Complete remission of symptoms is relatively rare (Manochio et al., 2018). Professionals usually associate the range of emotions mobilized during care with peculiarities of the patients' psychological functioning, such as a tendency to act out, communication difficulties, and challenges in stabilizing the bond and the therapeutic setting (Fleming et al., 2021; LaMarre & Rice, 2021).

A systematic literature review, followed by a meta-synthesis (Maia et al., 2023a), focused on health professionals, showed that some factors help these workers to manage the difficulties encountered during care, such as seeking out more experienced professionals for guidance, relying on peers in the multidisciplinary team, and dedicating oneself to studies; however, interprofessional difficulties may still persist. Hence, these findings indicate the importance of choosing healthcare professionals as the primary source of research, considering that they are involved in an extensive and complex network of relationships. Professionals have specific life stories and backgrounds, are committed to their teams and various healthcare settings in the institutions where they are affiliated, and depending on the quality of bonds, such connections may either help or make clinical work more stressful (Ynomoto et al., 2022). Therefore, these professionals are actors and protagonists in healthcare settings who deserve to be heard and have the opportunity to share their experiences.

Considering the context discussed earlier, there is a need to fill in a knowledge gap on factors contributing to strengthening the therapeutic relationship, especially with studies considering health workers' perspectives. Professionals providing care to individuals with ED may deal with an arduous work routine, where the rate at which cases are solved is low, and possibly deal with physically and emotionally complex and strenuous situations, which increases the risk of illnesses (Fleming et al., 2021; Souza & Santos, 2013b; Ynomoto, 2022). A review conducted by Brolese et al. (2017) identified several adversities related to the professionals' practice, such

as heavy workload, a perception of insufficient personal resources, and a lack of specific training to work with ED. These factors contribute to worsening healthcare-related stressors, with the potential to harm the therapeutic relationship.

In addition to health workers' mental health, such a topic requires new investments in the research agenda, as there is practically a consensus in the literature that the quality of the therapeutic relationship has direct repercussions on the effectiveness of the care provided to individuals with AN/BN (Souza & Santos, 2013b, 2014; Weeb et al., 2022; Werz et al., 2022). Hence, such a challenge led to the research question: "What meanings do the health team members specialized in ED give to their bonding experiences with patients with AN/BN?" Hence, this study's objective was to analyze the meanings assigned by a team specialized in ED to the bond established between professional and patient.

Method

Study design

This descriptive and exploratory study adopted a qualitative approach (Flick, 2019). It is based on the Clinical-Qualitative Method – CQM (Turato, 2013) and the Bonding Psychoanalysis (Berenstein & Puget, 2008) theoretical framework. This theoretical-clinical psychoanalysis of Franco-Argentine heritage proposes the reorientation of understanding the unconscious, focusing on its social dimension (transubjective space) and bonding dimension (intersubjective space).

Qualitative research is a methodological perspective based on understanding perceptions, motivations, beliefs, and representations from the perspective of the study's participants (Flick, 2019). The CQM was chosen because it is suitable for addressing research problems arising directly from the challenges experienced in social practices within the health field. This framework has an approximation with existentialist, clinical, and psychoanalytic positions and concepts as its epistemological pillar. Based on these three foundations, CQM is intended to offer interpretations of the meanings participants assign to their experiences in the health-illness-care process (Turato, 2013).

This study was performed at an outpatient clinic in a public health institution recognized in Brazil for pioneering work in the clinical follow-up of adolescent and adult patients diagnosed with AN/BN. This facility was selected because it is a reference for specialized care for ED. At the time of this study, most patients were adult cisgender women between 18 and 35 years old. The team includes professionals, postgraduate students, residents, and interns from psychology, psychiatry, nutrition, nutrology, and occupational therapy. This outpatient facility operates on Fridays with scheduled individual appointments for patients and their family companions. Hospitalizations are reserved for very severe and high-risk cases. Individual appointments are complemented by group care provided by psychological, nutritional, and occupational therapy teams. Follow-up appointments are scheduled according to each patient's needs, with a maximum interval of one monthly appointment.

Before starting data collection, the author spent eight months in the field, participating in weekly meetings to discuss cases and plan care strategies with the multidisciplinary team. The CQM recommends this immersion in the field to ensure familiarity with the context under investigation (Turato, 2013).

Participants

The sample was intentionally selected and comprised almost the entire health staff (n=23); only one psychiatrist declined the invitation. The following eligibility criteria were established: being a team member for at least one year and having been continuously engaged with the care activities throughout the period they worked in the service. This facility was chosen due to its long tradition in ED. It is a national reference in the field, connecting the dimensions of the tripod consisting of teaching, scientific research, and university extension. In addition to professionals and residents from different fields, undergraduate students who received training in curricular and professional internships were included in the sample because these participants provided regular clinical care under supervision in intensive training programs that lasted 12 months.

As previously noted, the study participants constituted almost the entire multidisciplinary team working in the specialized outpatient clinic at the time of data collection: 12 members of the psychology team, three of whom were professionals enrolled in graduate programs, one was a professional supervisor, and eight interns; three professionals from the nutrology team, being two residents and one supervisor; two residents from the psychiatry team; four participants from the nutrition team, three of whom were professionals attending graduate studies and one supervisor; and, finally, two professionals from the occupational therapy team, one resident and one supervisor. The participants' average length of professional experience was eight years.

Instruments

A sociodemographic form was used to characterize the participants, addressing information such as age, gender, profession, and experience within the team. A semi-structured interview script was applied, including questions about the experience of establishing bonds with patients, how bonds can contribute to the treatment success, aspects valued in the bond, conceptions about care, the objectives intended with the interventions, emotional impacts of the relationship established with patients, and sources of satisfaction and dissatisfaction with their practices.

Procedure

The process included a preparatory phase, during which the researcher was immersed in the research field to familiarize herself with the service routine. This was followed by data collection to characterize the sociodemographic profile and apply the semi-structured interviews.

The clinical attitude recommended by the CQM was adopted to conduct the interviews, i.e., free-floating attention was adopted, privileging the existential understanding of the distress experienced by the study participants to encourage the production of unique reports, valuing their personal concerns (Turato, 2013).

The primary author held individual interviews, mediated by a digital platform in August 2022; the interviews lasted 30 minutes on average. The interviews were held online to comply with the safety protocols established by the health facility during the COVID-19 pandemic (Fiocruz, 2021; Maia et al., 2023c; Santos et al., 2023).

The field researchers transcribed the interviews verbatim. Codes were assigned to each participant to protect their identities and ensure information confidentiality. The codes comprised the nomenclature of each profession followed by the number representing the order in which the interview was held. Thus, interviewees from the psychology field were identified as Psy, from psychiatry as Psych, nutrition as Nutri, from nutrology as Nutro, and those from the occupational therapy field were identified as OT.

Data were treated using Reflexive Thematic Analysis. This procedure proposed by Braun and Clarke (2013) enables textual narratives to be categorized according to the meanings assigned by qualitative research interlocutors, regardless of the theoretical framework adopted. Hence, the analysis followed the six methodological steps established by the previous authors. Two members of the research team worked independently in all the analysis stages. First, the textual material was submitted to floating reading. Next, they coded the reports, which were organized using Atlas-Ti software. One of the advantages of using this tool is that it facilitates the identification of codes that answer the research question.

The codes concerning the professional-patient relationship are highlighted according to the objective proposed here. The lists organized by the two reviewers were compared, and the preliminary codes were discussed individually. The agreeing codes were kept, and a third reviewer with extensive expertise in thematic analysis decided about divergent classifications so that consensus categories remained in the final list.

According to the third step of the Reflexive Thematic Analysis, the codes obtained in the previous step were grouped into broader themes, followed by their respective subthemes, seeking to preserve their connections with the general context. The fourth step consisted of reviewing all the themes to verify whether the data obtained were sufficient to support them. The fifth step consisted of a thematic data map to help organize the contents coherently and consistently with this study's objective.

After completing the analysis, the last phase was intended to prepare the study report. Therefore, representative excerpts of the participants' reports were selected to illustrate the themes. Finally, as recommended by Reflexive Thematic Analysis, an analytical narrative was developed according to the theoretical framework; such narrative transcends a mere description of the themes. Later, it was presented to the participants in one of the meetings when the findings were discussed. The participants contributed with suggestions to calibrate and enhance

the interpretations. As recommended by the CQM, this activity supported and enabled the research interlocutors to validate the results.

All procedures, from inviting the participants to data collection to the analysis and storage of data, complied with the ethical recommendations provided by Resolution No. 466/2012, which regulates research involving human subjects. Likewise, the guidelines of the Federal Council of Psychology (CFP) (Resolution No. 016/2000) were strictly adhered to. Finally, the Institutional Review Board at the Faculty of Philosophy, Sciences, and Letters of Ribeirão Preto, University of São Paulo, approved the project (CAAE No. 54292821.4.0000.5407).

Results and Discussion

Three thematic axes emerged, and the data were refined by rigorously applying the Reflexive Thematic Analysis.

Thematic axis 1: *the centrality of the therapeutic relationship and how to enhance it to favor the treatment*

The participants' reports show a consensus regarding the therapeutic bond's leading role as a structuring axis of care. Furthermore, team members revealed themselves as sensitive and attentive to the need to consider the potential repercussions of the professionals' attitudes on the therapeutic relationship. They emphasized behaviors and attitudes that they seek to adopt so that the bond established with patients promotes effective therapeutic care. The following excerpt highlights this concern with how to approach and relate with patients:

> Especially in these cases of eating disorders, I think we support and guide the patient in achieving improvement [...] and how do we do that? I think that the main thing... the main point is establishing a bond (Psych1, professional/resident).

Other participants corroborated the importance assigned to the bond, drawing attention to the professional's responsibility to identify appropriate paths to build a therapeutic relationship with each patient: "You need to make an effort to establish a better bond and understand a little more about how it works. So I think you have to be open to that" (Nutro2, professional/resident). "Trying to understand, to see that person from a different perspective, with a little more affection" (TO2, professional/resident). "We need to be ethical and responsible and look at the other person from an understanding and empathetic perspective. So, depending on our understanding, attitudes, and behaviors, I think we can make a difference in the treatment, you know?" (Nutri1, professional/researcher).

> I think the professional contributes when she is open and looks at the patient from a humanized perspective [...]. For example, she helps the patient think and feel their anxieties and identify their thoughts and feel-

> ings at each moment. I think this also depends on the professional being able to get in touch with these feelings, both the patient's and their own (Psy7, professional/researcher).

When reflecting on the strategies that can contribute to a successful treatment, the team members reinforced the need to care for the therapeutic relationship, especially by being available to listen to the patients and being empathetic when addressing their problems. This concept emerged strongly in the participants' reports, especially among those from the psychology field, who related it to an understanding and committed attitude towards the search for humanized care: "[...] it is about being there completely and listening to what that person has to tell you, so I think it is about being open. That is it" (Psy11, intern). "Of course, welcoming and listening are part of what psychologists usually do" (Psy3, professional/researcher). "First, understand how the patient functions, understand what food means to them, and try to understand how they are feeling" (Psy2, professional/researcher).

Other participants also valued the centrality of empathic listening in establishing a bond, as can be verified in the report of one of the psychiatry professionals: "The main aspect is the bond. We encourage the establishment of a bond so we help the patient work on issues that they need to work with on" (Psych2, professional/resident). An OT professional stated: "It is about genuinely wanting to be there with the patient" (OT1, hired professional). The therapeutic alliance, a fundamental bond component, is perceived as a resource that induces and enhances improvement. "I think the therapeutic alliance helped me a lot" (Psych2, professional/resident).

According to Puget (2015), bonding introduces a perspective of openness to differences and the identification of the new, which can ferment the seed of change concerning what is already known and established in the psychological situation. Thus, to build and strengthen bonds, the bonding individuals, as noted by this study's participants, must remain "open" and "permeable" and be willing to become sensitive and change by another's presence. It is not just about wanting the other to change but being willing to change oneself, being able to accompany them in the movement towards change, and learning to co-evolve with them. Presence, then, displaces and demands the working alliance and requires that the individuals involved in the bond promote a "doing with" the differences that emerge in the encounter, creating specific practices for each pair (Maia et al., 2023c; Puget 2012). This conception is directly opposed to the adoption of rigid protocols and schematic models of standardized interventions, understanding that the rigidity observed in the psychological functioning of people with disorders such as anorexia and bulimia requires a professional stance based on flexibility and acceptance.

Thematic axis 2: *Difficulty in maintaining the professional-patient bond: an exhausting and demanding exercise*

Some participants reported feeling tired when facing a patient's tenacity and resistance to change in response to therapeutic efforts to increase motivation for change. One practitioner expressed her feelings of disappointment and frustration with a particular patient:

> I suggested activities, but she never worked on them. Sometimes, she would refuse, and I would go there, with all the patience in the world, and talk to her. Sometimes, I encouraged her to do leisure activities, but she did not. So for me, I have difficulties dealing with that (TO1, hired professional).

Sometimes, difficulties in interaction are attributed exclusively to patients, as if they were "part" of their way of functioning in the psychopathological condition: "The individual conditions of each patient make it difficult [...] to form bonds with professionals" (Nutri2, professional/researcher). Such a view highlights characteristics that are supposedly intrinsic to the patients' personalities, which might reinforce some widely disseminated prejudices and stereotypes about the characteristics of the psychological functioning of people with anorexia or bulimia. The literature reinforces this negative perception by emphasizing that the recurring maneuvers that patients use to lose weight at any cost are conditioned by the severe distortion of their body image. Thus, the assumption that only the "individual conditions of each patient" (Nutri2) would be responsible for their difficulty establishing and maintaining healthy bonds with team members is reinforced. In favor of this argument, professionals evoke their clinical experience and highlight that patients usually rationalize that their symptomatic behaviors are the result of a conscious personal choice, supposedly related to the adoption of their lifestyle; therefore, they should not be reprimanded for it (Seah et al., 2017).

The participants emphasize that one's dissatisfaction with body image may reach extremes, to the point where patients feel obese when, in reality, they are emaciated and at imminent risk of death. However, they note that the patients' problems with the scale are just the visible face of a generalized dissatisfaction with life (Santos & Pessa, 2022). The reports highlight a perception that there is a deep discomfort in the relationship with one's own body and that it is not only weight and body shape that patients repudiate. Relationships are also a source of distress and rejection, leading the person to cultivate isolation and withdraw from social life.

Some study participants reported feeling a persistent sense of imprisonment when interacting with patients. This countertransference phenomenon, seen from the perspective of Bonding Psychoanalysis, can be understood as the result of processes of massive identification between the professional and patients' skepticism, which may lead to immersive experiences of fusion and loss of boundaries in the therapeutic bond.

> You need to be sensitive enough to understand that it seems like you are trapped in the session, perhaps in the same way they feel trapped in their bodies and lifestyle, you know? We may be trapped in our own disorder, and I think that being able to realize this is a great subtlety. It is something very, very difficult to look at. We often invite ourselves to fall into that trap as well: "Ah, I cannot handle this, I cannot handle this." Suddenly, you start to mix yourself with them. So you need to be able to get back, you know? (Psy6, intern).

> [...] I think that this mainly happens in services treating patients with severe conditions, as is our case. It happens that you disbelieve in the possibility of the patient making progress. You need to be aware of this when you are in contact with them (Psy8, intern).

To deal with their frustration, team members try to modulate their expectations regarding treatment progress and therapeutic results. One participant reported his disbelief through an expression of discouragement: "Honestly, I do not know if I know what I have to do [laughs] because I have not been able to do it until now [help the patient to improve her symptoms]" (Psych1, professional/resident). Another participant confided her difficulty in reversing the clinical condition of a severe and high-risk patient and admitted being afraid that she could give her "checkmate." In this case, the difficulty maintaining a hopeful perspective and envisioning the possibility of achieving a satisfactory treatment outcome seems to be overshadowed by the discomfort of imagining that, at any moment, the participant could be surprised by the worsening of the patient's clinical condition, which seems to lead to a feeling of hopelessness in biomedical knowledge in the face of "refractory" conditions. Such hopelessness might fuel skepticism and cloud a professional's ability to foresee solutions and devise possibilities for transformation to allow the restoration of trust at work and seal a commitment to change.

Thematic axis 3: *Responding to the challenges imposed on the therapeutic relationship: perseverance and tolerance to frustration*

The participants reported difficulties maintaining the therapeutic relationship under certain circumstances, which, in their understanding, are particularly worrying because they provide care to high-risk patients. Experiencing these difficulties on a daily basis increases a professional's susceptibility to fatigue and aggravates a perception that the therapeutic resources to deal with patients are exhausted. In extreme cases, this perception may lead to a desire to quit working when their practice becomes less than rewarding. Among the ways to respond to these challenges, one participant considers that professionals must be resilient and not succumb to the challenges inherent to the clinical care of ED:

> One thing I see a lot in the eating disorder clinic is that we have to be very healthy to be able to treat these people because they are very sick and have many comorbidities. Personality disorder is always present; thus, these are destructive people, people who are dead inside. There is a lot of this, so if you are not mentally healthy, if you have no life inside you, it is challenging to treat these patients... because if you do not take care of yourself, you die with them (Psycho2, professional/researcher).

This statement clearly and honestly points to the centrality of mental health issues among team members ("We have to be very healthy to be able to help these people"). The emphasis on intensity ("very healthy") concerns the need to be personally strong, such as having an integrated, equipped, and cohesive ego to be able to sustain self-esteem and a sense of

personal competence in order to cope healthily with adverse situations: "We know that they are very rigid, but at the same time, it is not impossible to achieve small changes" (Psy2, professional/researcher).

However, professionals are not always able or interested in examining their own emotional responses to identify their psychological defenses and potential limitations triggered by contact with patients (Bechelli & Santos, 2005). The interviewees recognize that professionals need to develop their resources, such as perseverance and tolerance to frustration, which enable them to maintain self-confidence and an inner conviction that they are doing a good job and remain committed daily to the transformative potential of the therapeutic bond: "I think we have to be very patient. We have to be very, very careful, you know?" (Psy6, intern). "Having the patience to understand that each person is different and has their own time" (TO1, hired professional).

Activities such as personal psychotherapy and supervision with other professionals are valuable strategies for developing resources and preserving the professionals' emotional health (Bechelli & Santos, 2005). Some participants also warn that professionals must discipline themselves to review and eliminate their prejudices. They need to be careful not to be influenced by socially constructed stereotypes about people with ED. A physician in the field of nutrology shared that she discovered that she needed to examine her feelings, prejudices, clichés, and commonplaces constructed by the dominant discourse about patients with AN/BN daily: "I think that if we can leave prejudice aside and try to open ourselves to new things, we tend to get better" (Nutro2, professional/resident). In this sense, other participants pondered: "[We need to] try not to get stuck on stereotypes that often end up 'sticking' in these cases, you know? For example: 'Oh, this one does not get better,' or: 'Oh, this one just gets worse'" (Psy8, intern). "We need to be very careful and be able to understand patients beyond their symptoms" (Psy6, intern).

In order not to be tempted by ready-made and stereotypical views, professionals must rely on the therapeutic relationship, using it as an empathic compass to guide the support interventions and psychotherapy: "The way of dealing with a patient, the way of talking, of being available, of treating ethically and having respect for that person, and understanding that there is, before anything else, a human being" (Psy7, professional/researcher).

These results show that the team members desire to break the stereotypes that stigmatize patients with anorexia and bulimia. Such stereotypes often appear in the literature and are naturalized in biomedical discourse. In the social construction of stereotypical representations of people with ED, there remains a widespread view that these patients are "resistant" and "refractory to treatment," "rebellious," "undutiful," "intractable," "obstinate," "untrustworthy," "little open to change," "self-destructive," "people who always live life on the edge" (Santos & Pessa, 2022). These conceptions, if uncritically endorsed, contribute to further distancing the professional from the core of the patients' suffering, putting these people in a place of vulnerability instead of recognizing their strengths and potential. Hence, we need to

think about the importance of, in addition to building bonds of empathy, acknowledging their resources and seeing them as agents of their own change (Bechelli & Santos, 2002), characteristics that can be identified and channeled in order to strengthen a pact for (self)care, to seek a creative and meaningful life.

Appreciation of this perspective aligned with the expanded concept of health was also evident in some reports from participants who considered that professionals can contribute to the progress of treatment by investing in the bond's transformative potential (Maia et al., 2023b), maintaining the confidence that the team can do a good enough job by offering opportunities to welcome and support change. "It is doing our job well, you know?" (Psych3, professional/researcher). "If we did not wait, we would not do what we do. We would not try. So, we wait for them to improve" (Psych2, professional/resident).

> It is about never giving up, you know? I think I experienced this a lot with X [patient diagnosed with BN]. Many times, I wanted to give up on her care because it was challenging and very exhausting. I had to persist for many years. Nevertheless, I look back and say: 'Wow, a lot has changed,' you know? A lot has changed over time" (TO1, hired professional).

Several team members stressed the importance of remaining steadfast and committed to working with people with ED. They had discovered from their own experience that perseverance and tolerance for frustration are indispensable ingredients.

> By understanding eating disorders [...], you can understand that you may be acting appropriately, but you will still not always get the result you expect or desire. In these cases, we must have a high tolerance for frustration (Nutri2, professional/researcher).

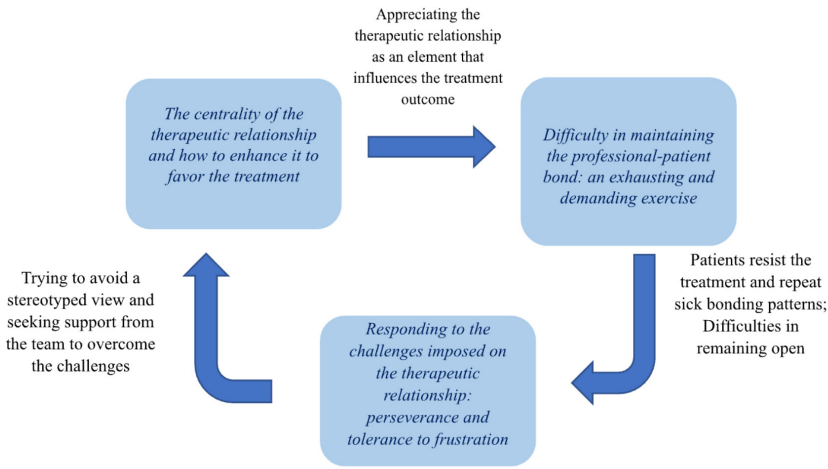
Some participants reported finding a place of comfort in the team by sharing their anguish due to the patients' severe conditions. By using this resource and strengthening ties with other team members, the participants can preserve their well-being and renew their confidence in the potential of the therapeutic relationship: "Although the cases are not easy, I think we can reach a common goal if everyone is involved" (Nutri1, professional/resident); "Working in a group, in a multidisciplinary and interdisciplinary team, is essential in these cases. [...] It is fantastic when we have very rich discussions in meetings, isn't it? To bring something new, or to reflect on something you had not perceived yourself" (Nutri2, professional/researcher).

Ynomoto et al. (2022) showed that medical professionals engaged in care perceive that their emotions are mobilized when in contact with patients with ED and feel the need to share their consultations with other interdisciplinary team members. However, they did not mention the use of complementary strategies, such as seeking case supervision, participating in study groups, or undergoing psychotherapy themselves, as self-care and mental health protection devices.

Connecting the three thematic axes can support a deeper analysis of data. Figure 1 presents a map of ideas that summarizes the themes identified in Phase 5 of the Reflexive Thematic Analysis.

Figure 1

Map of ideas with a summary of the themes identified



The team members who collaborated on this study highlighted the therapeutic relationship as a resource for managing and contributing to a successful treatment. This perception is in line with the literature and is a recurrent finding in studies in the field of ED (Graves et al., 2017; Manochio et al., 2018; Ramos & Pedrão, 2013; Souza & Santos, 2015; Souza et al., 2019; Weeb et al., 2022; Werz et al., 2022).

This study's significant contribution is that, despite the importance assigned to the establishment of bonds, difficulties in communicating and maintaining a good therapeutic alliance with patients were also reported, as they are often seen as "complicated to deal with" and insistently adhering to symptoms, corroborating the findings of a literature review (Seah et al., 2017). Several participants mentioned the risk of professionals becoming discouraged in the face of persistent symptoms and the participants' low response levels to treatment strategies. They expressed concern with the patients' obstinacy in maintaining their self-destructive behaviors despite the high level of psychological distress and the marked impoverishment of their well-being and quality of life.

ED symptoms involve intense suffering, which often masks other psychological conflicts, experienced in the dimension of intersubjective bonds related to sexuality dilemmas and conflicts, the construction of autonomy (negotiating a balance in the relationship between independence-dependence towards a potential interdependence at mature levels), and the

separation-individuation process experienced with parental figures (Leonidas & Santos, 2020a, 2020b). In general, this empirical investigation's results are consistent with the theoretical assumptions of psychoanalysis, enriched by the theoretical framework proposed by Bonding Psychoanalysis, in which patients with these characteristics may persist in their dysfunctional behaviors in an attempt to regulate and maintain their sense of self-coherence, with some level of psychological integration. On the other hand, they may resist change in response to the persistent fear of losing control over their eating habits, relationships, and emotional self-regulation (Granieri & Schimmenti, 2014; Leonidas & Santos, 2020b; Souza et al., 2019).

The recognition that professionals experience challenging moments, marked by frustration that often results in exhaustion and physical and psychological strain, is a finding that should be highlighted due to its importance and implications for the systematization of care. The persistence of symptoms and the frequent stagnation of patients' clinical conditions impact the team, leading them to experience less motivation and willingness to continue believing and renewing their commitment to the patients' potential to change, which is also reported by other international qualitative studies (Fleming et al., 2021; LaMarre & Rice, 2021). The team members often reported this countertransference effect. One participant mentioned: "Working here is like flogging a dead horse" (Psych2, professional/resident). This blunt expression highlights the importance of paying attention to occupational issues and, above all, to the psychological health of professionals providing care to patients with severe ED.

Despite these difficulties, the participants realize that their efforts to maintain bonds with patients are one of the primary tools to renew their confidence in the patients' improvement and continuously become motivated. These are elements necessary to obtain microchanges that enable a good adjustment to treatment. The corpus analyzed here reveals these aspects as a force that reinforces the establishment of bonds and therapeutic alliances, corroborating the findings from previous research (Leonidas et al., 2019; Souza & Santos, 2015).

From this perspective, understanding the unconscious aspect based on bonding, as proposed by Puget (2015), allows us to think of subjectivation processes as a continuum, a phenomenon in a constant transformation that remains unfinished due to its own nature and dynamism. Classical psychoanalysis understands that the first bonds between a baby in a situation of absolute helplessness and its caregivers are the foundation of the psyche, building the basis of the relational matrix that will influence bonding patterns and object relations throughout life. This understanding is redimensioned based on the theoretical framework of Bonding Psychoanalysis, in which the new bonds established by the subject gain greater relevance in the subjectivation processes, which reinforces the creative power of the therapeutic relationship (Maia et al., 2023b; Santos et al., 2020a).

Considering these premises, one conjecture is that the bonding established by the health team with the people using the service can mobilize transformative potential for both patients and professionals, since subjectivation is (dis)continuous and promoted in all bonding encounters. This study's findings show that most health team members believe that the working alliance can

mobilize mutative potential and that they are also aware of the limitations imposed by resistance to change, which may be anchored in both patient and professional, considering bonds are reciprocal.

A therapeutic relationship involves unconscious aspects that may emerge when catalyzed by the presence of a health professional; such a phenomenon enables accessing and analytically working with the patients' regressive bonding patterns. At the same time, the therapeutic bond requires that the health professional, being an *ajeno* (i.e., a representative of the radical difference present in the analytical scene) establishes a bonding pattern that is distinct from the archaic models internalized by the patients, thus creating the possibility of new outcomes and healthier solutions to the conflicts. This is so because, from the perspective of Bonding Psychoanalysis, the psychotherapist is also the subject of the bond and not just the object of the transference (Levisky, 2021).

The participants' statements clearly show the need for professionals to be resilient and persevere when facing frustration and exhaustion in their daily practice. Resistance to change is a reluctance to open up to new things and learn from the unknown to strengthen the relationship with one's growth. In other words, closing oneself off from the therapeutic relationship and the working alliance is a regressive way for patients to defend themselves from the threat that this openness to the new represents. Changing is perceived as a threat because it heralds the path toward differentiation and individuation inherent to growth. However, professionals also need to be willing to face the challenge of examining resistance to change that may be rooted in their own subjectivity.

This study's results show that team members also feel transformed by the professional-patient bond. When faced with the patients' differences and *ajenidad*, they may give in to exhaustion or become locked in the "certainties" that come with stereotypes, such as that patients are resistant and that there is no possible improvement when the other person is "not motivated" to face the burden of change. Holding on too tightly to these preconceived ideas may be a defensive way for professionals to close themselves to the uncertainties and difficulties inherent to the therapeutic bond. The patients' stoicism may be one of the potential results of this power struggle. However, this type of defensive configuration may have a boomerang effect and make professionals vulnerable, exposing them to skepticism and burnout. Therefore, caution must be taken because professionals may become so involved and absorbed in the "relational game" proposed by the person with anorexia or bulimia that they may end up discouraged and de-empowered.

According to the participants, a powerful response to challenging times would be to double down on the transformative power of bonding, striving to provide a unique bonding experience, opening up to the new (i.e., without being trapped by stereotypes and stigmas), and gradually encouraging change, in addition to seeking support and comfort from teamwork. Therefore, the team can also provide support when there are setbacks, backing up and facilitating the process whenever the participants face difficulties and uncertainties that permeate the working alliance with severely ill people affected by primitive anxieties.

According to Berenstein and Puget (2008), the group to which one belongs needs to provide support whenever doubts and ambiguities are caused by the differences awakened by an encounter with another; uncertainty can only be supported by the individual up to a certain threshold. The imaginary guarantee conferred by the feeling of belonging to a group confers certain stability, enabling one to remain open to the vicissitudes of the working alliance, which imposes challenges and transformations (Oliveira-Cardoso et al., 2018; Santos et al., 2020b).

Based on the sense of belonging and the sensitive support provided by the interdisciplinary team, this study showed that the participants can maintain a cohesive therapeutic relationship despite the difficulties experienced in the context of care. The members of the multidisciplinary team show an appreciation of attentive listening. Their reports reveal the importance of welcoming and supporting, an antidote to the feeling of helplessness that sometimes threatens to take over the care setting when facing frustration caused by the patients' persistence of symptoms. In this context, we assume that the difficulties experienced in the therapeutic relationship function as an *ajenidad*, which, if well tolerated, can boost the professionals' work. According to Puget (2003), presence imposes the encounter with otherness, which can be representable (such as sexual difference or difference between generations) or, on the other hand, with an *ajenidad*, i.e., an irreducible, radical difference that cannot be represented. It is based on *ajenidad* that bonding takes place.

Silva and Miranda (2022) emphasize that dialoguing about difficulties and establishing shared goals strengthen a collaborative spirit among professionals. Faced with the radical nature of symptoms, their duration, and persistence, one has to respond with redoubled patience and perseverance, using the potential group space provided by team meetings and discussions.

Final Considerations

In summary, this study achieved its objective of understanding the meanings assigned by the team of a specialized ED service to experiences involving the professional-patient bond. Based on the data collected through semi-structured interviews, held according to the CQM guidelines, we verified that the interdisciplinary team members value the commitment to the therapeutic relationship as a structuring axis of care and a determining factor for a successful change process.

Despite appreciating the therapeutic relationship, the participants reported setbacks in establishing such a bond, as they manifested feeling exhausted when facing the tenacity with which patients remain attached to their symptoms, a finding consistent with the literature in the field. In the psychoanalytic understanding of this phenomenon and based on the theoretical framework of Bonding Psychoanalysis, we can postulate that the encounter between professional and patient holds two latent dimensions: one, which highlights the unconscious repetition of the patients' bonding and symptomatic patterns of illness, and another that is enabled by the encounter between the differences imposed by the presence of another, which has the potential to pave new paths towards transformation. The connection of this dual dimension has the

potential for change in the subjectivation processes, which, by their very nature, are (dis) continuous and non-linear, and materialize through working with resistance to the emergence of the new.

In addition to being able to identify the potential for change from the patients' point of view, one has to broaden his/her perception to target the transformations that also occur in professionals. Encountering someone severely ill and (often, although not always) resistant to change can also give rise to defenses on the part of professionals. Hence, this study's participants considered the need to remain hopeful, not clinging to stereotypical views about ED, especially when faced with challenging moments. This hope can be found and nurtured in shared teamwork, which supports and strengthens the sense of belonging, favoring the clinical encounter with another person. Added to this is the mark of otherness that also materializes in the difference between professionals of different generations and areas of specialization that make up the team's unique plurality. Interestingly, there was no significant difference in the participants' reports based on their institutional affiliation, whether as professionals, residents, researchers, or interns, which reinforces the importance of including the entire team in the data analysis.

It is essential not to see patients from a stereotypical perspective, as if they were destined, by their own choice, to suffer, condemning their ways of existence because they diverge from the prescribed norms and ideals of normalization that permeate the community. Valuing empathy as a catalyst for bonding helps elevate patients to a condition of dignity. At first glance, suffering seems incomprehensible, given the strangeness that the symptoms arouse (e.g., a girl who fasts because she is afraid of food, while another eats voraciously so that she can vomit copiously afterward). These unusual and surprising expressions of suffering can take on human and symbolic contours if they can find sensitive listening that allows for the structuring of a narrative permeable to transformation.

Thus, the original results gathered in this study also allowed us to reveal the wealth of meanings assigned to the bonds established with patients with AN/BN. In addition to corroborating other qualitative data obtained by Brazilian and international studies, reiterating the relevance and protagonism of the therapeutic alliance for the outcome of clinical follow-up, these findings contribute to the literature in the field by proposing an understanding based on bonding. The theoretical-conceptual framework allowed us to reveal, from the team members' point of view, the vicissitudes encountered in the care setting and how it is possible to deal with the challenges, using the potential of the therapeutic bond as a care technology in the health field. It is important to emphasize the potential represented by mutual support among members in team meetings and care actions carried out with other professionals. Listening facilitates the elaboration of team members and proves to be a resource that can be mobilized to strengthen bonds between professionals and patients, collaborating to preserve the workers' mental health.

Although the results of qualitative studies are not intended for generalizations, they can bring relevant contributions to clinical practice by providing a comprehensive view of the paradoxical feelings and complaints of exhaustion and demotivation that can affect health

professionals. The team must remain open to accepting and sharing these feelings to promote support so that discomfort can be used as a working tool in the encounter with the difference imposed by the therapeutic bond. From a psychoanalytic perspective, repetition is expected within a well-established therapeutic relationship. This conception may not be congruent with the perception of workers from other professions, which suggests new possibilities for research, focusing on what each profession considers a good bond to be and what would be the place of repetition in this context.

In line with the CQM guidelines, the fact that the author became involved with the service before collecting data is one of this study's strengths, which should be highlighted, as it favored establishing rapport with the participants. On the other hand, this involvement may entail potential biases in data collection. In this sense, future studies are needed to include professionals from other services and contexts and further explore the specificities of the professional-patient bond and the therapeutic alliance, including investigating different psychopathological descriptions and examining potential differences in the therapeutic bond established between professionals and patients with AN and BN.

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