

Eating disorders in the course of life: A qualitative approach to vital change

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Eating disorders (EDs) have become one of the biggest mental-health problems in the last decades, especially among youth and women. The present study aims to analyse the suitability of Prochaska and DiClemente's Trans-theoretical Model of Change when applied to the living experiences of people diagnosed with ED and their carers. For this purpose, we applied a narrative biographic approach to the ways in which people face their problems and vital development in the ED domain. Through the narrative analysis of these autobiographies, we aimed to study the patients' own notions of 'change', 'problem' and 'vital trajectory'. We focused on five autobiographic interviews of persons diagnosed as ED (four women and a man). The analysis yields three discourses which organize and give sense to our participants' vital transitions: a discourse of functional adaptation to events and experiences; one that pays attention to random events and people entering your life; and one that has the personal initiative and agency of an individual agent at its core. It also illuminates particular ways of understanding determination, contemplation and pre-contemplation. These ways of understanding change are shown to extend the possible ways of thinking about people's lives and ED patients' perspectives.

Keywords: eating disorders; autobiography; stages of change; transtheoretical model; narrative analysis

Essstörungen (ES) haben sich in den letzten Jahrzehnten faktisch zu einem der größten psychischen Störungsbilder entwickelt, vor allem unter Jugendlichen und Frauen. Die vorliegende Studie untersucht, inwiefern sich das von Prochaska & DiClementes (1983) entwickelte „Transtheoretische Modell“ (TMC) für die Analyse der bislang gemachten Erfahrungen

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von Menschen mit ES und ihren Betreuern eignet. Zu diesem Zweck haben wir einen narrativ-biografischen Ansatz ausgewählt, um mithilfe dessen den verschiedenen Wegen nachzuspüren, wie Menschen ihrer Essstörungs-Problematik begegnen und sich, in Anbetracht dessen, deren weitere Entwicklung gestaltet hat. Mithilfe der narrativen Analyse dieser Biografien zielten wir auf die den Klienten je eigenen Vorstellungen von „Veränderung“, „Problemen“ und „vitaler Verlaufskurve“. Die autobiografischen Interviews umfassen fünf Personen mit Essstörungen (vier Frauen und ein Mann). Die Untersuchung konnte drei Diskurse ausmachen, die die (weitere) Entwicklung der Klienten strukturieren und für sie Sinn ergeben: Einen Diskurs der funktionalen Anpassung an Ereignisse und Erfahrungen; ein zweiter, der auf zufällige Ereignisse und Menschen, die in deren Leben eintreten, abstellt. Im Mittelpunkt des dritten Diskurses stehen die Handlungsfähigkeit und Eigeninitiative des Aktors. Die Untersuchung erläutert darüber hinaus bestimmte Verständnisweisen von Entschlossenheit, Reflexion und „Vorüberlegungen“. Diese Formen des Verständnisses von Veränderungen werden aufgezeigt, um die vorhandenen Vorstellungen über das Leben anderer Menschen und die bislang verfügbaren Sichtweisen von Klienten mit Essstörungen zu erweitern.

Schlüsselwörter: Essstörungen; Autobiografie; Stufen der Veränderung; Transtheoretisches Modell; narrative Analyse

Los trastornos de la alimentación se han convertido en uno de los mayores problemas en el campo de la salud mental durante las últimas décadas, especialmente entre los jóvenes y las mujeres. El objetivo del presente estudio es analizar si el Modelo de Cambio Transteórico de Prochaska y Di Clemente (1983), es adecuado para ser aplicado al estudio de las experiencias vividas por personas que han sido diagnosticadas con trastornos de la alimentación y a las personas que cuidan de ellos. Se aplicó un método biográfico narrativo para estudiar la manera en que las personas enfrentan sus problemas y su desarrollo vital en la esfera de los trastornos de la alimentación. A través del análisis narrativo de estas autobiografías nos propusimos estudiar las nociones de "cambio", "problema" y "trayectoria vital" en los propios pacientes. Nos focalizamos en cinco entrevistas autobiográficas con personas diagnosticadas con trastornos de la alimentación (cuatro mujeres y un hombre). El análisis produjo tres discursos que organizan y dan sentido a las transiciones vitales en nuestros participantes: 1, adaptación funcional a eventos y experiencias; 2, atención a eventos imprevistos y a personas que vienen a formar parte sus vidas y 3, iniciativa personal y modo de operar como centro en la vida del individuo. Pudimos apreciar formas particulares para entender determinación, contemplación y pre-contemplación. Estas formas de comprender el cambio parecen extender las posibles formas en que pensamos acerca de la vida de las personas y las perspectivas de los pacientes con trastornos de la alimentación.

Palabras clave: trastornos de la alimentación; autobiografía; estadios de cambio; modelo transteórico; análisis narrativo

Negli ultimi decenni i Disturbi del Comportamento Alimentare (ED) sono diventati uno dei più grandi problemi di salute mentale, in particolare tra i giovani e le donne. Il presente studio si propone di analizzare l'ideoneità

del Modello Transteorico sul cambiamento (TMC di Prochaska & Di Clemente (1983)) ad essere applicato alle esperienze di vita delle persone con diagnosi di ED e a chi di loro si prende cura. A questo scopo, abbiamo utilizzato un approccio biografico narrativo per analizzare il modo in cui le persone affrontano i loro problemi e i cambiamenti della vita in presenza di ED. Attraverso l'analisi narrativa di queste autobiografie, ci siamo proposti di studiare le nozioni che i pazienti hanno di 'cambiamento', 'problema' e 'traiettoria di vita'. Ci siamo focalizzati sulle interviste autobiografiche di cinque soggetti (quattro donne e un uomo) con diagnosi di ED. L'analisi conduce a tre tipologie di discorso che organizzano e danno senso alle transizioni dei soggetti considerati: un discorso di adattamento funzionale a eventi ed esperienze; uno che pone attenzione a eventi casuali e persone che entrano nella vita del soggetto; uno che pone l'iniziativa personale e un singolo agente al suo centro. Si chiariscono anche particolari modalità di comprendere la determinazione, la contemplazione e la pre-contemplazione. Queste concezioni relative al cambiamento sono state presentate al fine di ampliare il modo di pensare alla vita delle persone con ED e alle loro prospettive.

Parole chiave: disturbi alimentari; autobiografia; fasi di cambiamento; Modello Transteoretico; analisi narrativa

Depuis quelques dizaines d'années, les troubles du comportement alimentaire (ED) sont devenus l'un des problèmes principaux de santé mentale, en particulier chez les jeunes et les femmes. Cette étude a pour objectif d'analyser la pertinence du modèle trans-théorique du changement (TMC) de Prochaska & DiClemente's (1983) lorsqu'il est appliqué à l'expérience vécue des personnes diagnostiquées avec des ED ainsi que celle de ceux qui prennent soin d'eux. A cet effet, nous avons adopté une approche narrative biographique de la façon dont les gens font face à leurs problèmes et aux développements cruciaux dans le domaine des ED. A travers l'analyse narrative de ces autobiographies, notre objectif était d'étudier les notions que les patients ont eux-mêmes du 'changement', du 'problème' et de la 'trajectoire vitale'. Nous nous sommes concentrés sur cinq interviews autobiographiques de personnes diagnostiquées avec un ED (quatre femmes et un homme). L'analyse a donné trois discours qui organisent et donnent sens aux transitions vitales de nos participants : un discours d'adaptation fonctionnelle aux événements et aux expériences ; un autre qui est attentif aux événements dus au hasard et aux gens qui entrent dans votre vie ; et un dernier centré sur l'initiative et la capacité d'action des agents individuels. L'analyse met également en lumière les façons particulières de comprendre la détermination, la réflexion et la pré-réflexion. Nous montrons que ces façons de considérer le changement prolongent les façons déjà existantes de comprendre la vie des gens et les perspectives des patients.

Mots-clés: Troubles du comportement alimentaire; autobiographie; étapes du changement; modèle trans-théorique; analyse narrative

Οι Διαταραχές στην πρόσληψη τροφής (ΔΠΤ) έχουν γίνει ένα από τα μεγαλύτερα προβλήματα ψυχικής υγείας τις τελευταίες δεκαετίες, ιδιαίτερα μεταξύ των νέων και των γυναικών. Η παρούσα μελέτη στοχεύει να αναλύσει την καταλληλότητα του Διαθεωρητικού Μοντέλου της Αλλαγής (TMC) των Prochaska & DiClemente (1983), όταν εφαρμόζεται στις εμπειρίες της ζωής των ανθρώπων που διαγιγνώσκονται με ΔΠΤ και των

φροντιστών τους. Για το σκοπό αυτό, εφαρμόσαμε μια αφηγηματική βιογραφική προσέγγιση για να μελετήσουμε τους τρόπους με τους οποίους οι άνθρωποι αντιμετωπίζουν τα προβλήματα και την ανάπτυξη της ζωής τους στον τομέα των ΔΠΤ. Μέσα από την αφηγηματική ανάλυση αυτών των αυτοβιογραφιών, στόχος μας ήταν να μελετήσουμε τις αντιλήψεις των ιδίων των ασθενών για την «αλλαγή», το «πρόβλημα» και «την πορεία της ζωής». Επικεντρωθήκαμε σε πέντε αυτοβιογραφικές συνεντεύξεις με ανθρώπους που είχαν διάγνωση ΔΠΤ (τέσσερις γυναίκες και ένας άνδρας). Η ανάλυση ανέδειξε τρία συστήματα λόγου, που οργανώνουν και νοηματοδοτούν τις μεταβάσεις της ζωής των συμμετεχόντων μας: το λόγο της λειτουργικής προσαρμογής σε γεγονότα και εμπειρίες, το λόγο που εστιάζει σε τυχαία γεγονότα και τους ανθρώπους που εισέρχονται ζωή και αυτόν που ενέχει στη βάση του την προσωπική πρωτοβουλία και κυριότητα του ατόμου. Επιπλέον, η ανάλυση αναδεικνύει ιδιαίτερους τρόπους κατανόησης των σταδίων του προσδιορισμού, του προ-συλλογισμού και του συλλογισμού. Αυτοί οι τρόποι κατανόησης της αλλαγής φαίνεται να επεκτείνουν τους πιθανούς τρόπους προσέγγισης της ζωής των ανθρώπων και των οπτικών των ασθενών με ΔΠΤ.

Λέξεις κλειδιά: διατροφικές διαταραχές; αυτοβιογραφία; στάδια αλλαγής; Διαθεωρητικό μοντέλο; αφηγηματική ανάλυση

The Transtheoretical Model of Change

The Transtheoretical Model of Change (TMC) emerged through the 1980s (Prochaska, 1979; Prochaska & DiClemente, 1983) in the field of psychological assistance to persons engaged in ‘problematic’ behaviours. It classifies patients into those who do not perceive their behaviour as a problem (pre-contemplation stage according to the model); those who are conscious of having a problem, but would do nothing to solve it (contemplation phase); those who are fully conscious of having a problem and looking for some kind of solution (preparation phase); those taking specific action to change (action phase); and those who have abandoned the problematic behaviour and are keeping the changes attained (maintenance phase).

The TMC was first applied to smoking behaviour (Prochaska, Velicer, DiClemente, & Fava, 1988; Schorr et al., 2008), then to addictions (Prochaska, DiClemente, & Norcross, 1992) and later to other health domains including eating disorders (EDs) (Dunn, Neighbors, & Larimer, 2003; Hasler, Delsignore, Milos, Buddeberg, & Schnyder, 2004; Sullivan & Terris, 2001).

The model is not just explanatory, but also clinically oriented. Attempts have been made to assess so-called change processes. The ultimate aim is to identify the stage of change (SOC) a person or group of persons is in, and to provide clinical recommendations accordingly (Prochaska et al., 1988; Rosen, 2000; Whitelaw, Baldwin, Bunton, & Flynn, 2000).

One of the most cited attempts to find clinical applications for Prochaska and DiClemente’s model has been the creation of what is called the motivational interview, which would integrate Prochaska and DiClemente’s categories with notions inherited from humanism, namely, the relevance of centering intervention in the person and her process of change. The general aim of the

interview is to reduce the latency in active participation in intervention, while the therapist assumes a passive role and becomes a companion who avoids confrontation with the suffering person (Martins & McNeil, 2009; Miller & Rollnick, 2002).

Some problems with the TMC

Interest in the TMC has produced an important amount of research with the aims, among others, of assessing, quantifying and predicting intervention success (Rodríguez-Cano, Beato-Fernández, & Segura Escobar, 2006). This research has been mainly quantitative. Some authors pose certain methodological and ethical problems (Littell & Girvin, 2002; Piper & Brown, 1998). Methodological problems include the difficulty to establish the ecological validity of the model; validity of claims relating the ‘problem’ behaviour to other negative behaviours (e.g. does smoking necessarily come with other damaging health behaviours?); and the validity of processes and SOCs. With respect to ethical problems, some authors consider that the model may be used coercively against persons in a pre-contemplation stage. In this sense, other authors argue for the use of qualitative methodology to give voice to those affected (Whitelaw et al., 2000).

Littell and Girvin (2002) reviewed 87 studies evaluating the validity of the model. They concluded that ‘The assumption that there are common SOCs across a range of situations, problem behaviors, and populations is not borne out by empirical data’; ‘Nor is there consistent or convincing evidence of discrete SOCs in relation to specific problem behaviors’; and ‘To our knowledge, there are no published studies of progression through the entire stage sequence’ (p. 252).

In most studies based on Prochaska and Diclemente’s model, SOCs are assessed through an algorithm based on yes/no responses to questions about current behaviour, future intention and (sometimes) former attempts to change; or through scales composed of items referring to the assessment of various stages (Prochaska, Redding, & Evers, 1997). In Díaz, Solano Pinto, and Solbes (2013), we review some of these instruments, highlighting some features of the construct which lead to a methodological and conceptual critique.

In the first place, even though SOCs are theoretically independent of the existence of institutional treatment, some formulations in the instruments suggest an equivalence between ‘changing to better’ and formal psychological intervention, thus identifying ‘change’ with ‘receiving psychological treatment’. This ambiguity affects content validity and relates to a crucial matter concerning ‘pre-contemplation’ as a construct that might be assessed through self-reports.

Of course, that is not the model’s conception of pre-contemplation. In order to find somebody in a state of pre-contemplation, there must be a problem in their behaviour *according to another person*, while the person claimed to be in trouble does not appreciate the problem.

Another obvious limitation of the instruments is diffuse reference to ‘problems’. The ambiguity persists in scales adapted to make reference to a domain of problems, such as ED (see Treasure & Schmidt, 2001). The problem is eating too much or too little? Eating what, or when? Being despised for being fat? We can suspect that problem-definitions by participants will not always equate with those conceived by the scale designers or its administrators. In fact, those who have applied the model to ED have been facing a problematic inherent to these disorders: what professionals consider ‘symptoms’, patients may consider sources of satisfaction or personal realization (Serpell, Treasure, Teasdale, & Sullivan, 1999; Vitousek, Watson, & Wilson, 1998).

But our purpose here is not to test or refute the construct validity of Prochaska and DiClemente’s model. We understand that its relevance does not emerge from its technical or scientific validity, but from the extension and normalization it has reached in the domain of psychological intervention. We concur here with Davidson’s (1992, p. 822) suggestion that just as people can take ‘apparently illogical but comfortable decisions’ about problematic behaviour, professionals can accept Prochaska and DiClemente’s SOC’s because they allow us to ‘grasp at the heuristics and partial truths which make us feel most comfortable’.

The ambivalence concerning the question ‘Who defines problems?’ emerges from the double origin of the model. If SOC’s emerge from the humanistic clinic, they are defined through a process of personal reflection guided by a therapist. If they emerge from the worries of health agencies to attend problems they know but their sufferers do not always admit, then they should be defined by health agencies. The contradiction is manifest in a double bond common in contemporary psychological care: ‘I will support you with your problem; but I will tell you what the problem is’.

Analysing biographies of persons diagnosed with ED

Our discussion so far points to an irremediable tension between two incompatible ways of considering how people change in life: mapping this ‘how’ onto a classification designed from the institutional definitions of healthy behaviour; or describing it according to the perspective of the person involved, which may require abandoning the project of consolidating a construct to embrace the goal of providing suitable resources to support their specific processes of change.

On the other hand, it seems misguided to invest in the refinement of multiple-choice instruments addressed at assessing important vital questions full of subjective nuisance in specific contexts, to aid a process of psychotherapeutic intervention which works precisely by talking about all that nuisance, near those contexts, with the person affected (Sullivan & Terris, 2001).

These reflections suggest the need to develop qualitative procedures to illuminate biographic change with relation to problems from the perspectives of sufferers. Rather than ‘proposing a new model’ or discussing the claims of the models at hand, the task would consist of attending to the experience of sufferers as they describe and narrate them, and taking it from there. Various authors have focused on EDs from narrative and biographic stances, using

qualitative approaches to show how these methods contribute to a deeper understanding of problems and recovery processes. Chan and Ma (2003) analysed the experience of a Chinese anorexic patient through her life history. Three topics emerged in her justifications of control: saving, reserving food and losing weight. Dawson, Rhodes, and Touyz (2014) studied the recovery processes of eight women with chronic anorexia and emphasized the importance of aspects such as hope, motivation, self-efficacy and support from others in this complex process. Weaver, Martin-McDonald, and Spiers (2012) analysed personal documents written by an adolescent with anorexia, her mother and her therapist. They found that mother and daughter shared similar strategies to deal with anorexia and highlighted six emerging topics.

The thrust of this paper consists of an analysis of change processes in the autobiographies of five persons diagnosed with ED, four males and one female whose ages range from 16 to 47. This analysis is part of a wider study comprising 20 biographic interviews of 5 people diagnosed with ED and their corresponding main carers; and 5 people without diagnosis, with characteristics matched with participants in the clinical group, and their relevant relatives (analogous to the main carers for people in the clinical group). So the total sample is composed of a post-clinic sub-sample and a control sub-sample, and each sub-sample is comprised of five autobiographies and their corresponding biographies as told by another person closely related to them (whom we will call 'carers'). Clinical participants and their carers were recruited by the psychotherapist (second author). Non-clinical participants were selected intentionally. The post-clinic participants went through psychotherapy with the second author or another colleague, and were interviewed by their respective therapists. All participants provided written informed consent to participate in the study.

The interview was structured as a life history: The vital trajectory and biography of the interviewee (or the patient in the case of interviews with carers) were the basic organizing thread. We tried to structure the narration along markers such as places of residence, educational institutions, partnerships, family relations or workplaces. Apart from that only one question was common for all participants roughly formulated thus at the beginning of the interview: *Tell me the story of your life to date, the most important things that happened to you, the ones that made you the way you are, your process up to here.*

Once the narration started with this generic question, we guided the interview through open questions. The interviewer would rely on a flexible guide, written as a list of domains or topics linked to body image, inviting the participant to discuss them on occasion. The 20 interviews were audio recorded and transcribed.

Analysis: six biographical repertoires

The materials for this analysis are 10 biographical interviews: five autobiographical interviews with persons diagnosed with ED, and the corresponding five interviews where their carers told the diagnosed persons' lives in the third person. We first coded these interviews in Prochaska and DiClemente's SOC categories, or in a general 'biographic change' category. The coded text was

then reviewed for ways of linking key events to key consequences, and rhetorical and narrative procedures articulated in the story plot. This analytical approach relies mainly on Potter and Wetherell's (1987) notion of interpretative repertoires, as discursive devices which are deployed by the speaker to make sense of events and account for them.

This coding procedure allows the contrasting of the applicability of the SOC categories with biography, letting other conceptions of change emerge through the process. Six categories emerged (*functional adaptation; chance and fate; personal agency and initiative; determination leads to action; prospective contemplation; pre-contemplation in retrospect/in the eye of another*) which recast Prochaska & Diclemente's conception of change and suggest different conceptions.

Three vernacular ways of understanding change

Functional adaptation

An emerging way of understanding change was what we call '*functional adaptation*', where the person changes as a reaction to former or ongoing events within a system. This includes short- or medium-term reactions to traumatic experience or to others' behaviour; changing through a learning process; coming to terms with experience; adjusting to social demands; using diet as a reaction to bodily shape; and problems emerging from the experience of suffering verbal abuse.

In the following extract, María makes reference to a couple of experiences in her childhood:

- 29 María: (...) So in that sad part of my life, on the one hand we have, body image is there because up to 10, I was a child, I got my first period, I developed, I developed before the rest, and what happens, well there comes the part where they abused me two or three times, where there's a part where it really hurt me, which is the one on the street, which I really think about it and I say 'they did touch me here and here', but in my mind, it was, 'maybe I got pregnant or whatever', I think that from then on I started to fatten and to cover everything uh, to cover all that.
- 30 Natalia: Were you 10, when-?
- 31 María: I think not, I think I was 11 or 12, but with a growing body, that you don't change coat, you stay with the same coat bursting it up, and that part improved, I told you, when I was with those friends in the Burger, I already told you, and each of them had suffered some abuse, they were four or three. Then I felt normal, and it was like ... well, all that ... or that weight disappeared, or it was like normal, I don't know how, that part, that part fell

In line 29, María is narrating a sequence whereby (1) she develops 'before the rest', (2) she gets abused two or three times and (3) she starts fattening and 'covering all that'. The sequence assumes that a girl who develops soon is

more vulnerable to abuse; that abuse is especially harmful for a girl who does not understand its meaning; that fattening is linked to 'covering' the abuse experience. 'Covering', in particular, can be interpreted in two possible ways: fattening may be a way of avoiding the body image of a beautiful and desired woman, thus avoiding sexual attraction associated to abuse experiences and 'covering' her body; or 'covering' as avoiding the recalls of traumatic experience through loss of control over eating.

In line 31, she tells how in a meeting with friends, she disclosed former abuse experiences and other friends disclosed similar experiences. This helped her to feel 'normal', and meant releasing a 'weight'. Both short stories unfold as an adaptation process: Abuse leads to adaptive behaviour patterns to fatten and cover up; sharing the experience with friends helps to normalize it.

Chance and fate

A second way of understanding change in life draws attention to the random appearance of events or persons through life, highlighting the role of *chance and fate*. Especially, meeting persons who allow you to live special experiences, or professionals who turn out to be helpful; but also including persons you wish you had not met, and professionals who make things worse.

For example, María gives an account of how she moved out of her family house, to live with friends in Madrid. Once in Madrid, she presents her search for rooms to share as a game like playing lottery; she finds two very interesting roommates just by chance; she presents them as valuable people casually entering into her life.

Personal agency and initiative

A third biographical repertoire is based on the narrating self as a reflexive, conscious and stable agent who takes decisions through time with her own *personal agency and initiative*. This is possibly the subject preferred by the TMC, or even the subject the TMC takes as both pre-condition and objective of therapy: A rational, coherent and strategic subject searching for balance, with a personal programme based on constancy. Some of the narrative threads relying on this repertoire tell how the accumulation of suffering leads to taking personal decisions, or how the subject transforms her perspective on the world.

A good part of Ana's autobiography has to do with a problematic boyfriend whom she took a long time to get rid of. The following extract gives some indication of the relevance of a strong autonomous self through the management of this process:

157 Ana: ((laughing:)) but the more you try,

158 Natalia: That's very good

159 Ana: ((laughing:)) The more you try, I think at the end you- you get it don't you? . And that time, (...) when I called my parents, 'Come over here I'm packing my things and leaving'. And when (.)

David finally came 'No don't leave me This can't be like this . Fuck no We have to find the solution Ana' . And so I let myself go for one more year. But it got to a point where (.) I was starting to see (.) at home that (.) that I was not going out not going out. And also that the quarrels we had were (.) more and more frequent . Before maybe (.) we had a big one every fortnight but then now it was every other day every other day . I had to make such efforts (.) to stay with his (family) on top of that it was a very- ((coughs)) very closed family like- . We had to do everything together, every weekend I would come here to eat with them, . ((coughs)) (...)

The idea of trying over and over until you achieve an aim involves a constant reflexive subject. This fragment shows a vivid description of the moment when Ana's determination to leave her boyfriend turns into action (even if the decision and action taken are not the kind of problems the TMC draws our attention to). As a whole, the process of change is constructed as an alternation between experiencing a problematic relation and autonomously reflecting about it.

Typically, the paradigmatic movement *from determination to action* promoted in the TMC appears in our biographies invested with this kind of agentive discourse. So when patients speak about their initiative to search for psychological help, from family or professionals, and how it is triggered, it appears as the outcome of a personal emotional reflection process or internal dialogue. This often includes self-attributions of responsibility or at least agency in the development of the problem, and admitting having a problem as such.

In the following extract, Gema describes the crucial moment in which she decided to disclose her 'bulimia' to her parents, thereby starting her search for professional help:

114 Gema: My grandfather had to be disconnected from a machine which I didn't understand why it had to be disconnected. I mean like I don't know. I think it was many things together and I had a bad time and then I generated even more. I was already very bad well again I generated a lot of anxiety, vomiting, lots of laxatives, it was all like (3)¹ very brutal

115 (2)

116 Gema: and then I got scared. I got so scared, I got scared because I could see that I felt like kicking the bucket. I mean saying. I can't stand it anymore, this bitch is killing me so then I sat with my parents and nothing I told them 'dad, mum (2) I have bulimia and I need your help'. I think at that point my parents must have thought, 'what a funny girl, ha, ha, ha' ((ironic tone)) but I knew it, I knew it because among other things, I was studying at college and also I investigated if I was (2) a possible, well if I had that problem. You know? So nothing, they called my uncle and I started to go to hospital

The sequence starts with a description that suggests functional adaptation to a difficult emotional situation: the emotional tension associated with her

grandfather's terminal illness leads to increasing purging behaviours and suicidal thoughts which alarm Gema herself. Fear of suicide leads to a resolution to share the problem with her parents, who call her uncle (to take advantage of his contacts in hospital).

The description also illustrates how Gema uses her knowledge from her psychology studies and investigates her condition, which involves a concerned and thoughtful agent. She attributes scepticism or puzzlement to her parents in the moment of hearing her disclosure. This suggests she feels alone or not understood in front of the people who will be helping her. Such feelings are common in the moment of disclosing mental suffering in general and EDs in particular, and are definitely an element that adds difficulty to the decision to disclose.

A closer view on contemplation and pre-contemplation

Contemplation, as understood in the TMC, i.e. a reflection about a problem being there without determination or disposition to do something about it, did not appear in our participants' stories. What we did find were comments about the prospective possibility of problems appearing at any time in the future. These reflections have to be understood taking into account that the interviews are held after completion of a therapeutic process in persons who acknowledge their diagnosis. They also show a recurrent conviction that the ED is chronic, persistent and never leaves you once it catches you. '*Prospective contemplation*' includes the consideration of possible future risky situations; current problems with social relations, body image or vital change as symptoms of illness; and doubts and contradictions concerning body image at present.

In our review of Prochaska and DiClemente's model above, we have proposed that '*pre-contemplation*' is a problematic concept, since, as opposed to the other SOC categories, it does not describe a state of mind or activity in the person but emphasizes the inexistence of cognitive activity which 'should be there', simply reflecting a contradiction between the perspective of the patient and that of the clinical institution. In our data, we did find two forms of existence for pre-contemplation as the localization of a failure in a person to notice a problem which, from a different perspective, could be there.

One possibility is *in retrospect*. In the following extract, Vero, the mother of Luis, gives an account of not reacting appropriately to her son's problems in the past:

- 9 Vero: So, for us, it was hard, for example, to see his eating problem. For that I mean it was seen, (.) but it was hard for us to see it
- 10 Isabel: mhmh,
- 11 Vero: because he was in his own world, (.) and now, . I mean one day he can talk to you about thousands of things, and another day he can say 'Hello good morning good (afternoon), goodbye'. (...)

Vero is presenting Luis as an introverted character. In line 11, she provides some evidence for this, describing him as somebody ‘in his own world’, who does not always talk about his issues. This description serves to support the conclusion that it was difficult for Luis’ parents to spot the ‘eating problem’.

Another possibility is for *somebody else* to see the problem in the affected person, while the affected person ignores it. In the following extract, Natalia and María (speaking here as mother of Tania and about Tania’s life) remember jointly the moment in which Natalia had to show that there was a serious problem that needed María’s attention:

165 Natalia: But how do you conjugate that in your head, . Right? Uh those emotions like-

166 (1)

167 María: Well suffering from- It’s my fault it’s my fault it’s my fault, . And then a lot of it, and that you know as well because you used to say it, that we couldn’t see it

168 Natalia: mhmh

169 María: And you even had to say to us ‘But she is ill and this and that’ and I remember one of the times you said to me ‘We won’t get out of here without you’ and I stayed, . ‘Well what do I have to do then’ So- I would often forget it . I really lived it in a different way. Now I can see it clearer every time . Cause when she was in the middle of the mess then playing with-

170 Natalia: But surely the mess was- was going out of hand. Wasn’t it? Because she was ill

171 María: Yes you would say ‘How is she getting on’ . ‘Very good’ . (...)

Natalia and María recall the contrast between María not seeing her daughter’s problem and Natalia (Tania’s therapist) seeing it and calling her attention to it. They describe an epic moment in which Natalia appealed to María’s collaboration, and María reacted adequately. In line 169, we can read a strong contrast between the past confusing moment in the midst of the trouble, and present clarity.

Discussion

Our aim in this paper has been to show the utility of oral biography to examine personal stages of change in the terms and narrative structures used by the subjects of change themselves. We described three implicit discourses which organize and give sense to their vital transitions: a discourse of functional adaptation to events and experiences; one that pays attention to random events and people entering your life; and one that has the personal initiative and agency of an individual agent at its core. These ways of understanding change are not incompatible with those promoted in Prochaska and DiClemente’s model, but they extend the possible ways of thinking about people’s lives.

With respect to the TMC, we showed how an ‘individual agency’ repertoire can be the template on which the transition from determination to action is constructed. Contemplation appears blended with a notion of the ED as a chronic, irremediable dependency. And we brought out aspects of how pre-contemplation is experienced as a recollection (while reviewing your own past after a process of intervention) or as a mutual warning (when a third person points out a problem).

At the same time, we have stressed the necessity to respect vernacular definitions of change objectives. Prochaska and DiClemente’s model systematically takes for granted that the only issue requiring change in a person is defined by their clinical diagnosis. In the ED domain, the problem would be eating behaviour and the purpose of change would consist of restoring it to a healthy pattern.

But when we listen to the lives of the persons diagnosed, we learn about other issues which demand legitimate attention, such as gaining autonomy from the family, overcoming problematic relationships or changing body shape through diet. To understand processes of change, we need to attend to these issues without judging them, being the issues that structure the lives and concerns of the patients.

Through the last decade, autobiographies of women with EDs have been a common resource to elaborate personal experience, to help other sufferers confront the problem or to furnish and dignify its complexities before the general public (e.g. Bowman, 2007; Saukko, 2008). Autobiography gives us the chance to learn about a highly theorized issue from the terms and meaning structures provided by its main characters. Qualitative analysis takes distance from the technical sophistication of open-ended questionnaires and from the diffuse aesthetics of literature, giving us the chance to understand this experience with rigour, in its human contexts and close to its vernacular categories.

A deeper knowledge of ED, grounded in patients’ perspectives and worldviews, requires more accurate assessment methods, where understanding emerges from the discursive environments which engender the relevant discourse (typically, verbal interaction environments). This should facilitate the adaptation of prevention and intervention strategies to the worldview of patients, and the improvement of professional training, to keep it in line with patients’ concerns.

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Note

1. In the excerpts, numbers between brackets indicate pauses in seconds.

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