The Push-Pull Dynamic in Eating Disorders:

A Grounded Theory Exploration of Motivation for Change

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Abstract

Eating disorders (EDs) represent a serious healthcare problem and are an expanding concern across numerous demographics. The majority of clients who seek treatment for EDs either drop out or do not improve, and relapse is common. One of the most frequently cited reasons for negative treatment outcomes is lack of client motivation. Recent studies have shown that clients who are more autonomously motivated at the beginning of treatment do better on outcome measures, and may persevere in treatment even when it becomes difficult or discouraging. However, a limitation of this research is that most ED clients do not begin therapy with an internalized quality of motivation. Therefore, in order to increase the probability of positive outcome, it is imperative to investigate how therapy can cultivate motivation and help clients to internalize their reasons for change. To date, existing measures have not examined the processes through which motivation for treatment is experienced by clients. Further, not enough is known about what fosters motivation or client adherence to ED treatment. This research study explores the development of motivation for treatment and recovery of 18 clients in therapy for an ED. The data were analyzed using grounded theory methodology. Results indicate that participants experienced a pervasive pushing-pulling dynamic throughout the recovery process. Within this dynamic, participants described their motivation to work through recovery as a continuous battle, where they felt wrenched in opposing directions; on the one hand wanting to get well, on the other, fearing what giving up the ED would entail. In the *push-pull dynamic theory*, participants depicted the context that led to the development of the ED, which comprised deep feelings of inadequacy, struggling with self-regulation, and experiencing stressors. Second, they illustrated the factors that catalyzed the ED, most of which involved cycling between using control and losing control. Third, participants detailed the strategies they employed to engage in treatment as they wrestled with their motivation and worked through the process of change. Finally, they explained the consequences of recovery, which involved building a sense of connectedness to themselves, to others, and to the world around them. The findings of this study provide support for motivation as a therapy process factor, one that must be attended to all the way through the recovery process and not simply at the beginning of treatment. In addition, participants underscored several other critical aspects of treatment that kept them focused on their task of recovery. They identified elements such as developing a sense of identity, becoming self-compassionate, improving the capacity to connect with others, expressing emotion, taking risks, and increasing self-regulation and autonomy. Many mentioned that these aspects made them more confident in their recovery than symptom reduction. The theory emphasizes the need to further examine how motivation intersects with these elements, and how the interaction may impact treatment. Implications for ED therapy are discussed, specifically that treatments must reflect the complexity of issues that clients present in order to be effective. An integration of existing approaches, such as ones that address interpersonal functioning, emotion regulation, distress tolerance, motivation, and empowerment, as well as those that focus on symptom management may be most useful.

Résumé

Les troubles de l’alimentation (TA) constituent un grave problème de santé et une préoccupation croissante dans de nombreux groupes démographiques. La majorité des clients traités pour un TA abandonnent en cours de route ou ne constatent aucune amélioration, en plus de faire souvent des rechutes. Une des raisons les plus fréquemment citées pour expliquer l’échec du traitement consiste en le manque de motivation du client. De récentes études ont révélé que les clients qui affichent une plus grande motivation autonome au début du traitement obtiennent de meilleurs résultats et ont tendance à persévérer même quand la situation devient difficile et décourageante. Toutefois, une des limites de cette étude est le fait que la plupart des clients souffrant d’un TA n’amorcent pas la thérapie avec une solide motivation internalisée. Par conséquent, pour accroître la probabilité d’obtenir des résultats positifs, il est essentiel d’examiner comment la thérapie peut cultiver la motivation et aider les clients à internaliser leurs raisons d’apporter des changements. À ce jour, les mesures existantes n’ont jamais examiné les processus qui motivent les clients à subir le traitement. De fait, on sait peu de choses sur les éléments qui incitent les clients à suivre ou poursuivre le traitement du TA. La présente étude explore le développement de la motivation vis-à-vis le traitement et le rétablissement de 18 clientes en thérapie pour un TA. Les données ont été analysées au moyen d’une approche de « grounded theory ». Les résultats obtenus indiquent que les participantes ont constaté une dynamique de « poussée-traction » envahissante pendant tout le processus de rétablissement. Dans le cadre de cette dynamique, les participantes ont décrit leur motivation pour assurer un rétablissement approprié comme étant une bataille continue où elles se sentaient déchirés : d’une part, elles voulaient se sentir mieux ; d’autre part, elles craignaient ce que le traitement du TA leur réservait. Dans la théorie de la dynamique « poussée-traction », les participantes ont premièrement décrit le contexte ayant mené au développement du TA, incluant de profonds sentiments d'incapacité, des difficultés au niveau de l'autorégulation et la présence de facteurs de stress. Ensuite, elles ont cerné les facteurs ayant eu un effet catalyseur sur le TA, qui oscillaient pour la plupart entre le contrôle et la perte de contrôle. Puis, elles ont décrit en détail les stratégies qu'elles ont utilisées pour amorcer le traitement pendant qu'elles étaient aux prises avec leur problème de motivation et géraient le processus de changement. Et finalement, elles ont expliqué les impacts de leur rétablissement, incluant le développement d'un sentiment de communion avec eux-mêmes, avec les autres et avec le monde qui les entoure. Les résultats de cette étude appuient la motivation comme étant un facteur du processus de thérapie, un facteur dont il faut tenir compte pendant tout le processus de rétablissement et pas simplement au début du traitement. De plus, les participantes ont souligné plusieurs autres aspects critiques du traitement qui les ont gardés concentrés sur leur rétablissement. Elles ont identifié des éléments tels que le développement d'un sentiment d'identité et d'auto-compassion, l'expression et l'acceptation des émotions, la prise de risques, ainsi que l'accroissement de l'autorégulation et de l'autonomie. Bon nombre d'entre eux ont mentionné que ces aspects, plus que la réduction des symptômes, avaient accru leur degré de confiance vis-à-vis leur rétablissement. La théorie met l'accent sur le besoin d'examiner plus à fond comment la motivation interagit avec ces éléments, et comment cette interaction peut influencer le traitement. Les répercussions sur la thérapie du TA sont discutées, et les traitements doivent spécifiquement refléter la complexité des questions que les clients soulèvent pour être efficaces. Une intégration des approches existantes, comme celles qui touchent le fonctionnement interpersonnel, la régulation des émotions, la tolérance envers la détresse, la motivation et la prise en charge, ainsi que de celles qui mettent l'accent sur la gestion des symptômes, pourrait être des plus utiles.

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CHAPTER 1: Introduction

Even when we can foresee a healthier future for ourselves, changing our current behaviour is an arduous process. Whether change has positive or negative consequences, it can be a challenging and uncomfortable thing to do. Engaging in treatment for an eating disorder (ED) is doubly challenging because the behaviours have likely become a way of coping with things deemed to be unbearable. Letting go of coping strategies even if they are unhealthy is often frightening and, in some cases, unthinkable. EDs are notoriously difficult to treat, with almost two-thirds of clients prematurely terminating therapy or having unsuccessful treatment outcomes (Stein et al., 2001; Thompson-Brenner & Westen, 2005a). Among those who complete treatment, there are high rates of relapse that place considerable strain on the health care system (Garvin & Streigel-Moore, 2001).

One of the most frequently cited reasons for dropout, failure to comply, and other negative treatment outcome in therapy is lack of client motivation. Motivational difficulties among clients with EDs have been noted since the first clinical descriptions of maladaptive eating behaviours and it is becoming clearer that motivation plays a significant role in treatment retention and success. Most researchers and clinicians agree that deficits or conflict with motivation for treatment are pervasive among ED clients (e.g., Geller, 2002a; Touyz, Thornton, Rieger, George, & Beumont, 2003; Vitousek, 2002; Vitousek, Watson, & Wilson, 1998). Moreover, motivational factors influence the degree to which clients are willing to engage in a therapeutic process. While motivational issues have been well documented, a comprehensive framework to understand motivational dynamics in ED therapy has yet to be articulated. In addition, current treatment modalities place substantial emphasis on symptom management and often do not consider or integrate important contextual factors of the client’s life into the treatment plan. This may make it more challenging for clients to cultivate and maintain meaningful changes in their everyday lives.

A number of theories have been proposed to frame motivational issues and to understand how they are implicated in the treatment of EDs such as the *transtheoretical model* (Prochaska & DiClemente, 1986; Prochaska, DiClemente, & Norcross, 2003) and *self-determination theory* (Deci & Ryan, 1985; Deci & Ryan, 2000). For example, researchers have demonstrated that clients who are more motivated at the beginning of ED therapy tend to do better on outcome measures than those who are less motivated at the outset of treatment (Treasure et al., 1999; Jones, Bamford, Ford, & Schreiber-Kounine, 2007). Moreover, client *readiness* for ED therapy has been shown to be predictive of dropout, symptom change, and relapse (Geller, Drab-Hudson, Whisenhunt, & Srikameswaran, 2004; Geller, Cockell, & Drab, 2001). Further, the quality or type of motivation at the beginning of therapy has been implicated in outcome. For example, women who enter therapy for external reasons (such as feeling pressured by friends and family) are more likely to internalize pressures to be thin, report greater body dissatisfaction, and more ED symptoms (Pelletier, Dion, & Levesque, 2004). Conversely, positive treatment effects are maintained longer term when the reasons for behavioural change are more internal, such as when they are congruent with women's values and their sense of self (Frederick, & Grow, 1996).

Within the body of research that relates motivation at the start of therapy to outcome, there are two significant areas that need further exploration. First, very few clients begin ED therapy with high levels of motivation. Consequently, how should treatment providers proceed with the majority of clients who enter therapy with ambivalence or resistance to treatment? Second, motivation does not remain static; it is a fluid factor that waxes and wanes throughout the course of therapy. How do therapists help clients maintain sufficient levels of motivation throughout the course of treatment? Most importantly, is there a way for therapists to help to increase levels motivation or to alter the quality of motivation experienced by clients? This study aims to address these questions.

Important knowledge has been gained from quantitative studies that have made the link between motivation for therapy and outcome. However, motivational theorists acknowledge that motivation for therapy is a therapeutic process factor and not a client characteristic. Like therapeutic alliance, it is a factor that fluctuates throughout the process of therapy and is influenced by other dynamics, such as the interpersonal environment (Miller & Rollnick, 2002; Deci & Ryan, 1985). To date, research has not examined *how* therapy can facilitate motivation to help ED clients persevere in treatment, and ultimately to choose wellness as a way of life instead of persisting in a dysfunctional relationship with food. In order to understand motivation as a process factor, it is essential to examine it as such. The use of qualitative inquiry in this research illuminates how this factor influences, and is influenced by, the course of therapy. Further, the study lays the groundwork for further quantitative and qualitative research that will give treatment providers essential information for best practice with the ED population.

CHAPTER 2: Review of the Literature

Epidemiology of Eating Disorders

Prevalence

One of the biggest challenges to motivation for ED treatment is that symptomatology is so commonplace that most clients feel a sense of ambivalence about eradicating it. While rates of EDs in the general populations may appear to be low (1 % to 4 % of women; Hudson, Hiripi, Pope, & Kessler, 2007), these rates are deceptive. In North America, sub-threshold ED symptoms are estimated in up to 30 % of the female population (Mulholland & Mintz, 2001). Sub-threshold symptoms are those that are clinically significant but would not reach an official ED diagnosis. For example, in a study of high school and college women, the majority (59 %) reported frequently skipping meals specifically to control their weight. Moreover, a large number of these women reported eating fewer than 1200 calories a day (37 %), eliminating fats (30 %) and carbohydrates (27 %) from their diet, fasting for more than 24 hours (26 %), using laxatives (7 %) and diuretics (7 %), and vomiting after eating (5 %; Tylka & Subich, 2002). In another study, findings from a community sample of Canadian girls in grades 6 through 8 (mean age = 11.7 years) revealed that 31 % were trying to lose weight, 17 % skipped meals to control their weight, and 57 % exercised to control their weight (McVey, Tweed, & Blackmore, 2005). While only a small percentage of cases from these two studies might obtain an ED diagnosis, the numbers point to substantial health care issues.

As a result of the secrecy and shame surrounding EDs in general, many people do not seek treatment and therefore the statistics very likely underestimate the actual numbers of people who are suffering. For example, evidence suggests that women are more likely to endorse engaging in ED behaviours on a self-report questionnaire under conditions of anonymity compared to only confidentiality (Anderson, Simmons, Milnes, & Earleywine, 2007). In other words, the more anonymous an individual believes her responses will be, the more likely she is to report what may be her genuine level of ED symptoms.

An Expanding Problem

Among males, EDs are receiving growing attention as there has been a gradual increase in the number of men seeking treatment over the last 20 years (Maine, 2000). Although the numbers of men with EDs are on the rise, EDs still occur disproportionately among women, with a female to male ratio of 10 to 1 (Wade, Keski-Rahkonen, & Hudson, 2011). Further, while EDs have traditionally been considered an adolescent concern, there has been a dramatic increase in the number of women requiring help for disordered eating in midlife (Bulik & Taylor, 2005), with body dissatisfaction more than doubling from 25 % in 1972 to 56 % in 1997 (Costin, 2007). It is clear that disordered eating is an increasing and expanding problem across numerous demographics.

For a significant number of girls and women, chronic dieting and restrained eating has become a way of life that is supported and encouraged by peers, parents, and society. Women who are able to stay slim are revered for their discipline while heavier women are considered to have “fallen off the wagon”. These ideals are so ingrained in Western culture that a therapy that aims to alter them seems almost counterintuitive. Being told by a therapist to change one’s ideas about the need for weight loss may create resistance from the outset because it contradicts the messages that are being received from every other source. The choice for wellness and a healthier relationship with food is a challenging one, particularly when this does not come with a promise of being thin as a final result. Understandably, in this context, treatment is often a long and turbulent road.

Eating Disorder Diagnosis

Eating disorders are not only about food. While symptoms do involve thoughts, attitudes, and behaviours around weight, eating, and body image, EDs comprise disturbances of identity, mood, impulse regulation, and interpersonal functioning. Up until the release of the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) in May 2013, there were two official ED diagnoses: *Anorexia nervosa* (AN) and *Bulimia nervosa* (BN). A third category, *ED not otherwise specified* (EDNOS), was used for cases that did not meet criteria for the other two.

DSM- IV criteria were so stringent that most symptoms did not “fit” for a diagnosis of AN or BN, and thus most women received a diagnosis of EDNOS. In fact, EDNOS rapidly became the most common ED diagnosis (60 %) in ED specialty clinics (Fairburn et al., 2007). EDNOS may be even more widespread in community-based outpatient clinics, with numbers ranging from 75 to 90 % of cases (Zimmerman, Francione-Witt, Chelminsky, Young, & Tortolani, 2008; Machado, Machado, Gonclaves, & Hoek, 2007). It is worth noting that EDNOS is especially common among populations that have received less research attention, such as ethnic minority groups (Alegria et al., 2007), males (Striegel-Moore, Garvin, Dohm, & Rosenheck, 1999), children (Nicholls, Chater, & Lask, 2000), and the elderly (Mangweth-Matzek et al., 2006). The lack of clarity around diagnosis may suggest that our current understanding of EDs has been based on a somewhat biased sample of adolescent, White women. Moreover, in many EDNOS cases the severity of psychopathology and degree of psychosocial impairments is equal to those diagnosed with AN or BN (Turner & Bryant-Waugh, 2004). Although EDNOS remains the most common ED diagnosis there are few studies of its treatment, leaving clinicians in the dark with regard to “best practice” with the majority of cases (Fairburn & Bohn, 2005).

A few changes were made to the ED diagnostic categories in the DSM-5 in effort to address some of these issues. The biggest change from the DSM-IV to the DSM-5 is the recognition of *Binge Eating Disorder* (BED) as an official diagnosis. Binge eating disorder had previously been included within the EDNOS category. The core diagnostic criteria for AN are conceptually unchanged from DSM-IV, except that the requirement for amenorrhea has been eliminated in DSM-5. This was altered because it could not be applied to men, to pre- and post-menarchal women, and women taking contraceptives. The only change from the DSM-IV to the DSM-5 criteria for BN is a reduction in the required minimum average frequency of both binge eating and compensatory behaviour from twice to once weekly. Research demonstrated there were no significant differences in clinical characteristics and outcomes between these two groups (van Hoeken, Veling, Sinke, Mitchell, & Hoek, 2009). Changes for the DSM-5 were made in order to reduce the need for a residual category (i.e., EDNOS), which has now been labelled *Other Specified Feeding or Eating Disorder*. It has yet to be seen if these modifications will improve accuracy of diagnosis as most studies published up to present still use the DSM-IV categories, as do clinicians working with the ED population.

Current Diagnostic Categories

Anorexia nervosa.

The diagnostic label AN is a little misleading because anorexia literally means “loss of appetite”. Individuals with AN rarely have no appetite, but rather resist hunger and satiation drives in a self-imposed starvation. Most often, the development of food rituals or constant preoccupation with food (e.g., cooking for others or hoarding food) is a result of prolonged food deprivation and heightened vigilance to food-related cues. Evidence of AN (restrictive) cases have been observed in every non-Western region of the world, from the Middle East to East Asia, suggesting that it may be less culture-bound than other types of ED. Furthermore, while it is less common, there is some support that perhaps AN restrictive type may be more heritable than other types of EDs (Keel & Klump, 2003). The defining feature of AN, according to the DSM, is that the individual has a body weight that is 85 % or less than what would be expected. Binge/purge behaviours may or may not be present.

Bulimia nervosa. Bulimia nervosa (BN) is characterized by recurrent episodes of binge eating in combination with some form of compensatory behaviour. Binge eating is defined as consuming abnormally large amounts of food coupled with the feeling of losing control. Compensatory behaviour can include self-induced vomiting, inappropriate use of laxatives or diuretics, fasting, and excessive exercise. Again, the label of BN is misleading because the term bulimia indicates a pathological drive to overeat. In reality, individuals who develop BN make relentless efforts to avoid food intake. Loss of control over eating occurs intermittently, and only following restrictive behaviour. In these individuals, the mind and body are so exhausted by the heightened vigilance around food that there is no longer a capacity for normal regulation. There is some evidence that BN may be a more culturally bound syndrome than other types of ED because incidence rates rise with increased exposure to Western ideals for thinness (Keel & Klump, 2003). For example, within three years of the introduction of television in Fiji, rates of girls who reported self-induced vomiting rose from 0 to 11.3 % (Becker, Burwell, Gilman, Herzog, & Hamburg, 2002).

Binge eating disorder. This new category is defined as recurring episodes of eating significantly more food in a short period of time than most people would eat under similar circumstances, with episodes marked by feelings of lack of control. The person has marked distress about the behaviour, and episodes occur, on average, at least once a week over three months (American Psychiatric Association, 2013).

Limitations of the DSM Categories

Regardless of edition, DSM criteria have always made AN and BN exclusive categories, yet the relations between these two diagnoses are not well understood. It is becoming clearer that the categories overlap in ways which threaten their utility. For example, in a study conducted over a seven-year span, the majority of women with AN experienced diagnostic crossover: more than half crossed between the restricting and binge eating/purging AN subtypes, and one-third crossed over to a diagnosis of BN but were likely to relapse into AN (Eddy et al., 2008). Similarly, in a study spanning five years, researchers found that 36 % of participants initially diagnosed with AN later developed BN, while 27 % of those with a BN diagnosis later crossed over to AN (Tozzi et al., 2005).

Another issue is that the DSM distinguishes between AN and BN primarily based on whether or not an individual is underweight, not on behavioural aspects of the disorders. Problems may arise, for example, when an individual exhibits only restrictive behaviour and has lost a significant amount of weight, but still has a higher body weight (which would preclude an AN diagnosis). Moreover, AN is categorized into a restricting type and a binge eating/purging type, and BN also involves bingeing and purging behaviours. In other words, bingeing and purging are a part of both AN and BN diagnoses, which creates more ambiguity about the recommended course of treatment. It has been suggested that empirical approaches to classification, such as latent class and taxometric analyses, may lead to more clinically useful ED categories (Wonderlich, Joiner, Keel, Williamson, & Crosby, 2007).

Most importantly, it is critical for mental health practitioners and researchers to gain clarity about diagnosis as the recommendations (both psychological and pharmacological) differ in terms of established evidence-based treatments for AN and BN. If clients are being offered inappropriate treatments based on incorrect diagnosis this may affect their motivation to remain in treatment.

Personality Correlates of Eating Disorders

An alternative proposal to diagnosis is to base categories on personality correlates of EDs. Indeed, emerging research suggests that there may be three personality subtypes that are common of people who develop EDs. These include groups of women who are: (1) constricted (over-controlled), (2) emotionally dysregulated (under-controlled), and (3) high-functioning/perfectionistic (Thompson-Brenner & Westen, 2005c). The constricted or over-controlled group is associated with traits of rigidity, emotional constriction, harm avoidance, and compulsivity (i.e., traits of over-regulation). Conversely, the emotionally dysregulated or under-controlled group are linked with greater behavioural disinhibition and emotional lability, self-injurious behaviours, and other impulsive characteristics (i.e., traits of under-regulation) (Westen, & Harnden-Fischer, 2001). The third group is generally high-functioning, although perfectionistic, and is characterized by self-critical attitudes and behaviours, and negative affectivity (Thompson-Brenner & Westen, 2005c). Researchers have demonstrated that constriction and emotional dysregulation are both negatively associated with outcome, and that personality patterns predict differences in treatment length and outcome. For example, clients in the constricted category attained recovery an average of five months after more high-functioning clients, and dysregulated clients took an average of ten months longer than high-functioning clients to be considered recovered (Thompson-Brenner & Westen, 2005c).

Personality disorder prevalence rates have also been assessed in the ED population. A recent meta-analysis reported that the personality disorders most commonly associated with AN restrictive are obsessive compulsive, avoidant, and dependent. BN was linked with borderline, avoidant, dependent, and paranoid personality disorders. On the whole, avoidant and obsessive compulsive personality disorder were most common across all EDs (Cassin & von Ranson, 2005). In one study, personality patterns had incremental validity in predicting ED symptoms, global functioning, history of psychiatric hospitalization, and history of sexual abuse above and beyond ED diagnoses (Westen & Harnden-Fischer, 2001). Therefore, personality patterns may provide important information for predicting treatment outcome and prognosis, and may also contribute to client engagement (or lack thereof) in the process of treatment.

Co-Morbidity

In addition to personality correlates of ED behaviour, evidence is indisputable that the vast majority of clients in treatment for EDs present with substantial co-morbidity (e.g., Gadalla & Piran, 2008; Blinder, Cumella, & Sanathara, 2006; Kaye, Bulik, Thornton, Barbarich, & Kim, 2004). In a study that investigated nearly 2500 inpatient women diagnosed with AN, BN, and EDNOS, 97 % of these women had a least one other diagnosable psychiatric disorder. Mood disorders (largely unipolar depression) were present in 94 % of the sample, 56 % were diagnosed with co-morbid anxiety disorders, and 22 % evidenced substance use disorders (Blinder, Cumella, & Sanathara, 2006).

Furthermore, there is evidence that early adverse experiences and stressors are more prevalent in individuals with EDs compared with controls (Raffi, Rondini, Grandi, & Fava, 2000). The presence of childhood trauma, such as emotional abuse, physical neglect, and sexual abuse, has been associated with poorer ED treatment outcome (Kong & Bernstein, 2008;

Rodriguez, Perez, & Garcia, 2005). With regard to sexual abuse in particular, much has been written about its potential link to EDs, yet the evidence remains unclear. A meta-analysis of 53 studies found a small but consistent relationship between childhood sexual abuse and the development of EDs, however, the authors noted that the relationship was marked by heterogeneity because of methodological differences among the studies (Smolak & Murnen, 2002). A more recent review of 41 studies demonstrated that survivors of sexual abuse were more likely to show signs of disordered eating when the abuse engendered increased distress, anxiety, and shame, poor self-esteem, family conflict, decreased social competence, negative body image, and behaviours related with impulsivity, self-harm, and dissociation (Collin-Vézina & Hébert, 2012).

Considering the elevated levels of co-morbidity and the increased likelihood of adverse events and experiences in people who develop EDs, treatment is a decidedly complex issue. Research utilizing the intricacies of interpersonal functioning and taking into account the impact of co-morbidities and complex trauma may aid clinicians in creating more tailored treatments. This may also provide clues to some of the motivational challenges associated with treatment for each type of ED.

Aetiology of Eating Disorders

It is essential to keep in mind that the aetiology of EDs is multifaceted. The literature suggests an intricate combination of biological factors (e.g., serotonin functioning, family psychopathology), psychological factors (e.g., perfectionism, a sense of powerlessness), developmental factors (e.g., family interaction, trauma/abuse), and social pressures for thinness (e.g., dieting; Jacobi, Hayward, De Zwaan, Kraemer, & Agras, 2004). These factors interact with each other throughout the lifespan and are difficult to tease apart definitively. Nonetheless, aetiological models attribute roughly equal weight to biological and psychosocial factors (Collier & Treasure, 2004).

Psychosocial Perspectives

Although an ED may appear to be an individual's problem, it can also be described as a signal that the environment is not meeting the individual's needs. Coping mechanisms are developed within the individual, but as a reaction to the context within which the individual lives. Contemporary treatments for EDs do not generally address many of these contextual factors and this may provide some clues as to why therapy is not effective with the majority of individuals. A sole focus on behavioural symptoms naively assumes that if the client can rid herself of restriction, bingeing, or purging, she will be well. This may be alienating for some clients who see their EDs as emerging from a larger context. It may also be damaging to the client's motivation to persist in treatment if she feels that her therapist does not "get it". Societal pressures, women's roles within their lives, the objectification of women's bodies, and issues of control and autonomy must be addressed in order for clients to think and behave differently, and to develop healthier ways of coping with the challenges in their lives. The following section reviews some of the psychosocial factors that contribute to and perpetuate EDs.

A Culture of Thinness

While rates of restrictive AN have remained relatively stable, with a small global increase throughout the 20th century, the incidence of BN in 10- to 39-year old women shows a marked increase, with rates tripling between the years 1988 and 1996 (Currin, Schmidt, Treasure, & Jick, 2005). There is no biological factor that could account for such a rapid increase of eating problems. Moreover, there is currently a $40 billion per year diet industry which was nonexistent 40 years ago (Groesz, Levine, & Murnen, 2002) and body dissatisfaction has become a normative component of the female experience (Bearman, Presnell, Martinez, & Stice, 2006).

Elevated weight and shape concerns are the most potent and best confirmed risk factors in the development of EDs (Jacobi, Hayward, De Zwaan, Kraemer, & Agras, 2004). Dieting, pressure to be thin, modeling of eating disturbances, appearance overvaluation, body dissatisfaction, depressive symptoms, emotional eating, body mass, and low self-esteem and social support predicted binge eating onset with 92 % accuracy in a two-year investigation of adolescent girls (Stice, Presnell, & Spangler, 2002). In a survey of over 1,000 adolescent girls, both dietary restraint and body dissatisfaction were significant predictors of disordered eating outcomes (Johnson & Wardle, 2005). There appears to be some conflicting evidence about the causal relationships between body dissatisfaction and dieting, raising the question about which factor precipitates the other (e.g., Stice, 2001; Johnson & Wardle, 2005). Regardless of which comes first, it is undeniable that increased cultural pressures for thinness plays a critical role in body dissatisfaction, negative self-image, depression, and a general sense of ineffectiveness and powerlessness (e.g., Piran & Cormier, 2005; Polivy & Herman, 2002; Striegel-Moore & Bulik, 2007).

Ethnicity and Acculturation

One of the most common myths about EDs is that they are exclusively limited to White girls from upper-middle class families. This has perpetuated an overabundance of research to be conducted with this population and has possibly skewed our ability to identify EDs in the wider population. There is evidence that women from various ethnic groups experience ED symptoms (e.g., Jennings, Forbes, McDermott, Hulse, & Juniper, 2006), but are significantly less likely to access or receive treatment (Gordon, Brattole, Wingate, & Joiner, 2006; Striegel-Moore &

Smolak, 2000). Further, researchers have found no consistent association between any socio-economic group and EDs (Favaro, Ferrara, & Santonastaso, 2003).

Studies now suggest that women from different cultural backgrounds may present symptoms differently and therefore EDs in these populations may not be as easily recognized (Franko, Becker, Thomas, & Herzog, 2007). In addition, it has been found that women of colour are significantly less likely than White women to have been asked by a doctor about ED symptoms and therefore published rates of EDs in various populations may be underreported (Becker, Franko, Speck, & Herzog, 2003; Cachelin & Striegel-Moore, 2006). For example, in a study that examined clinician's ability to detect an ED in White, Latina, and African American women, only 16.7 % recognized the client's eating problems when she was identified as African American. Conversely, when the client was identified as White, 44.4 % of clinicians identified the symptoms as an ED and recommended follow-up and treatment (Gordon, Brattole, Wingate, & Joiner, 2006). Finally, current treatment manuals do not address the ways in which clinicians can be more culturally competent when working with clients from diverse backgrounds, and therefore many struggle with delivering effective services.

Some research suggests that level of acculturation to Western values may have more of an impact on ED symptoms than belonging to a specific ethnic group. Within-ethnic-group differences are reported with more acculturated women having higher rates of ED symptoms (Davis & Katzman, 1999). For example, in Australia, Western-acculturated Hong Kong-born women demonstrate greater body image disturbance than less acculturated Hong Kong-born students (Lake, Staiger, & Glowinski, 2000). In addition, higher rates of EDs have been found in more industrialized cities versus in the countryside in China (Lee & Lee, 2000).

Gender

EDs are the most gendered disorder in the DSM and therefore one must examine what it is about being female that predisposes women to developing an ED. Interestingly, EDs and problem drinking share some personality profile characteristics and may share predisposing factors such as poor impulse regulation (Dawe & Loxton, 2004), and poor coping skills when experiencing distress (Fischer & Smith, 2008). However, the choice of eating or drinking in response to stressors is related to gender-role expectations. For example, it has been shown that women with high scores on femininity scales or low scores on masculinity scales are more likely to exhibit disordered eating than problem drinking as a way of coping with stress (Williams & Ricciardelli, 2003; Williams & Ricciardelli, 2001). In other words, women who have internalized a gender role of more feminine and less masculine qualities may be more vulnerable to developing eating problems. It may be pertinent for clients to explore the impact of gender and cultural values in the development of their ED.

Self-Silencing and Suppression of Anger

Whether in the role of daughter, wife, mother, or as a member of the larger society, women are generally expected to act as caregivers (Jack, 1999). Moreover, they are subtly pressured to silence their thoughts, feelings, and needs to achieve and maintain close relationships (Gilligan, Rogers, & Tolman, 1991; Brown, 2013). From a very young age, women are taught behaviour control and inhibition to the degree that some become overly submissive and unassertive. The internalization of these socialized patterns has been implicated in depression in women (Jack & Dill, 1992) and, more recently, in EDs (Piran & Cormier, 2005; Frank & Thomas, 2003; Zaitsoff, Geller, & Srikameswaran, 2002). Research has identified certain cognitive patterns that women are socialized to use which can lead to negative consequences for their well-being, such as holding on to feelings and opinions in order to avoid confrontations with others, putting the needs of others before their own, suppressing frustration/anger and presenting themselves as nurturing, caring and compliant (Jack & Dill, 1992).

Part of the popular ideal of women as nurturers is the notion that women should not express anger outwardly. Within this context, women learn that outward expression of anger will be judged as inappropriate by others, and that women themselves believe it to be inappropriate (Jack, 1999). Self-silencing and the suppression of anger present obvious challenges to the therapeutic process. If clients avoid conflict or silence themselves in their therapy, in doing so, they may lose the opportunity to work through difficulties that brought them to therapy in the first place. Further, they may be inclined to drop out of treatment if these issues are not addressed with sensitivity.

Objectification Theory

Physical appearance has been found to be the most important domain contributing to young adolescents' sense of self-worth (Lindberg, Hyde, & McKinley, 2006). However, girls' but not boys' body-image satisfaction is related to sense of self and development of identity. Further, physical attractiveness in women, but not men, has been linked to popularity, dating experience, and marriage opportunity (Fredrickson & Roberts, 1997). These experiences are hypothesized to have roots in objectification theory. Objectification theory (Fredrickson & Roberts, 1997) posits that women are acculturated to internalize an observer's perspective as a primary view of their physical selves. This affects how a woman views herself and how she is able to relate to others. The objectification experience involves being treated as a body or a collection of body parts valued principally for use or consumption by others. The internalization of the observer's perspective is called self-objectification and is carried out through persistent body surveillance, the act of consistently monitoring the body and its outward appearance. As a result, women's relationship to their bodies becomes parallel to an observer's relationship to an object, taking in socio-cultural values and attitudes and incorporating them into their sense of self (Noll, & Fredrickson, 1998).

Objectification theory further posits that persistent body surveillance can increase the occurrence of shame and anxiety, reduce opportunities for peak motivation, and diminish awareness of internal bodily states. Shame occurs when women evaluate their bodies negatively in comparison with the cultural ideal of thinness (Quinn, Kallen, & Cathey, 2006). As only 1 in 40,000 women actually meet the requirements for a model's size and shape, it is not surprising that so many women feel shame in their "failure" to meet the standards. The emotion of anxiety arises when women worry that this failure will be exposed and that others will observe their lack of discipline in maintaining the thin/beautiful ideal and will evaluate them negatively (Calogero, 2004). Moreover, objectification theory posits that peak motivational states, which improve quality of life and act as buffers to depression (Csikszentmihalyi, 1990; Deci & Ryan, 1985), are interrupted and reduced when women feel self-consciousness induced by persistent body monitoring (Szymanski & Henning, 2007). Beginning in adolescence and even childhood, dieting becomes a critical part of women's lives in their efforts to achieve or maintain a slim body ideal. Importantly, dieting and restrained eating require active suppression of hunger cues. Some have argued that it may not be possible to selectively tune out hunger, and that the compulsions surrounding restrictive eating may lead to a generalized insensitivity to internal bodily cues (e.g., Daubenmier, 2005). Inattentiveness to bodily cues would involve neglecting emotional signals as well, and therefore may impact interpersonal effectiveness.

Finally, objectification theory states that each of the consequences of body surveillance (i.e., increased shame and anxiety, decreased motivation, and awareness of bodily states) lead to disordered eating, sexual dysfunction, and depression (see Moradi & Huang, 2008 for a review). Research has demonstrated a direct link between self-objectification and disordered eating (e.g., Calogero, Davis, & Thompson, 2005; Slater & Tiggemann, 2002; Piran & Cormier, 2005). An exploration of self-objectification, particularly with regard to shame and identity, may be useful in understanding some of the challenges in ED treatment.

Parenting Processes and Issues of Control

It has been repeatedly suggested that family dysfunction and parenting processes play a role in the development and maintenance of ED (Polivy & Herman, 2002). First and foremost, family history of dieting, and valuing appearance have been implicated in all forms of ED (Abramovitz & Birch, 2000). While there have also been studies that indicate that women with BN report more parental indifference, discord, or neglect, and AN has been linked with overprotective parenting (Dominy, Johnson, & Koch, 2000), the research is inconsistent. Relating parenting processes to the development of EDs may have more to do with contingent love, perceived control/lack of control, and the development of autonomy.

Perceived parental psychological control. Perceived parental psychological control refers to parental behaviours that invade children’s thoughts and feelings (Barber, 1996). Typical behaviours may involve parents who use guilt or love withdrawal to ensure the child’s compliance to parental demands. Longitudinal studies have shown that perceived parental psychological control consistently predicts children’s and adolescents’ internalizing problems such as anxiety, low self-worth, and depression (Barber & Harmon, 2002). In addition, adolescents’ perception of parental control has been linked to binge eating (Dominy, Johnson, &

Koch, 2000). Most recently, perfectionism was found to mediate the relationship between perceived psychological control and ED symptoms (Soenens et al., 2008). The development of perfectionism may be a response to contingent love and attention or to high standards in the family environment.

Perfectionism. Childhood obsessive compulsive traits, such as perfectionism, have been shown to be predictive of the development of EDs later in life (Anderluh, Tchanturia, Rabe-Hesketh, & Treasure, 2003). Further, there is a well-established co-incidence between perfectionism and severity of eating symptomatology in AN and in BN (Halmi et al., 2012; Halmi et al., 2005). There are two kinds of perfectionism: personal standards (PS) and self-criticism (SC). PS perfectionism involves the setting of and striving for excessively high personal standards for performance and achievement. In contrast, SC perfectionism comprises constant and harsh self-scrutiny, overly critical evaluations of one’s own behavior, and chronic concerns about others’ criticism and disapproval (Dunkley, Blankstein, Zuroff, Lecce, & Hui, 2006). While high standards are positive if they foster goal-oriented activity, they become maladaptive when accompanied by negative self-evaluative tendencies which cause the individual to doubt everyday decisions and behaviours, and to be overly concerned that they may be negatively perceived by others (Powers, Koestner, Zuroff, Milyavskaya, & Gorin, 2011). These negative self-evaluations, coupled with excessively high personal standards, create vulnerability to a general discontentment and more specifically to internalizing problems (Dunkley, Blankstein, Masheb, & Grilo, 2006).

Studies point to a central role of maladaptive perfectionism in the development and maintenance of EDs (Soenens et al., 2008; Shafran, Cooper, & Fairburn, 2002; Bulik et al., 2003). Research has demonstrated that the manipulation of personal standards affects the consumption of high calorie foods, restriction of foods eaten, and feelings of guilt and regret after eating (Shafran, Lee, Payne, & Fairburn, 2006). Maladaptive perfectionism causes the individual to become rigidly focused on control over eating as a means to compensate for a pervasive sense of incompetence or lack of control. Controlling parenting may foster perfectionistic concerns in which the inability to live up to certain standards may be seen as unacceptable. Coupled with a feeling that parental love is contingent upon the extent to which standards are met, the stage is set for maladaptive perfectionism and an endless pursuit of unattainable goals (Flett, Hewitt, Oliver, & MacDonald, 2002).

Women internalize these standards at a very young age and begin to criticize and disapprove of their own behaviour while experiencing feelings of guilt and anxiety for failing to attain their standards. Indeed, an association has been found between fear of negative evaluation and attitudes surrounding restrictive eating. Women who are rated high in contingent self-esteem are more likely to make appearance-related comparisons with models after viewing an advertisement, and to feel badly about themselves after making comparisons (Gilbert & Meyer, 2005). In other words, a higher level of contingent self-esteem increases the likelihood that women will compare themselves negatively to unrealistic standards (Patrick, Neighbors, & Knee, 2004).

Control and Resistance

EDs have been described as originating from control issues, such as lack of control over one’s life and emotions, an extreme need for self-control, or seeking control in a family setting (Surgenor, Horn, Plumridge, & Hudson, 2002). The control of eating is chosen because it provides direct, tangible evidence of self-control when the individual feels a lack of control in other areas. A pervasive feeling of powerlessness and inadequacy is significantly related to body image and eating disturbance (Peterson, Grippo, & Tantleff-Dunn, 2008; Anleu, 2006). This is especially pertinent to the therapeutic setting because if treatment reproduces a controlling environment, it may exacerbate attempts to control by the client.

Since most ED clients enter therapy because of pressure from outside of themselves, higher levels of external pressures may explain higher levels of resistance to change (Vitousek, Watson, & Wilson, 1998). Refusal of treatment, noncompliance, and dropout are common factors in the treatment of EDs. It is hypothesized that certain therapist styles may elicit client resistance by heightening issues of control, particularly when decision-making is not shared. For example, client resistance rates rise when a confrontational therapeutic style is used (Miller, Benefield, & Tonigan, 1993), and increased levels of resistance negatively influence client motivation for change (Miller & Rose, 2009).

Treatment of Eating Disorders

Psychosocial Interventions

The most widely used model in adult treatment centres is the cognitive-behavioural therapy (CBT) approach for EDs (American Psychiatric Association, 2006; Costin, 2007). It is considered the "gold standard" in the treatment of BN by the National Institute for Clinical Excellence (NICE, 2004). There is evidence that CBT is associated with significant reductions of bulimic symptomatology (Fairburn, Cooper, & Shafran, 2003; Wilson, Grilo, & Vitousek, 2007), though full recovery rates are low. Studies using manual-based CBT yield remission rates for bingeing and purging in 30 % to 50 % of clients (Wilson, Fairburn, Agras, Walsh, & Kraemer, 2002). However, meta-analytic data suggest that, on average, 40 % of clients screened are excluded from randomized clinical trials (RCTs) because of co-morbid disorders (Thompson-Brenner, Glass, & Westen, 2003). Therefore, its generalizability for use with concurrent co-morbid disorders is unknown (Thompson-Brenner & Westen, 2005b). Further, although it is used in the treatment of AN and EDNOS, there is little empirical support for doing so (Treasure, Schmidt, & Van Furth, 2003).

Cognitive Behavioural Therapy

The CBT approach for the treatment of EDs is comprised of three overlapping phases (Agras & Apple, 1997; Fairburn, Marcus, & Wilson, 1993). The early phase of CBT treatment includes psycho-education about nutrition and the effects of starvation. Detailed self-monitoring of food intake and/or purging episodes are required as well as recorded thoughts and feelings associated with each of these episodes. Clients are encouraged to increase the regularity of their eating and to resist the urge to binge and purge. Some activities in therapy include making a list of pros and cons of maintaining the ED to help clients examine whether it is worthwhile to keep their disorder. In the middle phase, beginning around the ninth session, therapists help clients to identify and correct dysfunctional cognitions surrounding weight and shape concerns. This phase focuses on behavioural strategies, cognitive restructuring, problem solving, and gradual exposure to forbidden foods. Strategies for self-control are introduced, such as planning specific places and times to eat and avoiding trigger foods. The third phase, generally the last three sessions, involves relapse prevention and preparation for termination. The suggested overall treatment program is 18 to 20 sessions (Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000).

While there are a number of useful strategies in this treatment, the primary focus is on symptom reduction. Positive outcome has traditionally been measured by decreases in symptomatology and an increase or stabilization of body weight. Other criteria, such as general well-being, development of autonomy, interpersonal effectiveness, or personality functioning are often not used to measure outcome. In addition, clinicians report treating their clients for much longer than the 18 to 20 sessions prescribed in the empirically supported manual. The average treatment for BN is about two years with a mean of 69 CBT sessions (Thompson-Brenner & Westen, 2005a). Further, CBT has only limited success with certain groups of ED clients, such as those who have co-morbid personality disorders (Wonderlich & Mitchell, 2001), or interpersonal difficulties (Keel, Mitchell, Miller, Davis, & Crow, 2000).

Recently, CBT theorists have recognized that motivation is critical to treatment retention and success. Research suggests that a pre-treatment motivation enhancement therapy, followed by a regular course of CBT, promotes better outcome than CBT alone (Feld, Woodside, Kaplan, Olmsted, & Carter, 2001). Based on these and other findings, a new form of CBT for EDs was developed (CBT-enhanced) that addresses mood intolerance, clinical perfectionism, low self-esteem, or interpersonal difficulties, depending on the needs of the individual (Fairburn, Cooper, Shafran, Bohn, & Hawker, 2008). In a study that examined the effects of a pre-treatment motivational enhancement therapy group (MET) versus treatment as usual (TAU) in EDs, nearly all of the MET participants were still engaged in either inpatient or day program activities at the post-treatment assessment. In contrast, more than half of the TAU group had dropped out at post-treatment, suggesting that the MET promoted treatment continuation and fostered longer term engagement in clients with EDs (Dean, Touyz, Rieger, & Thornton, 2008).

Interpersonal Therapy

Interpersonal therapy (IPT) for EDs is not as common, but is also employed in certain treatment centres (Constantino, Arnow, Blasey, & Agras, 2005; Kotler, Boudreau, & Devlin, 2003). IPT treatment also has three phases and is manualized (Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000; Fairburn, 1997). In the first phase (comprising the first four sessions), the therapist conducts a detailed analysis of the interpersonal context within which the ED was developed and maintained. Interpersonal functioning is assessed within four domains: grief over the loss of a person or relationship, interpersonal role disputes, role transitions, and interpersonal deficits. The second phase (approximately 12 sessions) is aimed at helping the client to make interpersonal changes in the areas identified in the first phase. The third phase (the last three sessions) is a review of the client's progress, and an exploration of ways to handle future interpersonal difficulties.

Symptom reduction tends to be more rapid and more effective in CBT than in IPT. However, a large scale study found no significant differences between those who followed a CBT or an IPT therapy at 4-, 8-, and 12-month follow up (Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000). It may be that while CBT targets symptom reduction, IPT's focus on personality functioning is integral to the effective treatment of EDs, particularly when treating individuals with co-morbid disorders. Therefore, integration of the two approaches may be beneficial to target various client concerns.

Prognosis

For the majority of women, the course of an ED spans many years and the prognosis is pessimistic. In a review of 119 studies on ED treatment, only 46 % of women with AN achieved full remission within 4 to 10 years after initially seeking treatment (Steinhausen 2009; 2002). For women with BN, full remission occurred in only 48 % of women 5 to 10 years after presentation (Keel & Mitchell, 1997). For all women, relapse was common and occurred numerous times even after full recovery within the 10-year period. However, full recovery rates increased slightly between five and seven years, suggesting that some women continue to improve after treatment ends (Herzog et al., 1999). Finally, mortality rates (both all-cause and suicide) ranged between 5 and 10 % of individuals with all types of EDs (Crow et al., 2009;

Steinhausen, 2002). Keeping in mind that treatments are ineffective in almost two-thirds of cases, it seems imperative to determine how therapy can better serve this population. Traditionally, treatment failure has been attributed to client characteristics rather than to therapeutic factors.

Client Characteristics or Therapeutic Factors

There is a plethora of research that implicates the importance of therapeutic factors, such as the alliance, in the treatment of psychological problems (Martin, Garske, & Davis, 2000). However, in the treatment of EDs, the majority of research has focused on client characteristics that predict dropout, such as severity or duration of ED symptoms or co-morbid diagnoses. There are no consistent results that link specific client characteristics to drop out from treatment. Recently, certain researchers have shifted their focus to therapeutic factors in order to determine if there is something about the therapy itself that is contributing to high rates of drop out and negative outcome (Geller, Williams, & Srikameswarna, 2001; Kaplan, Olmstead, Carter, & Woodside, 2001).

Motivation and Eating Disorders

Motivation for treatment has been defined as the probability that a client will enter into, continue, and adhere to a specific change strategy (Miller & Rollnick 2002; Miller, & Rollnick, 1991). Motivation difficulties among clients with EDs have been well documented since the first descriptions of AN and BN. Most researchers and clinicians agree that deficits or conflict with motivation for treatment are pervasive among ED clients (e.g., Geller, 2002a; Touyz, Thornton, Rieger, George, & Beumont, 2003; Vitousek, 2002; Vitousek, Watson, & Wilson, 1998). For example, when a young woman with AN presents for treatment, she may not have any goals of weight gain, but may instead be coming to please her parents. Among clients with AN, there is often disagreement with others about the existence of a problem; the clients' views tend to be sanctioned by societies' focus on being thin along with the inability to recognize how thin one has become. Similarly, when a woman with BN enters therapy, she may want the health professional to help her stop bingeing but not at the price of jeopardizing her strategy for weight control. Clients with BN may be more cognizant of the problem but are known for their ambivalence about treatment and for more impulsively terminating therapy prematurely.

While motivational issues have been well documented, a comprehensive framework to understand motivational dynamics in ED has not been well articulated. There are two major theories that have been used to frame motivational issues in health-related fields: the *transtheoretical model* (TTM; Prochaska & DiClemente, 1986) and *self-determination theory* (SDT; Deci & Ryan, 1985). The TTM has been associated with the development of Motivational Interviewing (MI; Miller & Rollnick, 1991), which outlines therapeutic techniques for enhancing clients' treatment motivation. Both theories are discussed here because of their differential influence on the concept of client motivation in the treatment of EDs.

Readiness to Change

The TTM has been widely used to understand behaviour change in addictive disorders (Prochaska & DiClemente, 1986; Prochaska, DiClemente, & Norcross, 2003). According to the model, the impetus for change comes in stages or different levels of readiness to make alterations in behaviour: precontemplation (not thinking about changing the problem behaviour within the next six months), contemplation (intending to change in the next six months), preparation (planning to change in the next month, typically already having tried to change at least once in the past year), action (making health-relevant changes in the behaviour for as little as one day or as long as six months) and maintenance (having made behavioural changes for longer than six months. Different stages of readiness for change may predict treatment participation, dropout, and longer-term maintenance (Prochaska, Redding, & Evers, 2002).

The model has been successfully applied to a variety of health behaviours, such as condom use, exercise adherence, and use of sunscreen. It has also been valuable when investigating client's readiness to address obesity (Dalle Grave et al., 2005), smoking (Prochaska, DiClemente, & Norcross, 2003) alcohol use (Shields & Hufford, 2005), and drug use (Levin et al., 2006). Studies that have examined stages of change in the treatment for EDs have found that the majority of clients with a diagnosis of AN are in the precontemplation and contemplation stages, and not in the action stage, at the beginning of therapy. In contrast, approximately 80 % of individuals with BN have been found to be in the action stage when they begin treatment (Blake, Turnbull, & Treasure, 1997).

An important caveat is that the high rates of individuals with BN in the action stage may stem from desires for reducing bingeing behaviours and not for reducing compensatory weight control methods. In fact, it has been argued that existing stages of change measures may not be sophisticated enough to tap into the specific behaviours associated with restriction, bingeing, and purging. There is evidence that assessing readiness for changing binge eating separately from assessing readiness for changing compensatory behaviours accounts for greater variance in BN-related behaviours (Dunn, Neighbors, & Larimer, 2003). In general, measures of stages of change to date have shown that as with other behavioural problems, when clients are more motivated at the beginning of therapy, they tend to do better on outcome measures than those who are less motivated (e.g., Rodriguez-Cano & Beato-Fernandez, 2005; Wade, Frayne, Edwards, Robertson, & Gilchrist, 2009).

Stages of Change Instruments

In recognition that readiness to change impacts ones treatment outcome, researchers have begun to create instruments that assess readiness for changing ED symptoms (e.g., Rieger, Touyz, & Beaumont, 2002; Rieger et al., 2000). Some of these questionnaires have been successful in predicting certain treatment outcomes, such as improved body satisfaction and decreased drive for thinness (Gusella, Butler, Nichols, & Bird, 2003), weight gain (Rieger et al., 2000), and reduced frequency of binge eating (Treasure et al., 1999). The Readiness and Motivation Interview (RMI; Geller & Drab, 1999; Geller, Cockell, & Drab, 2001) was developed to assess ED client levels of motivation for treatment. This measure, carried out prior to treatment, assesses client stage of change in addition to the degree to which ED clients are making changes for themselves (internal reasons) or for others (external reasons). Symptoms are grouped into four domains (restriction, cognitive, bingeing, and compensatory behaviours) and motivation subscale scores are derived for each domain, as well as a global RMI score.

In the RMI interview, clinicians attempt to maximize the clients' internal motivation for change by exploring ambivalence about change. Global scores on the RMI at the beginning of treatment are predictive of dropout, symptom change, and relapse (Geller, 2002b; Geller, Cockell, & Drab, 2001). When looking at subscale scores, restriction precontemplation (i.e., not wanting to make change to dietary restriction at baseline) appears to be the strongest predictor of outcome (Geller, Drab-Hudson, Whisenhunt, & Srikameswaran, 2004). In other words, it may be clients' *lack* of readiness and motivation to make changes, rather than their contemplation of, or actual efforts toward change, that is most predictive of outcome. In one study, the RMI was performed prior to treatment, at week 7, and following a 12-15 week program, where they found that readiness to change behavioural symptoms preceded readiness to change cognitive symptoms (Geller, Zaitsoff, & Srikameswaran, 2005). This suggests that motivation changes throughout the course of treatment and, further, that motivation levels may be different depending on the symptoms under examination.

Methodological Problems

Although the TTM provides a basis for conceptualizing a client's readiness to change, it has been criticized for how the stages are defined and measured (Wilson & Schlam, 2004). For example, it has been argued that in order for a stage theory to be valid, it must be possible to assign individuals to one and only one stage category (Weinstein, Rothman, & Sutton, 1998). Further, some studies have found that, with the exception of the precontemplation stage, the different stages of change have not been shown to be discrete and that individuals may endorse items from two different, and sometimes non-adjacent, stages (Littell & Girvin, 2002). In recognition of this fact, the RMI has amalgamated certain stages because it has found only precontemplation, contemplation, and action/maintenance to be individually predictive of client dropout (Geller, Cockell, & Drab, 2001).

While the TTM may not be the perfect model, the theory behind stages of change has contributed an important focus on the motivational stance of the therapist in psychotherapy and its implication in client change. The interaction between clients and therapists can have a profound effect on client motivation and ED treatment success (Kaplan, Olmstead, Carter, & Woodside, 2001; Treasure & Schmidt, 1999; Wilson, Vitousek & Loeb, 2000). In the TTM, matching client readiness for change to therapist interventions may lead to better tailoring of treatment to individual needs (Geller & Drab, 1999). If there is a discrepancy between therapist interventions and client levels of readiness, damage to the therapeutic alliance and clients dropping out of treatment may result (Miller & Rollnick, 1991). Moreover, it is critical for the therapist to continually assess the client’s motivational stage and to work side by side, rather than ahead of the client, throughout the course of treatment.

Therapist Motivational Stance

The TTM has been linked to the development of Motivational Interviewing (MI), “a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence” (Miller & Rollnick, 2002, p. 25). Importantly, in MI, client readiness for change is conceptualized as a fluctuating product of the interpersonal interaction between client and therapist, and not as a client trait (Miller & Rollnick, 2002). There is always a difficult balance to be found between what is wanted by the client and what the health provider may judge is needed. Some have argued that the term *motivational* is best conceptualized as a therapist stance or approach to treatment rather than a treatment in and of itself (Geller, Williams, & Srikameswaran, 2001). Motivational stance can be understood as the manner in which treatment is delivered and so is amenable to application across different treatment modalities. A motivational approach involves emphasizing the client’s role as decision-maker, facilitating an understanding of barriers to recovery, and avoiding assumptions about the client’s experience (Geller, 2002a). In contrast with a more directive style, this stance may be particularly useful with the ED population.

As clinicians encounter resistance and ambivalence from ED clients, they may tend to slip into a more directive or expert role. Clinicians may also feel internal pressure, or face pressure from parents and demands from team members, particularly if they view rapid symptom change as a desirable outcome. In this case, clinicians may try to convince the client to make changes or attempt to scare the client into action by dwelling on the damage that the client is inflicting on her body. However, research has shown that greater psychological distress in ED clients is associated with less behaviour change (Geller, Williams, & Srikameswaran, 2001). The delicate interplay between therapist and client can elicit resistance and/or engagement and, therefore, can greatly impact client motivation to pursue treatment.

Motivational Interviewing

Motivational Interviewing assumes that all clients possess a potential for change and that it is the role of the therapist to evoke and reinforce this inner resource. Facilitation of this process occurs through (1) expressing empathy, (2) developing discrepancy, (3) increasing self-efficacy, and (4) rolling with resistance (Miller & Rollnick, 2002). Individuals are more engaged in the therapy when they are willing participants and when they have a sense that they are agents of their own process. As willing participants, they are more likely to incorporate behaviour change which results in better outcomes. If individuals feel coerced, they may be much more likely to resist the treatment and the therapist. Lasting change will not be engendered from “shoulds” or guilty feelings around disappointing the therapist. Instead, clinicians must create situations in which clients engage in self-exploration and contemplation of change so that the motivation comes from within (Amrhein, Miller, Yahne, Paler, & Fulcher, 2003). In spite of the intuitive appeal of MI, it says little about the mediating processes by which its techniques have effect. Further, there is a paucity of research examining the underlying mechanisms of *why* and *how* it works the way it does (Vansteenkiste & Sheldon, 2006). Self-determination theory (SDT) and MI share many fundamental ideas about behaviour, and SDT may be useful in understanding how MI works.

While both the TTM and SDT have been used to understand motivational issues, SDT offers an additional component to frame ED-related motivational concerns. Although the TTM acknowledges that motivation is a fluctuating factor and that clients cycle through phases of readiness at varying times, motivation is discussed in terms of quantity, that is, whether a client has the motivation to take action or not. Conversely, SDT places its emphasis and significance on the quality or *type* of motivation that the individual experiences, and how that impacts their behaviour. In SDT, motivation is still a dynamic concept whereby the type of motivation that is elicited at one point in therapy may be different than at another point. The type of motivation that is elicited in the client may depend on situational influences in the therapy, for example therapist interpersonal style, which in turn may impact perseverance or dropout from treatment.

Self-Determination Theory

Innate Psychological Needs

SDT suggests that motivation for any given behaviour may be intrinsically motivated, extrinsically motivated, or amotivated. The content of outcomes is differentiated from the regulatory processes through which the outcomes are attained. In SDT, there are three necessary conditions that foster the process of motivation and are essential for ongoing psychological growth, integrity, and health (Deci & Ryan, 2000). Each person has innate psychological needs for *autonomy* (feelings of volition or free will), *competence* (feeling effective in the ability to control outcomes), and *relatedness* (feeling attached to and accepted by significant others; Deci & Ryan, 1985; Deci & Ryan, 2000). The satisfaction of these three basic psychological needs is linked to the experience of well-being. In SDT, well-being is not simply a positive affect, but is a function in which people detect the presence of vitality, psychological flexibility, and a deep sense of inner wellness (Ryan, Deci, & Grolnick, 1995; Deci & Ryan, 2000). Research indicates that these needs are relevant across multiple domains (e.g., family, friends, school, work; Milyavskaya, & Koestner, 2011) and that they are cross-culturally applicable (e.g., Sheldon et al., 2004).

Types of Motivation: Amotivation, Intrinsic, and Extrinsic

Self-determination theorists distinguish between types of motivation that can have a differential impact on the integration and maintenance of therapeutic change. Amotivation is different from both intrinsic and extrinsic motivation in that it is a state in which people lack the initiative to take any action. People lack either a sense of efficacy or control to affect an outcome and are not able to regulate themselves (Pelletier, Dion, Tuson, & Green-Demers, 1999).

In contrast, *intrinsic* motivation is based in people's need to feel competent and self-determined (Deci, 1975). Intrinsically motivated behaviours are activities that people find interesting and would engage in the absence of rewards. They are performed because the activity is inherently enjoyable or satisfying to the person. SDT proposes that individuals will be more engaged in therapy when their actions are accompanied by a feeling of volition or willingness. The concept of *perceived locus of causality* (deCharms, 1968) captures the degree to which people experience their behaviour as self-chosen rather than pressured or coerced. Intrinsic motivation is represented by an internal perceived locus of causality (I-PLOC) because people see themselves as the agent of their own actions. When clients are more autonomously engaged in the therapeutic process, that is, when they have a more internal perceived locus of causality, they will be more likely to integrate learning and behaviour change, and to have more positive outcomes (Ryan & Deci, 2008). Studies have demonstrated that autonomously motivated clients experience therapy as more important, are less distracted during therapy, experience less tension about therapy, have greater intentions of persevering, experience lower levels of depressive symptoms, and have elevated self-esteem (e.g., Pelletier, Tuson, & Haddad, 1997; Zuroff et al., 2007).

Previous research on *extrinsic* motivation focused on how it affected and was antagonistic to intrinsic motivation. Extrinsic motivation is a type of motivation in which people will engage in activities to obtain goals that are separate from the activity itself (Ryan & Deci, 2000). Initially, it was characterized by an external perceived locus of causality (E-PLOC; deCharms, 1968). More recent theorizing suggests that extrinsically motivated behaviours may not necessarily be in opposition to intrinsic activities and may enable people to experience high quality motivation as well (e.g., Koester & Losier, 2002). Motivation researchers have discovered that extrinsic motivation may in fact be more nuanced, and that different types of regulatory processes involved in extrinsic motivation may mean that extrinsically motivated behaviours can vary in their degree of autonomy (e.g., Koestner, Losier, Vallerand, & Carducci, 1996). The term *internalization* has been adopted to describe the process by which externally motivated behaviours are “taken in” to individuals’ self-structures (Deci & Ryan, 2000). Internalization reflects the degree that these behaviours have been accepted as personally important and are now experienced with a sense of autonomy.

Regulatory Processes: The Internalization of Extrinsic Motivation

Motivations may be intrinsic, extrinsic, or amotivated; the resulting regulation of behaviours vary depending on the degree of internalization of values associated with the motivation. In SDT, the process of internalization occurs when people actively transform external regulations into personally endorsed values. On the far end of the continuum, *external regulation* occurs when people’s behaviour is controlled by external contingencies such as rewards and punishments. When behaviours are externally regulated they are experienced as highly controlling and show poor maintenance once contingencies are withdrawn. Next, *introjected regulation* is a form of extrinsic motivation that involves taking in regulations without fully digesting them. It is a partial internalization where behaviour takes place without the presence of rewards and punishments, but motivations have not yet become a part of the person's self. In other words, they are within the person but external to the "self". In this form of regulation, people's behaviours are not self-determined because they are motivated by guilt, shame, or contingent self-worth. Introjected regulation has been found to be an unstable form of regulation with regard to behavioural change (Koestner, Losier, Vallerand, & Carducci, 1996). *Identified regulation* occurs when people recognize the value of behaviour and have more fully accepted it as their own. While the behaviour is not being performed because of inherent enjoyment, personally identifying with goals provides a more autonomous experience of pursuing change. At the other end of the continuum, the most complete internalization of extrinsic motivation is called *integrated regulation* and occurs when individuals are able to integrate the importance of behaviours with aspects of their identity (Deci & Ryan, 2000). These different types of regulation impact the treatment of EDs as they implicate two salient factors which affect persistence, resistance, and levels of drop out from treatment: the constructs of autonomy and control.

Autonomous and Controlled Motivation

Autonomy refers to the self-endorsement of personal behaviour and the sense of willingness that comes with it (Ryan & Deci, 2008). The degree of internalization of a regulated behaviour influences the degree to which the behaviour is experienced as self-determined (autonomous) or non-self-determined (controlled). External regulation and introjected regulation, which involve feelings of shame and guilt, are the most extrinsic forms of motivation in which people feel most controlled. Both of these types of regulation are characterized by an external perceived locus of causality as people do not see themselves as agents of their own actions. In contrast, identifying with the value or integrating behaviours within a personal sense of identity allows for feeling more autonomous in one's actions. Intrinsic motivation and well internalized extrinsic motivation (i.e., identified and integrated forms of regulation) are the bases for autonomous or self-determined behaviour which is experienced as volitional and authentic. Table 1 visually depicts the relationships between type of motivation, type of regulation, locus of causality, motivational force, and autonomy and control.

Table 1

The Self-Determination Continuum

Behaviour continuum	Non self-determined					Self-determined
Type of motivation	Amotivation	Extrinsic				Intrinsic
Type of regulation	Non-regulation	External	Introjected	Identified	Integrated	Intrinsic
Locus of causality	Impersonal	External	External	Internal	Internal	Internal
Motivational force	Helplessness	Reward/ Punish	Guilt/ Shame	Values	Self-structure	Enjoyment/ Pleasure
Motivation	Controlled			Autonomous		

Note. Adapted from Deci & Ryan, 2000

Research on Autonomous and Controlled Motivation

Autonomous and controlled motivation is traditionally measured using the Treatment Self-regulation Questionnaire (TSRQ; Ryan & Connell, 1989; Levesque et al., 2007). This measure assesses possible reasons for engaging in change behaviours. For example, in a study assessing participants reasons for quitting smoking, a sample item measuring autonomy would be, “I’ve carefully thought about quitting and I believe it’s the right thing for me to do”. An item measuring controlled motivation would be, “I would feel guilty if I didn’t do what my doctor said”. Research has established that autonomous motivation enables people to experience enhanced well-being, lasting persistence, and higher performance in areas such as work, education, and sports (Deci & Ryan, 2000, 2002; Deci & Vansteenkiste, 2004; Vallerand, 1997). Further, it has been demonstrated that autonomous (and not controlled) motivation is related to goal progress and implementation planning for academic and leisure goals (Koestner, Otis, Powers, Pelletier, & Gagnon, 2008).

With regard to health care, autonomous motivation predicts treatment perseverance, lasting change, and well-being in the domains of smoking cessation (Williams, Gagné, Ryan, & Deci, 2002), medication adherence (Williams, Rodin, Ryan, Grolnick, & Deci, 1998), weight loss (Williams, Grow, Freedman, Ryan, & Deci, 1996), alcohol cessation (Ryan, Plant, & O’Malley, 1995), dietary self-care in diabetic patients (Senécal, Nouwen, & White, 2000), and adjustment to HIV infection and AIDS (Igreja et al., 2000). Further testing this idea, researchers assessed the degree to which clients engaged in psychotherapy for more autonomous (i.e., identified, integrated, or intrinsic) reasons or for controlled (i.e., external or introjected) reasons (Pelletier, Tuson, & Haddad, 1997). The more autonomous clients were in their motivation for therapy, the more important they believed therapy to be, the less distracted they were during sessions, the less tension they experienced about therapy, the more satisfied they were with their therapy, the greater their intention to persist, the higher their self-esteem, the lower their level of depressive symptoms, and the greater their life satisfaction.

In the ED arena, autonomously motivated women are less likely to endorse society’s positive beliefs about thinness and report fewer BN symptoms. Conversely, less autonomous women are more likely to internalize pressures to be thin, report greater body dissatisfaction, and more BN symptoms (Pelletier, Dion, & Levesque, 2004). Moreover, in a sample of 155 women with bulimia-spectrum EDs, higher levels of autonomous motivation at pre-treatment predicted lower post-treatment scores on binge eating, anxiety/depression, problems in relationships, impulsivity, and eating preoccupations (Mansour et al., 2012). These results were replicated in another study and expanded to include a transdiagnostic sample of women with EDs. Furthermore, this study demonstrated that individuals with higher autonomous motivation at pre-treatment were more self-compassionate and experienced greater social support (Carter & Kelly, 2014).

Regulating Motivation in the Treatment of Eating Disorders

With regard to motivational issues in the ED area, there are some subject-specific issues that may differentiate EDs from other health-related research. In both Motivational Interviewing (Miller & Rollnick, 2002) and the transtheoretical model (DiClemente, 1999), ultimate emphasis is placed on the importance of building *intrinsic motivation* for client success. It is possible that the focus on building intrinsic motivation is somewhat misguided, particularly in the treatment of EDs. A goal of increasing client intrinsic motivation suggests that therapists should help ED clients to experience changing their behaviour as enjoyable and satisfying. However, the chances are slim of enabling a client with AN to experience joy while gaining weight when the idea of weight gain is not only terrifying, but contrasts societal ideals of beauty and discipline. Similarly, a clinician will likely encounter dissonance while trying to encourage a client with BN to find inherent pleasure in stopping a binge cycle, when it has been linked to release from pressure or avoidance of intolerable emotions. Importantly, taking on new behaviours and getting rid of activities which brought inherent pleasure may come at considerable psychological cost for ED clients (Drieschner, Lammers, & van der Staak, 2004).

SDT specifies that extrinsically motivated behaviour can be experienced in the same autonomous and volitional manner as intrinsically motivated behaviour. In order to carry out non-enjoyable behaviours such as gaining weight or stopping the binge/purge cycle with a sense of volition, clients must be able to internalize the regulation of the behaviours by accepting the personal importance of the new behaviour into their own self-structures (Vansteenkiste, Soenens, & Vandereycken, 2005). In other words, the goal of therapy for ED clients is not building intrinsic motivation or learning to enjoy changing harmful and maladaptive eating patterns. Instead, treatment should be aimed at trying to foster the endorsement of change, so that it may be experienced in an autonomous manner, even if it is not pleasant. Lasting behaviour change does not depend on complying with demands for change, but rather on accepting the regulation for change as one’s own (William, Grow, Freedman, Ryan, & Deci, 1996). It requires the internalization of values and integrating them with one’s sense of identity.

Within the SDT framework, three factors have been found to facilitate the internalization of the regulation for uninteresting activities: (1) a meaningful rationale, so people will understand why the behaviour is important, (2) an acknowledgment of their feelings that the activity is not interesting, so they will feel understood, and (3) an emphasis on choice, so they will be able to accept responsibility for the behaviour (Deci, Eghari, Patrick, & Leone, 1994). While these factors are not therapy-specific, they demonstrate that there are aspects of the social environment (i.e., interpersonal interaction) that may influence and foster the process of internalization.

Application of SDT in Eating Disorder Therapy

Role of the Therapist

When ED clients feel pressured to change their behaviour, external regulation may be induced which can manifest itself as passive compliance or active defiance. Of course, using pressure may elicit change in the short-term, perhaps as a motivator to get out of treatment. However, if the change is not internalized it will not be maintained. It has been shown that there is a critical difference between the type of regulation (e.g., identified vs. introjected) that clinicians elicit in the area of weight loss in obese children. In a recent study, half of participants were encouraged in a manner which provided opportunities for choice and self-initiative (e.g., “You can choose your activity today”, i.e., identified regulation). Conversely, the other half were subtly pressured using guilt-induction (e.g., “You might feel guilty for not doing so”, i.e., introjected regulation). Interestingly, children in both conditions adopted healthier eating, attended diet sessions, and started to lose weight. However, when introjected regulation was induced, treatment effects were maintained for only three weeks. In the autonomy building condition, which elicited identified regulation for behavioural change, treatment effects were maintained more long term (Simons, Vansteenkiste, Braet, & Deci, 2003).

Importantly, if the children in this study had been tested on measures related to stages of change, they may all have appeared to be in the action phase because they were actively engaged in weight-loss behaviours. However, within SDT, researchers were able to predict who would maintain clinically significant change, based on the conditions of clinician behaviour. As mentioned earlier, research in the last 15 years has demonstrated that social context can foster the process of internalization and self-determination. This social context, which can theoretically be created in the therapeutic environment, is promoted through the dimensions of *structure*, and *involvement,* and *autonomy support* (Ryan & Deci, 2008; Markland, Ryan, Tobin, & Rollnick, 2005).

Structure. SDT suggests that structure can be implemented in controlling or in autonomy-supportive ways, and this has been demonstrated with children (e.g., Grolnick, 2003; Koestner, Ryan, Bernieri, & Holt, 1984). In relation to the treatment of EDs, there are certain *non-negotiables* that must be implemented into the structure of treatment, particularly when it comes to life-threatening weight loss or impulsive parasuicidal behaviours. It is important for clinicians not to confuse the concept of structure, which involves the implementation of goals, strategies, and limits, with a controlling style of interaction. Non-negotiables, such as the need for hospitalization if the client's weight drops dangerously low, may be a necessary part of ED treatment. However, the way in which policies are implemented can make the difference between the client feeling controlled and the client accepting the structure of therapy (Geller, 2002a).

Structure can bring coherence and direction to the work of therapy. Furthermore, it is theoretically proposed that clinicians can foster client competence when they help clients formulate clear and realistic expectations about what behaviour change might bring for them, when clients are encouraged to believe that they are capable of attaining their goals, and when positive feedback regarding progress is provided (Markland, Ryan, Tobin, & Rollnick, 2005). In the treatment of substance abuse, it has been demonstrated that therapists can foster motivation by increasing clients' perception of competence, specifically through focusing on client strengths, reinforcing positive change, and believing that the client can succeed (Simoneau & Bergeron, 2003). Further research is required to provide empirical support for whether or not it promotes the internalization of the values and goals of therapy in the ED population.

Involvement. SDT posits that a need for relatedness between client and therapist must also be met (Reeve, 2002). Relatedness involves a sense of being cared for and connected with another. SDT suggests that this component is critical to the internalization and valuing of the therapeutic process (Ryan & Deci, 2008). Involvement describes the extent to which clients perceive that the therapist is genuinely interested in them and their well-being. It may be conveyed by the therapist through understanding the difficulties that the client is facing and by providing psychological and emotional resources that clients can draw upon for support. Although involvement would seem to be a necessary factor in any successful therapy, further research is needed to determine if it facilitates the internalization of motivation in therapy for an ED.

Autonomy support. SDT proposes that the internalization of the reasons for change is most effectively promoted in an *autonomy-supportive* environment whereby the clinician supports the client in weighing options, takes interest in the client, and helps the client to reflect upon relevant information (Ryan & Deci, 2008). Autonomy support is a process therapeutic factor that requires the clinician to be non-invested in a particular client outcome. It includes assisting clients in taking responsibility for their actions rather than imposing the therapist's agenda. Further, it involves the therapist being able to trust the client in order to facilitate their process of self-organizing and self-regulating behaviours. SDT has identified certain components of autonomy support in the areas of education, parenting, and in laboratory studies, such as providing a meaningful rationale for any suggestions or requests (Deci, Eghari, Patrick, & Leone, 1994), supporting choice (Moller, Deci, & Ryan, 2006; Reeve, Nix, & Hamm, 2003), minimizing control and felt pressures (Ryan, 1982), providing unconditional regard (Assor, Roth, & Deci, 2004), and understanding and acknowledging individuals' perspectives (Koestner, Ryan, Bernieri, & Holt, 1984).

Research on Autonomy Support

Intuitively, the construct of autonomy support has the strongest relation to promoting or facilitating autonomous motivation for change. A recent study examined the effects of autonomous motivation and of perceived autonomy support from family and friends on weight loss (Powers, Koestner, & Gorin, 2008). Results showed that participants lost more weight when they perceived their family and friends to be more autonomy supportive. As anticipated, autonomy support was significantly related to autonomous motivation. However, effects of autonomy support remained after controlling for autonomous motivation, suggesting an independent role of autonomy support in the ability to foster behavioural change.

In a study on smoking cessation, researchers examined the effects of an SDT-based treatment intervention (Williams et al., 2006). The intervention was based on the 4-As model which comprises: ask (inquire about the patient's smoking habits), advise (inform them of the health risks associated with smoking), assist (encourage them to implement a plan), and arrange (set a follow-up appointment to discuss what happened; Williams, Gagné, Ryan, & Deci, 2002). Patients' autonomous motivation for treatment and perceived competence for change was assessed prior to treatment and at six months, and perceived autonomy support was assessed one month into treatment. In the SDT intervention, health care providers were instructed to remain neutral about the patients' choice to quit smoking. They were asked to relate to patients by listening and by attempting to understand the patients' internal frame of reference. Finally, they asked patients to reflect on what they did and did not like about smoking, and how continuing or ceasing to smoke might fit with their values and needs. Results showed that the SDT intervention was experienced as more autonomy supportive than the community-care alternative. Moreover, perceived autonomy support (at one month) led to increases in both patient autonomous motivation and perceived competence. Finally, the SDT intervention led to significantly greater smoking cessation at six-months and improvements were maintained at 18 and 32-month follow-up.

A central limitation to the smoking cessation study was that perceived autonomy support was only measured at one time point (one month into treatment). Therefore, it is not known if perceived autonomy support fluctuated over the course of treatment and how that may have influenced the process or the outcome. Further, autonomy support was measured using a Likert scale-type questionnaire, the Health Care Climate Questionnaire (HCCQ; Williams, Grow, Freedman, Ryan, & Deci, 1996), which provides no information about the quality of autonomy support experienced. Therefore, it is not known *how* and *why* the intervention influenced patient autonomous motivation, only that it was related to outcome.

Autonomy Support in Psychotherapy

Until very recently, research on autonomy support was conducted solely in the physical health domain. Numerous suggestions have been made to extend research on autonomous motivation from health-related problems to the domain of mental health problems and their treatment (Markland, Ryan, Tobin, & Rollnick, 2005; Sheldon ,Williams, & Joiner, 2003; Vansteenkiste & Sheldon, 2006). Not long ago, researchers looked at autonomy support and autonomous motivation and their impact on therapeutic outcome in a sample of clients treated for major depression (Zuroff et al., 2007). Clients were treated in one of three therapeutic modalities: cognitive behavioural therapy, interpersonal therapy, or pharmacotherapy with clinical management. In all three conditions, higher levels of perceived autonomy support were associated with higher levels of autonomous motivation and stronger therapeutic alliance. Furthermore, autonomous motivation predicted remission of depressive symptoms over and above the therapeutic alliance. Importantly, these findings support the contention that the construct of autonomy support is not modality specific but rather a "way of being" with clients that can be applied in any type of therapy. Most recently, researchers demonstrated that perceived autonomy support from fellow clients in a group-based ED treatment program related to changes in self-endorsed motivation over the course of treatment (van der Kaap-Deeder et al., 2014). This suggests that clinicians can foster an autonomy supportive treatment environment whereby clients benefit from supporting one another. Further studies are needed to explore how autonomy support and autonomous motivation play a part in the treatment of mental health problems.

Thesis Objectives

While SDT's theoretical tenets have received much support, the theory has received the least application in the fields of counselling and clinical psychology (Vansteenkiste & Sheldon, 2006). Surprisingly little empirical research has been directed toward applying SDT in the realm of psychotherapy, and even less in the field of EDs. As discussed, several instruments have been used to measure stages of change, readiness for change, internal versus external motivations for therapy, and autonomy support. Critically, SDT specifies that autonomous motivation for treatment is a process-oriented therapeutic factor (Deci & Ryan, 1985). Yet, to date, existing measures have not assessed the processes through which motivation for therapy is experienced by clients. Research has shown that autonomously motivated clients engage in therapy more carefully and effectively, and may persevere in treatment even when it becomes difficult or discouraging (Pelletier, Tuson, & Haddad, 1997). However, the question remains: through what processes or mechanisms does autonomous motivation lead to better outcomes? Further, how can therapists help clients internalize their reasons for change and become more autonomous in their motivation for change? Finally, are there factors outside of therapy that may influence clients' motivation for recovery?

There is a plethora of research that demonstrates the critical impact of motivational factors in the treatment of mental health disorders, and burgeoning evidence that an autonomy supportive environment greatly influences clients' motivation for engaging in meaningful and sustainable behavioural change. Therefore, it seems imperative that energy and emphasis be dedicated to further expanding knowledge and understanding of the factors that build client autonomy in the therapeutic environment. Furthermore, given the unique motivational issues in the treatment of EDs, and the potential challenges in building autonomy in this population, it seems even more crucial to examine the processes of therapy that contribute to treatment adherence and perseverance in the ED population.

Research Questions

In order to attend to the identified gaps in the current literature, this research study addressed the major question: How do clients with an ED develop their motivation for change? Sub-questions included: (a) How is motivation for change experienced by clients throughout the process of ED therapy? (b) What is the process through which clients in therapy for an ED internalize their reasons for change? These questions directly tap into client experiences and client perception of recovery. Furthermore, they aim to elucidate how motivation develops, how it is experienced by clients, and how it fluctuates and changes throughout treatment for an ED.

CHAPTER 3: Methodology

This chapter on methodology is separated into four sections. The first section presents the conceptual structure of this dissertation. I begin by establishing my epistemological framework, the constructivist-interpretivist paradigm, which guides my methodological approach to research. Then, I propose the rationale for the choice of qualitative inquiry. The second section reviews the procedures involved in participant recruitment and data collection. I detail the interview process and explain the transcription procedures. The third section describes the data analysis, from an overview of grounded theory to a more detailed explanation of how the analysis led to the findings. In the fourth section, I explore the specific strategies used to ensure trustworthiness and credibility in the research. I conclude by presenting my biases and ethical considerations.

Section I: Research Paradigm

In qualitative design, there are different paradigms within which researchers situate themselves. The main paradigms are postpositivist, contructivist-interpretivist, and critical-ideological (Guba & Lincoln, 1994). In the postpositivist paradigm, the researcher assumes that there is an objective reality that cannot be fully known but can be approximated, and uses terms such as internal and external validity, reliability, and objectivity as benchmarks of rigor. These benchmarks are referred to as extrinsic criteria, having emerged from quantitative methodologies outside of the qualitative genre (Lincoln & Guba, 2000). The constructivist-interpretivist paradigm has a relativist ontology, and assumes that there are multiple realities rather than one absolute truth. A main goal in this framework is to understand “lived experience” from the point of view of those who live it day to day (Schwandt, 2000). Research carried out within this paradigm is evaluated in terms of trustworthiness, credibility, transferability, and confirmability, and more recently, authenticity, dependability, and researcher reflexivity (Morrow, 2005). In the critical-ideological paradigm, the researcher takes on the role of activist and advocate and the aim is to challenge and disrupt the status quo. Reality is shaped by social, political, cultural, economic, ethnic, and gender values and accountability to participants and social transformation are the standards by which the research is evaluated (Denzin & Lincoln, 2008).

Constructivist-Interpretivist Framework

Regardless of methodology, I believe that as a researcher, I am always an active participant in the research process and that my involvement (from my choice of questions and instruments to my interpretation of the findings) will have an impact on the research outcome. Therefore, this study is rooted in a constructivist-interpretivist paradigm. In this tradition, knowledge is constructed by people through their interactions and the ways in which people perceive the world do not correspond to a “true” reality. Further, irrespective of whether or not there is a true reality, researchers’ knowledge is approximate and there are multiple versions of reality (Howitt, 2010). In the constructivist-interpretivist paradigm, the subjective reality of the investigator is recognized and integrated into the design and use of first person is preferred (American Psychological Association, 2010). Values and biases are assumed to exist and must be described and acknowledged. These enable the reader to understand the researcher’s stance vis-à-vis the research and to determine how transferable the information may be to another context (Morrow, 2005).

Qualitative research, as a form of inquiry, offers a means for capturing individual perspectives and helps researchers to understand the meaning that people attribute to their experiences. The purpose of this type of inquiry is to “describe and clarify experience as it is lived and constituted in awareness” (Polkinghorne, 2005, p. 138). The data are rich and thick and the research itself is about interpretation and elaboration of participants' experience rather than hypothesis testing. A major strength of qualitative research is its ability to examine processes, making it an ideal methodology for understanding and clarifying psychotherapeutic processes (Hill, 2005).

Rationale for the Use of Qualitative Inquiry

The nature of a research question should lead to the choice of research design. With regard to the present study, qualitative design was employed in order to comprehend and clarify client motivation throughout the therapeutic process in treatment for EDs. There is strong evidence that motivation is a critical factor in the treatment of EDs. Stages of change research specifies that in order to increase the probability of better outcomes for clients, it is important that they be ready for change before therapy begins (e.g., Rodriguez-Cano & Beato-Fernandez, 2005; Wade, Frayne, Edwards, Robertson, & Gilchrist, 2009). Research on self-determination theory indicates that ED clients who are engaging in treatment autonomously at the beginning of therapy tend to do better on outcome than those who are not (e.g., Pelletier, Dion, & Levesque, 2004; Mansour et al., 2012). However, the high levels of client drop out and negative outcome indicate that, in the ED population, the majority of clients are not entering therapy with sufficient readiness or internalized quality of motivation. Further, as delineated in the literature review, very little is known about the process of developing motivation within ED therapy. Presumably, if clinicians can facilitate the augmentation of autonomous motivation throughout the process of ED therapy, more clients will remain in therapy and will have better outcomes. Therefore, theory is needed to help us understand how autonomous motivation is experienced by clients in ED therapy and how it may be facilitated in order to improve client outcome. Importantly, qualitative methodology may facilitate theory-building when a process is not well known or understood (Morrow, 2005).

Studies situated in the qualitative framework are particularly appropriate to psychotherapy research because they are so effective at examining process (Hill, 2005). They seek to understand the meaning that people make of their experiences; meaning that cannot be ascertained through observation or by gathering surveys or questionnaires. By asking questions such as, “How?” and “What?” qualitative methods may help to bridge the gap between research and practice in the therapeutic setting (Williams & Hill, 2001). Psychotherapy is about connection, communication, and discovery and is experienced through conversation. Similarly in qualitative inquiry, language is used as a tool to construct meaning. Through interaction and dialogue, both the participant and the investigator come to deeper insights (Ponterotto, 2005). Qualitative designs provide critical information about the process of therapy that cannot be accessed without deep engagement with the material.

Section II: Data Collection

The term *research sample* implies a population to which results may be generalized. The goal in qualitative research is not to generalize but to illuminate the phenomenon of interest. Therefore, a purposeful selection of participants is necessary to access and illustrate the phenomenon (Polkinghorne, 2005). Sufficiency of data determines the selection process and how many participants will be necessary. Sufficiency is called data saturation or redundancy and it is the point at which gathering more data does not add new information to the theory (Howitt, 2010). This occurs when nothing new is being learned about the properties and dimensions of the categories or the relationships among categories in the data analysis process. In a grounded theory study, between 12 and 20 participants is a good estimate of how many participants need to be interviewed to reach data saturation (Morrow, 2005; Creswell, Hanson, Clark Plano, & Morales, 2007). It is important to note that in this type of study, it is concepts that are being sampled and not people, therefore, researchers are seeking sufficiency of data and not participants. This kind of data collection is called theoretical sampling and it is used to broaden and extend the theory to make it as comprehensive as possible (Payne, 2007).

Theoretical Sampling

In theoretical sampling, the researcher is purposefully seeking out concepts so that he or she can examine how the phenomenon varies under different conditions. Unlike conventional methods of sampling, data collection occurs concurrently with data analysis in theoretical sampling. More specifically, data collection leads to analysis, analysis leads to concepts, concepts generate questions, which, in turn, leads to further data collection (Corbin & Strauss, 2008). Sampling becomes more specific over time because the questions become more specific as the researcher seeks to saturate categories. For this study, it was necessary to access the experiences of clients in treatment for an ED in order to examine what kept them engaged in treatment, what made them drop out, and how those factors interacted with their journey toward recovery.

Recruitment

Although the numbers of men who are affected is rising, EDs still occur disproportionately among women, with a female to male ratio of 10 to1 (Wade, Keski-Rahkonen, & Hudson, 2011); therefore only women were recruited for the study. Recruitment of participants came from multiple sources in the Montreal community. Posters inviting women in treatment for an ED to participate in an interview were posted around the downtown core, on university and CEGEP campuses, at gyms, and at psychologist’s private practice clinics (see

Appendix D). Additionally, I was able to recruit participants from the McGill University Eating Disorder Program, where I had previously completed two years of clinical training. Each client at the Eating Disorder Program meets with a psychiatrist for an evaluation and official diagnosis before commencing treatment. Treatment involves a combination of individual and group therapy with multidisciplinary professionals (e.g., psychiatrist, psychologist, dietitian, nurse).

Inclusion Criteria

Inclusion criteria for the study consisted of medical and psychiatric stability as individuals needed the capacity to remember and reflect upon their recent experience of therapy sessions. Participants who were taking medication or were diagnosed with a co-morbid mood and/or anxiety disorders were included. Co-morbidity is the norm rather than the exception, with mood and anxiety disorders occurring in 55 to 97 % of individuals with EDs (e.g., Gadalla & Piran, 2008; Blinder, Cumella, & Sanathara, 2006). Inclusion of mood and anxiety disorders offers a realistic clinical picture of this population. Exclusion criteria were individuals with active psychotic, bipolar, and severe substance-use disorders. As a trained clinician and licensed psychologist for the last nine years, I assessed psychiatric stability throughout the interview. No participants were excluded because of these issues.

Participants

Participants recruited for the study were 18 women, ranging in age from 18 to 33 years (M = 23.6, SD = 3.9), who were currently in therapy for an ED or who had terminated therapy for an ED within the last year. Therapy had to have been ongoing for a minimum of two months. Therapists included psychologists, psychiatrists, social workers, and counsellors. In total, 19 women were interviewed. One interview was not used for analysis because the participant had not been through any form of psychotherapy or treatment nor had she been diagnosed with an

ED. See Table 2 for participant demographic information, and Table 3 for participant eating disorder histories.

Table 2

Participant Demographics

Criteria	N
Age (years)	
16 to 20	4
21 to 25	10
26 to 30	2
31 to 35	2
Mean	23.6
Self-identity	
Korean	2
Mixed (Asian/White)	1
Sri Lankan	1
White	14
Place of birth	
Canada	11
France	1
Korea	2
US	4
Current program	
High school	1[a]
College/vocational	2
Undergraduate	9
Master	4
Doctorate	2
Relationship status	
Partnered	9
Single	9

Note. [a]Program completed

Measures

Each participant was asked to complete: (1) a demographic form (Appendix B), and (2) a 60- to 90-minute semi-structured interview (Appendix C).

Demographic form. A demographic form was developed for this study (see Appendix B) in order to obtain information about participant's age, ethnicity, relationships status, education, occupation, length of previous treatments (for an ED or otherwise), and length of current treatment.

Table 3

Eating Disorder (ED) Histories

Criteria	N
Age ED began (years)	
11-15	11
16-20	7
Length of ED (years)	
< 5	5
6-10	8
11-15	3
16-20	2
Mean	8.2
Length of therapies (years)	
<1	6
1-2	1
2-3	6
3-4	1
4-5	2
10+	2
Hospitalization	
Inpatient	5
Outpatient	9
Family history of ED	
Parent	11
Sibling	7

Table 4 comprises participant reported diagnostic information, including current diagnosis (at the time of the interview) and prior diagnoses (both ED and other co-morbid disorders). Prior diagnoses are incorporated to highlight the complexity of diagnostic crossover and co-morbidity.

Table 4

Reported Diagnostic Histories

	ED at interview				Prior ED			Co-Morbid Diagnosis		
Participant	AN-R	AN-B/P	BN	None[a]	AN-R	AN-B/P	BN	Anx	Dep	Subs
1		x				x		x	x	x
2			x			x			x	
3				x	x		x			
4		x			x			x	x	
5			x				x			x
7				x	x	x			x	
8	x				x			x		x
9	x				x			x		
10		x			x				x	x
11	x				x			x	x	
12			x				x		x	
13				x		x			x	
14	x				x					
15		x				x		x		x
16			x		x			x	x	
17			x		x	x		x	x	x
18			x			x		x	x	
19		x			x			x	x	

Note: ED = Eating Disorder; AN-R = Anorexia Restrictive; AN-B/P = Anorexia Binge/Purge; BN = Bulimia Nervosa; Anx = Anxiety; Dep = Depression; Subs = Substance use.
[a] No active symptoms

Interview. A semi-structured interview guide (see Appendix C) was developed in order to conduct an in-depth interview with participants. The guide consisted of open-ended questions which provided participants with the opportunity to elaborate fully on their treatment experiences and on other aspects of their recovery process. Questions in the interview were broad and flexible so that participants felt free to construct the meaning or understanding of a given situation. The interview guide was comprised of several themes or areas of exploration based on the motivation and ED literatures (as presented in the literature review). It began with the discussion of change, touching on how motivation is experienced by participants and how it had transformed over time. The therapy itself was discussed; for example, how involved (or not) participants had been in deciding on the direction of therapy. Moreover, participant's perception of the relationship with their therapist was reviewed. Participants' relationships with important others, such as family, friends, and/or partners, was also explored. In addition, participants' sense of identity was addressed. This included factors such as cultural and gender influences, feelings towards their bodies, and issues of control. A pilot interview with a volunteer was conducted and it ran relatively smoothly and lasted just over 90 minutes.

It was anticipated that the protocol would undergo refining throughout the process of data collection and as other issues arose. Themes that were raised by several participants that were not broached in the guide were subsequently added to the interview protocol. For example, several participants recounted experiences that occurred outside of therapy that directly influenced their treatment motivation, particularly in important relationships. This led to asking more questions about the impact of significant others on their recovery. Allowing for changes in the interview protocol over time ensures that the emerging theory remains grounded in what participants are saying rather than my preconceived ideas of what I might find (Morrow, 2005; Patton, 2002).

Procedures

Participants contacted me if they had seen the poster and wished to participate in a research interview. In our initial contact I: (a) provided them with a brief explanation of the study, (b) informed them that everything discussed would be confidential, and (c) answered any questions. If they agreed to participate, I invited them to come to an interview and set up a convenient time.

At the start of the interview, I introduced myself, explained the purpose of the interview and the amount of time that it was expected to take, and asked participants to read and sign the informed consent (Appendix A). The informed consent was created to make certain that participants understood the purpose of the research, the tasks involved in participating, the limits of confidentiality, and their rights. More specifically, the form delineated participant's right to withdraw from the study at any time and how their privacy would be protected. It stipulated that the interview would be audio-recorded for transcription and data analysis purposes. The entire proposal including the informed consent obtained approval with the McGill University ethics committee. Participants were then asked to fill out a demographics form (Appendix B).

Grounded theory interviews can range anywhere from 45 minutes to three hours (Morrow, 2005; Ponterotto, 2005). Interviews ranged in length from 80 to 110 minutes and on average lasted about 90 minutes. Immediately after the interview, I recorded my impressions and reactions to the interview as well as any salient observations. Prior to beginning the research study, I received training in qualitative interviewing with Dr. Rob Whitley, who has published widely on conducting qualitative research in a health care setting. After completing the first four interviews, I met with Dr. Whitley in order to review my interview style. Together, we listened to the audiotapes of the interviews and we discussed things that should be altered in the interview protocol.

Transcription

The interviews were transcribed from the recordings verbatim; however, repetitive words such as "um" or "like" were omitted. All pauses were indicated with either three dots (…) for a short pause, or if there was a lengthy pause it was noted in brackets. Otherwise the transcripts were a direct copy of the interview itself. I transcribed the first fourteen interviews and an undergraduate student in psychology, who signed a confidentiality agreement, transcribed the final four. I listened to each interview three times to verify accuracy. All identifying participant information was removed during transcriptions. The transcripts were identified by a code and not by participant names. There was one list with the names and corresponding code numbers of each participant that was stored in a locked filing cabinet. Once the study was complete, the list was destroyed. The demographics information was kept in a separate filing cabinet from the interview transcripts. The signed forms, transcripts, and audio files remained in a locked filing cabinet at all times. The audio files were also destroyed at the completion of the study.

Section III: Data Analysis

Grounded Theory

Interview transcripts were examined using grounded theory; a systematic inductive, comparative, and interactive approach to data analysis (Charmaz, 2006). The intent of a grounded theory study is to move beyond description and generate a theory about a process or interaction (Strauss & Corbin, 1998). At first, grounded theorists (Glaser & Strauss, 1967) argued against conducting a literature review, as preconceived notions developed during literature reviewing would direct the research rather than allowing the data to speak for itself. However, more contemporary views suggest that an in-depth review of the literature actually provides the researcher with a multitude of ways for understanding the phenomenon under examination, thus, decreasing researcher bias (Morrow, 2005). Further, researchers must be sufficiently familiar with the research to ensure that they are contributing something new. Finally, in grounded theory, it is expected that as data analysis proceeds, there will be increasing incorporation of empirical and theoretical literature to link new ideas with existing work (Payne, 2007).

Since its inception, grounded theory has evolved and theorists have differed in the emphasis they place on various procedures, from data collection to analysis (e.g., Glaser & Strauss, 1967; Charmaz, 2006). The data analysis in this study is aligned with the version developed by Strauss and Corbin (e.g., Strauss & Corbin, 1998; Corbin & Strauss, 2008). Grounded theory research starts with an open-ended research question but explores the ideas and themes that are generated once in the field (Pidgeon & Henwood, 2004). The analysis of data occurs inductively as soon as data begin to accumulate. Themes or concepts emerge from participants' voices, and are grouped together by the researcher as a way of organizing the data. These concepts are subsequently tested deductively by comparing and contrasting them with new data (Morrow, 2007). Constant comparison of emerging theoretical ideas with data collected from new participants enables the analysis to remain "grounded" in the data. The alternating cycle of induction and deduction is called *iterative* or *recursive* (Behrens & Smith, 1996). The iterative process may lead to revisions in the design, in the interview questions, or throughout the analysis; researchers should be flexible and open to the need for modifications (Patton, 2002).

To begin the process of developing a theory, transcripts are analyzed to generate initial categories (open coding). Following this step, broader categories are suggested to explain the relationship between initial categories (axial coding), and finally, a theory is developed to explain the relationships among the categories (selective coding) (Strauss & Corbin, 1998).

Open coding. In grounded theory, the analysis of transcripts begins with open coding. Sometimes known as *in vivo* coding, open coding remains as close to the original data as possible. Transcribed data are examined line-by-line or by units of meaning (e.g., several lines or a short paragraph). The key concepts or ideas in each unit are labeled, often with words of participants. Open coding should not over-interpret the data and should keep the researcher grounded in the words of the participants. The labeled units of meaning are compared to other units of meaning in the text and the researcher gradually groups them together into categories that encompass similar concepts. These categories should be distinct, should not overlap, and data should not be forced into categories in which they do not fit well. As additional data are gathered, new data are compared to existing data and categories may undergo reorganization and modification.

During open coding, I coded the first four transcripts and asked a colleague, a PhD-level psychologist, to do the same. We both used an additional strategy, process coding, which involves the use of gerunds ("-ing" words) exclusively to connote action in the data (Saldana, 2009; Charmaz, 2002). Maintaining action in the data helped to remind me that this was an examination of process, and that participant experiences were "lived". For example, instead of coding a segment, *Feels ashamed*, we would use the code, *Feeling ashamed*. Together we generated 901 codes across the four transcripts. We reviewed each code, discussed it, and agreed upon a name for it. We both made efforts to stay close to participants' words, and therefore, in many instances our codes were exactly the same. When they were not the same they were often highly consistent. For example, what I called *Feeling unattractive* she labelled *Thinking I was ugly*, or what I called *Feeling tricked by the ED* she labelled *Feeling betrayed by ED*. If our interpretations or codes differed, we would read through the segment of transcript, explain the reasoning for our chosen code, and agree on appropriate code name.

Axial coding. The next task in grounded theory analysis is to find relationships among the categories and to identify key concepts. The data are now organized into broader, more encompassing categories that comprise several subcategories. The newer categories are more abstract and combine the initial codes in the way that the words "kite", "bird", and "airplane" could be grouped into the key concept "flight" (Corbin & Strauss, 2008). The researcher is in a process of constant comparison, which includes: (1) comparing and relating subcategories to categories, (2) comparing categories to new data, (3) exploring disconfirming evidence, and (4) delineating the properties and dimensions of each category (Fassinger, 2005). Properties refer to the characteristics or attributes of a category, while dimensions are the range or continuum along which the properties of a category vary (Strauss & Corbin, 1998). In order to stretch and refine a complete understanding of the properties and dimensions of each category, new data are gathered based on unanswered questions and underdeveloped ideas until data sufficiency is reached.

Through a process constant comparison, grouping, and reducing during axial coding, I brought the 901 codes down to 48 codes. For example, the codes *Being conflicted about my identity*, *Losing myself to the ED*, *Feeling lost*, *Losing things that were important to me*, and *Doubting my voice* were grouped into the key concept, *Giving up my voice*. In another example, the codes *Taking responsibility, Realizing I was the problem*, *Committing to the process,* and *Admitting what I'm doing* were grouped into the key concept, *Making myself accountable*. My colleague confirmed that these new codes captured the data as a whole in a more succinct fashion. I then coded the remaining 14 transcripts with the 48 codes. After the coding of the 14 transcripts was complete, I had added 10 codes, making a total of 58 codes. The additional10 codes were among the original list of 901 codes, and they were reintegrated because they were used often in the remaining 14 transcripts. I then went through a second reduction process, and trimmed the 58 codes down to 29 (see Appendix E); comparing and contrasting codes in order to retain the most salient information. I then recoded all 18 transcripts with the 29 codes.

I asked a second colleague, a doctoral candidate in a related field, to audit this process of reduction and recoding. She read through the transcripts and as I presented the 29 codes, we debated each one making sure that they each critically represented an aspect of the data. After much deliberation and reflection, eight major categories, containing 29 subcategories had emerged (see Figure 4 for a visual). The final categories were discussed with Dr. Whitley and his feedback was integrated into the findings. For example, he suggested the term *Connectedness* as the title of one of the major categories, as the one I had chosen, *Finding myself*, did not encompass all important aspects of the category.

Selective coding. Selective coding, in grounded theory, is the process in which the researcher identifies a core category that relates to every other category. This core theme subsumes all of the other categories and is a brief narrative of the most critical aspects of the data. Further, the researcher defines the relationships among the core and other categories, while repeatedly comparing original transcript data with the emerging theory. The theory is used to explain the phenomenon of interest through a set of well-developed categories that are systematically interrelated. This theory offers an explanation of "who, what, when, where, why, how, and with what consequences an event occurs" (Strauss & Corbin, 1998, p. 22). Existing literature is then used to flesh out the theory and provide it with explanatory power (Fassinger, 2005).

For this study, the eight major categories were explored as possible *contextual factors, contributing conditions*, *action strateg*ies, and *consequences* (Strauss & Corbin, 1998) in order to determine the connections among and between them. Once I had established the "who, what, when, where, why, how, and with what consequences", the overarching theme became clear (see page 71 for a description of the overarching theme).

Memo-writing. Throughout the entire process of analysis, memo-writing is a way to document the thoughts and decision-making processes of the researcher. It also functions as an audit trail which provides readers with the opportunity to assess the research as a whole for quality and rigor and for its applicability to other settings. Memos can vary in length, content, and degree of conceptualization depending on the research phase, the researcher's goal, and the materials being analyzed; the form of the memo is less important than the act of doing it (Corbin & Strauss, 2008).

I took time to document my thoughts and impressions after each interview when the data were fresh and ideas had formed about what was discussed and explored. This helped me to determine avenues for further exploration in subsequent interviews. I also wrote memos throughout the analysis process. For example, in my efforts to remain as close as possible to participants' words, I began my analysis with 901 codes. Understandably, I felt overwhelmed at the prospect of grouping, interpreting, and reducing these codes into key concepts. I wrote memos about which were the most salient concepts, where I saw emergent patterns and themes, and what I felt was missing from the data. In addition, I used memo-writing while identifying the properties and dimensions of each category. This helped in the decision-making process about the relationships among and between categories, and deciphering the theory. Finally, I used memos to document my personal reactions to participants and their experiences. As a clinician who has worked with the ED population for a number of years, I have preconceived ideas about what works in therapy and what does not. I felt it was important to memo about my biases in order to remain aware of my own voice in the interpretation process.

Section IV: Trustworthiness

Qualitative inquiry is subject to various standards to make certain that there is rigor in the research. These standards are derived from the paradigmatic underpinnings of the method. The validity of this type of study lies in the trustworthiness of the interpretations that are made about the data (Creswell, 1998). There are numerous strategies that may be used by qualitative researchers to ensure that their own subjectivity does not dominate the voices of participants and that the researcher has employed a meticulous and rigorous process. The issue of trustworthiness was addressed by involving participants and outside scholars throughout the research using the strategies delineated in the next section of this methodology chapter.

Reflexivity

The self-reflexive process addresses the issue of subjectivity in qualitative design. It refers to the sensitivity or awareness of how the researcher’s biases and assumptions may influence the nature of the data collected and the analysis. For this reason, researchers explicate their attitudes, values, and other potential biasing factors which may have impact on the research process. Memo-writing is a critical part of the entire process, as it is the step where the researcher thinks about and processes data, codes, and emerging theory (Fassinger, 2005; Morrow, 2005). As mentioned above, I used memo-writing extensively to contemplate and document my decision-making and evolving ideas, during the interviewing and throughout the analysis of transcripts. In addition, I held weekly one-hour Skype meetings with my second auditor over the course of the last year to reflect on, deliberate, and remain conscious of my choices and my process. Through these lengthy discussions, I was forced to come up with a rationale for each of my interpretations and conclusions.

Auditing

Although the data analysis was an independent effort, throughout the process there were several opportunities for me to check-in with outside sources in order to ensure that my analysis was not disproportionately filtered by my own world view and preconceived ideas. Auditing is a method for reducing individual researcher bias and can occur at two levels: (1) *peer debriefing* and (2) *inquiry auditing*.

Peer debriefing. Peer debriefing involves seeking consultation and using multiple perspectives throughout the course of the study. This was done in a number of ways. Dr. Whitley, an expert in qualitative research, and in particular grounded theory analysis, listened to the first four interviews to make certain that the protocol was appropriate and the interview ran smoothly. We discussed emerging themes, and necessary changes were made to the interview guide after discussion. A PhD-level psychologist reviewed the first round of coding and categories. She offered new insights to ensure that I had not made any glaring omissions and that the emergent findings were faithful to the data. I was able to integrate her feedback into the subsequent interviews and analysis. Further, a doctoral candidate in a related field reviewed the second round of coding, derived properties and dimensions, and theoretical findings, in order to ensure completeness and sufficiency of the data. Finally, Dr. Whitley also provided feedback in the final stages of analysis with the axial and selective coding.

Inquiry auditing. In inquiry auditing, an individual monitors the overall process and product to verify that procedures have been adhered to in a satisfactory way. In her role as my dissertation supervisor, Dr. Marilyn Fitzpatrick oversaw and monitored each stage of the research process, from initial research ideas, to the development of the research questions. She imparted valuable advice about the choice of methodology and provided consultation throughout the data collection and data analysis procedures.

Member Checking

Member checking refers to the extent to which the researcher's account corresponds to those of participants. It involves asking participants for feedback about how their ideas have been interpreted to make certain that they feel their voices have been truthfully represented. Participants were sent a draft of the findings to double-check that my understanding of their experience was accurate. I was able to reach 15 of the 18 participants; the other three had since changed email address and/or phone number. However, of the 15 people I was able to contact, 14 offered in-depth feedback of the research findings. Participants expressed tremendous support for the theory and the way in which it was articulated. Overwhelmingly, they felt that their experiences had been captured and represented with integrity. Further, several specified how grateful they were to be given the opportunity to be heard. Finally, they hoped their experience could be helpful for others who may go through treatment in the future.

Ethical Considerations

It has been suggested that interviews or conversations may be experienced by participants as much more powerful and empowering than completing a questionnaire (Morrow, 2007). At the same time, despite the best intentions to empower participants, there remains an inherent power imbalance between clinician and client, and between researcher and participant. There is always the possibility that participants may find themselves disclosing more than they had intended, perhaps because of the power difference. To address this concern, qualitative researchers are encouraged to treat informed consent as on ongoing process rather than as a single event (Smythe & Murray, 2000). Furthermore, in my professional life I am both a clinician and a researcher, and it was important to constantly maintain boundaries between these two roles (Haverkamp, 2005). While my clinical experience may have enabled me to gain the trust of participants or facilitated an exploration of their experience, the research interview is not a therapy session. If participants expressed distress or a need for assistance, I was prepared to ensure that they were referred to appropriate resources. One participant was given additional information about therapy resources as she did not feel she was being adequately supported by her therapist. Certain participants did not have a good relationship with their current therapist, and they stated the interview was an opportunity to voice those concerns. Some said that it inspired them to address this with their therapist and to ask for what they were missing. Thinking about their therapeutic process in the interview may have encouraged participants to engage more thoroughly with their treatment.

Researcher Biases

Axiology concerns the role of researcher values toward the investigative process. As a constructivist-interpretivist, I believe that my values and biases play a certain role in everything: from the framework of my methodology, to the questions that I posed, to the way that I analyzed the data; and I accept responsibility for my interpretive role. I take the constructivist position that our understanding of the world is constructed through our own histories and how we interact with the world. This impacts our areas of research interest and the ways in which we chose to advance knowledge. The term *bracketing* has been used to describe a process by which the researcher sets aside beliefs so that they do not influence the research. Although I do not deem it possible to completely separate who I am from how I have analyzed the data, I do believe that it is feasible to understand and represent individuals’ experiences without infusing them with my own values. It was my goal to be open and flexible in order to allow participants the space to create their own meaning from the themes that we explored in the interview. However, I must acknowledge that I am a co-producer of the data, because my own stance affected the set of questions that I posed and guided the answers upon which I built my theory.

In my work as a psychologist, I hold strong views about the clinician’s role in the therapeutic process and the importance of client autonomy and empowerment. In the process of psychotherapy, there is an inherent power imbalance with therapists consistently holding more power than clients. Often, clients may be intimidated by a therapist’s psychological expertise and defer to therapist opinion, or clients may simply look to the therapist to “tell them what to do” because of their role as “expert”. In addition, clients may omit information about themselves to avoid embarrassment or shame and, in doing so, lose the opportunity to work through difficulties that may have brought them to therapy in the first place. It is the therapist’s responsibility to make every effort to equal the power imbalance and to invite the client as a collaborator in the process of therapy. Importantly, if client change does not originate from within the client’s life experience, and it is placed upon him or her by therapist advice, there is a significant chance that the client’s life circumstances will “change back” when therapy has terminated. This is particularly true in the ED population where there is often a pervasive lack of power, sense of identity, and self-efficacy in their everyday lives. It is therefore imperative to access the client’s lived experience to be able to collaboratively generate potential solutions to problems or develop new coping skills that will create lasting change. As a researcher, I think that it is essential to gain knowledge from the client’s perspective if therapeutic effectiveness is to be improved. While I am firm in this belief, it was important throughout the research that I refrain from making the assumption that this is the only path to sustained change.

Summary

In this chapter, I described the conceptual framework and methodological approach as it was implemented for this research project. I presented the research questions and reviewed the procedures involved in the data collection, from participant recruitment to the interview process. I demonstrated the techniques I used from grounded theory (Corbin & Strauss, 2008), and offered a detailed account of how the analysis led to the findings. I concluded by presenting the steps I took to ensure the trustworthiness and ethics of the project as a whole.

CHAPTER 4: Findings

Throughout the analysis of the 18 transcribed interviews, an overarching theme and eight major categories emerged. In this chapter, I elucidate the major categories, their relationship to one another, and to the overarching theme. As previously stated, in order to move beyond description and into theory building in the analysis process, the categories were explored as possible *contextual factors*, *contributing conditions*, *action strategies*, and *consequences.* The major categories, each comprised of several subcategories, and their corresponding properties and dimensions are thoroughly presented. Direct quotes are integrated throughout to illustrate the categories and to keep the analysis grounded in participants' words.

The overarching theme, *pushing and pulling*, represents the core category in this grounded theory of client motivation in the treatment of EDs. The participants described their motivation to work through recovery as a continuous battle, where they felt wrenched in opposing directions. While all spoke about a desire to get well, they concurrently expressed fearing a life without the ED and all that would entail. All participants cycled through moments of hope and moments of absolute despair; willing to engage in certain parts of recovery and completely rejecting others. It is essential to note that while the categories are presented in a linear fashion for clarity, the process should not be interpreted as such. Participants tended to travel between major categories several times throughout their journey. Movement within and between categories was filled with tension, ambivalence, and conflict, as participants felt pushed and pulled, toward and away, from their motivation to recover.

While the majority of participants followed a similar trajectory, there was some variability, and the reader should note some terms for describing frequencies. When I have stated that *most* participants discussed a given category, it means that all but one or two of the 18 participants reported this experience; *many* indicates half or more of the participants, while *a few* or *several* refers to between five and eight individuals. For a summary of participant endorsed categories see Table 5, page 148.

Context

Context can be understood as the set of conditions in which problems develop. When asked about their motivation for recovery, most participants began by setting a backdrop for how the ED began. It was as though the recovery process could not be separated from the factors that led to the development of the disorder, and in many cases the contextual factors were the salient themes explored in therapy. While these aspects were considered to be part of their background or history, they were also considered by participants to be maintaining and even perpetuating factors for eating problems. In other words, having had these traits or experiences made them vulnerable to developing an ED and also, concurrently, made it more likely that the ED would persist. Finally, these factors made it more challenging for the participants to extricate themselves from the cycle of the ED once it had begun. I have grouped these contextual factors into three categories: *Believing I am inadequate*, *Struggling with self-regulation*, and *Experiencing stressors*, as shown in Figure 1.

Figure 1. Contextual Factors

Figure 1. Major categories and sub-categories constituting the contextual factors of the conditional matrix in the push-pull dynamic theory. The arrows between categories indicate the push-pull dynamic in the treatment and recovery process.

Believing I am inadequate

All participants, in one way or another, articulated having feelings of inadequacy. They expressed feeling flawed and deficient, and presented it as fact, as though they had simply been born that way. Believing they were flawed, many felt they did not deserve to be around others, and they isolated themselves so as not to burden others with their presence. Most voiced a profound sense of shame about being inadequate and a need to keep themselves apart so that others would not discover their imperfections. Most yearned for the ability to be close to others but felt that they lacked the skills or would not measure up to others' expectations. There was a strong pushing and pulling dynamic of wanting to be accepted by others but fearing rejection, of wanting to be close but, at the same time, pushing away. The Believing I am inadequate category comprised three subcategories: *Feeling different*, *Feeling ashamed*, and *Being alone*.

Feeling different. Most participants specifically mentioned a general feeling that they did not belong; that they had somehow always been different from others. Most expressed feelings that they were insufficient in some important way that made them unacceptable to others. They believed that there was something wrong with them and many centralized this notion in the body. They communicated feeling as though they were unattractive, even repulsive, and that their bodies had never been "right". No matter if their body was big, small, tall, or short, there was a longing to make up for its perceived shortcomings and a need to change it. For example, one participant stated, "It's just I felt...I was taller than my classmates and so I've always felt that I was this tall, tiny...tall, thin woman who was kind of like a stick" (P7). Another participant explained her constant self-judgement.

> I was thinking of these things, even before puberty, "I shouldn't be like this. Something's wrong. I should fix it. I should *do* things". And I would try, always try and start exercise programs but for the wrong reasons - and diets, and things like that. For me, I know that that wasn't healthy living because I wasn't happy. I was so preoccupied with

> it. Always judging, always concerned. That's just something that stressed me out since I was a kid. So that's not healthy. (P5)

One Asian participant expressed being very conscious of her ethnicity, growing up in a very White town in America. She felt insecure in her social circle because she felt different from the other kids. In efforts to belong, or be liked by the others, she overemphasized her difference but always felt unsure about whether or not she was truly accepted.

> I'm starting to realize that from a very young age I was very self-conscious about being Asian in the community. Because it was a primarily White Caucasian community, lots of people were Christian…and it's funny, someone showed me some list and apparently it's one of the five whitest cities in America. […] When I was younger I was teased a lot about my name. […] It eventually became something, when I was in high school that I overexerted or embraced. You know, I made Asian jokes myself and identified myself as that person. (P10)

Most participants sought acceptance, perhaps because feeling accepted would briefly stave off fears of inadequacy. However, many were highly sensitive to rejection from others and therefore found it challenging to develop close and trusting relationships. Some participants mentioned getting in with the "wrong" crowd, and taking part in activities that they did not necessarily agree with in order to be part of a circle of friends or blend in with the crowd. Some of these activities led them to feel distant from their values but the risk of being perceived as an outsider was too great. One participant explained that she had to pretend to be "normal" in order for others to be able to accept her.

> I'm always thinking about what other people think of me. I'm always very conscious about it. And I know that not everyone is pinpointing me and thinking about what I should be doing but at the same time, I'm just very sensitive to other peoples' judgment. And I guess because I always felt isolated, I never felt like I fit in…I was always conscious of what I should do to fit in and what I should do so people won't think I'm horrible, and find out who I am…find out the kind of person I am. I have to pretend I was normal. (P4)

The beliefs that they were fundamentally different from others and that they had to feign being "normal" contributed to the deep-seated feelings of inadequacy.

Feeling ashamed. All participants relayed feeling a deep sense of shame about themselves, for some, dating back as far as they could remember. They experienced debilitating worry that they were simply not good enough and would never be able to measure up. Several participants compared themselves negatively to siblings. For example, one participant stated, “It was very hard because my sister was always the star. She’s gifted, I’m not. You know, she won multiple awards in piano. I did not. So I always felt inferior. Like a fat person and just really useless” (P4). Further, she explained that her relationship with her mother was strained which contributed to her fears about shortcomings. She said, “She was very strict and I guess I was mad at myself because I wasn’t good enough for her” (P4). Another participant talked about “never feeling good enough” as a trait common to people who develop eating issues. She asserted that no matter the standard she used for self-evaluation, she would always feel that she was lacking and unsatisfactory.

Most participants recounted that they felt embarrassed if others paid attention to them and tried to ensure that they would blend in or be overlooked. They felt that because they were not “good”, or that they were only “pretending to be good”, they did not deserve to have others notice them. For many, losing weight was a way of disappearing or taking less space, so that they would not be a nuisance or a bother to others. One participant explained, “I remember I’d always want… as I was losing weight, I’d always be like, “Oh, I’m taking up too much space, and I don’t want to be here”” (P18). Another described the ED as a “cloak of invisibility”, one that allowed her to go unnoticed by others for long period of time. She would opt out of attending birthday parties, holidays, or other celebratory activities with family and friends because of her discomfort with the copious amounts of food available, but also because of the expected social connection with others. One participant imparted that she experienced shame when she stood out from the crowd or drew attention.

> I feel like sometimes when I go out with friends, if I've had a little bit to drink, I… sometimes I can be more loud…but I'm rarely a loud person, but sometimes. And then I feel so ashamed…or when I express my opinions about politics or something. When I'm one-on-one…when I'm with one person, it's OK, but when there's an audience sometimes I feel like I went too far and, I'm like, "Oh, no…" It's… I don't want to take a lot of place. I want to be… I want to get…unnoticed. (P19)

Furthermore, although they longed for acceptance and closeness, many expressed holding themselves back from others as a result of their shame about not feeling good enough. They worried that if others were close enough to get to know them, they may discover flaws or realize that they were not as good as they appeared. Puberty was a particularly difficult time because they began to sense that their developing bodies drew attention. One participant articulated her uneasiness about her changing body and how it garnered more interest from boys.

> I thought that I was attracting more attention just because of my height. And so I didn't want to be noticed. I thought that because I was growing breasts, I was turning into a woman and so I was even more likely to be noticed by the other gender. I had guy friends. I usually got along better with guys than girls during my middle school and high school. But I was ashamed to attract attention from them. Because I didn't feel...I didn't think...I thought very low of myself and so I didn't think anyone would be attracted to me. And so being noticed because I was tall and was turning into a woman would get me more attention but I didn't want people…I didn't want people to realize that I was ugly. That's more how I thought of myself at the time. […] Yeah...I'm not that good. (P7)

Many participants felt a need to punish themselves because of their belief that they were inadequate. They felt they did not deserve to have good things happen to them and many would actively sabotage positive experiences or opportunities. Many talked about engaging in activities that were bad for them or choosing relationships where they were not treated well in order to "prove" that they were worthless. One participant had recently been exploring self-sabotage in her therapy sessions.

> Self-sabotage. It's weirdly...it makes a lot of sense [laugh]. Just like, [voice breaking] not wanting myself to be powerful, or...not feeling like I deserve to be. […] Because I don't deserve to be powerful and also…What if I'm powerful and I do something great that I don't deserve to have done? [Voice breaking] You know...yeah, almost like keeping myself in my place. (P13)

For most participants, the shame they experienced about not being good enough went to the extreme of self-hatred, especially once the ED entered the picture. They felt that their bodies were the outward indicator of their ability to be disciplined or keep themselves in line. They believed that if others could see that their bodies were imperfect, this displayed to the world that they were deficient. Having others witness their perceived flaws was the ultimate shameful experience. One participant described the depth of her self-hatred.

> You know, when I was in the throes of my eating disorder, I truly believed I would rather be dead than fat. And fat, like...I would rather be dead than look how I look today. If I look back maybe four years ago, when I was...anorexia and bulimia…if I would see myself today I would have said, "I would rather be dead than look like that girl". And I would really mean it. That's such a messed up thing! (P3)

Many participants spoke about the profound shame associated with having an ED. Having an ED was something to be hidden from others because of the social stigma attached. They explained that when others found out they became afraid that the ED meant they had emotional baggage, and that they would be "too much" to deal with. One participant explained why having an ED was something to be ashamed of, "It's embarrassing because it says that you're weak, you're not comfortable with who you are" (P15). Shame was particularly associated with the binge/purge end of the ED spectrum. Several participants went into detail about the social stigma attached to bingeing and purging.

> I couldn't talk about this a year ago. I couldn't say the word bulimia. I couldn't even say it, let alone tell someone about it. The first couple of people that I told, it took me a half an hour to spit it out. I just couldn't even say it. (P5)

Another participant explained that she refused to even seek treatment for her ED until she could stop bingeing and purging. For her, it was more socially acceptable to seek help for restriction than for bingeing and purging. She waited four years before asking for help. Another described her father's response while bringing her into treatment.

> I could see his pulse ticking in his forehead. He was just sooo embarrassed that he had to be there talking about his daughter who couldn't stop herself from puking - or purging I guess is the proper word. And then, the doctors were all sitting there saying, "If she keeps doing this to herself she's going to die". They were like, "She will die in two years", which was a total lie, but anyway. That was the approach of this program...fear, which is ridiculous. So they're like, "Her teeth are going to fall out. Her heart is going to stop. She needs to really throw herself in this program and fix this problem. She needs to be here with us". And my dad, I'll never forget this, he leaned across the couch, turned to me and he said, "Why don't you just stop!?" You know? He was just so disappointed in me. Like, "You made us come here for this bullshit? Why don't you just stop what you're doing?" Like, "This is ridiculous!" You know, like, "How dare you embarrass our family like this?" And it was just like, "Oh this is horrible…I don't want to do this". It was just a negative experience. So [sigh] that's kind of set the tone for that and I just was never honest with them again. (P3)

Being alone. All of the participants expressed an overpowering awareness of being alone. They worried about their ability to connect with others, and for many, even when they were in the presence of others, they experienced feeling apart. One participant explained, "Every so often, being…looking out my window, and just thinking, "I feel so alone," you know? "So alone." I don't know where it comes from. And the sadness too, I don't know" (P17).

Most participants experienced social anxiety and many had been diagnosed with Social Anxiety Disorder. Most did not favour being alone but felt that it was preferable to being with others because social situations were so uncomfortable. Some felt that they had not learned how to make friends appropriately and that they did not have suitable social skills to navigate relationships. One participant conveyed the conflict she felt about her ability to have friends.

> I've always been very afraid that I didn't have enough friends. I'm kind of introverted, quiet, and my family never had...my friends were quite solitary. So I was always very anxious that I wasn't - that I didn't know how to be a good friend. (P9)

A second participant added:

> The solitude is horrifying. Even…I had a roommate in the dorm, she was there all the time but I just felt so lonely and so apart and so overwhelmed by the noise and the chaos of campus and this experience. I wasn't prepared for it. I was desperately shy. So, I wasn't ready, I didn't know how to make friends. I never had friends. My sister and my brother were my only friends. (P1)

Most avoided being close to others because it felt unnerving and awkward. Closeness was not something they were accustomed to, either because they had not previously had the opportunity or because they avoided the opportunity. One participant revealed that it felt safer to block herself off from others because of her intense fears of rejection. She preferred to keep herself distant from others which, she felt, often led to unhealthy relationships.

> Or especially with male/female relationships, like with guys I'm very…I just, I can't deal with it. I just don't like people being too close, it frustrates me, I'm like, "What are you doing? Why are you doing this? etc". I feel like I make poor relationship decisions. (P2)

Some participants pushed away from others because of being bullied or excluded, particularly by other girls, in earlier years. These negative incidents led them to lack trust in other peoples' intentions or led them to believe that others may have an ulterior motive for spending time with them. Not having developed any confidence in their friend-making skills, they had a very difficult time believing that others would willingly choose to spend time with them. One participant explained why she shied away from being around others, "I just always assume that they don't like me, they don't want to be around me, they're making fun of me behind my back…if they're hanging out with me they're doing it because they feel sorry for me" (P11).

Other participants remained alone because they worried that they were a burden to others. They were concerned that they were "too much" for others to have to deal with. One participant thought that she had placed a lot of pressure on her family when she was hospitalized for anorexia in her early teens. She explained that it would be too "selfish" to let them know that she was struggling with her ED again because that might take attention away from her siblings, one of whom was having a baby. As a result, she struggled through her relapse alone without the support of her family. Several others also feared that sharing their difficulties with parents or friends would cause alarm and they did not want them to feel encumbered. Instead they chose to be alone, to push away from others, and deal with things on their own.

Within the *Believing I am inadequate* category, participants described feeling different, feeling ashamed, and being alone. These three subcategories acted as important preconditions to developing the ED but also as ongoing factors that made it more challenging to believe that they deserved to get well. The pushing and pulling dynamic was most evident when participants described wanting to be connected to and accepted by others, yet at the same time holding themselves apart. Although they wished for the ability to be close, their deeply rooted beliefs about being flawed and insufficient kept them from being able to build trusting relationships with others.

Struggling with Self-Regulation

The second contextual factors category was *Struggling with self-regulation*, in which all participants expressed having challenges with the development of autonomy. Participants felt that they lacked the basis for being able to make decisions or for asserting their needs. Their behaviour was, for the most part, defined by pleasing others and being afraid of disappointing others. Rather than behaving with volition or paying attention to their preferences, the majority were reactive to others as a result of feeling controlled or abandoned. Many had experienced controlling or neglectful environments in their formative years and were now adults, living on their own. They noted that these environments continued to shape how they responded to the world because they had internalized many of the external expectations placed on them. Struggling with self-regulation was comprised of four subcategories: *Feeling controlled, Living up to expectations, Learning emotions are not acceptable,* and *Feeling abandoned*.

Feeling controlled. Many participants spoke about feeling as though they had not developed an ability to make choices for themselves. Others felt that they had not been given the opportunity to have input into important decisions about their lives, particularly when they were younger. Many mentioned the responsibility they felt to be a "good daughter" and, therefore, did what was asked of them in their family home. They feared disappointing important others (e.g., parents, teachers, coaches) and went out of their way to demonstrate their compliance. They described wanting to please others or to make others proud and matched their behaviour to what they believed others wanted from them. They often found themselves paying such close attention to what made others happy that they ignored their own needs. After years of inattention or consideration to their own opinions and wishes, they found they had lost touch with their interests, choices, and desires. One participant stated, "I never really looked that far into my future because my parents always set it out for me and I just followed what they said. So as a child I never really looked this far" (P4). She went on to say, "I mean, as a child, you are powerless. And I would say maybe I felt less power than other children because I was so obedient" (P4).

Upon reflection, many participants felt that they had not been encouraged to develop their own point of view on matters. They were often praised for their obedience, conformity, and for being a good daughter, a good student, or a good girl. In adulthood, however, this led many participants to feel lost and stuck, unable to make decisions without external approval. Moreover, it seemed that as young adults, they were now expected to be independent, self-regulating, and self-sufficient, and this felt very confusing and overwhelming. Some began to worry they were letting others down by not being independent enough.

> When I was a kid, I was told how to do everything. I think one of the repercussions for that is now I feel lost. […] It was just very confusing for me because as I grew older my parents *did* ask me the question, for university, which program are you going to…and I honestly had no idea. […] A lot of people seemed like they knew what they wanted to do because they were asked and they were encouraged and they thought about it. But for me, I was just told that I should go to university and have a scholarship. They didn't tell me anything else to do. And so I just kind of floated around not knowing what to do and not knowing how to make choices and not really knowing what my choices entailed. (P4)

While many participants spoke about the desire to be "good" and comply with external demands, others mentioned that they reacted to feeling controlled with rebellion and defiance. One participant said that her "mother's way was the only way" and detailed how difficult it was to develop a sense of personal identity within such an oppressive system. She often felt criticized, judged, and misunderstood. Fearing that she would never be able to do things in a way that would please her mother, she felt her only option was to be the opposite of what her mother expected of her. However, she came to recognize that she was not acting in response to personal choice; the rebellion was simply a reaction to what her mother wanted, and in essence, she still felt controlled.

Several other participants spoke about how difficult it was to recognize themselves as adults, capable of self-reliance. They had not developed trust in themselves around making appropriate decisions or being self-sufficient. One participant talked about her surprise that she had been able to make it through since she had been away at university, "I think I always felt that way, I just was unable to take care of myself. It actually blows my mind how I survived the past three years" (P3). Another participant talked about being raised in a very sheltered environment and feeling as though she was being disloyal to the family by growing up and becoming more independent. She believed that going away for university was perceived as a betrayal by her father who wanted her and her sister to stay close to home. She felt guilty about developing different ideas and about pursuing her education, particularly if career plans took her far from the family. At the same time, she was absorbed in graduate school where she was required to think independently and was expected to produce her own ideas.

> That sense of…allowing myself to be an adult. I think there is still part of me that's very much...even sometimes how I act socially, is an...eager to please...little girl. And I think that that's a part of the strand. I've switched into a program where I'm no longer just receiving knowledge, I'm supposed to be able to produce it and...retain it in a new way. And also I've moved into a situation where I own my own appliances [laughs]...and for a while I've felt like I'm just play-acting [laughs]. I'm playing house or something. (P9)

Many participants relayed that receiving love or approval from others was contingent upon behaving in specified ways. Some felt that acceptance was conditional to meeting certain standards which led them to feel controlled by external forces. One participant explained the academic pressure in her family.

> I didn't care if I had to beg teachers for marks, I was getting on that honour roll, because I was not getting a disappointed remark from my parents when I brought home my report card. […] There was one semester when I got 81- to be on the honour roll you have to have 80 - and I was almost warned that that was very close to not being on honour roll. (P12)

For many, the ED had started out as a sense of accomplishment, a way of demonstrating that they were trying to please or be good. Participants described trying to fulfill the role of happy daughter and making others proud. For most, they did not realize that the ED would turn out to be a disappointment or a source of shame. Even through their struggles, they felt the need to uphold an image of themselves as cheerful and positive. One participant explained that she could never tell her parents that she had an ED. The fear of them knowing that she was not as happy as she appeared was too great.

> I: So letting them know that you were struggling with eating would be…
> P: devastating…for me to even have a little bit of a problem…they'd be like, "We're failures as parents". I feel like I would let them down…and I know that they wouldn't

> help me. Whatever help that they could give would be like… it would not… the pain that I would cause them would be more than any help that they could give me. And I don't think I would gain anything from it. So…that's why I haven't told them. (P15)

Feeling controlled came from guilt, fear of disapproval and disappointment, and the fear that being loved was contingent upon certain standards. Regardless of whether their outward behaviour appeared compliant or rebellious, participants expressed that they experienced difficulty behaving autonomously.

Living up to expectations. Most participants spoke about an intense pressure to live up to expectations that emanated from parents, from friends, and from society as a whole. They felt that they constantly had to negotiate these expectations, with regard to their bodies, societal beauty standards, and their social role as a woman. Expectations came in many forms, from overt statements to covert messages about how one "should" be. Numerous participants recounted hearing from important others about the significance of thinness and beauty in order to be acceptable. Many messages were absorbed by watching how family members treated themselves, for example, witnessing parents or siblings "watch" their weight. Some participants received accolades from their parents when they were thinner, for example, one participant was flown to Europe. Several recalled receiving the most compliments about their appearance when they were the sickest. One participant talked about not living up to her mother's expectations of femininity.

> What really bugged me at the time was more like my mom's perspective on...beauty standards or physical appearance. She's a very feminine person, she's very pretty. I like to say that karma didn't do her a favour and she got two girls who ended up being tomboys during school. And she wanted girls. She wanted little girls, with little skirts - and my sister and I were just not that [laughter]. We were playing with boys and getting home covered in dirt and it was kind of like...I guess not fun for her. Not that I consider myself masculine or anything. But with my mom's standards, I got the impression that we weren't - I wasn't living up to her expectations in terms of how...especially when I got older, even how a teenager…a young woman should dress. (P7)

Another participant explained that her father's perception of how women should look influenced her sense of worth.

> My father was the first man that I ever loved and looked up to and appreciated, right? That's your dad. And he set the tone for all other men in my life and I knew that he valued beauty very, very much. So, in order for any other man to love me I felt that I needed to be very beautiful. Or as skinny, or as fit, or whatever as I can be. Then a man will love me. So if I was anything less than that, I was worthless...like literally worthless, and I think that's where it came from. I think that's really where it started. (P3)

Reinforcing the need to live up to expectations, participants heard negative remarks about their bodies from multiple sources (e.g., men, friends, parents, and society). It seemed that feeling negatively about one's body was a universal phenomenon, one that women should expect to experience. They spoke about being influenced and pressured by friends who were also disturbed by the inadequacies of their bodies. Many felt overwhelmed by the relentless focus on dieting and compensatory eating surrounding them.

> Sometimes I'm in class and I hear people talking, I have to say mostly girls, talking about dieting. Like, "Oh, I skipped breakfast this morning and, for the next three weeks I'm going to go on this water diet". I mean everywhere - we're living in such a sick society where I want to say everyone is almost predisposed to developing an eating disorder. (P7)

Most participants described the implicit social norms and expectations related to being a woman. One participant relayed the cultural expectation of being a "nice" girl in order to be accepted in her small town. She revealed that women who deviate from the norm (as she did by coming out as bisexual) face being ostracized and shunned. Another participant witnessed family discord when her mother did not take on a traditional gender role, for example, by preparing the family meals. Many spoke about the implicit social and cultural expectations of women as nurturing, passive, compliant, and self-sacrificing.

> Wanting to be good at what I do, wanting not to fail…yet also feeling this really intense guilt and lack of self-worth. I think maybe that is something that just gets carved into you because as a woman, I mean, generally speaking, you're taught to be, you know, make everybody happy…can't say anything outright that's going to upset anybody. And

> that's really strong in my extended family. I think with my grandparents, it's really strong like that. My grandma would never say a harsh word to anybody, ever...even when she has great cause to and probably should have. So, I think there's lots of sort of, quiet ideas about that that maybe this is responding to. (P13)

Another participant illustrated the enormity of what society expects of women in general.

> I think there's a lot of pressure on women to get that great career, and meet Mr. Right, and have a family, but yet still keep working, and bring home the bacon, and make it, and do the laundry, and pick up the kids from soccer, and be beautiful all and the same time, and be a size two. (P3)

This same participant later explained that despite these unreasonable pressures, she wanted all of these things for herself and believed that it should be possible to attain all of them.

Although participants felt there was a tacit expectation to display "feminine" qualities in order to be acceptable, there was concurrently an aversion to social norms around femininity, illustrating another example of the pushing and pulling core category. Several participants mentioned a general distaste or even loathing of feminine qualities, which they likened to fragility and weakness. Some participants expressed discomfort with the way that women's bodies are objectified and they used the ED to deflect attention they may otherwise have been subjected to. Instead of attempting to comply with the pressure to be feminine, these participants rejected femininity altogether.

> [Long pause] I think also my eating disorder and…getting skinny was a way for me to not deal with sexuality. I wasn't ready, maybe. I wasn't ready. I just knew that if I got skinny enough, people stopped looking. And I had no more feelings of any sort, no more period, no more reminders of any of that, you know? I think I hid that way for a while. [Pause] I don't know where it comes from, but a general sense of disgust or something related with the way men… some men look at women. And not wanting to be part of it [soft laugh]. (P17)

Another participant talked about rejecting certain expectations of women. She saw how her mother worked diligently to perform in a male-dominated work environment and determined that it was not something she wanted for herself.

> My mom works in a firm where it's mostly all men and she freaking hates it, she's like, "They're all assholes!" And they don't listen to her, and they figure because she's a woman she's incompetent, and guess what? She's not! I've seen the woman work…she's got her shit together. So there's a part of me that's like, what's the point of being an independent, strong woman that goes into the workforce, if you're just going to get your ass whooped every day? (P8)

Living up to explicit and implicit expectations about their bodies, their behaviours, and their role in society felt like an uphill battle; one that was constantly out of reach. This led to further disappointment and deepened feelings of inadequacy and shame. In addition, to expectations around femininity, participants described certain expectations around the expression of emotion.

Learning emotions are not acceptable. All participants talked about a general discomfort with emotions. Many talked about their family environment in which they learned that emotions were unacceptable or that emotions should not be expressed. As a result, participants came to fear their emotions and believed that they should be suppressed. One participant described herself as an excessively emotional child who experienced tantrums for hours. Although she understood that it was very challenging for others to deal with her rages, learning that her emotions were unacceptable led her believe that there was something wrong with her.

> If only someone had looked at me when I was a child, screaming on the floor, and been like, "You must feel so frustrated". You know, "What does it feel like?" Just give me some kind of emotional vocabulary...instead of beating me or removing me from the family…or physically putting me in isolation. Because then you develop this horrible sense of shame, and feeling like, "I am a dysfunctional human being". If someone had just sort of acknowledged that all feelings are legitimate and just given me some kind of vocabulary to talk about them, it would have been so much better. (P1)

Several participants mentioned that they witnessed caregivers or important others have difficulties expressing or dealing with emotions. Some had one parent who was considered "overly" emotional and was ridiculed by the other parent, and it became clear that was not an appropriate way to act. Some spoke about disconnecting themselves from their emotions in an effort to control or not experience them.

> My dad's anger is very…very quiet. It's not...he has real problems expressing anger. So when he does...he never...when he wants to express disapproval or something...it might come out in a burst of a bit of a lecture. But there's no conversation. It's him...he says his piece. You could say, "Well, dad, can you just hear it from my side?", and no, he goes to his room, closes his door, and he can't deal with it. (P9)

One participant expressed that emotions were not discussed or displayed during her upbringing, particularly by her father. As she had never seen a demonstration of his affection, she felt uncertain of his feelings for her.

> My father, I think that was one of the moments where I saw the most proof that he really, really has love for me…was after a suicide attempt. I was in the psychiatric ward, and they didn't know about it. And we were in a…it turned out that the staff made a big meeting […] and my family was there. And my psychiatrist didn't tiptoe around the subject, she just basically said, "Do you know why [your daughter] is hospitalized?" And my parents were like, "No". And they just said...what happened. And my father, it was the most painful thing I've ever seen in my life...trying to stuff his tears inside himself. He was just trying to push it in, push it in. It broke my heart. But then I saw… and I came out of the meeting and he took me in his arms and said, "I don't want to lose you. Don't ever do that again." But it was… seeing him…because I didn't see much emotion from my father ever in my life. To see him try to keep it in, it really…Because often I would doubt, you know? Because maybe he wasn't the type to hug a lot or say, "I love you" a lot, or things like that...doubt, "Does he really love me?" (P17)

Several participants mentioned growing up in an atmosphere where things were not talked about openly, which influenced the notion that emotions were not acceptable. They learned not to speak about problems or conflicts and received the message that certain things should be "kept a secret." A number of participants had parents who were terminally ill during their childhood or adolescence and they learned to quiet their emotions about the illness. One participant described her family's response after her father had been diagnosed with cancer.

> But...it was very hush hush. It was very - we don't talk about problems that are going on at home. I kind of learned from that that we don't talk about problems. So, I didn't talk about my eating disorder for over two years before getting help. (P12)

She then explained the way that she dealt with her emotions after her father passed away.

> I was training for the [provincial] team...and the day after he died, I was at practice. No one understood or could believe I was there, but I needed to not think...and practice is what made me not think [soft laugh]. But I never...to this day, I still haven't fully faced those emotions that should have come then. (P12).

Learning that emotions were not acceptable meant that many participants did not express themselves or reach out to others when they were in need. This had implications for their sense of belonging and feeling supported by others.

Feeling abandoned. Several participants spoke about feeling as though their needs were not heard by important others. They talked about not being supported but also feeling, at times, as though they were invisible to others. Several mentioned that after their parents separated or divorced, one parent was not really a part of their upbringing and they felt "left" by that parent. For others, parents were at work for long hours and it seemed as though other things took priority over their relationship with each other. They voiced feeling as though they were on their own with things.

> What definitely helped my restriction is that when my parents split up, my mom moved out. And I stayed with my dad and my sister. And because my mom was out, my dad was cooking…but he wasn't cooking, and he was in a really bad place because [quietly] my mom had left him and so he wasn't really around...really. So my sister and I were kind of at the liberty of buying the food we wanted and eating what we wanted for dinner. […] But yeah, everything was diet. And no one... really stopped me from doing anything. And so it got really comfy at home to practice my restriction because really I was in charge. (P7)

More than one participant had a parent who left the family home to go live with a boyfriend or girlfriend. One participant relayed that she felt abandoned by both parents. After her parents split, her father, who she described as irresponsible, went to live with his parents. Her mother, who had been granted custody of her and her sister, decided to move in with her boyfriend. She had experienced conflict with her mother's boyfriend and did not wish to live with him, so remained alone in the family home. This left her, at age 14, with no groceries in the house, and feeling as though her needs were not important to anyone.

> And so, I went to my father's place. My father was living with my grandparents because [laughing] he's not very responsible. And so, from the age of 28 to 43, he was living with his parents. And so I went to my grandmother's place and I stayed there for a few months. Because, for me, it was unacceptable that I had no food and everything. So, I think maybe the feeling of abandonment… I don't know if… it emerged from there, or if it really was intensified by that episode. (P19)

Several participants felt abandoned when their parents discovered their ED. For some, parents did not believe in eating "disorders" and participants were told that they would simply have to begin eating normally again. They felt misunderstood, judged, and this exacerbated their worries about being "defective" and "wrong". Others felt as though they were dropped off at a hospital with the expectation that the treatment centre would "fix" them. This intensified their anxiety that they had created this problem independently. Many participants sensed that there were dynamics in the family system that had at least contributed to the development of the ED. However, being perceived as "the sick one", they took on the responsibility for the "illness". One participant said that her family was invited into treatment in order to work through some family dynamics. Her father refused, leading her to feel as though she was solely accountable.

> That was the one thing my doctor wanted us to do, and that was the one thing my dad was like, "That's too far". He was like…this is the thing that kind of bothered me, was the whole time he was like, "*You're* crazy, but *I'm* not crazy." And I'm like, "I'm only crazy because of *you* two. Love you…but…family therapy wouldn't have been a bad idea." But he straight up refused. (P8)

In addition to feeling as though they were abandoned to deal with the ED on their own, sometimes participants felt as though important others facilitated the development of eating problems. Some participants revealed that they were encouraged and even pressured to diet in order to fit in or be "healthier". Some elucidated that others turned a blind eye to their restriction or bingeing and purging. Caregivers saw what was happening but did not have the tools to deal with it, and therefore did not intervene. This too, led them to feel abandoned, as though no one was taking care of them in their time of need. One participant explained how her father knew about her bingeing and purging, and even purchased her binge foods.

> Why did he never tell me, “It’s enough”? Sometimes I lived with my father, and he became a bit complacent in my eating disorder…especially the bulimia. We would go to the grocery store every four days and, “Oops, it’s three days this time, [participant’s name]. You’re supposed to stretch it out to four days”. And then, “How am I going to put the food in the basket to make it look like there’s less stuff?” And he’d take me to the grocery store he would just…became part of it…a little bit. And I remember thinking to myself, “When is he going to say it’s enough? When is he going to tell me it’s enough?” So I guess I realized not to wait for him to tell me [laughs]. (P17)

Some participants responded to the sense of abandonment by creating their own structure through restriction and rules. Left to figure things out for themselves, they generated a system through which they could understand right from wrong, and good from bad. For others, the abandonment perpetuated feeling lost, and they became chaotic in their search for connection. A few turned to friends who gave them a sense of belonging or support. For some, this was a positive experience, for others, the friends introduced them to drugs and other kinds of pressures in order to assimilate.

Whether participants grew up in an environment where they felt controlled by expectations and/or neglected and emotionally unsupported, the common theme seemed to be the lack of opportunity to learn how to self-regulate appropriately. Messages from others were often unclear or confusing, for example, “Be a good daughter (i.e., be compliant) but be independent and decisive”, or “Be feminine and pretty but do not be weak”, or “Be nurturing and kind to others but do not express your needs.” As such, the forces of pushing and pulling operated from the outside in addition to being experienced internally. In effort to be what others expected of them instead of listening to internal cues, participants became more and more distant from their autonomous selves. Challenges with self-regulation simultaneously activated the development of the ED and continuously operated as a maintaining force in the push-pull of the recovery process.

The first two contextual factors, *Believing I am inadequate* and *Struggling with self-regulation*, represented more internalized vulnerabilities to the development of mental health problems. The third and final contextual factor, related to more specific triggers or external incidents in participants' lives.

Experiencing Stressors

Most participants described the experience of one or more major stressors, either presently or in the past that contributed to their experiences of an ED and treatment for it. Stressors were experienced with differing levels of severity but they each had an impact on the resilience and well-being of participants. Under the stressors category there were four subcategories: *Having mental/physical health problems in the family*, *Experiencing parents' divorce*, *Being bullied*, and *Moving away from home*.

Having mental/physical health problems in the family. Many participants spoke about being concerned about the health of family members during their upbringing. For some, the problems led to the death of a parent, for others, health problems led to abuse and/or neglect. They depicted these stressors as having a major influence on their well-being. One participant explained, "I had a lot of problems in my family and with my mom. My mom was suicidal for a bit and really depressed and in [a different city] and I kind of had to look after her from here" (P5). Another participant disclosed that she had been removed from her parents' home during childhood as a result of her father's mental health problems.

> When I was initially going in for bipolar disorder to a bunch of the mental health clinics in [State], the way I described my father they thought he was...bipolar. […] And then they would talk to my mom...I wasn't in those sessions when they talked to my mom about my dad's habits, but he was very, very aggressive and violent to my mom when we

> were...I was...I didn't... because I was taken out of my parents house for about a year. (P2)

Another participant described the abuse she suffered at the hands of her mother.

> We don't really know what's wrong with my mom, but everyone thinks that there is something…some sort of problem. She was abusive…verbally, physically, psychologically, whatever…everything [laughs softly]. That…that didn't help with my…self. She was very verbally abusive towards me, and then as time passed, I became her main target. Yeah, and after, in high school, it started getting a bit worse the way she was talking to me and stuff like that, or yelling at me. (P18)

As her ED developed she realized that the abuse had influenced her self-perception, "My eating disorder's voice is a lot… is sort of like my mother's voice. It basically tells me everything my mom told me my whole life." (P18)

More specifically, in relation to health problems and food, over half of participants revealed that they had a parent and/or a sibling with some form of disordered eating behaviour. One participant explained that she only recently realized that her father experienced eating issues quite similar to her own. She had grown up thinking that his behaviour was normal, however, through therapy came to acknowledge that it may have influenced her attitude toward food and exercise.

> Not willing to admit his own thing, I think. My dad is kind of weird in the fact that he only eats once a day. He only eats dinner, and he walks 100 minutes a day, like power walks, he does not…walk, he's like…crazy. So, I think he has his own disorders of anxiety and stuff like that. I think he just doesn't want to deal with those issues. (P8)

A number of participants spoke about being concerned about their parents' physical health from a young age. Some families were dealing with illnesses such as diabetes and others terminal illnesses and death. One participant described how her mother's cancer negatively influenced her ability to feel grounded and secure.

> My mom, she had cancer when I was nine and then she died when I was 20. [...] And I very much internalized everything…my mom having cancer made me extremely anxious

> and very upset. Whereas, my sister seemed really resilient to it and she seemed to handle it a lot better, where I just became super scared of her dying any minute. (P4)

When family members were experiencing mental or physical health issues, this triggered vulnerability to the development or maintenance of the ED. Health issues created uncertainty for participants in their ability to trust that they were protected and safe and, in many cases, influenced how they viewed themselves.

Experiencing parents' divorce. Divorce also acted as a stressor for many participants. A number of participants described how their parents' divorce impacted their eating patterns. Several participants were free to restrict or binge and purge during the split because their parents were dealing with their own issues. One participant described how the family went into total disarray after the discovery of her father's affair. Her younger sister began engaging in self-harm which she and her older sister decided to keep hidden from their parents. In addition, while both of her sisters stopped speaking to their father, the mother was never told about the affair.

> My younger sister discovered that he was having an affair, and that just blew up into this big thing between my sisters and I. And we never told them. And my sister was cutting, and then we just kind of didn't tell anyone. She was getting help for it, but we didn't tell… well obviously we're not going tell our parents. […] I didn't condone what he did, but I kind of forgave him…I didn't want to be involved in any of that anymore, but my sisters still were. And my older sister went off on… she was really pissed at him. And she still is, and she started… they were both extremely disres- they were mean and disrespectful, and spiteful. They just really didn't like him. They didn't want to talk to him, they didn't want to see him. (P18)

One participant spoke about how the divorce brought out her desire to be the "perfect" daughter. She absorbed the stress around her and took on the responsibility of making things better for everyone involved.

> My parents' divorce was really messy. I spent a lot of time doing things on my own and sort of taking care of myself to a certain degree. I was always trying to make my mom happy. Not that I…I knew I wasn't responsible for their divorce, that never came into my head. But at the same time I wanted to make people happy. There was a lot of sadness

> and negativity around and I guess I felt I would get more attention if I could bring that [positivity]. (P5)

Experiencing parents' divorce, despite having nothing to do with participants' own choices, often involved distinct changes in living arrangements and impacted participants' sense of security. These factors spurred on, contributed to, or fueled the ED. Other stressors, however, more specifically targeted the participants as individuals, such as being bullied.

Being bullied. Several participants described how they had been bullied by others during their formative years. One participant talked about how the experience impacted how she felt about herself, "I always felt very left out. Up until high school I felt this sense of being really uncool and really [pause] shut out of things…shut out of friend groups or shut out of games in the playground or whatever" (P13). She described some of what occurred during the bullying.

> Name calling…hitting me on the head with a rock once…that was weird. I got called a lesbian a couple of times before anyone knew what it meant - mostly, just exclusion and labeling as somebody who was weird or somebody who was undesirable. Dirty looks… like I shouldn't be there or...you know. Just feeling excluded, more than actively picked on…subtly excluded [voice cracking]. (P13)

Another participant described how she was bullied by a boyfriend. She explained that he had intimidated her and encouraged her to drink and do drugs in order to reduce her inhibitions. She ended up being convinced to do things that led her to feel ashamed, "I had...there was one guy who I was involved with who gave me a bunch of drugs and made a video of us having sex and showed it to a bunch of people" (P5). Participants articulated that being bullied simultaneously reinforced the belief that they deserved to be ostracized because something was wrong with them and strengthened their conviction that people were untrustworthy.

Moving away from home. As participants were predominantly university-aged at the time of their interview, many spoke about the stresses involved in moving away from their family home. One participant illustrated what it felt like to move to a big city for the first time on her own, “I was just 18, coming out of a very sheltered suburban life. I’m an only child too, and so it was just all of a sudden like this whole other world” (P8). All of a sudden being responsible for cooking their own meals and not necessarily having healthy foods available made the transition very difficult. Participants missed the comforts of home and found it challenging to adapt to their new living arrangements. One participant gave details about her transition from home and its significant impact on her mood.

> I wasn’t really ready emotionally to leave home. I was very, very homesick. I had a boyfriend who was still back in our home town so that was really hard. I probably should not have tried to do the long distance thing but I didn’t know any better back then. So I didn’t really make any friends. But that was my fault because I was really withdrawn and not talking to anybody. The living situation was awful. They made you live in the residence for the first two years and they didn’t give you a choice of where you lived. So I was stuck in this really horrible rundown place that was tiny, tiny, squished in with three other girls that I didn’t know and didn’t get along with. And there were bug infestations and the plumbing didn’t work and that was really depressing. (P11)

Another participant described feeling lonely when she moved so far from home and how the ED came in as comfort to deal with her loss.

> It was my first year here in [city]. I’d left my friends, I’d left a boyfriend. So I was just...I was making excuses, saying, “Oh well, you know what? I’m bingeing on food because I’m lonely, and I’m sad, I’m missing people”. So that’s how I was accounting for it at first. Kind of like, filling up the emptiness. (P7)

Within the *Experiencing stressors* category, each event was experienced with differing levels of severity but each had an impact on the resilience and well-being of participants, on their sense of security about the world, and on their self-concept. The three major categories, *Believing I am inadequate, Struggling with self-regulation*, and *Experiencing stressors,* comprised the contextual factors. The first two were conceptualized as internal vulnerabilities and the third included external events that triggered the development and maintenance of eating problems.

Contributing Conditions

The contributing conditions can be understood as factors that catalyzed the ED. Whether eating problems or body image concerns had begun to develop or not, the act of "controlling" exacerbated the issue and made the ED take on a life of its own. Contributing conditions can be split into two categories but were, in actuality, part of one construct: control. Participants cycled back and forth between *Using control* and *Losing control*, providing another example of the pushing and pulling theme. In attempts to exert unyielding control over themselves and their lives, the tension inevitably became too great and participants would experience feelings of loss of control. Loss of control was described by all as terrifying; therefore relentless efforts were made to avoid this state. Participants tried to regain control at any cost and, as such, became trapped in the cycle. The relationship between the contributing conditions and the contextual factors is depicted in Figure 2.

Using Control

Participants used control in order to feel a sense of order, mastery, and power; feelings that they did not experience in their everyday lives. They explained that creating a sense of order was a way of managing their severe anxiety. It was a method for feeling as though they had some influence over the chaos of the world. Using control was comprised of three subcategories: *Creating the structure*, *Needing to be perfect*, and *Using the eating disorder to cope with emotion*.

Figure 2. Contextual Factors and Contributing Conditions

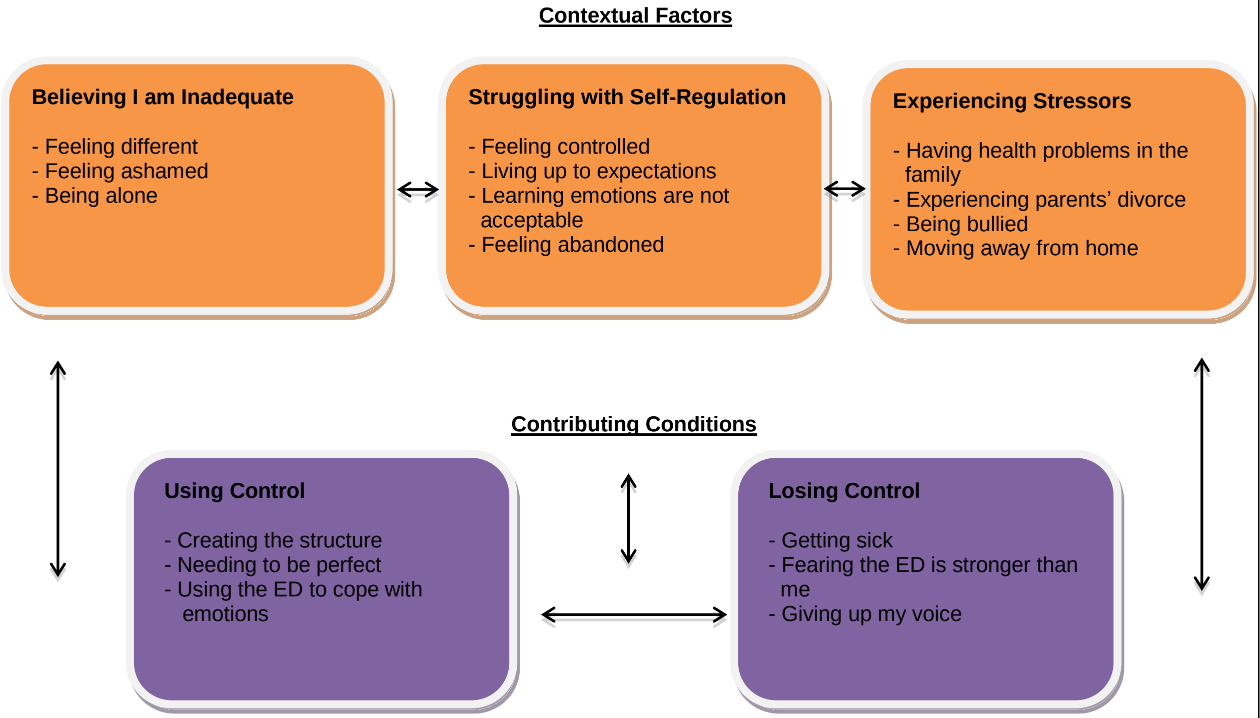

Figure 2. Major categories and sub-categories constituting the contextual factors and contributing conditions of the conditional matrix in the push-pull dynamic theory. The arrows between categories indicate the push-pull dynamic in the treatment and recovery process.

Creating the structure. Creating the structure was about establishing a set of rules, often food related, to feel a sense of organization about the world. It usually involved having a list of “good” foods and “bad” foods. Foods that were low calorie, low carbohydrate, or low fat were typically on the “good” list, and allowable in specified quantities. The “bad” list often comprised foods that were forbidden or dangerous in some way, either because they were consumed during binges or they were perceived to cause weight gain. Within the structure, participants were able to evaluate their behaviour on any given day, and if they had restricted their intake or exercised a certain amount then they were able to go to bed feeling that they had been “good” or “successful”. Following the rules enabled them to feel a sense of accomplishment. However, days when they strayed from the structure were considered to be "failures" and they would often find ways to punish themselves for not meeting the rules of the system. One participant explained her set of rules in very simple terms.

> When I feel bad I stop eating because it's...it makes me feel better to have that measure of control. And I feel…I'm not eating anything - so I'm being good. In my mind that's the connection. Eating is bad and not eating is good. So, when I eat I'll feel worse. (P11)

She detailed how having control over her food intake had helped her to feel more powerful in her interaction with her parents.

> Kind of powerful, I guess. Because once my parents realized what was going on they would make me sit at the dinner table with the plate in front of me. And, "You have to eat one more bite of that fish". So I'd take my fork and cut the smallest morsel I possibly could and eat that and be like, "I ate a bite." (P11)

One participant explained how she used her rules to combat the unruliness of the outside world. She felt that she could never live up to the wider expectations of society so she created her own system for feeling acceptable.

> Well...it's just sort of following your own guidelines. You develop these methods for yourself, these structures that suddenly define and shape goodness for you. So it may be avoiding certain foods or eating at specific times. I know how long it takes me to prepare dinner. I start it at 6:30 and I start eating at 7...it is done by 7:30. But not even deviating by a minute. You just develop these random- I have candy Sunday. It's where I'm allowed to have candy, one piece of candy, and I get to go pick it and every Sunday I do that. You know? It's just sort of this strange…because you can't be good by your familial or society's expectations, you can make your own system and then you can live up to it. It's great when you're living up to it and it's not when you are not. (P1)

Another participant relayed how her rules began to gradually take over her life. As with the others, she had to continually adapt the structure, becoming stricter and stricter, in order to feel that same sense of accomplishment. She had to test herself further and add more challenges to the list to feel successful.

> So all of a sudden it was like an obsession. […] I have to do all these things, and it just took over really quickly. I had to go on the elliptical at least an hour to two hours a day. I pretty much cut out all forms of food, except for salad and cereal. So, it was like, cereal in the morning and then, salad and cereal, and salad at dinner, and it was very much like I had to stick to these things. And I think the fact that residence had predictable food, it

> was easy for me to structure what was coming at me, because I knew how I could plan it. And then my routine kind of fell into running…plus swimming. (P8)

Although the rules may have become tyrannical and unfeasible after a while, many participants expressed feeling discomfort, even lost, without the imposed system. For most, giving up the ED meant the loss of knowing how to “be good”. They found comfort in the structure and the thought of living without it made them very uneasy and anxious. One participant disclosed her fears about recovery. She realized that giving up her rigid system, including the thoughts that kept her “in line”, would bring up a great deal of anxiety. This contributed to her desire to hang on to the ED behaviour.

> I’ve had this sort of strange feeling in my head that I’m worried about getting better. If I start eating like a normal person, what…I almost don’t want that. I *do* want to not have to think about it as much, but on the other hand it’s like I’ve had this for so long I don’t know...if the thoughts were out of my head, I don’t know what I’d do with myself. I almost don’t want to get completely better. Which is sort of a strange thing and I guess I need to figure that out before I keep going forward. But it’s just a thing that’s been coming up recently. (P11)

The core theme of pushing and pulling was apparent when participants feared letting go of their imposed system. While most felt safe and protected by the structure because it provided clear guidelines, at the same time it became onerous and oppressive. Participants simultaneously felt the desire to free themselves from the structure, yet also to cling to it.

Needing to be perfect. Almost all participants mentioned feeling an imperative to be perfect. Many mentioned the desire to have the ideal body but for most, the need for perfection was pervasive in all areas of their lives. For example, they expected themselves to excel in school, to be captain of the sports teams, to be president of different clubs, and to create meaningful works of art. They pushed themselves beyond reasonable limits and expected themselves to attain these standards without faltering, without feeling exhausted, and without any indication of struggle. Most articulated that they could not bear to be perceived as weak or deficient in any way. They talked about being very sensitive to other peoples' opinions, and it was very important that others see them as "having it all together". One participant expressed how she pushed her body to extremes to see how much she could handle.

> Well, to me it was that I'm gifted at being super motivated, at working until my hands just stopped working and I think that's exactly why I had anorexia, you know? Because I was someone of extremes. I even went through high school where I told myself I would not sleep for a whole week - and I went through it. Because I wanted to see if I could do it. I just liked to make myself go to these extremes and standards and tests…I have to be super thin, I have to not sleep, I have to do homework forever. I was drinking coffee at 10 years old to try to do my homework. (P4)

In conjunction with the need to be perfect, participants elaborated an extreme fear of failure. Perceived failure of any kind was akin to being worthless and was to be avoided at all cost. One participant illustrated this construct in describing the group of women who were in her group therapy. She began to realize that the group members, like her, were terrified of failure and felt compelled to attain more and more in order to "outrun" this fear.

> We're a bunch of ten girls...ten women. And four of them have PhDs...we're all into those very competitive programs. I mean, we're all having part time jobs and doing two. And we're successful...we're doing a lot of things at a time and we're successful. And we're pretty cute. And it took me a while to actually see that and to be able to say it. That's why I'm saying it really is this theme of success and failure...it's what's driving the eating disorder. I find that it's definitely at the core of the restriction process. And the binge is definitely the biggest failure you can ever experience. […] It's kind of like a trait of people who go on to develop an eating disorder. It's just part of us. It's who we are. Failure it's...failure is the hard one. I'm still sensitive to failure, even today. (P7)

Another explained how she used the constant threat of failure to push herself to perform and achieve.

> I had won all these academic awards coming out of high school...but I still, for some reason that wasn't validation enough for me. It wasn't like, "OK I can handle this in university", it was still like, "What if I fail? What if I don't...what if I fail? What if…this? What if…that?" And of course I didn't. Not only that but I won the same academic awards coming out of university. It just…it's just always this continual feeling of like [voice breaking] "What if I fail, what if I screw up"? You know…catastrophizing and then coming back and saying, "Well now I have to work really hard and put all this pressure on myself to make sure that doesn't happen." (P13)

Most participants described themselves as being very sensitive to other peoples' judgments, and felt a need to control how they were perceived. Many said they would not be able to handle if someone felt negatively about them. Appearing perfect on the outside meant that they could not convey any vulnerabilities. Most felt incredible strain from the pressure they placed on themselves but they always kept the struggle hidden. One participant said, "Nobody ever knows what I'm really thinking". Another said, "Having people know that you're not happy is embarrassing". Constantly having a smile on, in most cases, led them to feel as though they were not being genuine and many portrayed themselves as "wearing a mask". One participant disclosed that she became a chameleon around others. Her strategy for being liked by others was to be exactly who they wanted her to be. However, this left her feeling bereft of an identity.

> I have problems being honest with anyone. I've never been fully honest with my family, friends, anyone, and I am probably the definition of a pathological liar. I just naturally lie all the time. I not saying I'm lying to you right now - I'm not, but...I do lie a lot. […] But I've gotten to the point where I'm so comfortable lying that, first of all, I don't notice it. […] I always saw myself as the type person who could become friends with anyone, which I think I can, but it's because I can wear so many masks and I can transform myself into someone anyone will like. (P10)

Among the drawbacks of portraying themselves as perfect was that this never allowed others to get to know them. In presenting an image or mask to others, instead of how they genuinely were, they kept others at a distance and never truly felt accepted. Ironically, acceptance was the very thing they were seeking.

Using the eating disorder to cope with emotions. Participants spoke about the need to establish control over themselves and their emotions. They experienced their emotions as chaotic and uncontrollable, things that should be suppressed. Most participants used the ED, and in some cases drugs, as a strategy to rid themselves of unwanted emotions. For many, food restriction served to numb not only hunger cues but other bodily sensations. Bingeing and purging was frequently used to assuage feelings of anxiety or to bring about a sense of calm. One participant specified how she used restricting, bingeing, and purging to quell intolerable emotions, "I think through not eating, being more numb, or through the bulimia…I managed to alleviate some anxiety. Too much anxiety, "OK, eat and then go purge" [exhales deeply]. For me anxiety's a huge one" (P17). Another participant illustrated how she used the ED to cope when life felt insurmountable and overwhelming.

> Sometimes when I feel really out of control. When school feels nuts…or, I just got out of this kind of crazy relationship. And when everything outside of my life feels out of control, or I feel like I can't make decisions…just that out of control feeling. I can use what I ate, or how much I walked today, or how much diet coke I drank as a way to be like, "At least I still have a little bit of the reigns in my life". […] It's kind of like a blanket. Or that feeling of being empty and kind of light headed? I know that's terrible, but sometimes I'm like, "I wanted this". This is my control. (P8)

The high co-morbidity between drug use and ED behaviour was exemplified by several participants in their descriptions of coping with unbearable emotions. One participant explained her use of drugs in conjunction with the ED in order to avoid negative feelings, "I started smoking lots of marijuana, because it would make me...I'd always smoke it after I binged and purged because I just felt so horrible, and it made me feel more calm" (P10). Another participant, who used cocaine to suppress her appetite explained:

> It was one or the other sometimes. I was like, "Either I'm going to go use, or I'm going to be bulimic tonight". […] And sometimes I would justify that, "I've had enough, I've been sick enough for the past couple of days. I'm going to go use," and it was one or the other, you know? (P17)

Many participants articulated feeling powerful when they were able to rid themselves of the unwanted emotion. In many cases, when participants felt the ED was going "well" (usually during a restrictive phase), it was used to cope with feelings of powerlessness and worthlessness. One participant depicted her efforts to counteract those feelings of helplessness, "I think that there was a sense of power that came with having an eating disorder, that maybe I didn't get in my other social interactions" (P8). Another participant also described the ED as a strategy for coping with her deeply ingrained feelings of inadequacy.

> I think maybe that's why the anorexia was a way of making me feel better. Because, unfortunately, at the age of 12, girls are dieting. And everyone was poor at it but I was able to be really good. So, it made me feel better in some way…and special. It just made me feel better about myself. (P4)

Creating the structure, *Needing to be perfect*, and *Using the eating disorder to cope with emotions* were described by participants as methods for feeling as though they were in control of an uncontrollable environment, and all three fell under the category *Using control*. Using control in this manner acted as a contributing condition to the development and/or deepening of eating symptoms. The rigid adherence to their system of control made participants extremely vulnerable to losing control in moments when they were not able to keep everything in line.

Losing control

As a result of creating unattainable standards, participants constantly felt that they were falling short. Most described feeling as though they were perpetually cycling between regaining control and feeling entirely out of control. Being out of control led them to feel disgusted with themselves and several expressed that they had lost the ability to trust themselves. One participant disclosed her ultimate fear. She detailed what it would mean if this fear came to be.

> P: Gaining weight. And also losing control, I feel like if I allowed myself to, you know, eat more things...eat more diverse foods, I would just get out of control.
> I: And what does getting out of control mean?
> P: [Pause] I guess it would mean that I'm...that I'm a bad person, I guess [laughter]. That I don't have any control over myself and that I'm [pause] just sort of disgusting and don't have any control. (P11)

Many remarked that, after prolonged abuse, their physical health was deteriorating which led them to feel that things were getting out of control. They noticed that they could not push themselves as hard because their bodies did not respond in the same way they once had. Further, most expressed that the rules began to take on a life of their own. They no longer felt as though they were in control of the ED, instead many expressed that it began to control them. Many described its power as so encompassing that they felt they were losing their sense of themselves. They talked about the loss of hope that they would ever be able live without an ED, and several contemplated and/or attempted suicide. *Losing control* was made up of three subcategories: *Getting sick*, *Fearing the eating disorder is stronger than me*, and *Giving up my voice*.

Getting sick. At some point during their ED, most participants began experiencing physical complications as a result of their severe restriction, over-exercise, and binge/purge behaviours. Although these complications were an obvious clue that something was amiss, for most, it did not cause the behaviours to stop. The ED had gained such momentum that they felt trapped, as though they were locked in a moving vehicle with no way to get out. Experiencing tangible effects from the ED was very disconcerting for most because this made it more likely that others would detect a problem or a “weakness”. One participant shared that she had torn her esophagus a couple of times, a condition that could be life-threatening. Another participant revealed that she developed an irreversible condition.

> I’ve developed an autoimmune TSH thing...my thyroid doesn’t function anymore. It was really frustrating because I didn’t know this until I saw a doctor here and did a couple of blood tests...that whenever I would eat, my body would hold on to that because it was so scared that it would go into starvation mode, you know? (P2)

Another participant talked about the loss of her hair.

> My hair...I used to have so much hair, like thick, thick hair...even though I shouldn’t be complaining now because it’s not that bad but…I don’t know what’s happening with my bones...my teeth. I’ve had a lot of cavities where I had none at all for 20 years of my life, I had no cavities and then all of a sudden I get cavities. I have concentration issues. (P14)

Yet another spoke about the loss of her teeth.

> And my teeth I have now… I lost my top four teeth and I'd say to myself, as my teeth would shrink and shrink and shrink. People may have known a bit, but me, I felt like everyone who looked at me saw that I had the face of a girl who vomits all the time, you know? And that's hard. I would be ashamed to smile, things like that. (P17)

One participant detailed the physical effects of starvation. She feared that she would lose control over her ability to function.

> I think it was the severe drop in weight and what came along with it, which was - oh my god - terrible insomnia. And then what comes along with that is depression and heightened anxiety. Now I know, when you're starving...everything becomes...you can't focus and you're paranoid. All these things…I thought I was going crazy and it was actually...to anyone else on the outside it might be really obvious but that sense of..."This isn't a sustainable way of...you can't continue this". I never thought, "You're going to die if this continues" [soft laugh], but it was, "You're not going to be able to function at all". But I think it was especially the sleep. Now I know I wake up...in the middle of the night, I'd wake up sweating and panicking, and now I know it was because my body was telling me, "You're starving". You know? But that was the number one thing is that the horrible, the sense of horrible discomfort all of the time, physical discomfort all of the time, and being cold all the time. (P9)

Participants revealed what it felt like when others began to notice that they looked unwell. They related the embarrassment and shame of no longer being able to hide their ED. They felt exposed and vulnerable, the very things they had tried so hard to avoid.

> I'd walk down the street, and I remember people walking by and [making whispering sounds], things like that. And I would be like, "Yeah, what's the problem?" Did I have makeup on my face or whatever? "No! You look like a skeleton! People are reacting!" And you know, because I didn't see myself as becoming a…It's like any weight I had was too much, it was already too much to start with. So it's not like it became, "Aw, I lost too much weight", or "You went too far". No, no, it's like, [switches to French] "Tant qu'il y en a à perdre…" [there's still more weight to lose]. (P17)

Another participant conveyed the indignity of having her vulnerabilities discovered by others. No longer able to hide her secret because of extreme weight loss, she felt as though she was losing control over her ability to portray herself as competent.

> A real problem for me was when I lost a ton of weight, it was obvious that I had a problem. Before, *I* knew something was a bit weird…I didn't really have to admit it. No one really could see it. And then all of a sudden it was like, "Whoa, you're wearing it". That's the thing I find with...anorexia at least, I can't speak for any - I don't want to say

> eating disorders in general because they're very different. But, especially the people you're close with, and close to, it's very obvious that something's wrong. And then it feels increasingly like you're being watched too. Then your habits start being watched. And so it's no longer a secret. (P9)

For several participants, the struggle with the ED brought them to a point where they felt they had lost all hope. Many contemplated suicide and some attempted. One participant described a moment when she felt that the ED had destroyed everything in her life. She had composed goodbye letters to her family members because she decided it was time to give up.

> I remember crying…I cried a lot, I couldn't sleep. And I remember no joy. There was no, no, no more joy. And that's it…I remember writing my letters. I remember crying a lot as I was writing my letters, and that was the feeling that I had. It's… "I gave it the best I… I gave it the best I could, and I've come to terms with the fact that, for me, it's never going to get better. This is… this is the way it's going to be". And "I don't want it anymore", you know? […] It was hiding… it was hiding all the time, and the shame…just in itself is nothing pleasant. (P17)

Fearing the eating disorder is stronger than me. Most participants reported, at some point, feeling like the ED had taken on a life of its own and that they were no longer in the driver's seat. They described being unable to escape its clutches; some portrayed it as an addiction. They explained that while they originally used the structure of the ED to regain a sense of control over their lives, at some point the ED had changed the rules, and they now felt at the mercy of its reign. One participant explained, "Something that I thought I was in control of started to control me" (P12). Another participant delineated how she felt completely powerless against the ED and its demands.

> It just turned into this massive problem consuming every moment of the day. So being able to tell someone, "Oh yeah, I ate food out of the garbage yesterday." You know? It's kind of hard to say [laugh] how insane…this disease drives you to do crazy things. I remember being so broke, I had no money, my parents would send me maybe 100 bucks every few weeks...because I'd run out of money from my job that I'd saved up from the summer. I just remember, I had like five dollars left for the rest of the week and I spent it on two bags of cookies...just so I could binge. It was ridiculous, "I only have five dollars for the next seven days because I used it up on other food!" It just doesn't make any logical sense but I've done so many...disgusting, horrible things, I couldn't even…[sigh].

> Now, I can talk about it because I don't do that anymore but in the time...to tell someone, "Yeah, I do this." You know? "And after I talk I'll probably go home and do it again." It's weird. To me, I felt like a drug addict or something. And I just...I don't think anybody wants to admit they're a drug addict. (P3)

Several attributed human qualities to the disorder, as though it was a separate being inside of them, and described it as underhanded and devious. Some felt betrayed, saying that it had started out as a companion that helped them to cope, but that it had become insidious and threatening. They described fearing that therapy would not be enough to combat the strength and massive power that the ED had become. Many worried that the ED had taken over so much of their "self" that it would be impossible to extricate.

> If you put up a mirror to it, realizing...what a dark thing it is - and how it really rages against the treatment. I think that...sometimes it really does feel like a divisive kind of internal thing. Where it's like, you know you need to eat, you know you need to treat-assess it, and look it right in the eyes...but it is so sneaky. It knows you so well [laughs] Because it's a buildup of habits and behaviours…and understanding...it knows you, I guess it knows me incredibly well. And it knows the trigger points and it knows how to get around treatment. And that's the hardest thing I think. Even if I finally had a full lunch, "Oh, I feel good about this", you know, "I did good...I'm responding well to treatment". Maybe I only feel good about it because I know - something in me knows that I won't eat properly later. It's already planned it. And it's become so good at it that there's that fear that maybe it's stronger than I am. (P9)

Another participant exemplified cycling through using control and losing control. She described how the ED had originally helped her to feel "in charge" but had eventually led her to feel completely powerless.

> I guess you could say subconsciously I was looking for more power in myself. But I mean the irony is that you don't have power when you have anorexia because you get entrapped in the disease. When you've been starved, people start thinking about things and acting in certain ways. I became obsessive compulsive, I cut my food into pieces, I had no idea why. You become entrapped in it. You're not gaining more power or any power really. I guess it is just a vicious cycle. (P4)

Participants feared that the ED had become an indestructible force and most felt powerless to take action against it. Many expressed feelings of confusion and betrayal that the system that had once provided them with structure and orderliness now bestowed chaos and disarray. All participants, in some way or another, relayed that the ED became so encompassing that it stripped them of their sense of identity.

Giving up my voice. Many participants talked about losing things that were essential to them as human beings. As they prioritized the ED over everything else, many found that friends, family, school, and important activities came secondary to its demands. Some, particularly after others discovered the problem, said they felt that the disorder became synonymous with them and how others perceived them. One participant elaborated on how every moment of her life was consumed with the ED.

> So definitely...everything...every single time I woke up in the morning until I went to bed at night, and even in my dreams, it was all about food. Everything that I ate...mattered. You know when I was really anorexic, I remember making an 800 calorie meal plan for every day. Eight hundred calories and that was it. And that was overestimating too...which was not to account for how active I was, which is crazy! So every moment of my life was about food. Every single moment. And being bulimic, you make decisions all of the time based on, “OK well I’m going to a potluck tonight so I’m going to have to purge after so I’ll just say that I’m not feeling well and I’ll leave early”. Every moment of your day is planned around that. (P3)

Several participants were removed from school and fell behind because they were placed in inpatient programs. Not only did they lose the sense of normalcy of progressing with their peers, but they lost friendships as others were confused about how to relate to them. One participant described the loss of an activity through which she had found joy for most of her childhood.

> I was part of the swim team in high school and...I was a really good swimmer. But because I lost so much weight and so much muscle mass [soft laughter]…I was competing...my times were not so good. I would also make up excuses for that, I would be like, “It was just a bad race; I was tired that day”. But the next time they actually didn’t get better, the following times, they just kept going down. So there’s that that helped because swimming was really, really important to me. It was...I think it was important during the eating disorder because it allowed me to exercise. But also, I remember loving it, from the age of seven. And actually I don’t like swimming

> anymore...it's interesting. But, yeah, I remember loving swimming. It was just so peaceful. And it stopped being peaceful because of the eating disorder. I would get bored swimming but I would keep on going just for the sake of losing calories. (P7)

Another participant, who had defined herself as an athlete, was forced to stop playing her sport because she was not physically well enough to compete.

> I was playing for the national team, and I was going to all these tournaments, and I had all these friends, I was doing really, really well in school…and then I collapsed on the field of a [sport] game and my coach was like, "You can't come back...until you deal with your issues...we can't have you on the field, it's a liability." (P2)

Critically, participants recounted that not only did they lose important activities and friends, but they began to lose themselves to the ED. Many became conflicted about their identity, who they believed themselves to be, presumably as a result of behaving in ways that conflicted with their values. Several felt that they had ceased to exist as themselves. One participant recalled that others began to call her "the eating disorder girl". Another said the ED was all she had, "I was dysfunctional… I was a dysfunctional human being because I was purging. It's not normal for food to be coming out. "You're broken". That's how I felt" (P17). Another participant explained that she came to recognize that she was no longer who she wanted to be.

> Also what was depressing, I was just ruminating about the fact that...it wasn't who I wanted to be. I didn't want to be the girl sitting in the corner at a party when everyone was laughing and dancing, which I loved to do before. So I think being so different from my ideal self or my old self helped me see that, well, I had changed. (P7)

The category *Losing control* comprised the three subcategories: *Getting sick, Fearing the eating disorder is stronger than me,* and *Giving up my voice*. Losing control involved experiencing physical and emotional consequences, having others witness their vulnerability, and losing important aspects of their identity to the ED. The core theme of pushing and pulling was ever-present as participants continually re-engaged in their efforts to establish control even when they knew it would perpetuate the downward spiral. Participants communicated that they felt caught in a cyclone of exerting control and then feeling out of control. The contributing conditions intensified the contextual factors, particularly *Believing I am inadequate* and *Struggling with self-regulation*, as participants experienced shame and helplessness at their failure to remain in control at all times.

Action Strategies

Whether they recognized it or not, participants played an active role in shaping their outcomes by the way they dealt with or did not deal with events that occurred in their lives. The action strategies represent the ways in which participants responded to their situation through action and emotional process. There were two categories of action strategies employed by participants: *Wrestling with motivation* and *Working through change*. Figure 3 (below) is a visual representation of the action strategies as they relate to the contributing conditions and the contextual factors.

Wrestling with motivation

Whether through witnessing the decline of their physical well-being, experiencing mental anguish and emotional turmoil, or being confronted by loved ones, all participants came to a point where they acknowledged that they were struggling. Although they may have accepted that there was a problem, the problem was often defined differently from the way that friends, family, or partners perceived it. Challenges with motivation were clear from the outset, with participants asking themselves questions such as, “Am I ready to do something about this?”, “Am I strong enough to deal with this?”, and “What will happen if I don’t have this in my life anymore?” There did not seem to be a straight route to treatment or recovery for anyone and nowhere was the push-pull dynamic more apparent. Most fluctuated between feeling powerless to change and having moments of hope where they felt confident enough to try something different. All mentioned vacillating between wanting to heal and rejecting recovery altogether. Not one participant talked about recovery as a linear process, and there was a continuous dialogue around the struggle with motivation.

Figure 3.Contextual Factors, Contributing Conditions, and Action Strategies

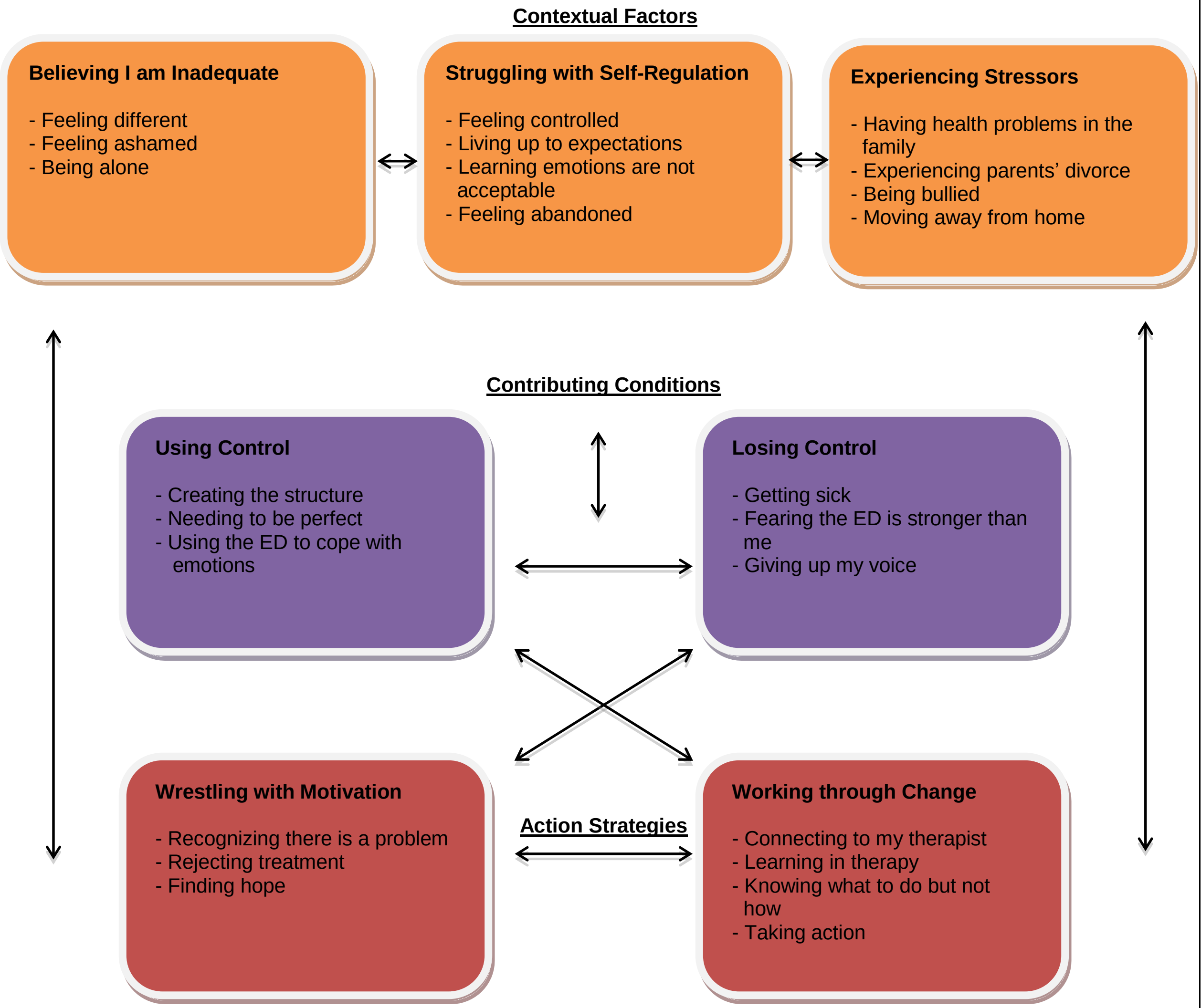

Figure 3. Major categories and sub-categories constituting the contextual factors, contributing conditions, and action strategies of the conditional matrix in the push-pull dynamic theory. The arrows between categories indicate the push-pull dynamic in the treatment and recovery process.

There did seem to be a distinction between those who chose treatment of their own will and those who felt forced or pressured into treatment. Those who felt coerced took longer to connect with the treatment process, if at all, and rebelled more aggressively. However, even those who chose it on their own elaborated on the challenges of remaining engaged. All participants experienced relapses throughout their treatment that were very de-motivating and frustrating. Some lost the belief that they were truly capable of implementing changes in their behaviours. Others were able to hold on to the hope that it "would not always be this way". Wrestling with motivation was comprised of three subcategories: *Recognizing there is a problem*, *Rejecting treatment*, and *Finding hope*.

Recognizing there is a problem. For most participants, the ED had to be confronted when they recognized that they were not able to function at the level they expected of themselves. There was a realization that they had pushed themselves too far and that they had reached a breaking point. However, concern for their health, for most, was secondary to the fear that they were not measuring up to standards in the areas where they were accustomed to excelling. One participant described how she was able to see that there was something wrong.

> When I finally decided that I need to at least start looking into getting some help was when I...was literally was not consuming anything during the day. Whatever I ate I would purge. And I was exhausted, I looked like crap. I was an athlete at the time, training nationally, and I still don't know how I kept up with practices [laughter]. And I think it was just all starting to hit me, all at once, I wasn't functioning well. (P12)

Participants spoke about the numerous challenges to seeking help, from the shame of admitting there was a problem to accessing treatment resources. Some spoke about the lack of publicly funded ED treatments available and how that hindered their progress. One participant explained how she felt incapable of continuing under the oppressive rules of the ED. Being told that she required treatment was almost a relief, however, hearing that she would have to wait was more than she could bear.

> So tired, and I remember, the first day, I was in [Dr.'s] office, that's the program that I was originally in, and he was like, "Yes, you need to be in treatment immediately", and I remember getting this feeling of [exhaling loudly], "OK". And then when he told me it could be up to six months wait, I literally burst into to tears, and I told him, "I can't do this anymore, I can't live like this anymore." (P8)

Although this participant accepted that she needed treatment, even sought it out, she further explained that once inpatient treatment had begun she felt threatened by the expectations of the program and firmly resisted changing her behaviour.

For all participants, ambivalence about getting help was apparent from the very beginning. Most sought release from their emotional anguish but could not conceive of giving up their methods for weight control; many mentioned being willing to give up certain behaviours, but not others. Participants talked about wanting to stop their suffering but not necessarily being ready to challenge their ED, particularly if treatment involved gaining weight. There was a constant battle between wanting to alleviate the distress caused by the ED and being unwilling to let it go. This dilemma represents one of the most critical aspects of the pushing and pulling theme and was also a major contributing factor to participants turning away from treatment. One participant, who quit after a few sessions, elucidated her struggle.

> I went in, I was really open-minded. I was like, "I want to change". But then they kept on focusing on how it was bad to be vegan and it just made me feel criticized. How I have to gain all this weight to be normal, but I just didn't… I don't want to gain weight, I was happy where I was. I just wanted the eating disorder to stop. I just wanted to be happy about the food I was eating…not focusing on eating cookies and stuff just to gain the weight back. That was the biggest deal for me…made me feel like the therapy was not… didn't have the same goals that I did. And it was hard to tell them that I didn't want to gain weight because that just sounds like a person with an eating disorder. (P15)

Another participant described her motivation to engage in treatment.

> My mom booked me the appointment. [Pause] I didn't want to…she didn't force me or anything. I went into treatment, but if I'm being honest I didn't want the restricting to stop. I just wanted more people to talk to. And also I guess I was just trying to fix - there was a problem with my eating, I was aware of it. But for me the problem that needed to be fixed at the time...it was more, why I was awkward during social situations, which is actually tied to the eating disorder. At the time, that's not what I wanted to fix. (P7)

Recognizing there is a problem did not necessarily lead participants to seek help. For some, it meant becoming more secretive, but for others it started them on the road to recovery. Most participants quickly learned that giving up the ED would be far more challenging than they had ever anticipated, particularly because they wanted the "problem" to go away but wanted to maintain many of their ED behaviours. Further, many found that matching their goals with the goals of their prospective treatment program to be an enormous stumbling block.

Rejecting treatment. All participants related being dissatisfied with their treatment at one point or another. Some rejected treatment altogether and others rejected certain aspects of their treatment, but accepted others. Many rejected it when they felt they were being coerced or pressured into treatment rather than choosing it of their own volition. Feeling forced negatively influenced their desire to remain in therapy, increased their likelihood of dropping out prematurely, and decreased their continued engagement in recovery after treatment. One participant presented her outright rejection of treatment.

> My family brought me home from college, put me in therapy. I was entirely uninterested, not willing to tell the truth, not willing to follow a meal plan, in no way wanted any part of recovery. I was, "When I'm done with this, then I'm going to move on, and I'm going to be fine on my own, I don't actually need any of this." (P1)

Another participant recounted feeling as though she actually got worse in the treatment environment. She described how she learned "tricks" to make it seem as though she was complying with treatment, and fooling the staff became a game to her. She would drink excessive amounts of water prior to her weight check in order to seem heavier than she was. Of course, the staff would test patients' urine prior to weigh-in to ensure that they were not "water-loading". However, she learned to switch out her pre weigh-in urine for her first-morning's urine (which would be more concentrated) and duped the staff into believing she had gained more weight than she actually had.

> There were lots of tube feedings, and we were weighed every single day. If you had…I think it was a variant of 100 grams from your target weight, you had a tube feeding the whole day. How are you supposed to not be focused on your weight when you have to make sure you're 100 grams close or you have a tube feeding all day long? And they would do urine tests. So I would take my pee in the morning, put it in a little jar in my purse in my bag. So when they would ask me to do the pee test, I would use…drinking water before being weighed, all this business. (P17)

After months and months of hospitalization, this same participant realized that she would only regain her freedom (to resume ED behaviours) if she achieved weight-restoration. She explained her decision to "comply" with treatment demands.

> I just told myself, "Do what they want you to do, and then you can leave." So … that's a bit how I went through it. I wasn't, "OK, how am I going to better my life?" No, no, no. I was, "Get it done and get out." (P17)

Several participants, particularly those who were too young to legally object to treatment, described the environment as controlling and cold. Some recounted being followed to the bathroom, being forced to finish their meal, or being put on bed rest so that they could not walk or exercise. They characterized these experiences as a waste of time; they articulated not understanding the point of treatment or feeling as though they were being kept in the dark. The worst part, they expressed, was not being informed about what was being done to them. These negative experiences led them to feel discouraged and made them lose hope and trust in their treatment providers. They felt, at times, as though they were objects to be observed and monitored rather than people who were being supported or helped. One participant depicted her dislike and distrust of the process.

> I always felt like I would go into the room, they would stare at me, ask me what's happening. I wouldn't really respond very...openly about that. But they wouldn't do anything. And then I just felt like they were staring at me for a few minutes and then I would just be like, "OK", and then she would be like, "Come back in two weeks". I felt like I was just travelling there just for them to check my weight and my vital signs. (P14)

Another illustrated how she felt disrespected and dehumanized by her health care provider.

> You know what my psychiatrist used to tell me when I would come in for my weekly visits or whatever? [switches to French] "Embarque sur la balance, on va voir comment ça va." [Step on the scale and we'll see how you're doing] And I was like, "Ask me how I'm feeling!" Don't look at the number on the scale to determine how I'm feeling. (P17)

Some participants explained that their lack of engagement resulted from inappropriateness on behalf of the treatment teams. One participant noted that many assumptions were made by the team that their choice of treatment would be effective and beneficial across cultures. She recounted an experience which led her to feel ostracized and humiliated, and she expressed that the treatment as a whole was more damaging than helpful.

> I remember when it came to the family therapy - that was really difficult because not only did I not have any idea what was happening but my parents didn't even know what family therapy was. They thought this was a meeting for them to tell the therapist all the things that were wrong with me [laughter] and I remember they were going on about all of the terrible things I've done. It was just really odd and awkward and I remember I was very uncomfortable sitting on the chair because I was very thin and the bones from my bottom were really hurting me. I was really uncomfortable and I really sat in a kind of cocoon and crouched situation and I didn't realize it until they pointed it out to me. But that's how I felt. I was really uncomfortable and I really felt anxious about talking about things and answering their questions. And then having my parents, who I was little embarrassed about, say strange things to them. And my mom in her broken English…it was just a bit of a weird circus. […] Honestly, when I think about my dad now, I'm not even sure he realized he was in therapy [laughter]. […] Like psychology, psychiatry, the concept of the human mind having disorders…were all something new to them. (P4)

Numerous participants divulged that they agreed to take part in treatment because they worried about the strain of their situation on loved ones. In most cases, even if their symptoms improved, gains were not maintained after their treatments were complete, and relapse was a disappointment for everyone. One participant explained that she engaged in treatment because she hoped that it would alleviate her mother's distress.

> It was pretty emotionally scarring…to see someone that worried. I mean I sort of associate it with disappointment more than anything...not anger. She already had enough going on...my dad was still sick at the time. There was enough going on that she didn't need that on her plate on top of it. But then again I know she was doing it for me, she didn't want to lose me and she wanted to make sure I was healthy. But I definitely did it because I felt badly. I felt she was disappointed and this would make her prouder of me. (P12)

Another participant explained how she complied with all of her treatment demands while her mother was in treatment for cancer.

> During that time, when I was in the hospital, I was really upset that I would do this to my mom and I felt very horrible about being selfish and about wanting these things. So I did whatever the nurses and people at the hospital wanted me to do. There were some girls who had a horrible time and would run away, and jump on the train, and throw food, and lock themselves in. And I was very obedient. I tried to do whatever they wanted so that my mom could be happy. So I got to the minimum weight but I still didn't menstruate, I was still pretty thin. (P4)

Most participants revealed that one of the biggest challenges to getting well was that they desperately feared life without their ED. They related that much of their refusal to engage in recovery was about being terrified of letting it go. Most had never lived as adults without the ED and it felt too disconcerting to try to live life without a structure that clearly delineated "good" and "bad". Some feared that others (e.g., parents and therapists) were trying to take their safety from them. They felt very threatened by others, who they understood were trying to control them yet again. One participant shared her reluctance to let others in to her private sphere.

> That's been my biggest internal resistance to the treatment. Even, for example, the food log practice...taking food journals. At first I faked it a little bit [soft laugh] because I don't want...this is my private world. That's something that was good to talk about in the group therapy was, how we all...this was our little secret. And then the way that some people describe it, it's like a friend you make for yourself, a companion almost that's like simultaneous to you. And it's protective of you but you're also very protective of it. That's the kind of dangerous vicious cycle. (P9)

Another participant justified her need to hold on to her ED as a form of regaining control and because of the purpose it served in her relationship with her parents. She had been through a treatment program, understood the function of her ED, and decided that she still needed it, albeit in a smaller form.

> Some days I don't eat very much or I'll drink too much coffee or I'll smoke drugs, and that's my mini rebellion. At the end of the day, I'm not going to run five thousand kilometers, or only eat lettuce. Because coming out of program, I was like, wait a second, if I want to keep having a life, and being who I am, this has to be a very minimal problem in my life. I mean...I still keep my eating disorder as a comfort thing, and the fact that it's still pretty big with my parents. When they come to visit, because they don't see me very often, the first thing they worry about is food. So, at least when they come, I'm like, "Well, the eating disorder hasn't gone away entirely". I've still got it in my pocket if I need it and stuff like that. So I think that's kind of been my coping mechanism…it's there if necessary. (P8)

Finding hope. Finding hope involved feeling ready to start doing things differently. Most participants described transient moments of feeling hopeful, and for some, they occurred more often than others. For those who had found some hope, their language tended to shift from talking about "illness" to talking about "recovery". They reported wanting new opportunities for themselves and began pondering how life could be different. Several mentioned wanting to start a family at some point in the future and recognized that it may be very difficult to get pregnant and carry a child to term with their ED behaviour. As they felt more hopeful, participants relayed the belief that change was feasible and expressed they were regaining a sense of agency that had been lost. They began entertaining various possibilities for the future and felt that they had developed enough confidence that they might be ready for life without an ED. One participant spoke about what it felt like to truly engage in treatment for the first time. She had been in treatment on and off for nine years.

> For me, that sort of realization that I don't have these resources. I have one and a half semesters left of my program. Then I'm going back to the States and there is no more treatment. There is no insurance. There's very few insurance companies that will: 1)

> cover pre-existing conditions, and 2) cover an eating disorder, explicitly. And the other is….I want to have children. And my mom...this is in part a reaction to her. Oh god, I can't do this to my own children. There's no way: 1) I could carry a child to term healthily with this kind of behaviour, and 2) there's no way I could raise a child to be a healthy adult like this. And so all of a sudden I became very motivated. (P1)

Another spoke about her dreams of having a family.

> Since I'm very, very little, it's like a dream of mine. And I'll be so happy the day that I'll be pregnant. I'll be happy throughout my pregnancy. I want to be a wonderful mother, and build my child's self-esteem. I love being with kids. And so I put it on my fridge. I did a little drawing of a pregnant belly [laughs]… put diamonds around it and I wrote [switches to French] "Le rêve, un jour," [the dream, one day]. And it's on my fridge. Because I'm 33 now, and I know that, come forty, it's not…your eggs are not…as fresh [laughs]. So I have a bit of a time constraint. So I'm like, "OK, you've got to put things into place in your life now to bring you toward what you want, where your dream is at…my ultimate dream." (P17)

Recognizing there is a problem, *Rejecting treatment*, and *Finding hope* were the three subcategories that made up the larger category *Wrestling with motivation*. Wrestling with motivation was, at best, an uphill battle. All participants wanted something different for themselves but grappled with how to achieve this without their ED. Often, although they sought release from the ED's grasp, they simultaneously clung to it and resented others for trying to take it from them. The contextual factors and contributing conditions pushed and pulled against participants' ability to feel hopeful and to engage meaningfully in treatment. Nonetheless, within their action strategies, participants pursued their recovery process and made efforts to work through change.

Working through Change

Participants talked about many different factors in treatment that led to the impetus to start making changes. All participants mentioned the critical impact of the relationship with their therapist on their treatment, be it positive or negative. They elaborated on the many different things that they learned in therapy and how these new skills helped them participate in change.

In contrast, many participants spoke about their frustrations that developing insight, while helpful, did not seem to be "enough" in order to make changes. Importantly, actively making changes outside the therapy office was the factor that contributed most significantly to participants feeling like they were moving forward with their recovery. Working through change was comprised of four subcategories: *Connecting to my therapist*, *Learning in therapy*, *Knowing what to do but not how to do it*, and *Taking action*.

Connecting to my therapist. Most participants had been through more than one treatment program, and therefore had experiences with multiple therapists. Over half of participants described having a significant positive experience with at least one therapist. Working with this therapist was, for some, the first opportunity to be in a safe and dependable environment where they were able to disclose things about themselves without fear of judgment or consequences. In connecting to their therapist, they developed an ability to trust that often spread to other areas of their lives. One participant described her therapists' response when she disclosed her self-harming behaviour of cutting. Although she experienced a great deal of shame around this behaviour, her therapist's non-judgmental reaction helped her to let go of the need to self-harm.

> My counsellor was always like, "I don't think you should be, but if you do, make sure you're safe and make sure you clean so you don't get infected". He would never…I feel like if you try to take something away from someone…they just want to do it more. That helped, because I ended up… gradually, I started doing it a lot less. […] He never judged me, and that was one thing… I don't trust people. Once I started talking to him, I gradually came to trust more people. Don't really know how that happened. It's just because I guess I told him more, and it was less that I was… keeping everything in, and then it just kind of became a lot easier to tell people or talk to people. (P18)

One participant spoke about feeling as though her therapist truly "got" what she was going through and described how that helped her to feel understood. The therapist disclosed that she herself had recovered from an ED. The participant expressed how the disclosure gave her hope that recovery was possible and, furthermore, she felt that her therapist would appreciate how very challenging the process could be.

> One, it signaled recovery is possible, “Look I’m a successful human being and I’m OK and this doesn’t torture me every day anymore”, and, two, she also understands what it’s like to…because if you look at it this has been my religion, my system, my code of ethics and guidance that shapes almost everything that I do. Losing that is really threatening, and so, it signaled to me that she understood like what a giant thing it is. (P1)

Another participant described an act of kindness by her therapist that made her feel cared for and supported.

> With therapy last week, I had to cancel an appointment because I had school and I was going to try to work something around it but it didn’t end up happening. My therapist called the day before asking if she stayed later in her workday to see me, if I could make it. Which, I mean, if I want to spin it negatively [laughter]...she’s getting paid to be there anyway. But at the same time she didn’t have to go out of her way to do that for me...and that, I found, was huge. (P12)

One participant described how her current therapist had empowered her through offering her options about medication intervention. She explained that she had never before been consulted about what choices she might make within her own treatment. Being consulted helped her to feel included in her recovery and helped her to trust that she was a capable and competent contributor in the process.

> Her giving me the choice for medication was amazing. It’s the first time anyone has ever said you actually have the right to refuse this. That was awesome. And not even refuse in a way that’s being defiant. It was just like, “Oh, I acknowledge these are really heavy side effects, you have to get your blood checked, there are risks. Here are some options”. […] Because it completely gives you back your agency. And that has been the best part because then you’re not coming at it from a place of resistance or defiance or this skewed power relationship. (P1)

While many experienced a positive relationship with their therapist, a significant number of participants disclosed that the relationship with one of their therapists had a negative impact on their desire to move forward. One participant explained that her negative feelings toward her therapist resulted in her leaving treatment after just a few sessions.

> I don't think a psychologist should just stare at someone. And she was like, "I think something is really wrong with your head" or something. She was like, "I think something has gone...", because I didn't remember something or I misinterpreted what she said. And then I felt like, "I can't do this anymore…I don't need you telling me that I'm mentally retarded or something". And she was very, very stern and I just felt so uncomfortable. So after a while just sitting in that room, just quiet, and she was just staring at me and I was like, "I'm not doing this...I'm doing this by myself." (P14)

Another participant was still attending sessions but was not able to feel a sense of connection with her therapist. She described feeling alienated and closed off and this affected her desire to engage in sustained change.

> I closed off from her because I don't, I mean, just perfectly honest I don't particularly like her that much. But I know she's trying to help me and I couldn't see that for a while. There is this impersonal aspect to it that I struggle with. I don't feel fully connected and I feel, and I'm not saying she is…and it might be I'm crazy but I feel I'm being judged a lot of the time by her. […] But that's the biggest thing I'm struggling with…is that I don't feel that personal connection. (P10)

Whether positive or negative, the relationship with one's therapist had a major impact on participants' desire to pursue the work of therapy. For some, feeling that sense of connection was what helped them to work through change even when it was difficult. For others, not being able to connect with their therapist was yet another confirmation that other people should not be trusted and this left them feeling alienated and alone.

Learning in therapy. All participants talked about the various things that they had learned or were learning through their therapy, from recognizing triggers to skill-building. Most recounted developing awareness and insight about what made them vulnerable to the ED. They reported focusing on numerous kinds of skills, such as assertiveness, mindfulness, being able to tolerate and process emotions, and exposing themselves to anxiety in a safe environment. The things they learned in therapy facilitated their ability to start effecting real change in their lives.

Several participants spoke about the usefulness of food logs in therapy, specifically, using a journal to document their emotions before and after eating. Becoming more aware of the impact of emotions on their eating helped them to understand their ED, to be better prepared for potential triggers, and to cope more effectively. Through examination with her therapist, one participant discovered that her ED had roots in her self-perception. She said, “A lot of my eating disorder was really based in feelings of self-hatred or feelings of inadequacy and being perfectionistic and stuff like that...more than feelings of needing to be thin or conform to a specific body image” (P13). Comprehending this helped her to separate eating from her emotions and to deal more specifically with the underlying issues.

Another participant explained how she became aware of the restriction/binge/purge cycle. Developing awareness facilitated her understanding that she could not simply choose to give up certain parts of the ED and keep others.

> Because in my head at the time…I guess I still wanted to restrict. So sticking to a meal plan was counterproductive to what I really wanted to do. That’s what’s very paradoxical is you want to get rid of the bingeing but you’re not at the point where you understand that in order to get rid of the bingeing you need to get rid of the restricting. […] Now, I fully understand how the restriction leads to the bingeing but at the time I had no clue. […] It took me a while to understand the connection between the two. I saw it as a loss of control and…I tried to make up excuses because I didn’t want to see that it was linked to the restriction. Because I guess my first thought about it was like, “OK I’m going to get rid of the binge and then I’m going to come back to the restriction”. So I didn’t want to look, I didn’t want to see connections between the two. (P7)

One participant experienced such severe social anxiety in her youth that she felt she never developed appropriate social skills. She explained that learning these skills in therapy helped her to feel more confident and capable in her everyday life.

> I didn’t have adequate friend-making skills. I learned that with my last therapist in two years. We would talk about, “This is what friends do, they meet each other and sometimes they have small talk and sometimes they don’t...and they share things with each other and this is how you can make friends”. I found it mind-blowing…but being explicitly taught this is how you make small talk. You know? I had none of that. I had no idea. (P1)

In addition to individual therapy, group therapy was a significant component of most participants' treatment process. The majority of participants were very reluctant to partake in group therapy at first, perhaps because of social anxiety or the fear of judgment. Despite their reluctance, most participants specifically pointed to group therapy as a vital experience in their treatment as a whole. One participant expressed, "It's one thing to talk with your therapist…it's a different thing to talk with your peers who are going through the same thing as you" (P7). For most, knowing that they were not alone and experiencing empathy for others helped them to be less judgmental of themselves. Many participants described group therapy as the first place where they were able to be genuine and to let go of their façade; revealing secrets and letting go of shame.

Learning to process emotions was mentioned by most participants as a central aspect of therapy. Most had grown up in environments where emotions were viewed as unacceptable or intolerable and so even acknowledging emotions was challenging for many at first. One participant relayed how she learned to tolerate anxiety by voicing her feelings instead of avoiding them or ignoring them. Becoming skilled at expressing her emotions helped her to be mindful that her anxiety was temporary and would not destroy her.

> I learned how to calm myself after an anxiety attack, and close my eyes and breathe, breathe, breathe…they helped me through that too. As you're putting on the weight, it gets hard to be in your own skin for a while…really, really hard, especially when, me, I gained my weight rapidly enough. I think I put on 60 lbs in three months…quick enough. And for a while you're just really, really, really not comfortable in your own skin. But it helps talking about it, I learned that much. Talking about it, even if it doesn't make it go away, just talk about it and [exhales]…it's like you're letting go a little bit. It keeps coming up…keep talking but say, "I find it hard, I find this hard right now". And it's not going to make it go away, but it's said. Once it's said, I'm like, "OK, [exhales deeply] OK." (P17)

Another participant specifically told her therapist that she would not discuss the emotions surrounding her father's death in her first attempt at treatment. It was only in a subsequent effort at treatment that she learned that accepting those emotions helped her to explore the purpose of her ED. She came to understand why it developed and how it helped her survive through such a challenging period in her life. Developing insight into its purpose enabled her to find more effective ways to cope when she felt overwhelmed.

> It's been so far, much harder than the last time. It's much more me having to think about my emotions that I don't face [soft laugh] and it's a lot about...talking about my dad and when he was sick, and...when he passed away...not dealing with those emotions. It's all kind of... everything is kind of bottled up and now with the added stress of school and finding a job, there's no more room for things to be hidden. So they're...all my emotions are kind of coming out in every which way, mostly with the eating disorder. (P12)

Exploring the function of the ED made it possible for participants to consider other strategies for getting their needs met. After almost two decades of treatment, one participant found the most valuable strategy for dealing with her ED at an addictions program.

> I stopped using and I haven't…it's been over a year now. And I haven't done it since. And what really helped me, and it also helped with my eating disorder, in this therapy, which is different from going to [hospital ED treatment centre]… I was telling you, we do the same psycho-ed, and [switches to French] c'est redondant. [it's redundant]. We talk about food - we're not talking about the real stuff anyways while we're talking about the food. But at this program, what we had to do at the end of each day, we had a little journal, and you would write down, "Am I at risk of using tonight? If so, to what percentage?" And then [switches to French] "C'est quoi le vrai besoin?" [What is my real need?] So it made me stop, every single day I would have to think about, "OK, if I'm at a risk of using at a 9 out of 10 tonight, what's the real need?" So it made me…pay more attention to what my real needs are and then find a more adequate way of responding to my need. Because going to use is not really responding to your need. And I would do it for coke, and I would do it for the bulimia too. So I kind of did the two in one, while I did this program. And of all the treatments I did for eating disorders, this treatment for drugs was the one that helped me the most with my eating disorder. Just asking, "What's your real need?" (P17)

Developing awareness, working on new skills, discovering triggers, learning to tolerate and express emotions, and being able to trust others were all important components of *Learning in therapy*. Engaging in each of these new tasks required willingness on behalf of participants, as they were in previously unchartered territory. For example, participants were not particularly eager to try new skills that were anxiety-provoking, but they pressed on because they had begun to value what treatment could offer and they hoped that pursuing this course would lead them further on the path to recovery. However, the pushing and pulling dynamic was always present. Even as participants pushed themselves to move forward, many articulated intense disappointment and dashed hopes along the way.

Knowing *what* to do but not knowing *how* to do it. In making efforts to change their behaviours, many participants questioned if their treatment would be “enough” to help them get better. Some expressed deep frustration with therapy as they hit a number of very large roadblocks. In engaging in the therapy process they had developed insight, awareness, and knowledge about *what* they needed to do in order to move forward with their recovery. However, frustrations flared when they felt they did not know *how* to follow through with the plan. For example, many participants expressed that they learned to recognize when they were feeling upset or angry. It was another challenge altogether to tolerate and accept those emotions when they arose. Other participants spoke about being able to implement the treatment plan effectively when they were in a structured setting, but not alone. One participant conveyed her doubts.

> It’s like you *know*…but you don’t know what to do with it. It’s like, “OK, I’ve discovered it…now what”? Some therapists will say, “Well, you know so you can play on your mindset or the way you think”. It’s not that easy. (P19)

Another participant delineated the disconnection between knowing and feeling. Logically, she knew all of the steps that needed to be taken in order to get well. She explained that the missing piece for her was being able to tolerate the emotions surrounding taking those steps.

> I find it infuriating when people are like, “Just eat”...or give you meal plans. I understand what you want me to do. I can tell you the calorie count of every known food in the

> universe, and I know what a serving size is, but, I have found the lack to be an appropriate education about how to deal with those feelings that arise when you're participating in orderly eating. I understand what you want me to eat but you are going to need to hold my hand when I freak the fuck out about eating it. Because, that's- oh my god- that's the biggest...that's what I'm really struggling with now. (P1)

Yet another participant described her struggle with implementing the tools that she learned in therapy. While developing insight was helpful, it did not seem to be sufficient to get her to take different actions.

> I think it gave me insights. I think CBT was great in terms of it gave me insight and it gave me tools but whether those tools could be effective was a question. Whether my insight could be effective, that's another question. I like being able to see, and kind of make sense of myself and my actions and my thoughts... But changing those things was a whole different matter. I knew what I needed to do but *doing* it was so different. And doing it was so difficult. When you step back you think this is what normal people do but for me it was like a mountain. I couldn't deal with it. So, it was just really...I mean, obviously, I'm still here today dealing with this. So, I think it was effective in many, you know, in terms of giving me insights and what kind of tools to use, but, it has continued to be hard for me to actually use those tools. (P4)

Participants felt discouraged when they encountered the limitations of change. It seemed unfair to them that one could spend years in therapy working through certain challenges only to realize that some things are impossible to change. Participants discovered that while they may be able to change things about themselves, they would unlikely be able to make changes to their families or to society.

> I feel like every single time I do seek treatment, it's like, treatment's not going to change other people. It only changes how you look at situations but I feel like I've never quite gotten over my family situation. Even though I've talked about it all for many, many years, I just have never quite moved on from it. (P2)

Accepting the limitations of treatment was frustrating and demotivating for participants. Some became stuck and their aggravation hindered their momentum. Others decided that it was necessary to take action, to try things differently, and to take risks on their own.

Taking action. About half of participants demonstrated the critical impact of taking action outside of the therapy office. Interestingly, these were the same participants who spoke about themselves as though they felt they were on their way to recovery. These participants had begun to internalize their reasons for change and connected with the value of life without an ED. They indicated feeling ready to take small, consistent steps to challenge their rigid systems. One participant illustrated how she began building up her confidence to change her behaviour by making minute, almost imperceptible alterations.

> If the ideas aren't implemented in everyday life then they never will. I can talk about all my food issues all day everyday but if I don't...even if it's something so minuscule. I normally didn't eat breakfast, so I started just having an apple or even celery during breakfast. Just eating at that hour, even how tiny that was...after you have an apple a day for breakfast, you go, "Oh my god I did that". It may seem really stupid then, you're like, "Why am I doing this?"... but after a couple of weeks of having celery sticks during breakfast, you go, "Oh my gosh, I did that, and I was OK with it". So you can build up to it. (P2)

Another participant noticed that she was mostly grazing throughout the day instead of eating full meals. For example, she would ingest small portions of vegetables, fruits, or a handful of nuts several times a day. She remarked that normalizing meals made an enormous difference on her mood and in her ability to concentrate. Even though breaking out of her cycle was difficult, it had a large influence on her feelings of hope that things could change.

> It's always hard getting out of...when you're in the habit of doing something, that initial change, but having big meals I constantly felt better. I was saying to my boyfriend, you know, "I'm trying to have more structured lunches", and I just felt better throughout the day. I think it was just what I was getting out of it...doing that was the biggest motivator. I felt better. I felt better able to concentrate. (P16)

Several participants talked about challenging themselves to explore what life might look like without an ED, even when that felt frightening. Taking action often involved taking risks, ones that felt uncomfortable but enabled them to stretch the boundaries of their strict rules. Most delineated the significance of setting goals in order to help them move forward. In addition to goals, they built what many called a "toolbox" of skills so that they were able to draw upon those skills when they encountered distressing situations. Some spoke about "living life", instead of letting the ED take over. For example, one participant noticed that she had changed when a friend came to visit her from out of town. They were able to do what they would normally do together, such as have a meal or go for a walk, things that were unthinkable at the height of her ED. She described some specific elements of the treatment that she actively used on her own in order to make changes.

> There's a couple of specific things from treatment that have been helpful. Mechanical eating, just eat, just f-ing eat it [laughs]...basically is the internal kind of monologue. And a phrase that the psychologist gave me is like, "Food is medicine…you need it". So it hasn't reached the point of, "Oh, this is really enjoyable", it's, "You have to, you need this". And distractive methods. And I've been trying to make the self-talk more positive. As opposed to, "Don't be stupid" to, "OK, now it's dinner time and you are going to make this for yourself". And I find that talking myself through has been... Slowing down, because that's another thing, I'm kind of an anxious, always on the edge of my seat, ready for the next thing. And what I've had to do is kind of slow that down, but like really rein it in. (P9)

An important treatment focus for many was the need to accept themselves as worthy of a different way of life. The contextual factors (e.g., feeling inadequate) pushed against this change and tried to pull participants back to the belief that they did not deserve to get well. A skill that some participants mentioned was learning to self-soothe in times of distress. Actively choosing to use skills instead of resorting to their typical way of dealing with things (i.e., with food) made a big difference. Several participants related that changing their "self-talk" and developing self-compassion had an impact on their levels of self-acceptance. One participant explained the process of changing her self-perception.

> When I'd look in the mirror before, I would be very critical. It's like, "What is not right? What do I have to fix? What do I have to get rid of?" And at one point, I just told myself… I would write quotes, positive quotes and plaster them around my walls, to try and brainwash myself. "Love yourself", "Be kind", things like that. I told myself once, I said, "OK, if you can't give yourself a compliment, maybe that's too much to ask, but at

> least don't degrade yourself. Look in the mirror and stay neutral. Don't even say anything…but don't say something bad." And that was already halfway to acceptance when I stopped beating myself up and degrading myself. (P17)

Participants outlined their strategies for *Working through change* within the four subcategories, *Connecting to my therapist*, *Learning in therapy*, *Knowing what to do but not how to do it*, and *Taking action*. Through the ups and downs and pushing and pulling, participants challenged themselves to trust, learned knew skills, and most importantly, took actions in their everyday lives. In each of the categories, *Wrestling with motivation* and *Working through change*, participants described their struggles to move away from the ED and toward a different way of life. These action strategies were up against the powerful forces of the contextual factors (e.g., negative self-evaluation) and contributing conditions (e.g., control). Most participants revealed that they took many steps forward, only to take many steps back, and then to pick themselves up all over again. The utter strength and perseverance among participants was truly astounding. For some, their determination led them to experience some of the positive consequences of recovery.

Consequences

Experiencing Connectedness

In working through the process of recovery, participants spoke about building a sense of connectedness. They elaborated on developing the ability to feel connected with other people: to build trust in friendships, to be in healthy romantic relationships, and to feel acceptance about the relationships with their parents and family members. They detailed an emerging sense of connectedness to themselves, a burgeoning sense of identity, and a connectedness to what they may want for themselves in the future. They talked about coming to accept the difficulties and challenges in the process of recovery, and accepting some of the things about themselves that they may previously have found unacceptable. In finding connectedness with themselves and significant others, many of the participants also spoke about having a sense of connectedness to those who may be suffering in the same way that they were. Further, many expressed that their decision to participate in this research project stemmed from a desire to help others, to work toward a solution so that someone else may not have to go through what they had been through.

Not all participants had reached this place, some were still struggling with motivation and change, and a couple had cycled back into control issues. While some participants may not have described themselves as having reached this level of connectedness, they spoke about it as a wish or a desire for the future. They talked about connectedness as the next step that they needed to take. The *Experiencing connectedness* category was comprised of: *Accepting the process*, *Learning to be an adult*, *Connecting with others*, *Finding myself*, and *Turning it into something good*. Figure 4 (below) offers a visual of the Consequences, Action Strategies, Contributing Conditions, and Contextual Factors and how they relate to one another.

Accepting the process. About half of participants had come to accept that recovery from an ED was an ongoing process, one that consisted of numerous trials and pitfalls. Some participants spoke about acceptance as something they were currently engaged in and others spoke about it as something they aspired to; a direction they knew they needed to head if they wanted to move forward. They talked about wanting to shift their focus from living in the extremes to searching for balance and moderation. Several were making efforts to let go of the shame and guilt they had held on to for so long. Accepting the process involved challenging their previously held system of beliefs and required adjusting expectations of themselves and others.

Figure 4. The Push-Pull Dynamic Theory

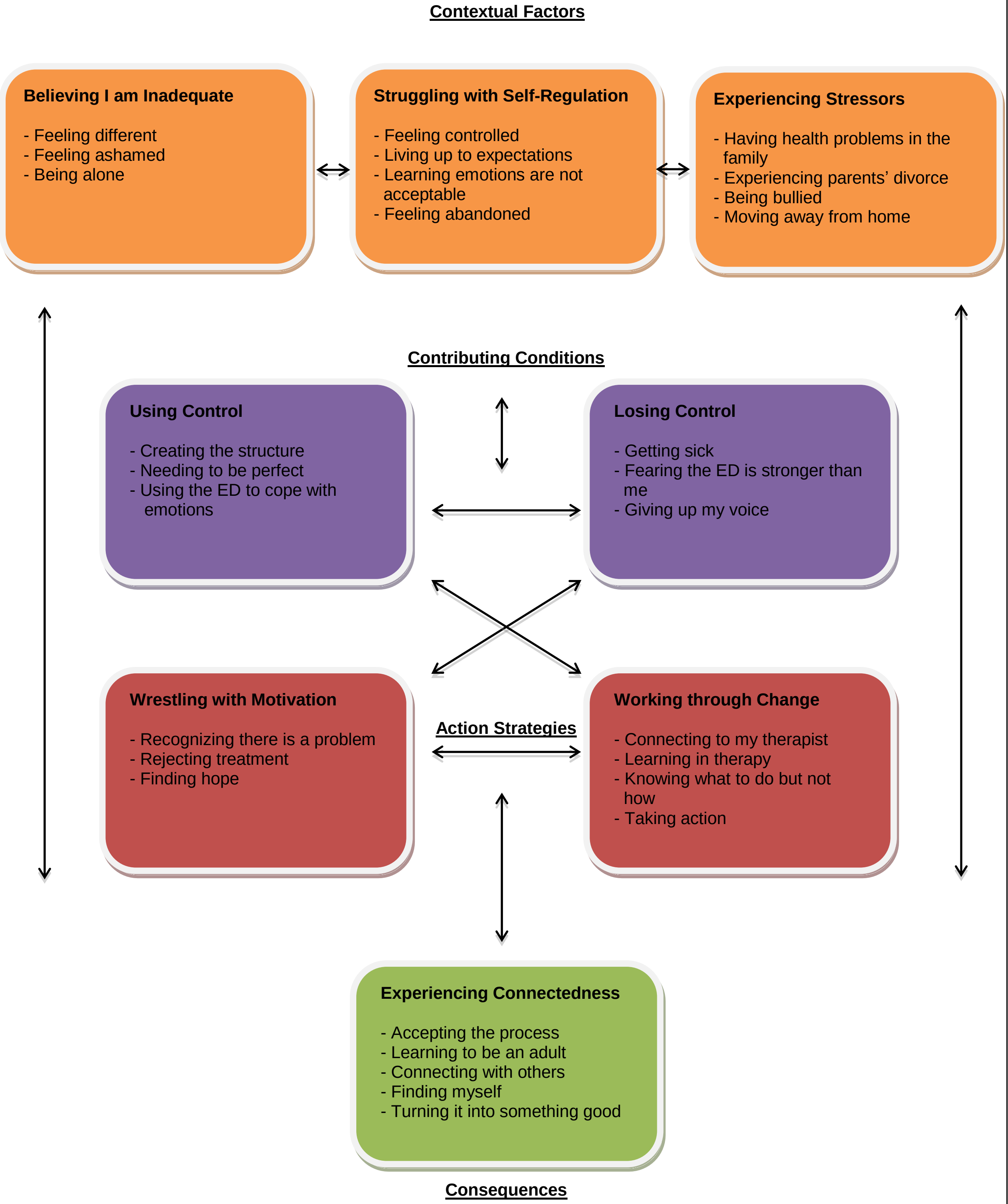

Figure 4. Major categories and sub-categories constituting the contextual factors, contributing conditions, action strategies, and consequences of the conditional matrix in the push-pull dynamic theory. The arrows between categories indicate the push-pull dynamic in the treatment and recovery process.

One participant revealed her excitement when she realized that she had created the rules and so she could also break them.

> [Sighs and pauses] I realized that I had created a whole bunch of rules, not even just in terms of food but my whole life…I would make rules. And realizing that - start breaking the rules! Start shaking them up a little bit! I would have rituals when I would eat and so shaking it up a little bit - break the rules to realize you can create whatever rules you want. At one point I told myself, "It doesn't have to be this. You can…decide. It can be anything you want." (P17)

Although the thought of creating new rules felt exciting to some, it also meant that it was no longer simple to determine if one had lived up to expectations. Breaking free of the rigid structure and loosening the control was liberating but also very frightening as the categories of "good" and "bad" would become blurred and imprecise. Participants felt pushed and pulled as they sought to make their expectations more realistic so that they would not judge themselves as harshly as they once had. This was an especially difficult task because they feared that shifting their expectations, even slightly, would result in "falling off the rails". They were terrified that if they allowed themselves some lenience they would turn into failures. Finding the willingness to risk making those changes differentiated those who continued to progress from those who felt stuck.

Participants worked toward letting go of expectations of themselves, but also expectations they held of others, in order to move forward with getting well. Some participants mentioned that through their treatment they had learned to forgive others and to let go of anger and resentment. Several participants began seeing parents and caregivers with compassion. They recognized that although they may not have made the same choices, they understood that the other person did the best that they could under the circumstances. One participant explained that she had worked on letting go of her disappointment about how she was not able to talk about things in an open and honest manner with her mother. Holding on to the anger was keeping her stuck and she wanted to accept reality rather than continue to waste energy pining for something that was not possible.

One participant described her changing attitude towards eating. She would no longer allow herself to restrict food and she explained how this helped her to stop her binge/purge cycle.

> I haven't made myself binge and purge for two months. […] I just allow myself to eat what my body wants to eat and I don't feel guilty about it. And if I'm really hungry, I eat a lot...it's no big deal. And if I feel really full one day I don't do anything about it that's unnatural. I just sit with the full feeling like normal people do. And I just don't obsess about food anymore. I don't let myself think about calories and I don't let myself read the calorie labels. I try to eat as healthy as I possibly can, but I mean...if I have a cheeseburger, I don't have ten. I'm fine with having one because I allow myself to eat that should I want to...every day, if I wanted to. I have a little bit of chocolate every day and so because I allow myself to be OK with that it's not a "do or die" situation with food. It's not like I'm never going to be allowed to eat this again. I can have pasta today, and tomorrow, and the next day...so I don't need to eat seven servings of it right now. (P3)

This same participant relayed that each time she would attend her supper support group, she challenged herself to eat things on her "bad food" list, in effort to break free of her tightly held food rules. She pursued even in the face of weight gain, which had previously been the most terrifying consequence of all. She explained that she made the choice to accept her body and to live through the discomfort that this raised. This is what made her confident that the ED no longer had control over her.

> I started challenging myself every time because this past fall, I was like, "I really need to take this more seriously, I want to get over this". So I was like, "What do I always purge on, or binge on all the time?" So I started bringing foods that I had really big problems with. I started bringing pasta with creamy sauce on it, and cheese, and I just...had to sit with that after. And I realized that nothing bad happened after. I was fine. I had a lot of stomach cramping at the beginning, but I was fine. The end of the world did not come because I had pasta, or a cookie. And it made me happy, actually. I just woke up feeling happier because I'd eaten the day before. And so I was feeling positively about it and my body was starting to feel better about eating. So, I think that's probably why, like all the positive effects of it. However, it was difficult because I have gained a significant amount of weight. I mean, since I started the program...and specifically in the last two/three months that I've been eating normally. I've gained about 15 pounds which is really difficult when you have an eating disorder...to gain weight. It's so ironic. [laugh]

> So, that's the only thing that's been really bothering me but...that still doesn't make me restrict food. So, that's when I know that I'm really getting over it. (P3)

Accepting the process meant trusting themselves; trusting that they were strong enough and trusting that they would survive the risks and challenges. Many talked about the realization that change was difficult and was not always rewarding, but that pursuing change even in the face of challenge would bring them to a place that they wanted to be. One participant, who had a developed a great deal of awareness throughout her treatment, was just at the precipice of taking risks to do things differently. She elaborated on what would need to happen in order for her to start making some changes.

> [Pause] I think it has to start with me, I mean I have to be willing to make myself vulnerable and to reach out and...learn to not be afraid of how it might be interpreted or received. And just kind of have...faith in the process and just making small steps. (P16)

As they moved toward acceptance, participants began placing emphasis on taking responsibility for themselves. They expressed wanting to make themselves accountable for their decisions and their actions. One participant had spoken about her food rituals as secretive and private and said that she was very hesitant to share them with others for fear that they would be taken away. She detailed the moment when she decided to be honest with herself and the dietitian about what she had actually been ingesting. She said that she had to face the wrath of the ED in order to move forward.

> That's when I started fully engaging with treatment and not doing food journals just because I was about to go see the dietitian and she was going to look at them - and I was kind of scribbling and making up because I knew what I should have eaten. I went in and said, "OK, here's what I actually ate today. Let's start from this point and I'm not going to fake it anymore". And I'm just going to deal with the conflicted problems...like the rage. (P9)

Several participants mentioned that a major step toward accepting the process was to challenge themselves to be less than perfect. For most, expectations of themselves were so high that any small deviation from perfection was perceived as a “failure”. Failing to live up to expectations was described as terribly threatening because any minute letdown would define the whole person as worthless. Accepting the process helped participants to break out of that mindset. They realized that living with setbacks, for example, accepting that relapse is a part of recovery, and tolerating unpleasant emotions was much more conducive to getting back on track than wallowing in one’s “failures”. One participant explained that she learned to forgive herself for doing her best.

> I think I’m a little more open to failure than I was before. [Pause] It used to be the end of the world. When you slip…it used to be something that was defining the person. I was taking it to the extreme. I guess on a continuum now, it’s more like, “I slipped and I’m trying to tell myself that’s OK”. That’s more my understanding of it. That’s how I try to normalize it. I don’t know if I’m there yet. Maybe one day. But I’m trying to normalize it and I think that’s why also...because I’m kind of getting there that’s why I’ve allowed myself to get challenged a little bit more. It still hurts…I’ve failed. It still hurts. But I’ve learned to try and detach myself from it and not see it as a defining feature of myself. Which wasn’t the case two years ago. I think that’s a really, really hard part...to accept to fail. I think it’s hard for everyone. But it really is hard for people with eating disorders. (P7)

Accepting the process involved letting go of shame and guilt, being open to taking risks (and possible failure), challenging their rigid system, and readjusting expectations. Although it was very difficult, learning to accept the process was a critical part of recovery.

Learning to be an adult. While learning to be an adult usually involved moving out of the family home, being responsible for themselves, and being independent from their parents, this was not all that it entailed. Part of growing up also meant developing the mental flexibility to see the world in shades of grey instead of simply “black and white”. Participants began to recognize that placing everything into categories of “good” and “bad” could be limiting and unrealistic. Being able to perceive life as more nuanced gave them permission try things that were “outside the box”, and to have new experiences they may not have previously allowed.

Further, several participants discovered that taking care of themselves involved self-nurturance and self-compassion. Many believed self-nurturance to be indulgent as, in the past, they had attained goals and achievements through ignoring their discomfort and pain. Although this was challenging, learning to be kind to oneself turned out to be a more sustainable route to recovery.

Many participants talked about how the process of learning to be an adult helped them to become more connected to themselves, their needs, and their desires for the future. Rather than assuming that others' needs should be prioritized, they learned to negotiate their needs with the needs of others, for example, by being more assertive or asking for space. These tasks were never easy and required sustained commitment to their goals. Even though it may have led to positive consequences, prioritizing their own needs felt "selfish" and most feared they would lose the relationships they had begun to build.

Several participants felt that they had not had the opportunity, or that they had shied away from the opportunity, to make decisions for themselves. As a result, they felt they were never able to develop the confidence that they were capable of taking care of themselves. In challenging themselves and taking on a more active role in their life choices, there was a newfound pride and a deeper sense of who they were and what they wanted for themselves. Being able to make choices based on their newfound sense of self was now something to look forward to, whereas in the past it may have been perceived as threatening and scary. One participant recounted that from early adolescence she had been pressured into treatment and the effects had never been lasting. Living away from home, she had chosen to do treatment for herself for the first time ever and she had a new sense of hope.

> I haven't told my mom I'm actually in therapy here yet. Because it's always been her kind of pushing me to do it so maybe I just need to… I don't really want to talk about it with my parents anymore. It's just something I need to make my own goal rather than having someone else be accountable for it. I don't really want to be checked up on about

> it. I want to do this for myself. I want to see if I can beat this. I mean, obviously, with their support but maybe not now. (P2)

She went on to say that it felt good to be accountable for therapy and for other things in her life. In fact, she realized that regardless of whether the consequences were positive or negative, it was only in taking responsibility for her choices and actions that she was free to develop confidence in herself.

> When I am independent and when I feel that the consequences are in me - whether positive or negative - are on myself, I'm really proud of that. Like, "I did that for myself". Or "I did well in this class because I studied or I did this...just me". Or "I had a really good day today. I worked out healthily, I had a good meal today, I went to class, I did a bunch of good things, I had coffee with a good friend of mine, I was really happy, blah, blah, blah". And I'm like, "Wow, that was all on me and there's no one else to attribute credit to but myself". That's a good feeling. That's a really great thing. (P2)

One participant disclosed that making choices for herself and learning how to cope with her stressors was going to be a challenging process that she coined "the scary of growing up." However, she was confident that going through that process was the very thing that was going to help her to reach the other side.

> When it comes to what I want, now that I've finished school...and I have to get through all the scary of growing up before I can get there. Because I mean, it's going to involve moving out and getting jobs and getting experience and travelling here and there and just seeing where and what exactly I want. The next six months I think are going to be very tough. It's going to be an ongoing battle, but I'm hopeful it's going to be worth it in the end...not hopeful [laugh], I'm expecting it to be worth it in the end. And in six years, I'm hoping that I'll be able to deal - understand more how to deal with my stressors - and not turn everything as negatively...and understand that life has its challenges...that every day we're here to fight. Everyone has their own challenges so this is mine, and to keep going. (P12)

Most importantly, *Learning to be an adult* entailed being accountable to oneself and taking responsibility for one's choices and decisions. These actions allowed participants to begin to build a sense of confidence and self-efficacy that they had not had the chance to experience.

Connecting with others. Most participants expressed that through their process of recovery, they had begun to develop the ability to connect with others in a new way. They spoke of building friendships and feeling as though they could be themselves around others. Many expressed that in learning to trust their therapist, they developed confidence that others may also be nonjudgmental and trustworthy. Positive feelings toward their therapist or toward other group members spread to other people in their lives. A few participants mentioned that while they had traditionally been in unhealthy relationships, they were currently in the healthiest relationships of their lives. They attributed this to feeling better about themselves and believing that they deserved to be treated well.

Several participants became aware that, in the past, they had pushed others away. They felt more comfortable letting others be close as they no longer wanted to hide. They learned to reach out to others in their times of need rather than suffering in silence. One participant described a blossoming relationship with her brother where there had previously been none. After her father had withdrawn financial support of her education, her brother stepped in to support her. Through her recovery process, she learned to reach out to others when she needed help, shifting from the idea of being a burden to others.

> We never had a relationship and he just recently made an effort with me and that was really nice. So we've been talking a bit more openly about things and life. You know, the whole - get a house, get married, have babies - thing; all of that. And he's just made an effort to say I'll be here for you. […] It was nice because my brother at that point said, "Whatever happens…if you need help getting through your last year of school, I'll help you". He's got a good job now. That was really cool. He sort of stepped up to the plate for me. And with my boyfriend too, he's always there when I need him. (P5)

Several participants portrayed a new capacity to let others "in". They tended to share more of themselves with important others which, they noticed, made relationships closer, stronger, and more intimate. As they offered more of themselves, they felt more understood and less criticized by others. One participant described a unique interaction with her father. She had disclosed to her mother that she was struggling with her decision to take antidepressants. Even though it had improved her mood, taking the medication made her feel weak as she felt should be able to get through her depression on her own. When she went home for a visit, her father took her out to lunch and shared, for the first time ever, that he had suffered from depression for most of his adult life. Learning this new information, she felt more confident to pursue her course of treatment.

> I went home to visit for two weeks in August and we went out to lunch and we were sitting outside and he just randomly started telling me that he's taking antidepressants and he's been doing this for years now. I was like, "You didn't tell me this." I've been telling the psychiatrist, "No, there's no family history of depression, no one in my family takes antidepressants". I was like, OK, I guess that kind of changes things a little bit. […] It made me feel a little better that my dad was taking medication because he's very…Mr. Stoic, "I get through things and I don't complain". So it made me feel better because I still didn't like the idea of taking antidepressants even though they were helping. But it made me feel better that he was doing it. That it was something he felt was necessary. (P11)

For this participant, her experience in treatment influenced the family pattern of "not talking about things". As she became more open, her father learned to do the same. A number of other participants mentioned that as they began to "be different" with family and friends, others responded to them in new ways.

Most participants conveyed that as they broadened their capacity to accept things about themselves, in turn, they felt more accepted by others. Instead of wanting to appear perfect, or wear a "mask", they now wanted to be themselves and to be accepted as they truly were. This enabled them to reveal some of their challenges with others rather than dealing with things on their own. One participant described that sharing her struggles enabled her and her boyfriend to make positive changes in their relationship patterns. She learned to let him in by inviting him be a part of her recovery process.

> As opposed to him making the food, we made it together. And that was something he said, “Well, maybe this will help”. So he’s been trying to find ways that he can help. Because I’ve told him what I need and I’ve said that even if I resist, it’s good for me. I know that what I’m resisting...I need to slowly accept. So I basically just had to tell him to...be a little less eager at trying to help [laughs], “And I’ll slowly tell you what I’ve learned”. We get hand-outs from the group therapy and stuff and I’ll pass them along to him sometimes. (P9)

Connecting with others represented another significant aspect of moving forward with recovery. As participants allowed themselves to be “real” or more vulnerable with others, they discovered a sense of acceptance and trust that they had been seeking.

Finding myself. Participants who felt they were on the road to recovery talked about connecting to a new sense of identity. Several spoke about becoming a new “self” who was separate from the ED and all of its demands. They found that they were building confidence in themselves and connecting with new values, for example, ones that came from themselves as opposed to more externally derived standards. In developing this new sense of self, one participant expressed she felt that she had her “life back”. In taking ownership over decisions, they had the opportunity to feel proud of themselves in ways never before experienced. Several mentioned that while they had begun the treatment process because of pressure from loved ones, they were now engaging in the process for themselves and for what they were getting out of it. One participant said, “I feel detached from my eating disorder. We’re not the same person. It’s kind of fading away. But it’s been a year. I think I’ll feel more comfortable when I get one more year...out of the way” (P7). She described what it felt like to be without an ED after living with it for most of her life. She articulated the challenge of really paying attention to and connecting to her values, as opposed to what the ED had always told her was important.

> My own self. I feel like I have...I’m wearing a new skin. Because the old [me] is still here. But like the good old [me]. I think that’s what makes me really, really sad about the eating disorder…when I think of it…is how it just kind of covers you up, it becomes you. And you’re kind of like being smothered by [soft laugh] your eating disorder and

> there isn't any room for you and so you end up choosing things not because you like them but because your eating disorder makes you like them. And that's what's been hard for me in therapy - is to be sure of what I want. And I still have problems with that today sometimes. It's really, really hard because in the process of detaching yourself and untangling the things that are a part of your eating disorder or part of yourself, it's tempting to cut everything off, to cut all cords. And you can't really do that because, I mean, when you develop an eating disorder when you are 15, you can't really cut off 15 years of your life. And in my process, I cut one cord after another and…I guess I definitely I gained a sense of myself. That's for sure. I'm actually able to say what I like and what I dislike. (P7)

This participant went on to say that she wondered if her old friends, friends who had been so supportive in sharing their concerns about her health, would be able to connect to this burgeoning new self. Further, she was concerned that once back in the environment where the ED developed, she may be tempted by her old system of values.

> I'm going back to [home] this summer and I haven't seen my friends...I still talk to them on Skype but I haven't seen them in two years and a half. And I get this weird feeling in my stomach because I'm still the same self...I'm still the same person, probably wearing the same things, nothing has changed. But I *feel* a lot different and *I've* changed. I know they'll accept me the way I am, I don't have any doubts about that but still inside me, because I feel so different I have this weird feeling, gut feeling...a little bit anxious. Because I'm a different person with....I definitely have different values. That's why I've waited to come back...to be sure of my own values, to be able to stand up for them when I'm being confronted with... because I'm going to be confronted with my old ones. And I want to be sure. I want to be 100 % sure that I chose my new values. (P7)

Other participants said that in the process of finding themselves, they discovered the importance of having new experiences and finding the place where they felt they fit in. One participant talked about how difficult it was to pay attention to what she wanted for herself rather than persisting with what she thought she *should* do. Previous decision-making had always been about pleasing others or refraining from disappointing others who had certain expectations of her. As she had always excelled academically, she had pursued higher education without necessarily being certain that was what would make her happy. She was just beginning to discover how important it was to listen to what she valued.

> [Long pause and voice breaking] I'd like to be happy [laughter and sniff]. I'd like to be able to be ambitious and to make music. I'd like to stop feeling ashamed or scared of myself. [Pause] And I'd like to have an interesting life. And I'd like to do things that I actually want to do...instead of things that I think I *should* do. I mean, if I'm honest with myself I really do just want to play music [laughter]. But I've always felt this sort of internal pressure or this, "You're good at school, you should go to school". So it's really hard for me to think about not doing that anymore. But I think I need to give myself the opportunity to clear my head a bit. To do something else for a while...or forever, I don't know. I think that's a result of the major change that I would want which is having a clear and more purposeful relationship with what I want and not what I feel like I *should* want. (P13)

Another participant talked about developing confidence in her opinions. Earlier in life, she had not necessarily been encouraged to develop her own point of view on issues. It was exciting for her to discover that she did, in fact, have opinions and wanted to express them. As she built confidence in her ability to express herself, her beliefs, and her values, she felt that she was being genuine and true to herself.

> Taking a stance on something, taking a side has always been…it's easier to ride along the fence. I think it has to do with, my family is really conservative and very religious, so there were times where people would ask me "Why do you think this, why are you against this?" And I...I didn't know. It was how I was brought up, it was…this is what we believe. So it was always easier for me to ride the fence. […] And so just living on my own I'm realizing more and more that I'm finding it easier to sort of figure out, what are my actual thoughts on this, and not be under the influence of anyone else. It's very liberating, when I am able to...I'm finding more and more, if an issue arises in the news, I am able to take a stance and express why I do think this is wrong without fear of somebody attacking my opinion. (P16)

As they began to listen to their own values, opinions, hopes, and dreams, participants learned to let go of external expectations. *Finding myself* was about untangling their identity from the ED, and developing confidence in what they wanted for themselves and who they wanted to be.

Turning it into something good. Over half of participants talked about wanting to transform their experience with an ED into something beneficial for themselves and others. They now perceived their experience as something that made them stronger, capable of deeper self-acceptance, and capable of making a difference for others who may be suffering. Several even expressed feeling grateful for their struggle because, in engaging in treatment, it gave them the opportunity to genuinely learn about themselves in a new way. This next participant explained that because of the ED, she had been forced to look deeply at herself in a way that many people never do. She decided to feel grateful for having the chance to engage in a process of self-reflection.

> Being in treatment has opened up so many of the things about the way that I interact with the world, and make me more, not efficient but more able to be part of society. I actually love…as much as the eating disorder sucked and it still sucks because it causes anxiety…part of me is super glad that I had this opportunity to really examine things. (P8)

One participant felt saddened that her multiple hospitalizations resulted in her taking a different path from that of her sister. She was dismayed that she had not been able to pursue the "normal" trajectory of going to school or finding a job. However, through treatment, she discovered that she was a "people person" and realized that she wanted to study social work so that she could help others to reveal their own potential.

> I suffered a lot through the eating disorder, through not being well in my head and stuff like that. But I wouldn't change it for anything because I learned a lot about compassion, forgiveness. Listening - in doing group therapies…listening to what makes the person who they are, what they lived, how that made them who they are and why they react the ways they do…and just being fascinated by it. I have no regrets for that. (P17)

Several participants talked about wanting to connect with others who were currently suffering by pursuing careers in medicine, nutrition, nursing, psychology, and social work. They expressed how ostracized and alone they had felt at various points in their recovery and that working with a health professional who demonstrated deep understanding and non-judgment made all the difference. They wanted to be that person for someone else. They wanted to be able to use their experience to establish social change for others. More than one participant expressed that they had chosen to take part in this particular research project because of its focus on the treatment process, and their desire to be part of the solution so that they may alleviate someone else's suffering. One participant reframed her experience into something that helped her to feel powerful.

> When people conquer their eating disorders...I think that's such an incredible thing to do. It's so hard. It's so easy just to give up. And I feel like now that I am conquering it, I'm really doing it. I feel like such a fighter, like I can do anything. Because I really do believe that. If I can conquer this demon - I've been dealing with this for seven years - that's consumed my entire existence...I could probably achieve anything that I want. I actually felt so strongly about that that I got a tattoo on my rib cage that says...it's a German philosophy saying but you've probably heard...Kanye West wrote a song about it...it's "What doesn't kill me makes me stronger". It's such a cliché but it speaks such volumes for what I've been through that I just I never want to forget that. So I truly appreciate what I've been through. I think...I can use it now. (P3)

Experiencing connectedness was comprised of five subcategories: *Accepting the process*, *Learning to be an adult*, *Connecting with others*, *Finding myself*, and *Turning it into something good*. In experiencing connectedness, participants forged new relationships with themselves and with significant others. They made efforts to challenge their rigid rules in favour of seeking balance and moderation. They discovered the importance of taking risks and being accountable for themselves and their life decisions, which enabled them to build self-efficacy, confidence, and a newfound sense of identity. Finally, they worked to find acceptance and to transform their experience with an ED into something beneficial for themselves and others.

Summary

In this chapter, I have presented the findings from the analysis of 18 interviews. I have outlined a theory, with interdependent relationships among the components, that reflects the complexity of the development of motivation for ED treatment. The core theme, *pushing and pulling*, represents the continuous battle that participants faced on their journey to recovery. In order to build the theory, the eight major categories were explored as contextual factors, contributing conditions, action strategies, and consequences.

The contextual factors, which laid the backdrop for the development and maintenance of the ED, comprised *Believing I am inadequate*, *Struggling with self-regulation*, and *Experiencing stressors*. The first two categories represented internal vulnerabilities and the third involved external events or triggers. All three factors made it more challenging for participants to build and utilize motivation for recovery once the ED had taken hold. The contributing conditions comprised the two major categories *Using control* and *Losing control*, which acted as catalysts to the ED. Participants alternated between trying to control (e.g., their emotions, how they were perceived by others) and feeling as though they were out of control and had lost everything that was important. In this cycle, participants became further entrenched in the ED and their rigid structures. The action strategies employed by participants in their efforts to engage in recovery included the two major categories, *Wrestling with motivation* and *Working through change*. The action strategies delineated how participants worked through their struggle with motivation to engage in the tasks of therapy. Consequences of the whole process consisted of *Experiencing connectedness*. Not all participants reached this place, however, even those who did not, spoke of the concepts in this category. Those participants spoke about experiencing connectedness as the next steps they needed to take.

Table 5 (below) offers a visual representation of all of the categories and subcategories, and how they relate to each of the participants. Green indicates that the participant spoke about the concept and endorsed it. Red denotes that the participant spoke about the concept but in a negative way, for example, in the *Taking action* category, red signifies that the participant had difficulty taking action. Purple symbolizes that the participant spoke about both positive and negative experiences. For example, in the *Connecting to my therapist* category, purple indicates that the participant talked about a significant positive relationship with a therapist and a significant negative experience with a therapist.

Table 5

Participant Endorsement of Categories

		Participant																	
Category	Subcategory	1	2	3	4	5	7	8	9	10	11	12	13	14	15	16	17	18	19
Believing I am inadequate	Feeling different	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	
	Feeling ashamed	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩
	Being alone	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩
Struggling with self-regulation	Feeling controlled	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩
	Living up to expectations	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩
	Emotions not acceptable	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩
	Feeling abandoned	🟩	🟩	🟩	🟩	🟩	🟩		🟩			🟩		🟩	🟩	🟩	🟩	🟩	🟩
Experiencing stressors	Family health problems	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩		🟩	🟩	🟩		🟩	🟩
	Parents' divorce		🟩	🟩		🟩	🟩		🟩								🟩	🟩	🟩
	Being bullied	🟩			🟩	🟩		🟩		🟩	🟩	🟩	🟩			🟩			
	Moving away from home	🟩	🟩	🟩	🟩		🟩	🟩	🟩		🟩				🟩	🟩	🟩	🟩	🟩
Using control	Creating the structure	🟩	🟩	🟩	🟩		🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩
	Needing to be perfect	🟩	🟩	🟩	🟩	🟩	🟩		🟩		🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩
	Using the ED to cope	🟩			🟩	🟩	🟩	🟩	🟩	🟩		🟩	🟩				🟩		
Losing control	Getting sick	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩
	Fearing ED stronger than me	🟩	🟩	🟩	🟩		🟩	🟩	🟩	🟩		🟩		🟩	🟩	🟩	🟩	🟩	🟩
	Giving up my voice	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩
Wrestling with motivation	Recognizing a problem	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩
	Rejecting treatment	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩
	Finding hope	🟩	🟩	🟩		🟩	🟩	🟩	🟩			🟩	🟩	🟩		🟩	🟩		🟩
Working through change	Connecting to my therapist	🟩	🟥	🟩	🟥	🟩	🟩	🟩		🟥	🟥	🟩	🟩	🟪	🟥	🟩	🟪	🟪	🟪
	Learning in therapy	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩		🟩	🟩	🟩	🟩
	Knowing what but not how	🟩	🟩		🟩	🟩		🟩	🟩	🟩	🟩				🟩			🟩	🟩
	Taking action	🟩	🟩	🟩			🟩		🟩		🟥	🟩			🟥	🟩	🟩		
Experiencing connectedness	Accepting the process	🟩	🟩	🟩			🟩		🟩		🟥	🟩	🟩		🟥	🟩	🟩	🟥	
	Learning to be an adult	🟩	🟩	🟩	🟩	🟩	🟩	🟥	🟩			🟩					🟩	🟩	
	Connecting with others	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩		🟩	🟩		🟥	🟩	🟩		🟩
	Finding myself	🟩	🟩	🟩	🟩	🟩	🟩	🟩		🟩		🟩	🟩	🟩	🟥	🟩	🟩		🟩
	Turning into something good			🟩		🟩	🟩	🟩	🟩				🟩	🟩	🟩	🟩	🟩	🟩	

Note: Green = endorsed positively; Red = endorsed negatively; Purple = endorsed both positively and negatively

Within the description of each category and subcategory are multiple examples of participant's own words. Great efforts were made to stay close to participants' language and experience in order to ensure that their stories were adequately represented and that the theory developed from a strong grounding in the data.

Member Check of the Findings

After the transcripts had been analysed, coded, categorized, and audited, the findings were sent to the participants to obtain their comments and reactions. This process, called member checking, is a measure of validity and trustworthiness, and was defined and delineated in the methodology chapter (see page 67). One participant offered this feedback on the findings during member checking, "I identify with all of the parts of the [findings] you sent. In a sense, I am and have always been tied to each category simultaneously." This statement encapsulates the notion that recovery cannot truly be teased apart into a linear process, but must be conceptualized as a complex, interacting, and interchanging path.

Another participant shared that her struggle still continued, even though she had been deemed fully recovered by her treatment team. Although she no longer experienced physical symptoms of the ED, some of the interpersonal and contextual factors had yet to change. As a result, she did not feel completely released from the ED's hold.

> It's interesting for me to see [the results] at this stage, as I am no longer undergoing any treatment and am considered to be "fully recovered" from anorexia nervosa - physically, at least. Even though the constrictions of "ED thinking" have subsided, something of them remains. Kind of like a defunct machine sitting in the corner of an otherwise very full and active room. […] Reading over the *stressors* and the sections about [*control*] as well as [*working through change*] my internal response is, "How completely true!" […] And it even highlights some of what still remains from the ED (i.e., the fact that "recovery" is an ongoing and variegated process, in many ways just as solitary as the illness itself was).

The opportunity to share their story, to reflect on it, to have their experience validated may have been an important turning point for some of these women. Throughout the interview process and in the feedback they provided during member checking, participants disclosed how much they appreciated being heard. At the end of her interview, one participant said, “And I’m really happy that I came here to talk to you. It makes me feel like I’m doing something, maybe a little bit, in the long run for someone else. I would love to think that”. Another participant echoed these sentiments after I had sent her the findings, “Thank you for sharing your results and for giving me the chance to talk about being sick - I hope it can help other people in the same situation. Thank you so much for your work!” Yet another participant expressed her gratitude that someone cared about the experiences of women in treatment, “I also wanted to say a sincere thank you for choosing this area for your dissertation. I'm sure your contribution will be significant in helping other young people with recovery”.

As a result of changes in their contact information, I was not able to reach three of the participants who were interviewed, for the purposes of member checking. However, of the 15 women I contacted, 14 of them provided in-depth feedback about their experiences of the interview, their continued recovery process since the interview, and their thoughts on the findings. For me, this high level of response indicates that the interview was important and defining for the participants, and that the opportunity to tell their story and to reflect on their motivation may have even been a catalyst to their recovery process. One participant responded with very positive remarks about the research findings.

> I love, love, love what you've done - it really resonates with me and my experience. […] Treatment was so, so challenging - the most challenging thing I've ever done, and I so desperately wanted to be better. However, treatment made me feel (at times) less controlled and more terrified than my eating disorder, you know? Because I was learning how to handle my feelings and life stressors WITHOUT resorting to disordered behavior. […] Now I'm at the very very last step, for sure.

Another participant shared similar sentiments. Further, she indicated her willingness to participate in continued research should the opportunity arise, “If ever you progress further with this study and need someone who has been in therapy for longer periods of time, or someone who has overcome the disorder, please do not hesitate to ask.”

CHAPTER 5: Discussion

In this chapter, I discuss how the various aspects of the push-pull dynamic theory support, refine, extend, or contradict previous work. I also present the limitations and the broader implications of this study for the field of ED treatment with regard to theory, research, practice, and training.

This research study addressed the question of how clients in therapy for an ED develop their motivation for change and internalize their reasons for change. In addition, the goal was to capture clients' perspectives on the recovery process, the factors that led them to persist or drop out of treatment, and their experience of motivation throughout. Within the many aspects of the process that participants identified, the most potent was the pushing and pulling struggle. The theme of cycling back and forth permeated throughout, from the contextual factors to the consequences. This suggests that recovery cannot be represented as a linear process, but must be conceptualized as a complex, interacting, and interchanging path.

Working through Resistance and Ambivalence

The findings of this study signify that addressing motivation for treatment is of primary importance in the recovery process. Participants talked about how finding and utilizing motivation was a constant and on-going battle. At certain moments their motivation and feelings of hope promoted engagement, and at other moments their lack of motivation and feelings of hopelessness made them want to give up the whole process. This advocates for a motivational stance from clinicians throughout treatment, a stance that is central to Motivational Interviewing (MI; Miller & Rollnick, 1991). In MI, exploring and resolving client ambivalence is facilitated through (1) expressing empathy, (2) increasing self-efficacy, (3) rolling with resistance, and (4) developing discrepancy (Miller & Rollnick, 2002). While the first three skills are proposed to promote an autonomy supportive environment, developing discrepancy in ED therapy may be an especially useful tool as clients work through the push-pull struggle. If clinicians can help clients tolerate and normalize the push-pull, it could assist them in persevering with their treatment. Learning to accept that opposing forces can co-exist may assist clients in developing flexibility rather than living in the extremes. While MI is intuitively appealing, it has been critiqued for saying little about the mediating processes by which its techniques have effect (Vansteenkiste & Sheldon, 2006). These findings shed some light on why and how some of the strategies of MI may work the way they do, particularly with ED clients.

The findings are also in accordance with aspects of the transtheoretical model (TTM; Prochaska & DiClemente, 1986; Prochaska, DiClemente, & Norcross, 2003), which theorizes that matching client readiness to therapist interventions will provoke the least amount of resistance to change. However, critics of the TTM argue that the different stages are not discrete and that individuals may endorse items from two different, and sometimes non-adjacent, stages (e.g., Littell & Girvin, 2002). The push-pull dynamic provides support for this criticism, in that participants were continuously vacillating between readiness to take action and rejecting change altogether. In addition, participants were ready to let go of certain behaviours (e.g., bingeing) and not yet ready to give up others (e.g., restricting). Therefore, when measuring client readiness for change, clinicians may want to be very specific about which behaviours or symptom domains are being targeted. Assessing domain-specific readiness and motivation (as recommended by Geller, Drab-Hudson, Whisenhunt, & Srikameswaran, 2004), may be the most useful strategy.

Whether or not participants were acting from internal or external reasons had a large impact on commitment to treatment. When participants chose to be in treatment because of reasons that corresponded with their values and their vision of the future, they were more likely to persevere. Conversely, feeling controlled or being forced into treatment made them want to hang on to the ED. This is aligned with self-determination theory (SDT; Deci & Ryan, 1985; Deci & Ryan, 2000) which proposes that when clients are more autonomously engaged in the therapeutic process they will be more likely to integrate learning and behaviour change, and to have more positive outcomes (Ryan & Deci, 2008). The results provide support for attending to the *quality* of client motivation in the treatment of EDs.

Further, according to SDT, therapy can promote or deter the internalization of change by supporting or thwarting three innate and basic psychological needs: the needs for autonomy, competence, and relatedness (Ryan & Deci, 2008). This study suggests that the satisfaction of these three needs were indeed a part of recovery from an ED (e.g., the categories *Finding myself*, *Learning how to be an adult*, and *Connecting with others*). However, the findings propose that there may be additional elements of the therapeutic process that contribute to the internalization of change. Participants identified that developing compassion and acceptance (of self and others), risking failure, and wanting to engage in social change so that they may alleviate or prevent others' suffering, were also important components to their journey toward recovery. These findings provide new insight into how SDT may be applied in treatment for EDs and, furthermore, offer new avenues for facilitating the internalization of change.

In addition to focusing on the quality of client motivation, the findings suggest that therapists attend to motivation throughout the recovery process and not simply at the beginning. Participants grappled all the way through, and at any given time in the process were pulled to give up and go back to disordered eating patterns. Most became disheartened after many ups and downs and relapses, and they began to lose the belief that they may actually be able to make changes. Some experienced setbacks at the very end of their process or even after they had been considered fully recovered. Discouragement about relapse or feeling stuck may contribute to drop out, unless clients are well-informed that this is a normal and, even expected, component of recovery.

Measuring Outcome

The most common outcome measures in research and in recovery programs focus on weight restoration, symptom reduction, and reduced body image distortion. While these issues are important in the treatment of EDs, they may represent the goals of the treatment centres more than the goals of the clients. In essence, they are the most tangible evidence that the client has undergone some sort of transformation, objective indicators that the chosen treatment strategy has been “effective” and had an impact on the client. However, the few studies that have examined recovery from the client’s perspective demonstrate that clients may relate recovery to aspects of self-esteem, self-determination, and self-acceptance (Redenbach & Lawler, 2003; Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2003). Similarly, clients with EDs who exhibit increased readiness for treatment also report increased importance of friendships and personal development, and decreased importance of shape and weight as determinants of self-esteem (Brown & Srikameswara, 2009). Participants in this study identified the development of self and connection with others as critical factors that led them to feel confident on their journey to recovery. More often than not, symptom relief was seen as transient and not a true indicator of change.

Concurrent with the literature on client perspectives of recovery (e.g., Redenbach & Lawler, 2003; Brown & Srikameswara, 2009), the findings of this research study suggest that there are more subtle components of recovery that clients themselves identify with a lasting sense of change, such as developing a sense of self, cultivating acceptance and compassion, improving the capacity to bond with others, taking risks, and increasing self-regulation and autonomy. Therefore, while symptom reduction is an important part of recovery, it represents only a piece of the puzzle. Similarly, while addressing motivation is crucial, it is not sufficient. There are numerous other issues at hand that affect the recovery process and current treatment protocols may need to re-evaluate the standards for measuring outcome.

Gender, Identity, and Diversity

Gender. As EDs occur so disproportionately among females, clinicians need interventions and frameworks that speak to the experiences of women. Some have proposed gender as a potent risk factor in the development of EDs (Piran, 2010), and this study is consistent with this view. Research indicates that women who have internalized a gender role of more feminine and less masculine qualities may be more likely to develop eating problems (Williams & Ricciardelli, 2003; Williams & Ricciardelli, 2001). On the contrary, the women in this study struggled with their feminine identities and spoke about conflicting values around femaleness. Several mentioned that there was a push-pull around the expectations of exhibiting traditionally “feminine” qualities such as compliance, nurturance, and prioritizing others needs above their own. They discussed a dislike for these qualities, which they perceived to be “weak” or inherently “bad”. The data nuance the conflict around feminine identity and suggest a link to feelings of inadequacy and other contextual factors. It may be helpful for clinicians to examine the socio-cultural impact of how clients internalize their feminine identity in the process of engaging them in therapy. Attending to gender and its significance in clients’ lives may be a protective factor against potential relapse in the future.

Western treatments tend to have individualistic perspectives and highlight the internal locus in the foundation and the maintenance of EDs. While 50 % of EDs can be attributed to biology, it is critical to remember that the other 50 % is attributable to psychosocial factors (Collier & Treasure, 2004). The findings from this study suggest that when societal pressures, women's roles within their lives, the objectification of women's bodies, and issues of control and autonomy are addressed, clients think and behave differently, and develop healthier ways of coping with the challenges in their lives. Treatment modalities must be able to target and encompass physical, psychological, interpersonal, and environmental factors of the individual in their life context. Expecting clients to make significant changes without a corresponding change in their environment may cause damage to the therapeutic relationship, as clients feel that their therapist does not understand their situation. The findings reveal that it is vital to make changes at the societal level, which evokes the need for prevention programs that target the inequities of gender, the objectification of women, and empowerment/disempowerment (e.g., Piran, 2010).

The complexity and depth of these issues undoubtedly take longer to address than short-term treatment programs are able to provide, given that the suggested treatment length for CBT is 18 to 20 sessions (Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000). Although symptom reduction may be possible to achieve in a shorter time frame, interpersonal and/or personality-based changes may require extended engagement and commitment to obtain. The dose-effect model of psychotherapeutic effectiveness (Howard, Kopta, Krause, & Orlinsky, 1986) was based on an examination of 2,400 clients over the course of 30 years of psychotherapy research. In this model, effective psychotherapy followed three phases: *remoralization* occurred within a few sessions, *remediation* or symptom relief required roughly 16 sessions, and *rehabilitation*, which focused on relearning maladaptive, habitual behaviours and patterns, was undetermined in length. The findings are aligned with the dose-effect model in that ED clients may not yet have reached the rehabilitation phase in a typical short-term treatment. They may be repeating treatment numerous times because they need more time for meaningful and lasting change to occur. Longer treatment programs may be needed in order to address some of the relational, societal, cultural, and contextual factors at play.

Identity. Without a clearly defined sense of self, individuals may search for external sources, such as societal standards for attractiveness, to give them an impression of worth and belonging. Indeed, identity confusion and feelings of ineffectiveness predict greater eating symptomatology in university-aged women (Wheeler, Winter, & Polivy, 2003). Conversely, higher levels of self-esteem are negatively related to internalization of socio-cultural beliefs about thinness (Clay, Vignoles, & Dittmar, 2005; Fingeret & Gleaves, 2004), but positively related to a feminist identity (Murnen & Smolak, 2009), and a clear self-concept (Vartanian, 2009). Taken together, this suggests that a poor sense of self or diffuse identity may make certain women more vulnerable to adopting externally defined values about beauty and body image.

The findings from this study confirm that the experience of an ED tends to correlate with a poorly defined sense of identity and “self”. Some participants felt they were not given the opportunity to develop a clear identity because of the expectations to comply with familial and societal demands. They felt they were not nurtured in autonomy-supportive environments and were discouraged from having opinions that may have differed from their parents. However, several participants disclosed that even if their autonomy had been encouraged, they may not have taken the opportunity to express it. The need for external approval was so great, and the anxiety surrounding failure was so high, that participants said it was often less risky to comply with externally defined expectations. Regardless of how it originated, there was a dynamic that developed between parent and child, between expectations and the fear of failure, which made it safer to not assert a sense of individuality. The delicate interplay between individuals not being ready to take on the task of autonomy and not being offered the opportunity needed to be addressed in order for participants to move forward with self-efficacy and identity development. Recent research has favoured a more continuous, interactive approach to family dynamics (Wheeler, Winter, & Polivy, 2003).

Participants indicated that identity development was a decisive part of the process of recovery; the more they had distance from their ED, the more they had confidence in their sense of self and their desires for the future. However, it is important to note this process was marked by the pushing and pulling theme. Several participants had negative interactions with their therapists because they felt that they were being asked to "take responsibility" or to "be accountable" for their choices, their emotions, and ED behaviour when they did not feel ready. In the process of therapy, clients may continue to pull for external approval or push away from the development of identity/responsibility because it is threatening or anxiety-provoking. One of the contributions of this study may be to sensitize therapists to the dynamic, the potential pull to take a directive stance, and of client readiness to engage in the development of self.

Diversity. Several participants experienced the treatment environment as inappropriate in their cultural context. Although the evidence is clear that EDs are an expanding problem and women from diverse backgrounds and ages are affected (Bulik & Taylor, 2005; Jennings, Forbes, McDermott, Hulse, & Juniper, 2006), some are much less likely to be referred to appropriate services in mental health care (Gordon, Brattole, Wingate, & Joiner, 2006). Research as well has been disproportionately focused on young, White, upper socio-economic status individuals, thus skewing our understanding of EDs, from diagnosis through treatment. Some of these participants felt that treatment teams did not understand their family dynamics or know how to intervene in a culturally competent way. The findings suggest that in order for clients to truly engage in the recovery process, they must be able to trust that their needs are being respected and acknowledged. Accordingly, treatment programs must offer services to diverse groups that are multiculturally sensitive according to an inclusive definition of multiculturalism that extends beyond race and ethnicity to include nationality, socio-economic status, religion, gender, sexual orientation, age, dis/ability, etc (Stone, 1997). Current ED treatment manuals do not address the ways in which clinicians can become culturally competent, so teams may struggle with delivering effective services. The results indicate that it is imperative for treatment approaches and manuals to reflect the growing diversity of the ED population. Further, practitioners must undertake ongoing efforts to examine their capacity in providing multiculturally competent services.

Diversity is also related to diagnosis. Research data shows that up to half of ED clients are excluded from randomized clinical trials (RCTs) for empirically supported treatments because of co-morbid disorders (Thompson-Brenner, Glass, & Westen, 2003). Yet, evidence is strong that the vast majority of clients in treatment for EDs present with substantial co-morbidity (e.g., Gadala & Piran, 2008; Blinder, Cumella, & Sanathara, 2006; Kaye, Bulik, Thornton, Barbarich, & Kim, 2004). This implies that treatments that are considered “gold standards” may not have been tested on the very populations on which they are currently being used. In this study, almost every participant reported being diagnosed with a co-morbid Anxiety Disorder (mostly Social Anxiety Disorder and Obsessive Compulsive Disorder), Depressive Disorder, Substance-use Disorder, or Personality Disorder. Perhaps treatments are not effective in two-thirds of cases because they are not addressing the needs of the majority of clients. It seems essential for treatments to reflect the complexity of the issues of ED clients in order to be effective. An integration of existing approaches, such as ones that address interpersonal functioning, emotion regulation, distress tolerance, motivation, and empowerment, as well as those that involve a focus on symptom management may be more useful.

Negative Self-Evaluation and Shame

Women with EDs tend to demonstrate a self-schemata (Vitousek & Hollon, 1990) characterized by long-standing negative self-evaluation (Fairburn, 1997). Scores on five core beliefs (mistrust/abuse, social isolation, defectiveness/shame, failure to achieve, and vulnerability to harm) were found to be significantly lower in recovered women than in women currently suffering from an ED. However, significantly higher scores in recovered women than in controls (Jones, Harris, & Leung, 2005), suggest that negative core beliefs may represent vulnerability to relapse and/or a lasting psychological scar from the ED. In this study, participants' negative self-evaluation was pervasive and all-encompassing. Participants' feelings of inadequacy and deep-seated feelings of shame dated back as far as they could remember. They felt that they merited punishment for being "bad" and did not deem themselves worthy of compassion from others or from themselves.

Researchers have found that higher self-criticism is associated with elevated ED symptoms through feelings of shame (Kelly & Carter, 2013), implicating shame as an especially important factor in the development of EDs. Self-compassion has been proposed as the antidote to shame, and compassion-based interventions may be helpful in ED treatment (Gale, Gilbert, Read, & Goss, 2014). Moreover, individuals who score higher on self-compassion may be more resilient to shape and weight concerns (Geller, Srikameswaran, & Zelichowska, 2014). However, the findings suggest that, while intuitively appealing, building self-compassion may be particularly challenging with ED clients. Participants in this study rejected encouragements to become self-compassionate and self-nurturing because they believed that their strict personal standards were what made them marginally acceptable to others. Giving up their unattainable standards meant potentially exposing the innumerable flaws they believed they possessed. For participants, the ED developed as a way to compensate for their feared inadequacies, and relinquishing it was exceedingly threatening. In others words, although developing self-compassion may be beneficial for ED clients, they may be exceptionally resistant to it.

A recent study examined the role of self-compassion and fear of self-compassion in the treatment of EDs. They found that higher fear of self-compassion was associated with higher shame and more severe ED pathology. Further, clients with both lower self-compassion and higher fear of self-compassion had no significant changes in ED symptoms over their course of treatment, suggesting that this combination may impede response to treatment (Kelly, Carter, Zuroff, & Borairi, 2013). The findings support the assertion that self-compassion and fear of self-compassion both play critical roles in client change. Clinicians must find ways to truly impart to clients that they are good and worthy of love, care, and affection in order for them to engage in learning self-compassion. Findings from this study suggest this occurred through building a solid foundation of trust and acceptance. The need for connection with others coupled with the belief that one is unlovable or unworthy is a conundrum that must be worked through with ED clients in order to progress with recovery.

Limitations

This study has several key limitations. Although a grounded theory methodology made it possible for me to access clients' perspectives of their therapeutic process, there is the limitation of using self-report evidence. Since their experience was not directly observable, data gathered from participants depended on: (1) participants' ability to distinguish and reflect upon aspects of their experience, and (2) participants' capacity and willingness to communicate their experience. These interpretations, based on participant accounts of their experience, may contain distortions of that experience based on forgetting or misrepresentation. This is, however, very similar to psychotherapy, in that it is based on client self-report and clinicians, like researchers, must use their skills to obtain richness and detail. Further, as the primary investigator, I conducted the interviews and analysis; therefore, the findings represent my understanding of participants' experiences. Although I involved external scholars and the participants themselves as auditors, and kept memos comparing the data with my pre-existing ideas, my biases may have influenced the questions I posed in the interview and the subsequent interpretations of the data.

While efforts were made to recruit a diverse sample, with regard to age-range, cultural background, diagnosis, and treatment experiences a limitation of this study is the small sample size and relative homogeneity of the participants. While the use of qualitative research enables the investigator to gain thick and rich descriptions from participants in their own words, it is not possible to generalize the findings to other populations. Nonetheless, the transparency of the methodology, data collection, and analysis process, allows the reader to make their own decisions about how applicable the results are to themselves or to the populations with whom they are working. Future research that examines how motivational process specifically intersects with gender, culture, age, and diagnosis, may nuance these findings.

Finally, participants were self-selected. It is possible that the specific characteristics of the women who chose to participate in the research interview may have influence the findings in ways that are not understood. To address this limitation, measures were taken to broaden and stretch the properties and dimensions of each of the categories (e.g., women with both positive and negative experiences in therapy, women who considered themselves recovered and those who did not, women who felt autonomously motivated and those who still struggled with motivation for recovery). However, the findings may not fully represent the many, possible diversities in ED experiences.

Contributions to Knowledge and Future Directions

This study constitutes an original contribution in the understanding of treatment for EDs. Traditionally, research has focused on whether or not treatment has effects while overlooking *how* and *why* it impacts clients (Beck & Lewis, 2000; Kazdin, 2003). More specifically in ED research, the focus remains on outcome with little attention devoted to understanding how change occurs in psychotherapy (Kazdin, 2007). Although it has been well established that autonomous motivation is significant (e.g., Carter & Kelly, 2014; Mansour et al., 2012; Zuroff et al., 2007), little research has examined the processes through which it can be facilitated in ED therapy. This research demonstrates that the development of autonomous motivation is related to therapy process and therapy outcome. Moreover, it sheds light on how autonomous motivation develops, how it fluctuates and changes over the course of therapy, through what mechanisms it works, and how it is maintained long term. The major contributions of this study extend to theory, research, practice, and training.

Theory

This study nuances our theoretical understanding of motivation as a therapy process factor in ED. The findings underscore the struggle with motivation as a key feature that may contribute to negative client outcome and early drop out. Elucidating motivation as an intricate and on-going process in ED treatment expands current theories to emphasize the importance of addressing client motivation on a session by session basis, and across treatment as a whole. In addition, the findings suggest that motivation and readiness to change may develop at different rates for different behaviours and attitudes. Therefore, the process of facilitating motivation may differ depending on the specific behaviour or attitude in focus. Our conceptualization of motivation, specifically in the treatment of EDs, needs to incorporate this complexity instead of viewing motivation as a single entity or construct.

Moreover, participants identified that risking failure, developing acceptance and self-compassion, and creating change for others were central features of their recovery. These findings provide new insight into how SDT may be applied in treatment for EDs and, additionally, offer new avenues for facilitating the internalization of change. Furthermore, the findings suggest that motivation intersects with client contextual factors. SDT may be strengthened by exploring how the interaction is implicated in client change. In addition to the development of autonomy, competence, and relatedness, this study proposes that the internalization of motivation for change may be obtained through supplementary routes such as empowerment, self-compassion, and acceptance, taking action, and risking failure. SDT may be broadened by further examining how these elements contribute to the facilitation of autonomous motivation in ED treatment.

Research

By accessing client perspectives, the use of qualitative methodology provides us with novel information for refining interventions, and areas for expanding current research. Looking at motivation from a different methodological perspective underlined the push-pull tension. For participants, these simultaneous and opposing forces were the source of their ambivalence and resistance toward therapy. It may have been interesting to triangulate the data by interviewing a member of participants' social environment (e.g., family or friend), in order to gain multiple perspectives of the recovery process. Another future suggestion would be to explore therapist narratives of client motivational processes. Highlighting the convergent and divergent experiences of clients and clinicians may shed light on how to adjust clinical practice to better meet the needs of clients.

Increasingly, psychotherapy research is recognizing that outcome is not just about symptom reduction. It concerns quality of life, interpersonal functioning, and social change. Findings of this study underscore that outcome research in EDs may not necessarily address the important issues that clients associate with sustained recovery. Factors that participants distinguished as critical to their engagement in treatment were the importance of identity, acceptance and compassion, connection with others, taking responsibility, taking action, and developing awareness. Comparing longer-term outcomes of integrative interventions with symptom-reduction interventions, or examining interventions that combine aspects of both, may be useful to provide further information about treatment effectiveness.

Practice

With regard to clinical practice, understanding how autonomous motivation works and how it may be facilitated in the treatment for EDs may optimize client perseverance for treatment, increase therapist effectiveness and, ultimately, lead to decreased treatment costs. Currently, clients who are not motivated for change at the beginning of therapy are deemed to be less appropriate for treatment and the hopes for their treatment outcome are less than positive. Seeing client ambivalence and resistance as factors that fluctuate session by session, and along the course of treatment, may provide health professionals with the hope that there are alternative ways to engage clients - and that motivation may be facilitated - throughout the process of therapy.

In addition, the findings of this study indicate that clinical practice itself may benefit from expanding and/or changing focus in order to better meet the needs of ED clients. For example, the inclusion of more non-traditional therapeutic tools may be especially useful in the treatment of EDs. Participants revealed that while developing awareness was helpful, it was not enough to spur on the critical *action* component of treatment. Participants expressed that they needed help in the “doing” part of change. Assistance during anxiety-provoking activities (e.g., preparation of meals, going to the grocery store, a restaurant, etc.) may offer clients the support they need to begin taking some of the necessary risks for inciting change on their own. Moreover, facilitating social interaction (perhaps through bringing family members, friends, and partners into session) and increasing opportunities for practicing emotion regulation and distress tolerance, may help clients develop the confidence to take action in their everyday lives. Further, assisting clients in the development of self-compassion and self-acceptance may be critical, in response to the elevated levels of shame and negative self-evaluation in this population. Clinicians must impart to their clients that they are worthy of love, and further, that they deserve to be well. If therapists can attend to clients’ social, environmental, and contextual life factors they are likely to empower clients to make changes in these areas. This may be essential to keeping them involved, engaged, and hopeful in their recovery process.

Training

Few internship and training opportunities are available to Master’s and Doctoral students in the area of EDs. Yet, EDs are so prevalent that it is likely that every therapist will encounter ED clients in their practice. Training programs can increase knowledge by offering course work in the treatment of EDs. Further, practicum and internship opportunities can be improved by ensuring that trainees have ED treatment skills in their repertoire.

Conclusion

As a result of the rich description of the treatment process for EDs from the clients' point of view, the findings emphasize how clients regard their process of change. Listening to participants' narratives and accessing their perspective was at the heart of the purpose of this research project. In my clinical experience, the most pervasive and common experience of clients with EDs is the feeling of disempowerment. My primary reason for conducting this research was to enable participants to feel empowered, to regain a sense of their voice, and to believe that someone cared enough about their experiences to bring them to light. Indeed, the literature review for this study revealed the absence of the voices of ED clients in the defining of their unique therapeutic needs. Most ED research focuses on therapist-driven assumptions about what works in therapy and what does not. Further, many of the assumptions about what "works" (i.e., what causes symptom reduction) are not the same factors that clients in this study identified as indicators of change.

Overall, this work argues for attendance to aspects of clients' social, contextual, relational, and identity development. Finally, in order to empower clients to engage in their own recovery process, they must develop internal resources and resilience to counter the barriers and obstacle they face.

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Appendix A: Informed Consent to Participate in Research

This form states that I agree to participate in the research project entitled ***Client motivation in the treatment of eating disorders: A Grounded theory exploration of autonomous motivation for change.*** This dissertation study is conducted by Susan Gamberg, M.A. (doctoral candidate in Counselling Psychology at McGill University) under the supervision of Marilyn Fitzpatrick, PhD (Associate Professor and Director of Training of Counselling Psychology at McGill University).

The Purpose of the Study

The goal of this project is to understand how clients develop their motivation for treatment when they are in therapy for an eating disorder. Your participation in this study will be an important contribution to this endeavour. The results of this study are intended for publication in academic journals and presentations at psychology conferences.

What to Expect If You Participate in the Study

Your participation will involve the completion of two forms and an interview of approximately 90 minutes. The two forms include: a) this consent form and, b) a demographic information form. When data analysis is complete, you will be offered the opportunity to view a summary of the findings.

Potential Risk

In the interview you will be asked to reflect on your experience of treatment for your eating disorder. It may elicit some unpleasant thoughts and feelings but there will be no pressure to respond to any questions that you feel uncomfortable answering. You may withdraw from the study at any time without penalty, any information you provided up to that point will be removed from the database.

Confidentiality and Privacy

Your therapist will not be informed of whether or not you decided to participate in the study and your decision to participate will have no affect on your treatment.

The interview will be audio-taped and transcribed so that the dialogue can be coded. To ensure your anonymity and confidentiality, all identifying information will be deleted or altered to conceal your identity. Once the transcription is complete the audio recording will be destroyed.
Auditors will be professionally trained psychologists, bound by a code of ethics that regulates their professional conduct relating to all matters in the conduct of research, including confidentiality. Your consent and demographic forms will be stored separately from the transcript and all electronic files will be password protected.

The results of this study will be compiled as a doctoral dissertation, and may be presented at research conferences or published in scholarly journals. No identifying information will be published. Your name will be changed to a pseudonym if direct quotes are used.

Contact Information

Please contact the researcher if you have any questions or concerns at: susan.gamberg@mail.mcgill.ca
Please sign below if you agree to participate.

Name (please print)____

Signature____Date_________________________

If you have any questions or concerns regarding your rights or welfare as a participant in this research study, please contact the McGill Ethics Officer at: 514-398-6831 or Lynda.mcneil@mcgill.ca

Appendix B: Demographic Form

Date of birth ________________________________

Ethnicity ________________________________

Education (highest level attained) ________________________________

Current occupation ___________________________________

Which best describes your current annual income?

	Under $20 000		$80 000 - $100 000
	$20 000 - $50 000		Above $100 000
	$50 000 - $80 000		

Your current relationship status (Please check all that apply)

	Single		Divorced
	Married		Widowed
	In relationship		

Do you have children? Yes / No

If Yes, how many _________________________________

Have you been in therapy before your current therapy? Yes / No

If Yes, please indicate:

Year:	Reason for therapy:	Length of therapy:
Year:	Reason for therapy:	Length of therapy:
Year:	Reason for therapy:	Length of therapy:

How long have you had your eating disorder? _________________________________

Are you currently taking any medication? Yes / No

If Yes, please indicate: _________________________________

Appendix C: Interview Guide

Opening Question

I am interested in understanding your experience of treatment for your eating problems. More specifically, I'd like to hear about what motivates you to be in treatment for your eating disorder.
How did you decide to seek treatment for your eating problems?

Change Questions

How does it feel to make changes in your eating behaviour? What emotions arise for you?
How has that changed over time?
Does change come from inside or outside of you? (Ask for elaboration).
How capable (or not) do you feel to make changes in your behaviour?

Therapy Questions

What does recovery mean for you?
What has helped your recovery? (Ask for specific examples).
What comes between you and recovery? (E.g. Describe a specific moment or session where your motivation became an issue).

What was happening in therapy that helped you start to change the way you were thinking or behaving?
What made you persevere?
How involved were you in deciding upon the goals of your treatment?
How involved were you in deciding upon the things you had to do to reach those goals?

Relationship Questions

Who are the most important people in your life right now?
How do they influence your eating behaviours? How do they impact your motivation to get well? (E.g. Father? Mother? Partner?)

How is the relationship between you and your therapist? Has it changed at all?
How has your therapist influenced your motivation to change?

Identity Questions

How do you feel your cultural/family background influenced your recovery?
How does being a woman influence your eating disorder?

Control Questions

What is it like to be in charge of your health? (E.g. to make decisions about what to eat and how much to exercise?)
How has control/lack of control played a role in your recovery?
How has perfectionism played a role in your recovery?

Debriefing Questions

How was this interview for you?
Is there anything else you'd like to tell me?

Appendix D: Recruitment Flier

Would you like to talk about your therapy for an eating disorder?

Research Participants Needed

We are seeking women who are currently (or have recently been) in therapy for an eating disorder for a study aimed at understanding the development of motivation in treatment. The results of this study may help clinicians to understand the role of motivation in therapy and how it may influence treatment.

Whether you are motivated in your therapy or have decide that treatment is not right for you, I would like to hear about your experience.

TO PARTICIPATE:

- You are currently in therapy for an eating disorder for a minimum of 2 months
  OR
- You were in therapy for an eating disorder within the last year for a minimum of 2 months

- You are between the ages of 18 and 35

If you agree to participate, you will be asked to complete a brief demographic information sheet and to participate in a confidential interview about your experience of treatment. The interview will be conducted in person, will take approximately 1 to 1.5 hours, and will be audio-recorded. The interview is completely confidential and your privacy will be protected.

Participation in this study is voluntary and you may withdraw at any time.
Participants will be compensated with $40.

If you wish to participate please contact:
Susan Gamberg, M.A.
Doctoral Candidate
Department of Educational and Counselling Psychology
McGill University, Montreal, Canada
susan.gamberg@mail.mcgill.ca

**This study is conducted under the supervision of Marilyn Fitzpatrick, PhD (marilyn.fitzpatrick@mcgill.ca)*
Associate Professor and Director of Training of the Counselling Psychology Program at McGill University

Appendix E: Code Reduction Scheme

Selective Codes	Sub-category	Major Category
Feeling different (not “right”) Not fitting in	Feeling different	Believing I am inadequate
Not wanting others to see me Feeling ashamed Denying myself pleasure	Feeling ashamed	
Being alone Feeling anxious (keeping my distance)	Being alone	
Feeling controlled Not being able to grow up Disappointing others Not becoming my parents (rebelling)	Feeling controlled	Struggling with self-regulation
Living up to society’s expectations Being feminine	Living up to expectations	
Learning emotions are unacceptable Not being honest	Learning emotions are not acceptable	
Being abandoned by mom/dad Lacking support/closeness Wanting others to see me	Feeling abandoned	
Having ED in the family Mental/health problems in the family	Having health problems in the family	Experiencing stressors
Experiencing parents’ divorce	Experiencing parents’ divorce	
Experiencing trauma in childhood	Being bullied	
Moving away from home	Moving away from home	
Liking structure Being in control	Creating the structure	Using control
Needing to be perfect Fearing failure	Needing to be perfect	
Using restriction to control anxiety Bingeing to soothe myself	Using the ED to cope with emotion	
Getting sick Losing control	Getting sick	Losing control
Fearing the ED is stronger than me Feeling betrayed by the ED	Fearing the ED is stronger than me	
Giving up my voice Feeling lost	Giving up my voice	
Recognizing there is a problem Seeking help	Recognizing there is a problem	Wrestling with motivation
Rejecting treatment Feeling dissatisfied by treatment	Rejecting treatment	
Finding hope	Finding hope	
Connecting to my therapist Being understood	Connecting to my therapist	Working through change
Learning in therapy Learning about the ED Developing awareness	Learning in therapy	
Not knowing how to change	Knowing what to do but not how	
Finding tools Seeing change	Taking action	
Accepting the process Relapsing Finding balance	Accepting the process	Experiencing connectedness
Learning to be an adult Making myself accountable	Learning to be an adult	
Connecting with others Learning from group	Connecting with others	
Finding my own self Being honest	Finding myself	
Turning it into something good	Turning it into something good	