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A Grounded Theory Analysis of Early Treatment Motivation in Anorexia Nervosa

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Empirical thesis submitted in fulfilment of the requirements for the degree of

Master of Science

August 2013

Statement of Authentication

This thesis is submitted to the University of Sydney in fulfillment of the requirements of the degree of Master of Science (MSc). The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

Signature

Date

Acknowledgements

There are many people whose efforts have made this work possible. I wish to thank my primary supervisor, Dr Paul Rhodes, for the opportunity to learn and explore the world of qualitative research. I am fortunate to have worked alongside you and to have shared in your tremendous knowledge and enthusiasm for this field. Thank you for having faith in me throughout the journey.

To my associate supervisor, Professor Phillipa Hay, thank you for trusting me throughout the research process. Your constant support and unwavering confidence has been invaluable. Your expertise, encouragement and valuable time were gratefully accepted.

Thank you to the therapy team for being so supportive throughout the data collection process. In particular, I would like to thank Lisa and Tara for their efforts to make this research possible. For her cheerful willingness to bear the burden of the administrative tasks of the project, I would especially like to thank Andreea.

To the amazing women who participated in this study, I wish to acknowledge your openness, honesty and willingness to delve into the deeply personal and difficult aspects of the experience of illness. I was inspired by the determination and strength you showed in your journey to recover.

To my friends, thank you for the consistent understanding and acceptance. In particular, I would like to thank Yen, for being such a kind and gentle soul through the ups and downs, and Harshani, for being my rock. Without those late

night hangouts, interventions and laughter through the tears, I simply would not have made it.

For the endless love, kind words, and warm hugs, I would like to thank my parents. Thank you for keeping your faith in me and giving me strength to fight. It is because of you that I have come this far. Thank for being there to catch me at every step of the way. Sid, thank you for being a caring, annoying, understanding and loving little brother. Your persistence in pushing me to achieve my best and willingness to hold my hand though the process was everything I needed.

To Abhi, your unfailing love has been a lifeline during these past few years. Your words of encouragement, patience, understanding and conviction in my abilities, has made this possible. Thank you.

Statement to the Examiners

The present qualitative study is nested within an ongoing randomised controlled trial (Hay, 2010) comparing the Loughborough Eating disorders Activity therapy Out-patient version (LEAPOut; Touyz et al., 2010) enhanced Cognitive Behavioural Therapy (CBT; Pike, Carter, & Olmsted, 2004), with CBT alone for the treatment of Anorexia Nervosa. Funded by the National Health and Medical Research Council (NHMRC634922), it is a double-blind trial that is currently recruiting participants from Australia, the United Kingdom and the United States of America. As a consequence, there were a number of ethical issues that were considered in presenting this thesis.

Firstly, the importance of maintaining blinding within a randomised controlled trial cannot be overstated. This relates to participants, assessors and the chief investigators remaining blind to treatment allocation. This is particularly important given the potential impact it may have on participant outcomes or how the results of the trial are interpreted. Given that participants from the present study are currently in treatment, it was all the more important that treatment allocation not be divulged. As such, the thesis does not clarify which group each participant was allocated to.

Secondly, it is important for the fair assessment of treatment efficacy that the patients, therapists, assessors and investigators on the trial remain neutral as to the outcome of the trial. Any outcome data received during the course of the trial, including qualitative, may bias perceptions and threaten the validity of the results. As the associate supervisor of this research is one of the chief investigators of the trial, it was important to ensure that data regarding group comparison not be divulged. Therefore, the participants' experiences between the groups were not compared. It is anticipated that such a comparison will be undertaken following the completion of the trial. However, such analyses will not be presented in the current thesis.

Thirdly, it is acknowledged that providing detailed information regarding context is important for rigour in qualitative research (Charmaz, 2006). However, ethical approval for the trial was granted conditional upon participant confidentiality being maintained. Thus, the presentation of participant demographic details and outcome data was aggregated to protect participants' privacy. As such, individual participants cannot be identified either through their data.

Abstract

Introduction:

Anorexia Nervosa (AN) is classified as one of the most serious chronic illnesses to affect adolescent and young adult females (Beumont & Touyz, 2003). Recovery rates are poor (Steinhausen, 2002) and evidence of the efficacy of treatments is sparse (Hay, 2013), with motivation being identified as a constraining factor (Vitousek, Watson, & Wilson, 1998). Current understanding of the ‘active ingredients’ of treatment or the psychotherapeutic processes that effect change are significantly limited (Rhodes, 2011), particularly in terms of motivation in AN. An ongoing randomised controlled trial (RCT), comparing the Loughborough Eating disorders Activity therapy- Out-patient version (LEAPOut; Touyz, et al., 2010) enhanced Cognitive Behavioural Therapy (CBT; Pike, et al., 2004) with CBT alone, provided a unique opportunity to examine the therapeutic and change processes in relation to motivation to recover from AN in the early stages of treatment.

Aim:

Nested within the RCT, the study aims were to; (i) develop a grounded theory of the process of change in motivation in patients in the early stage of treatment; and (ii) isolate particular aspects of treatment which contribute to changes in motivation, including those referred to in treatment manuals as well as processes unique to patient-therapist interactions.

Methods:

Semi-structured, qualitative interviews with sixteen women who had completed two assessment sessions and either eight sessions of CBT or LEAPOut were analysed using grounded theory principles (Charmaz, 2006; Glaser & Strauss, 1967).

Results:

The results yielded a model of the process of change in motivation occurring in three phases; illness, turning point and recovery. The majority of participants firstly described the illness as an uncontrollable entity (illness) before experiencing a point at which they developed the will to recover (turning point) and then engaged in a constant struggle to change (recovery). Participants' whose experiences did not fit the dominant model are also discussed. Psychotherapeutic processes that impacted on motivation were therapist professionalism, non-judgemental approach, reliability, and ability to be collaborative and flexible. Trust, rapport, disconnect and perceptions of the treatment as a bandaid were identified as being significant factors of the relationship. The aspects of treatment that were isolated as impacting upon motivation to change were challenging fears, externalisation, food diaries, goal setting, information and weigh-ins.

Conclusions:

It was concluded that there may be merit in the application of the Self-Determination Theory (SDT; Ryan & Deci, 2000b) in AN treatment and research. The application of the recovery model (Anthony, 1993) to AN treatment is recommended, given the importance of self-determined motivation identified. In the area of AN, the findings have provided indications for improved theoretical conceptualisation of the motivation change process and have highlighted the therapy-related factors that facilitate change. It provides much needed investigation in evidence-based practice and process research. This study contributes to a field where there is a paucity of research on motivation to engage in treatment and improving patient outcomes is critical.

Overview

Chapter 1 of this thesis provides an overview of the area of motivation and process research in Anorexia Nervosa (AN). This includes a description of (1) AN and treatment research, (2) a review of the key theories and treatments targeting motivation, (3) an outline of process research in the field, and (4) the qualitative research methods used for this purpose. The chapter concludes with an introduction into the rationale and objectives for the present study. Chapter 2 provides details of the procedure of the present study with an overview of the grounded theory process, from data collection to write up. Chapter 3 presents the findings of the study, detailing the emergent themes and theory. Chapter 4 provides a general discussion of the study, outlining the key findings and conclusions, limitations and directions for future research.

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Chapter 1: Introduction

1.1 Clinical Presentation

1.1.1 Diagnostic Criteria

Anorexia Nervosa (AN) is characterized by weight related psychopathology, disordered eating and emaciation (American Psychiatric Association, 2013). According to its most recent conceptualisation, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; American Psychiatric Association, 2013), AN has three essential features; intake restriction, an intense fear of weight gain, or behaviours that interfere in gain, and body image distortions. The diagnostic criteria are presented in Table 1.1.

1.1.2 Specific features

AN is also characterized by excessive exercise, hyperactivity and a variety of purging strategies to avoid or prevent weight gain (Royal Australian and New Zealand College of Psychiatrists, 2005). The illness occurs predominantly in females (Ackard, Fulkerson, & Neumark-Sztainer, 2007) with onset being in adolescence or early adulthood (Beumont & Touyz, 2003). It tends to have a strong familial association (Keski-Rahkonen et al., 2007).

Table 1.1: Diagnostic criteria for AN (American Psychiatric Association, 2013, p. 338)

Diagnostic criteria for Anorexia Nervosa

- A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. *Significantly low weight* is defined as the weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.
 - B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.
 - C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.
-

Specify whether:

Restricting type: During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.

Binge-Eating/Purging type: During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Specify if:

In partial remission: After full criteria for Anorexia Nervosa were previously met, criterion A (low body weight) has not been met for a sustained period, but either Criterion B (intense fear of gaining weight or becoming fat or behavior that interferes with weight gain) or Criterion C (disturbances in self-perception of weight and shape) is still met.

In full remission: After full criteria for Anorexia Nervosa were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity:

The minimum level of severity is based, for adults, on current body mass index (BMI) (see below) or, for children and adolescents, on BMI percentiles. The ranges below are derived from the World Health Organization categories for thinness in adults; for children and adolescents, corresponding BMI percentiles should be used. The level of severity may be increased to reflect clinical symptoms, the degree of functional disability, and the need for supervision.

Mild: BMI ≥ 17 kg/m²

Moderate: BMI 16-16.99 kg/m²

Severe: BMI 15-15.99 kg/m²

Extreme: BMI ≤ 15 kg/m²

1.1.3 Prevalence

There is no recent data on the point prevalence of AN in Australia, though New Zealand statistics suggest that it is less than 1% (Oakley Browne, Wells, & Scott, 2006). Research indicates a higher point prevalence in adolescence (ages 15-19; 0.5%) than early adulthood (ages 20-24; 0.25%) (Beumont & Touyz, 2003). Lifetime prevalence for AN in a cohort study for Australian female twins was estimated at 1.9% (Wade, Bergin, Tiggemann, Bulik, & Fairburn, 2006). This increased to 2.4% when the criterion for amenorrhoea was removed, as is the case for the latest diagnostic criteria (American Psychiatric Association, 2013; Wade, et al., 2006).

1.1.4 Comorbidity

AN is a disorder associated with significantly high comorbidity, with 56.2% meeting diagnostic criteria for at least one other illness (Hudson, Hiripi, Pope Jr, & Kessler, 2007). Comorbid illnesses include mood (Godart et al., 2007), anxiety (Swinbourne & Touyz, 2007), and substance abuse disorders (Blinder, Cumella, & Sanathara, 2006; Salbach-Andrae et al., 2008). Research also suggests that personality disorders contribute to comorbidity, with Obsessive Compulsive Personality Disorder (22%) and Borderline Personality Disorder (25%) being the most common (Sansone & Sansone, 2011).

1.1.5 Aetiology

The causes of AN are not currently known (Fairburn & Harrison, 2003), however, a number of factors have been implicated such as genetics and psychological factors. Twin studies suggest that AN occurs in concordance in monozygotic twins at a rate of 55%, and in dizygotic twins at a rate of 5%, suggesting genes play a significant role in AN (Treasure & Holland, 1989). Psychological factors implicated include an

increased need for control and overvaluation of shape and weight (Fairburn, Shafran, & Cooper, 1999).

1.1.6 Impact

AN is classified as one of the most serious chronic illnesses to affect adolescent and young adult females (Beumont & Touyz, 2003). The standardised mortality ratio in AN is 5.86, with 20% of deaths occurring due to suicide (Arcelus, Mitchell, Wales, & Nielsen, 2011). The rate of mortality in AN is five times higher than age equivalent peers (Harris & Barraclough, 1998). Chronicity of the illness leads to medical problems (e.g. osteoporosis), mental illnesses (e.g. dysthymia), and social problems (e.g. isolation, leading to disability equivalent to that of schizophrenia) (Beumont & Touyz, 2003). This illness has a substantial impact upon patient's functioning in their social, familial and occupational domains, leading to poor quality of life (Jenkins, Hoste, Meyer, & Blissett, 2011). This is said to persist even after individuals no longer meet diagnostic criteria (Mitchison, Hay, Mond, & Slewa-Younan, 2013; Rie, Noordenbos, & Furth, 2005).

Not only does the illness affect the patients, but AN is associated with high levels of distress in carers of the patients, with guilt and shame being salient themes (Treasure et al., 2001). It has a significant impact upon the healthcare system, with a recent review suggesting the economic burden of the illness is substantially high (American Psychiatric Association, 2000; Berkman, Lohr, & Bulik, 2007; Stuhldreher et al., 2012). For the individual and their family however, the cost of AN is great due to profound psychological and physical impact upon the individual (Couturier & Lock, 2006). Thus the development of efficacious treatments for this debilitating disorder is crucial.

1.2 Treatment

1.2.1 Overview

Medication, hospitalisation and therapy have been explored as treatment for AN (Bodell & Keel, 2010). It has been recommended that medication not be the primary treatment (NICE, 2010). Similarly, inpatient treatment is only recommended in situations of medical instability, with the general preference being for outpatient therapy (NICE, 2010; RANZCP, 2005). The current guidelines favour outpatient treatments which take a multidimensional approach with the treating team composing of psychiatrists, psychologists and dieticians, to name a few (NICE, 2010; RANZCP, 2005).

In child and adolescent populations, Family-Based Therapy (FBT) has been recommended as the treatment of choice (National Institute of Clinical Excellence; NICE, 2004; Smith & Cook-Cottone, 2011). For adults, Cognitive Behavioural Therapy (CBT) is generally the recommended treatment, despite limited evidence (NICE, 2010; RANZCP, 2005). For example recent review by (Hay, 2013) found only six new follow up and treatment trial studies since 2005, but noted that the quality of research in AN is improving. The conclusions support the use of CBT for eating disorders (Hay, 2013). CBT has shown to reduce relapse in weight-restored AN patients (Pike, Walsh, Vitousek, Wilson, & Bauer, 2003) and achieve 'good' outcome for 66% of patients who had completed the treatment (Fairburn et al., 2009). This suggests CBT has promising potential, however further research is needed.

One direction for investigation has been developing treatments which complement and enhance current CBT for AN. Emerging research suggests that treatments which target AN patients' exercise behaviour is likely to yield better treatment outcomes (Clausen, 2008). Specifically, the **Loughborough Eating disorders Activity**

therapy (LEAP; Touyz, et al., 2010) was developed as a supplement to CBT to promote healthy exercise behaviours in AN patients. In a pilot study, with a sample size of 19, eight sessions of LEAP delivered in an group inpatient treatment setting was found to improve Body Mass Index (BMI), depression, anxiety, AN related cognitive distortions and, most notably, motivation to change (La Puma, Touyz, Taranis, & Meyer, 2008).

Thus to further expand the evidence base, there is currently an ongoing double-blind randomised controlled trial (RCT) that will examine the efficacy of outpatient version of LEAP enhanced for manualised CBT for AN (termed LEAPOut in this study) compared to CBT alone in individual therapy (Hay, 2010). The RCT has been funded by the National Health and Medical Research Council (NHMRC634922). It is expected that findings of this RCT will contribute to the evidence base for AN treatment. The RCT also provides an opportunity to investigate which specific components and processes of treatment effect change. It provides a valuable opportunity to explore the aspects of treatment that influence motivation to change. As such, the present qualitative study is nested within this trial. A brief description of the treatments being investigated is presented below.

1.2.2 LEAPOut and CBT RCT

Loughborough Eating disorders Activity therapy (LEAP; Touyz, et al., 2010)

The aim of the LEAPOut is to promote healthy attitudes, beliefs, and behaviours towards exercise in eating disorder patients through individual sessions in an outpatient setting. Based on cognitive-behavioral principles, through education, the program endeavors to correct any misconceptions that the patients may have regarding exercise behavior. By empowering individuals to make informed decisions regarding health-appropriate exercise behaviour, it is expected that participants will be motivated to choose the appropriate physical activity level based upon their health status. Importantly, the

treatment does not specify that patients cannot engage in physical activity. The LEAPOut program consists of eight one-hour long sessions that consist of four key themes; education, guided discovery, cognitive skills, and relapse prevention.

Cognitive Behavioural Therapy (CBT; Pike, et al., 2004)

In the current RCT (Hay, 2010), the CBT manual being utilised was developed by (Pike, et al., 2004). It is adapted from the manual initially developed by Pike, Vitousek, and Wilson (1993). The therapy was developed by improving upon pre-existing treatments for eating disorders by incorporating the latest research across a number of therapeutic approaches. For example, aspects of schema therapy (Young, Klosko, & Weishaar, 2003) and Motivational Interviewing (MI; Miller & Rollnick, 2002) have been included. The CBT program is an active treatment targeted at weight restoration and the normalisation of eating habits through cognitive restructuring and behavioural modification (Pike, et al., 2004). The treatment consists of four treatment stages, which have been extended across 34 sessions of treatment. These stages will be briefly described below:

Stage 1: The key tasks in this stage are socialisation to treatment, assessing and enhancing motivation through principles of MI (Miller & Rollnick, 2002) and those discussed by (Vitousek, et al., 1998).

Stage 2: The second stage includes developing skills in cognitive restructuring, as well as affecting behavioural modification to normalise eating patterns and establish weight restoration.

Stage 3: Using a schema-based approach, address the issues that extend beyond, but do tend to impact, the eating disorder.

Stage 4: The focus here is upon a treatment review, relapse prevention and treatment termination.

An earlier version of this program was utilised in a clinical trial by (Pike, et al., 2003). Results suggested that when compared to nutritional counselling, CBT was significantly more effective in reducing drop-out and relapse, and improving good outcomes for post-hospitalisation, weight restored AN patients (Pike, et al., 2003).

1.2.3 Further Research Needed

Whilst the LEAPOut trial results are pending (Hay, 2010), there is still a dearth of research regarding efficacious treatments for adults. Current guidelines state that it is “extremely difficult to draw general conclusions about the efficacy of specific treatment options for anorexia” (RANZCP, 2005, p. 618). Therefore, the majority of guidelines tend to be based on expert opinion and uncontrolled trials (RANZCP, 2005). This is due to both methodological limitations as well as the paucity of literature in the field.

Methodological limitations cited in the field include the limited number and poor quality of controlled clinical trials, over-reliance upon retrospective rather than prospective studies, poor reporting with imprecise or limited information, high attrition rates which impact analysis of outcomes and follow up, and insufficient investigation of any one specific treatment (RANZCP, 2005; Steinhausen, 2002). The rationale put forward to account for the dearth of research includes the nature of the illness, in that it is low in prevalence and is associated with high morbidity, ethical issues associated with exposing this at-risk population to yet unproven treatments, and the egosyntonic nature of the illness (RANZCP, 2005; Steinhausen, 2002; Vitousek, et al., 1998).

The limitations in treatment research are all the more concerning given the seriousness of the illness. The overall mean rate of recovery, when averaged across studies, appears to be less than 50% (Steinhausen, 2002). Chronicity can be estimated to approximately 20%, with mortality at 5% (Steinhausen, 2002). The majority of patients improve in somatic symptoms yet the core dysfunction of AN, the psychopathology,

appear to be persistent and resistant to change (Bachner-Melman, Zohar, & Ebstein, 2006; Berkman, et al., 2007; Steinhausen, 2002).

Recovery and improvement rates in AN have not markedly improved over the previous half century (Steinhausen, 2002). The seriousness of this psychiatric illness, and the risk of mortality associated renders the current rate of recovery unacceptable (Beumont & Touyz, 2003; Forcano et al., 2011; Steinhausen, 2002). According to Steinhausen (2002, p. 1284) “...there was only limited evidence that the outcome of anorexia nervosa has improved significantly across these five decades”. Therefore greater research into improving the treatments of AN is required. One key area identified as being important to improve recovery rates is motivation (Vitousek, et al., 1998)

1.3 Motivation

1.3.1 Motivation and Recovery

In the field of eating disorders, motivation is identified as being critical to treatment success. According to (Fairburn, Cooper, & Shafran, 2008), without sufficient motivation, “treatment stands little chance of succeeding” (Fairburn, et al., 2008, p. 147). The importance of addressing motivation has been widely acknowledged. According to NICE guidelines, motivation is a key factor to be considered when implementing treatment for eating disorders (NICE, 2010).

Motivation to improve in patients with AN is notoriously difficult to both foster and maintain (Vitousek, et al., 1998). Ambivalence with regard to recovery is considered typical in presentations of AN (Geller, Srikameswaran, Zelicowska, & Williams, 2012). Given the increasing encroachment of third parties, such as insurance companies and Medicare upon the therapy dyad, it is even more important motivation be addressed (Ryan, Lynch, Vansteenkiste, & Deci, 2011). This is because patients may be presenting due to pressure from parents, families and physicians (Guarda, 2008). However, when

patients themselves do voluntarily seek treatment, it tends to be for the purpose of alleviating immediate physical and psychological distress without the intention to gain weight (Guarda, 2008). Patients who do ultimately drop out of treatment are likely to engage in a cycle of ineffective behaviours which continue to maintain the disorder (Geller, Williams, & Srikameswaran, 2001). This lack of motivation also presents a trying challenge for clinicians (Geller, et al., 2001; Vitousek, et al., 1998). Active attempts by patients to avoid treatment have contributed to the general perception amongst clinicians that AN patients are difficult and frustrating to treat (Geller, et al., 2001; Kaplan & Garfinkel, 1999).

There is much empirical research to support the view that motivation plays an important role in AN. For example, in a prospective study, reductions in levels of motivation during treatment as well as lower post-treatment motivation were identified as risk factors for relapse in AN (Carter et al., 2012). Low motivation has been associated with greater attrition (Kahn & Pike, 2001). Similarly, low motivation at baseline was associated with greater hospitalisation in adolescents (Ametller, Castro, Serrano, Martinez, & Toro, 2005). Conversely, higher motivation at baseline has been linked to improved outcome (Herzog, Sacks, Keller, Lavori, & et al., 1993). Moreover, a shift from low readiness to change to high readiness to change predicted significantly better outcome and eating pathology at follow up (Wade, Frayne, Edwards, Robertson, & Gilchrist, 2009).

A literature review on the current conceptualisation of motivation in AN, both as psychological theories and treatments, will be presented. Specifically, the literature review will focus upon the two key motivational theories and one treatment that have held prominence in the field of eating disorders; the Transtheoretical Stages of Change Model (SoC; Prochaska, DiClemente, & Norcross, 1992) and the Self-Determination

Theory (SDT; Ryan & Deci, 2000b), and Motivational Interviewing (MI; Miller & Rollnick, 2002)

1.3.2 Theories and Treatments

Transtheoretical Stages of Change Model (SoC; Prochaska, et al., 1992)

Originating in addiction literature, the SoC model was developed to account for how behaviour change occurs, both within and outside of therapy (Prochaska, et al., 1992). According to the model, changes in motivation follow a structured sequence of stages which are qualitatively different to one another (Prochaska, Redding, & Evers, 2008). A temporal pattern of movement is presented, in that progress through the stages is considered time-limited (Prochaska, et al., 1992). The spiral modal of the SoC is presented in Figure 1.1.

The model consists of five stages that identified as being qualitatively different from one another. The *precontemplation* stage is where there is no intention to change one's behaviour within the next six months, due to individuals being unaware or “under-aware” of their difficulties (Prochaska, et al., 1992, p. 1103). The *contemplations* stage is marked with an active consideration of the benefits of change versus the cost of the problem, with a serious intention to change behaviour in the next six months (Prochaska, et al., 1992). The *preparation* stage is one where intention to change translate to some behavioural change within one month (Prochaska, et al., 1992). This stage was initially referred to as the “decision making” stage (Prochaska, et al., 1992). The *action* stage is one in which individuals actively modify behaviour to effect change, and spans for a period of six months. *Maintenance* or *termination* stage is one at which the gains made during behaviour change are consolidated and relapse prevention is undertaken (Prochaska, et al., 1992).

Figure 1
A Spiral Model of the Stages of Change

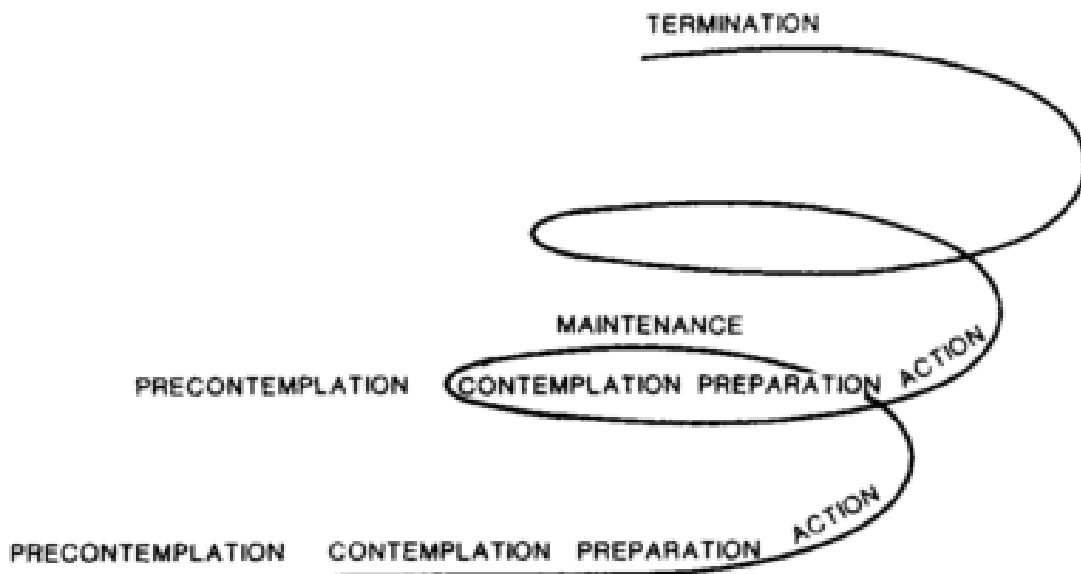


Figure 1.1. A spiral model of the stages of change from Prochaska, DiClemente, and Norcross (1992, p. 1104)

In addition, the model identifies ten processes of change which are predictive of, and enable, behaviour change (Prochaska, et al., 1992), see Table 1.2. These processes transition from cognitive processes, such as consciousness raising and dramatic relief, to behavioural processes such as counter-conditioning and stimulus control, as one transitions along the stages. They are defined as overt or covert activities or experiences which the participant engages in as they transition through the stages (Prochaska, et al., 1992). As these processes have emerged from multiple theoretical domains and treatment approaches, they are referred to as transtheoretical (Prochaska, et al., 1992). A tabulated presentation of the processes as they relate to the different stages is presented in Table 1.3.

Table 1.2.

Processes of Change. Adapted from Prochaska, DiClemente, and Norcross (1992, p. 1108)

Processes	Definitions: Interventions
Consciousness raising	Increasing information about self and problem: observations, confrontations, interpretations, bibliotherapy
Self-reevaluation	Assessing how one feels and thinks about oneself with respect to a problem: value clarification, imagery, corrective emotional experience
Self-liberation	Choosing and commitment to act or belief in ability to change: decision-making therapy, New Year's resolutions, logotherapy techniques, commitment enhancing techniques
Counterconditioning	Substituting alternatives for problem behaviors: relaxation, desensitization, assertion, positive self-statements
Stimulus control	Avoiding or countering stimuli that elicit problem behaviors: restructuring one's environment (e.g., removing alcohol or fattening foods), avoiding high risk cues, fading techniques
Reinforcement management	Rewarding one's self or being rewarded by others for making changes: contingency contracts, overt and covert reinforcement, self-reward
Helping relationships	Being open and trusting about problems with someone who cares: therapeutic alliance, social support, self-help groups
Dramatic relief	Experiencing and expressing feelings about one's problems and solutions: psychodrama, grieving losses, role playing
Environmental reevaluation	Assessing how one's problem affects physical environment: empathy training, documentaries
Social liberation	Increasing alternatives for non-problem behaviors available in society: advocating for rights of repressed, empowering, policy interventions

Table 1.3.
Stages and Corresponding Processes of Change, adapted from Prochaska et al. (1992, p. 1109)

Precontemplation	Contemplation	Preparation	Action	Maintenance
Consciousness raising				
Dramatic relief				
Environmental reevaluation	Self-reevaluation			
		Self-liberation		
			Reinforcement management	
			Helping relationships	
			Counterconditioning	
			Stimulus control	

The processes most relevant in the transition from the pre-contemplation to the contemplation stages of change are consciousness raising, dramatic relief and environmental revaluations (Prochaska, et al., 1992). Consciousness raising is the process of gaining insight into one's difficulties and becoming more informed about the problem. Dramatic relief involves expressing and processing one's feelings regarding their problem. Environmental re-evaluations involve understanding how the problem impacts one's external environment.

Shift from contemplation to preparation is attributed to the self-evaluation process, whereby there is a shift in one's understanding or perception of the problem (Prochaska, et al., 1992). The action stage is posited to occur through the process of self-liberation where individuals' make an active choice to change and commit to recover (Prochaska, et al., 1992).

Transition from the action to maintenance stage is said to involve four processes; reinforcement management, helping relationships, counter conditioning and stimulus control (Prochaska, et al., 1992). Specifically it includes the use of contingency based rewards and punishments, engaging significant others as supports, utilising alternative coping mechanisms rather than the problem behaviours and either avoiding or changing one's response to the problem behaviour related stimulus.

Popularity of the SoC

The SoC model has gained wide popularity in the area of eating disorders (Prochaska, et al., 1992; Waller, 2012). The model has spurred the development of a number of tools for the assessment, such as the Readiness and Motivation Interview (RMI; Geller & Drab, 1999) and Anorexia Nervosa Stages of Change Questionnaire (ANSOCQ; Rieger, Touyz, & Beumont, 2002; Rieger et al., 2000).

The model's popularity may be attributed to two causes; its high face validity and the intuitive appeal of the matching hypothesis (Treasure & Schmidt, 2001; Ward, Troop, Todd, & Treasure, 1996; West, 2005). The matching hypothesis suggests that treatment should be matched to the participants' stage of change (Prochaska, et al., 1992). The model's posited ability to predict treatment completion and outcome, as well as to serve as a guide to clinical decision making has been seen favourably (Prochaska, et al., 1992; West, 2005).

Despite the plethora of research examining motivation through the lens of the transtheoretical model of change, some proponents argue that it does not sufficiently address motivation in AN (Waller, 2012; Wilson & Schlam, 2004). A brief overview of the criticism will be presented below.

Criticism of SoC Model

The SoC model has been heavily criticised for not adhering to the key tenets of a staged model (Wilson & Schlam, 2004). Namely, (Bandura, 1997) argued that a genuine stage theory requires transformation across stages that are qualitative in nature, with the sequence being predictable and linear. However, the general weight of evidence suggests that the SoC does not meet these criteria (Bandura, 1997; Dray & Wade, 2012; Wilson & Schlam, 2004).

Specifically, criticisms of the model include that it is difficult to define the boundaries between each stage, thus making measurement problematic (Wilson & Schlam, 2004). The mutual exclusivity of these stages is challenged with research suggesting participants can be in all stages at the one time (Sutton, 2001). Similarly, the calculation of the time constraints on the categories, such as preparation stage being defined by behaviour change within six months, have been deemed arbitrary (West, 2005).

For example, based on the SoC the Readiness and Motivation Interview (RMI), which is an interview-type measure for assessing motivation for each eating disorder symptom (RMI; Geller & Drab, 1999), patients can be deemed to be in different stages at one time point, which is in direct opposition of the assumptions of the model (Geller, Zaitsoff, & Srikameswaran, 2005). Rather than the categorised approach, a continuous measure of motivation in smoking cessation along the SOC continuum was found to significantly account for greater variance (Kraft, Sutton, & Reynolds, 1999). As concluded in the review by (Wilson & Schlam, 2004), the evidence overwhelming suggests that the stages are not discrete categories.

One explanation for the apparent lack of mutual exclusivity of stages may be that it is likely that patients endorse a number of different stages based upon the specific behaviour in mind. Both the RMI and the ANSOCQ attempts to accommodate for this finding by identifying a stage of change for specific behaviours (Geller & Drab, 1999; Rieger, et al., 2000). However, the comprehensive nature of these tools prevents frequent measurement of motivation in clinical settings.

The second criticism of the SoC model is that the transition through the stages does not follow the linear path as expected (Bandura, 1997; Sutton, 2001; Wilson & Schlam, 2004). The lack of predictable, linear movement has been acknowledged by the proponents of SoC (Prochaska, et al., 1992). The original model presented the stages in a linear fashion, though it was later modified to depict a spiral model (refer to Figure 1.1) with change depicted as a reiterative process with relapse being anticipated as an important learning process (Prochaska, et al., 1992). Furthermore, it is stated that movement through the stages does not have to occur in the series presented, as “some people may move from one stage to another at any time” (Prochaska, et al., 1992, p. 1105). (Weinstein, Rothman, & Sutton, 1998) account for this by stating that should all the necessary ingredients for change co-occur, it is likely that individuals would progress

rapidly through the stages. This movement then is unlikely to be captured by the self-report measures which tend to be admitted at various time points.

Nonetheless, research suggests that prediction of transition through the stages is particularly difficult in the shift from preparation to action stage of change (Armitage, Sheeran, Conner, & Arden, 2004). The authors attribute this to the fact that preparation and action define the boundary between the change from a cognitive to a behavioural domain (Armitage, et al., 2004). Specifically, the model may struggle to account for actual behaviour change (Ryan, et al., 2011).

Related to this, the processes outlined in the SoC model have too come under scrutiny. Proponents of the SoC argue that the processes identified are transtheoretical and can be considered the variables related to transition from one stage to another (Prochaska, et al., 2008). However, it is argued that some of these processes, such as stimulus control, are tasks rather than theoretical processes, resulting the model being deemed “atheoretical” (Bandura, 1997, p. 9) rather than “transtheoretical” (Prochaska, et al., 1992).

The extent to which the processes relate to the stages, as theorised, have also been questioned (Wilson & Schlam, 2004), with (Guo, Aveyard, Fielding, & Sutton, 2009) concluding that the processes of change are not related to movement through the stages. Research suggests that the order in which these processes occur tends to vary according the symptom domain, with behavioural and cognitive processes tending to co-occur in the area of diet and exercise (Rosen 2000). For example, in examining the correlations between the processes and stages in eating disorder patients, only emotional involvement, stimulus control and continuing treatment was significantly correlated with stages of change (Hasler, Delsignore, Milos, Buddeberg, & Schnyder, 2004). Other important processes such as education and consciousness raising were not (Hasler, et al., 2004).

As a result of the limited evidence for both the model and the processes identified, it is not surprising that there is limited support for the matching hypothesis (West, 2005). The model posits that for treatment to be successful, the intervention must be aimed at the patients' current stage of change (Prochaska, et al., 2008). Specifically, one of the critical assumptions behind the model is that treatment strategies need to be matched to the patients' stage of change as individuals not prepared for action "will not be served effectively by traditional action-oriented behaviour change programs" (Prochaska, et al., 2008, p. 103). Thus the model proposes treatment progress from cognitive to behavioural strategies as motivation improves.

However, this is in opposition to empirical evidence which suggests that behaviour change proceeds cognitive change (Bandura, 1969); a finding replicated in eating disorders research where there was limited support found for the matching hypothesis (Treasure et al., 1999). Reviews of the SoC invariably conclude that matching treatment to stages of change have to a large extent failed to deliver results (Ryan, et al., 2011; Sutton, 2001; Wilson & Schlam, 2004).

To examine the utility of SoC in eating disorders,(Dray & Wade, 2012) undertook a systematic review, yielding 12 studies. The results suggested that greater motivation at baseline predicted lower eating pathology, greater BMI, low psychopathology and improved eating disorder attitudes, only when measured using a particular measure (Dray & Wade, 2012). Treatment completion rates were not related to the initial stage of change (Dray & Wade, 2012). The review identified inconsistencies in methodologies and measures as limitation of the field. That a robust connection between the stages and eating disorder pathology or completion rates could not be demonstrated, suggests that the SoC is limited in its utility in the eating disorders.

Self-Determination Theory (SDT; Ryan & Deci, 2000b)

SDT is a broad theory of personality and human motivation (Ryan & Deci, 2000b). It is often referred to as a ‘meta-theory’ as it encompasses five sub-theories. The theory and literature relating to eating disorders will now be reviewed. The structure of this section is as follows; (1) the key concepts within the SDT will be defined; (2) the five sub-theories will be briefly outlined; (3) a discussion of the SDT relates to eating disorders will be presented below.

Key Concepts

Intrinsic and Extrinsic Motivation

The key concept within the SDT is the delineation between intrinsic and extrinsic motivation. Intrinsic motivation is defined as the innate human tendency to grow, explore, develop, seek novelty and experience challenge (Ryan & Deci, 2000b). Intrinsically motivated behaviour is driven by personal enjoyment, interest, or pleasure. It energises and sustains activities through the satisfaction of basic psychological needs (Ryan & Deci, 2000b), discussed below.

On the other hand, extrinsic motivation refers to engagement in behaviours in order to obtain an outcome which is independent of the activity (Ryan & Deci, 2000a). That is, the action is performed not because it is intrinsically rewarding, but because the consequences are rewarding. It is important to note that behaviour can be driven by desire for an outcome, yet still be self-determined and autonomous.

Autonomy, Competence and Relatedness

According to the SDT, human motivation and personality integration can be attributed to satisfaction or thwarting of three basic psychological needs of competence, relatedness and autonomy (Ryan & Deci, 2000b). Autonomy refers to the need to express

oneself freely, and the need to feel that one's actions are of their own free will.

Competence is the need to feel a sense of mastery or control over achieving an outcome in ones' internal and external environment. According to (Deci & Ryan, 1985), perceived competence is seen as a prerequisite for engaging in an action, as it would be seemingly pointless to engage in an action that one does not, even in the slightest, hope will reach the desired goal. Relatedness refers to the need to belong and feel connected within one's social network as well as feeling valuable and worthwhile within these relationships.

To explain the complexity of interaction between ones' environment and motivations, five sub theories are posited. These will be outlined below, followed by a discussion of how the SDT relates to disordered eating.

Five Sub-Theories

Basic Psychological Needs Theory

The Basic Psychological Needs Theory articulates the role of the three basic psychological needs (autonomy, competence and relatedness) in driving behaviour (Ryan, 2009). The assumptions of the theory are that, (1) humans are active entities with the ability to regulate internal and external forces, (2) humans have an innate and intrinsic desire to grow and develop, (3) that external factors either support or hinder this process (Verstuyf, Patrick, Vansteenkiste, & Teixeira, 2012). It is posited that the satisfaction of these needs are associated with growth, integration, social development and well-being, whilst thwarting is associated with dysfunction (Ryan & Deci, 2000b). It is argued that the environment plays a critical role in the satisfaction or thwarting of the needs. Risk behaviours, then, are seen as maladaptive coping strategies for satisfying these needs in environments that are not need supportive (Verstuyf, et al., 2012).

Cognitive Evaluation Theory

According to the Cognitive Evaluation Theory, the three basic psychological needs and the environment interact to influence intrinsic motivation (Ryan, 2009). Intrinsic motivation is enhanced by an increased sense of competence. However, this is to the extent that the behaviours are considered self-regulated. That is, external rewards and control can reduce one's sense of autonomy which, despite clear competence, reduces intrinsic motivation and increases extrinsic motivation (Deci, Koestner, & Ryan, 1999). Relatedness is also distally associated with intrinsic motivation in that security and a sense of belonging contribute to an individual 'flourishing' (Ryan & Deci, 2000b, p. 71). This theory however, only applies if the activity is inherently intrinsically motivating, in that it is novel, challenging or aesthetically valuable (Ryan & Deci, 2000b).

Organismic Integration Theory

Organismic Integration Theory focuses upon extrinsic motivation and the extent to which external regulations become an integrated part of the self (Ryan, 2009). Despite previous accounts of extrinsic motivation as being "pale and impoverished" (Ryan & Deci, 2000a, p. 55), it is important to note that extrinsic motivation can be self-determined motivation. The majority of behaviours in adulthood are engaged in due to social pressures and increased responsibility. The extent to which these behaviours are self-determined, as opposed to leading to amotivation, unwillingness or passive compliance, is dependent on the degree of integration. Integration is the extent to which a reward or regulation is incorporated into one's sense of self and becomes a cohesive part of one's identity (Ryan & Deci, 2000b).

According to the Organismic Integration Theory, motivation can be placed on a continuum of self-determined motivation, ranging from amotivation to intrinsic motivation (Ryan, 2009). As depicted in Figure 1.2., there are six different types of

motivation on this continuum. The first is the absence of motivation, the following four are categorised as extrinsic motivation, with the final type being intrinsic motivation. The types of motivation, with a brief description are presented in Table 1.4.

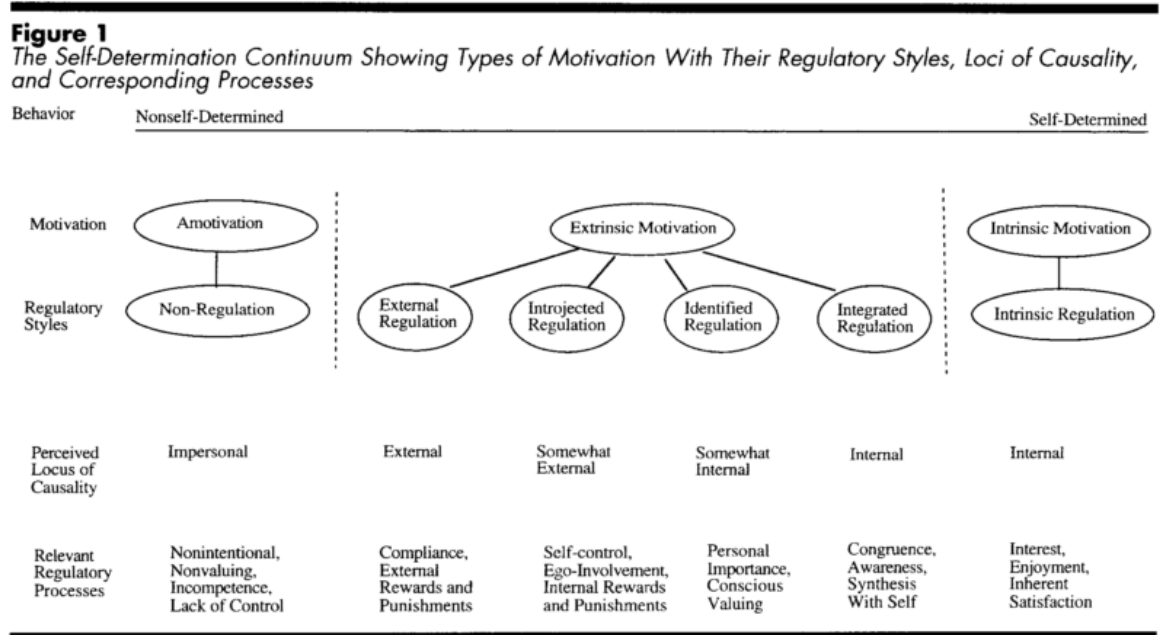


Figure 1.2. The Self-Determination continuum showing types of motivation with their regulatory styles, loci of causality and corresponding processes from Ryan and Deci (2000, p. 72)

There is empirical support for this theory, with a simplex pattern being reliably demonstrated across various domains and cultures (Pelletier, Tuson, & Haddad, 1997). That is, the pattern of correlations suggests that types of motivation were as theorised along a continuum of autonomy (Pelletier, et al., 1997; Ryan & Deci, 2000b; Ryan, et al., 2011). Furthermore, in investigating the psychometric properties of the Client Motivation for Therapy Scale, as expected, greater autonomy was related to greater satisfaction, tendency to persist and less distress regarding treatment (Pelletier, et al., 1997). This finding was also replicated in the CBT literature, with outpatients that were more autonomously motivated showing better outcomes (Michalak, Klappheck, & Kosfelder, 2004).

Table 1 4.

Types of Motivation According to Organismic Integration Theory (OIT); Ryan, 2009; Ryan & Deci, 2000)

Type	Description
Amotivation	Amotivation describes a state where the individual is lacking intent or not engaging in the behaviour either due the lack of a salient reward (Seligman, 1975), or due to beliefs about competence in performing an action (Bandura, 1999).
Externally Regulated	Externally regulated is a type of motivation in which actions are performed due to an external control or reward (Ryan & Deci, 2000). The behaviour is considered alienated from one's sense of self, and it is acknowledged that the locus of control for the behaviour is external. The use of reinforcement contingencies falls into this categories, such as using a minimum weight gain criteria to allow participants rewards in treatment (Ryan, Lynch, Vansteenkiste, & Deci, 2011).
Introjected Regulation	In introjected motivation, behaviour is seen as somewhat internally regulated, though not of one's own volition (Ryan & Deci, 2000). Guilt and shame, pride or contingent self-esteem is common in behaviour regulated through introjection. This type of motivation is marked by "should" statements (Ryan et al., 2011).
Identified Regulation	This is form of regulation is one where an external control or regulation is valued and is considered important to oneself (Ryan & Deci, 2000). The locus of control is considered somewhat internal. The individuals value the activity and are willing to accept responsibility for the behaviour and actions (Ryan et al., 2011).
Integrated Regulation	This is the most self-determined type of extrinsic motivation in that the external control or consequences is assimilated into a cohesive sense of one's identity (Ryan & Deci, 2000). There is an internal congruence between one's values and sense of self, and the activity (Ryan et al., 2011). It is autonomously regulated and the actions are considered volitional. However it differs from intrinsic motivation in that the activity itself may not necessarily be enjoyable but is still self-determined.
Intrinsically Motivated	This form of regulation is innate (Ryan & Deci, 2000). The behaviours performed are experienced as inherently enjoyable and satisfying of three basic needs. Usually as the activity itself is interesting and enjoyable, which tends not to be the common type of motivation when presenting for therapy (Ryan et al., 2011)

However, unlike the SoC, Organismic Integration Theory does not suggest that one must move through the types of motivation as stages (Prochaska, et al., 1992; Ryan & Connell, 1989; Ryan, et al., 2011). Neither are the types of motivation mutually exclusive, like the SoC (Prochaska, et al., 1992; Ryan, et al., 2011). Rather, one can have multiple motivations, with differing levels of autonomy (Ryan, et al., 2011). The level of autonomy perceived by the individual will be a function of the net difference between the multiple motives involved (Ryan, et al., 2011). Therapy can work to increase one type of regulation over others, with the therapeutic approach determining the types (Ryan, et al., 2011).

Causality Orientations Theory

According to this theory, quality of motivation can be placed on two continuums; autonomy and control (Ryan & Connell, 1989). Autonomous motivation is viewed as dimensional with one end being intrinsically motivated whilst the other is identified regulation. The level of control examines the extent to which the regulation is considered external versus integrated. The theory relates to the perceived locus of control of one's behaviour and individual differences in the way external controls impact the individual to influence their behaviour.

Goal Contents Theory

This theory relates to goals, their degree of intrinsic/extrinsic motivations and the extent to which this contributes to wellbeing (Ryan, 2009). The theory posits that intrinsic goals are more likely to be need satisfying (e.g. intimate relationships, community contribution, personal growth) than extrinsic goals (e.g. image, fame, financial success). There are three goal orientations, which are autonomy (e.g. acting as it is in personal interest and consistent with sense of self), control (e.g. focus on outcomes/rewards) and impersonal/amotivation (e.g. anxiety concerning competence).

SDT and Eating Disorders

There has been a growing interest in examining motivation to recover in eating disorders through the SDT lens (Pelletier & Dion, 2007; Vansteenkiste, Soenens, & Vandereycken, 2005; Verstuyf, et al., 2012). This includes using SDT to understand the regulatory processes contributing to the development (Verstuyf, et al., 2012) and maintenance of disordered eating (Pelletier & Dion, 2007; Vansteenkiste, et al., 2005). The following section will provide a brief overview of the current conceptualisations of AN from the SDT perspective, followed by a general discussion of treatment recommendations from the SDT perspective.

SDT and AN

According to (Verstuyf, et al., 2012), from the SDT perspective, eating disorders can be considered a maladaptive coping mechanism for satisfying thwarted needs (Verstuyf, et al., 2012). These maladaptive coping mechanisms can broadly be categorised as need substitution and compensatory strategies. Need substitution refers to the general process whereby one aims to meet psychological needs by focussing on extrinsic goals to meet intrinsic needs. In terms of eating disorders, should one be unable to achieve a sense of relatedness, it is hypothesised individuals are more likely to strive for extrinsic goals, such as attractiveness and thinness in the expectation that it would lead to greater acceptance by peers and significant others. However the success of this strategy is limited in that thinness does not directly lead to acceptance and belonging.

Compensatory behaviours on the other hand, refer to motivated deregulation or excessive use of self-control with the aim of escaping psychological distress (Verstuyf, et al., 2012). For example, this could involve excessive eating or rigid dietary restrictions to cope with psychological needs being dissatisfied. There is empirical evidence to support

such a link. For example, in a non-clinical sample of women, fear of negative evaluation was associated with restrictive attitudes towards eating (Gilbert & Meyer, 2005). Thus supporting the hypothesis that external controls and perceived threats to belonging, such as perceived pressure and criticism from others, contributes to reduced well-being.

Both needs substitution and compensatory behaviours are unlikely to meet genuine needs for satisfaction, as anorexic behaviours and psychopathology impact upon the patients' ability to engage in meaningful relationships and achieve personal goals, leading to a positive feedback cycle. This is evidenced by high levels of distress in patients' families (Treasure, et al., 2001).

Whilst (Verstuyf, et al., 2012) focused upon the mechanisms for the development and maintenance of eating disorders from the SDT perspective, (Vansteenkiste, et al., 2005) focused upon motivation to change. According to (Vansteenkiste, et al., 2005), limited motivation to change in eating disorders can be attributed to limited internalisation of the value for change. It is argued that that the pressure to attend treatment by others may lead to motivation for change being externally regulated, which may not translate into sustained change (Vansteenkiste, et al., 2005). Therefore, for AN patients to consider recovery, the drive for this change must be self-determined (Vansteenkiste, et al., 2005).

SDT and Treatment

According to the SDT, then, the role of treatment is to facilitate either intrinsic or integrated motivation to recover (Ryan & Deci, 2008). (Vansteenkiste, et al., 2005) in particular, argue that working with patients so that recovery becomes a reflection of their identity is necessary for sustained change. To do so, treatment needs to be need-supportive (Ryan & Deci, 2008). An account of how treatment can support the need for autonomy, competence, and relatedness is outlined below.

Autonomy

According to the SDT, autonomous engagement in therapy is more likely to lead to positive behavioural change as the locus of control for that behaviour is likely to be seen as internal (Ryan & Connell, 1989). This is to the extent that (Ryan & Deci, 2008) claim that there can be “little hope for long-term success” without the individual internalising responsibility for change. Therefore, the role of therapy is seen as a means of supporting one’s autonomy to allow for the integration of the goals of treatment with one’s self, thereby facilitating change (Ryan & Deci, 2008).

Similar to the existential psychotherapy approach (Yalom, 1980), the SDT rationale behind an autonomy supportive therapy is the assumption that humans have an innate desire for growth and development to reach their potential (Ryan & Deci, 2000b). Thus, the existential approach suggests that the role of the therapist is not to “inspire the patient with the desire to grow, with curiosity, will, zest for life, caring, loyalty, or any of the myriad of characteristics that make us fully human” (Yalom, 2002, p. 1). Rather, the therapist’s role is to “remove the obstacles to growth” (Yalom, 2002, p. 23) to allow the innate and intrinsic process of self-actualisation to occur. SDT argues that the therapist should endeavour to support the autonomy of the individual to scaffold the innate drive to flourish (Ryan & Deci, 2008).

Features of an autonomy supportive therapy include the therapist taking onboard the participant’s views, as well as providing opportunities for and respecting their ability to make decisions for their own lives (Ryan & Deci, 2008). Strategies to support autonomy, particularly in eating disorders, include helping patients identify behaviours that satisfy as oppose to thwart their needs, thereby developing more adaptive behaviours (Verstuyf, et al., 2012). This includes allowing the individual choice and removing external controls of their behaviour, such as reward contingencies (Ryan & Deci, 2008). From education literature, strategies used by teachers that were perceived as autonomy

supportive by students included listening, providing opportunities for students to voice their opinions and acknowledging their views, praising and encouraging efforts and not just outcomes, offering suggestions when stuck in order to enhance competence, and being responsive to their questions and comments (Reeve & Jang, 2006).

In the area of eating disorders, research suggests that creating opportunities for autonomy and allowing participants to decide can improve treatment engagement and reduce dropout, particularly in the early stages of treatment (Vandereycken & Vansteenkiste, 2009). Specifically, the study compared the previous treatment strategy that included pressure from medical staff and family to engage the patient in an inpatient treatment program, to a new strategy in which the patient was provided with detailed information regarding treatment options, and allowed the patient to decide whether or not to engage in treatment, and if so, which one (Vandereycken & Vansteenkiste, 2009). Allowing informed decision making and respecting the patient's autonomy to decide upon course of treatment was associated with significantly greater treatment completion rates (Vandereycken and Vansteenkiste 2009). This suggests that autonomy supporting opportunities increase participant engagement.

Competence

Along with autonomy support, treatment can help with the internalisation of values and goals by increasing perceived competence and confidence (Ryan & Deci, 2008). Competence can be supported through two strategies; feedback and structure (Ryan & Deci, 2008). Positive feedback, given that is informational rather than controlling, is considered helpful in improving competence in that it provides direction about one's performance. This empowers the individual to modify their behaviour accordingly, thereby increasing autonomous motivation (Ryan, et al., 2011). Results of a meta-analytic review support this theory (Deci, et al., 1999).

Structure, similar to feedback, can also serve to increase competence (Ryan & Deci, 2008). However, this is to the extent that the task is structured to reduce failure and is supportive enough to prevent failure (Deci, et al., 1999). For example, goals and the relevant rewards are considered helpful when the individual is able to achieve them. Therefore, providing feedback and a structure that supports the sense of mastery is necessary to satisfy the need for competence.

Relatedness

Similarly, relatedness is considered important in supporting integrated motivation (Ryan & Deci, 2008). Relatedness relates to the sense of belonging and feeling valued in the therapeutic relationship, which is conveyed through the therapists' genuine warmth and regard for the patient (Ryan & Deci, 2008). It is related to the concept of attachment (Bowlby, 2005), with security within the therapeutic relationship empowering exploration and change.

Summary

SDT posits that humans are motivated by the desire to meet three basic psychological needs for autonomy, competence and relatedness (Ryan & Deci, 2000b). Satisfaction of those needs is associated with wellbeing whilst thwarting is related to dysfunction (Ryan & Deci, 2000b). The environment is implicated as a key variable that may either facilitate or hinder need satisfaction (Ryan & Deci, 2000b). From the SDT perspective, AN is considered a maladaptive solution to satisfying thwarted needs (Verstuyf, et al., 2012). On the other hand, greater autonomy and need satisfaction can lead to greater self-determination and healthier eating patterns (Verstuyf, et al., 2012). Therefore, the aim of treatment is to support self-determined motivation for eating and weight management, either as intrinsic motivation or integrated motivation (Ryan & Deci, 2000b; Verstuyf, et al., 2012).

Motivation and CBT

A number of different treatments, which are based upon the cognitive-behavioural approach, have been developed for eating disorders (Fairburn, 2008; Garner, Vitousek, & Pike, 1997; Pike, et al., 2003; Waller et al., 2007). CBT has now become an umbrella term for a treatment that encompasses a plethora of approaches, from mindfulness (Segal & Williams, 2012) to Dialectical Behaviour Therapy (DBT; Linehan, 1987a, 1987b). According to (Ryan, et al., 2011), the two common aspects of CBT are, firstly, understanding the role cognitions in mediating the relationship between the situation and resulting behaviour and emotions, and secondly, the value placed upon empirical evidence to drive treatment decisions. Motivation in this approach is addressed in a number of ways.

In some CBT approaches, high motivation is a prerequisite for inclusion into the program, as is the case for DBT for eating disorders (Safer & Telch, 2009). Similarly, providing adequate treatment rationale and engaging patients in a verbal commitment or contract at the outset of therapy is used as a means of enhancing motivation (Ryan, et al., 2011). Motivation in CBT, according to Ryan et al. (2011), is linked to the concept of self-efficacy (Bandura, 1999). According to Bandura (1999), self-efficacy is the extent to which individuals' believe that their persistent effort will yield a particular outcome, despite the challenges. CBT then aims to improve self efficacy by creating opportunities for individuals to succeed, for example through graded exposure, or by challenging the negative beliefs that efforts will not achieve desired outcomes. However, more often than not, motivation in CBT tends to be enhanced through the addition of a motivational component.

A plethora of motivational enhancement modules exist in the field of eating disorders (Bewell-Weiss, 2011; Cassin, von Ranson, Heng, Brar, & Wojtowicz, 2008; Knowles, Anokhina, & Serpell, 2013; Macdonald, Hibbs, Corfield, & Treasure, 2012;

Price-Evans & Treasure, 2011; Treasure & Schmidt, 2008). Examples of this include Readiness and Motivational Therapy (RMT; Geller, Brown, & Srikameswaran, 2011) and Motivational Enhancement Therapy (Feld, Woodside, Kaplan, Olmsted, & Carter, 2001; Treasure, et al., 1999). These treatments are invariably based upon MI (Miller & Rollnick, 2002).

This is also the case for the current CBT program (Pike, et al., 2004) being trialled (Hay, 2010), which includes a component aimed at enhancing motivation based upon the principles of MI (Miller & Rollnick, 2002). It specifies the enhancement of motivation as a specific aim of the treatment (Pike, et al., 2004). Given the popularity of MI in the field of eating disorders, a brief literature review is presented below.

Motivational Interviewing (MI; Miller & Rollnick, 2002)

Developed in the field of substance abuse, MI is designed to increase patient's motivation to change behaviours and increase treatment engagement (Miller & Rollnick, 2002). It has become a popular clinical method (Ryan & Deci, 2008), that has been advocated as an intervention to improve motivation, engagement and treatment outcome in eating disorders (Geller, et al., 2001). It has been used as an adjunct to CBT for eating disorders (Treasure & Schmidt, 2008). The aim of this intervention is to allow the participant to view the illness as a problem, increase commitment to treatment and decide to change (Miller & Rollnick, 2002). It works by exploring the participant's ambivalence to change through Socratic questioning and maintaining an openness regarding their experience (Miller & Rollnick, 2002).

Due to the widespread use and modification of MI, the original authors clarified what MI is, by identifying what it is not. (Miller & Rollnick, 2009). It is argued that MI is not based upon the transtheoretical model. Although a decisional balance is included, MI is a clinical method and not a series of simple techniques. Though it has been associated

with SoC, its theoretical underpinning are yet to be confirmed. MI is not a means of tricking individuals into making a decision deemed suitable by the therapist, rather it respects autonomy. Unlike Motivational Enhancement Therapy (MET; Miller, 1994), which has been trialled in eating disorders (Treasure, et al., 1999), MI does not require assessment feedback. Despite its proliferation in CBT, such as in the current CBT manual being trialled (Pike, et al., 2004), MI is not a form of CBT as it does not involve changing one's beliefs (Miller & Rollnick, 2009).

As MI does not claim to be based upon a theoretical foundation, the mechanisms by which the method works is unclear. According to (Markland, Ryan, Tobin, & Rollnick, 2005), these mechanisms can be understood through the SDT perspective. The authors argue that MI works by satisfying the three basic psychological needs of autonomy (though non-directive, Socratic questioning), competence (by providing information for informed decision making), and relatedness (through the unconditional positive regard that is prescribed in the therapeutic relationship) (Markland, et al., 2005).

In terms of efficacy, there have been three recent reviews investigating the efficacy of MI in eating disorders (Dray & Wade, 2012; Knowles, et al., 2013; Macdonald, et al., 2012). (Dray & Wade, 2012) reviewed nine studies that investigated efficacy of MI in eating disorders. Although there was some evidence to suggest that MI may be helpful for binge eating, in terms of AN, the authors concluded that judgements regarding the efficacy of MI was not possible given the limited evidence (Dray & Wade, 2012).

Similarly, (Knowles, et al., 2013) questioned whether motivational enhancement interventions improve (a) motivation, (b) treatment engagement, (c) outcome, and (d) do changes in motivation across treatment relate to symptom change. The results were as follows; (a) There is limited evidence to suggest MI-based interventions improve motivation in clinical samples, with research suggesting they are no more effective than

the commonly available CBT; (b) Though there is some evidence to suggest that MI-based interventions improve treatment engagement, (c) on eating pathology, the impact of MI appears to be limited to binge, but not restrictive eating; (d) MI was found not to improve general psychological distress and quality of life. The authors concluded that “there is almost no evidence supporting the use of [adaptations of MI] in the eating disorders” (Knowles, et al., 2013, p. 105).

The most recent review of MI in eating disorders, (Macdonald, et al., 2012) examined the efficacy of the intervention for both patients and carers of patients. The authors suggested that, similar to previous reviews, there was much heterogeneity in the field with significant methodological limitations (Dray & Wade, 2012; Knowles, et al., 2013). However, unlike (Knowles, et al., 2013), the reviewers concluded that MI has potential in that it can improve readiness to change. This differing conclusion may be attributed to (Macdonald, et al., 2012) including literature on carers of patients, whilst (Dray & Wade, 2012) and (Knowles, et al., 2013) did not.

Overwhelmingly, the research suggests that the efficacy of MI in eating disorders is limited. The popularity of motivational techniques in the face of limited evidence may be due to the face validity of such an intervention (Kitson, 2012). One explanation for the limited effectiveness of MI in eating disorders has been posited by (Waller, 2012). According to the proponents of MI, “change talk” or self-motivational speech is considered a mechanism by which MI works (Miller & Rollnick, 2002). However, (Waller, 2012) argues that verbal accounts of motivation in eating disorders may not translate into action.

Specifically, Waller (2012) argues that motivation in eating disorders is best understood in behavioural rather than verbal/cognitive terms. Namely, the current understanding of motivation involves assessing patients’ intent to change behaviours by relying on statements, such as “I would like to get rid of this [eating disorder]” (Waller,

2012, p. 2). Waller (2012) argues that such statements should be viewed as a manifesto, which are the public declaration of the patients' motives or intentions which may not necessarily and directly translate into action.

One reason why the motivational statements may not be sufficient is that despite the patient placing recovery as an important priority, the protracted nature of the illness tends to lead to a sense of helplessness (Waller, 2012). This can be interpreted as reduced self-efficacy (Bandura, 1999). Similarly, it is argued that behavioural assessments of motivation should be considered, as verbal assessments of motivation are often influenced by clinicians' emotional investment into the patients' recovery (Waller, 2012). Evidence to support this comes from a study which found that the most accurate predictor of treatment outcome based upon measures of motivation were by observers rather than the clinicians or patients (Geller, 2002). Thus, (Waller, 2012) argues that facilitating "change talk" through MI is unlikely to lead to meaningful change and recovery in AN.

1.3.3 Summary

In sum, motivation in AN has typically been conceptualised using the SoC model (Prochaska, et al., 1992), however there have been significant conceptual difficulties identified in this theory. The increasing interest in the application of the SDT in eating disorders suggests that it may be effective in the conceptualisation motivation in AN, as well as identifying direction for treatment research. At present, treatments for motivation generally tends to rely upon MI (Miller & Rollnick, 2002), despite empirical evidence for the application of MI to eating disorders being limited. Thus, current theoretical conceptualisation of motivation is limited, as are appropriate treatments.

Moreover, when treatments such as CBT (Pike, et al., 2003) and LEAP (La Puma, Touyz, Taranis, et al., 2008) do lead to significant improvement in motivation, it is unclear as to which specific treatment components or processes contributed to the

positive change. As prognosis for the treatment of AN is still rather grim (Steinhausen, 2002), what is needed is a systematic analysis of what processes in therapy influence patients' motivation to change as this would provide directions as to how to improve current treatments. Specifically, process research in the treatment of AN is required.

1.4 Process Research

1.4.1 Definition

Process research focuses upon what occurs during therapy sessions (Elliot, 2012), and attempts to describe how and why change occurs in treatment (Greenberg, 1986).

Processes within therapy are defined as the psychological interactions, events and transformations that occur between contextual determinants and consequences (Orlinksy, 2001). Whilst outcome research focuses upon studies that evaluate treatment effectiveness, process research is primarily concerned with the dynamics and interactions between the patient and therapist during the course of treatment (Orlinksy, 2001).

Psychotherapeutic processes can include the observable interactions within therapy sessions (therapy session processes), or the changes which patients undergo as they improve (therapeutic change processes) (Orlinksy, 2001). Process research includes examining the helpful factors that bring about change, examining the sequential processes of researcher under which change occurs, or examining the significant events during therapy to study the micro-outcomes of change (Elliot, 2012).

1.4.2 Need for Process Research

Process research is critical in order to examine which aspects of treatments are the 'active ingredient' of therapy and to understand how treatment results in change (Rhodes, 2011). There is currently a gap between evidence-based treatments and evidence-based practice (Kazdin, 2008, p. 146). The former refers to interventions which

have lead to change in RCTs, and the latter to the clinical practice informed by empirically validated interventions, clinical expertise, etc. (Kazdin, 2008). The knowledge gap leads to difficulties such as results from RCTs, conducted with a uniform sample of clients and standardisation of methods of delivery, not leading to easy translation to clinical practice (Rothwell, 2005). RCTs fail to describe the nature of the relationship between treatments and change, which is critical information for evidence based practice (Elliot, 2012). For example, evidence-based manualised treatment may not be applicable to complex cases in which treatment is a dynamic processes with fluctuating motivations and goals (Ryan & Connell, 1989; Ryan & Deci, 2008). One of the key questions that remains is regarding the mechanisms of change in therapy; “What processes within or during treatment are responsible for (not just correlated with) outcome (mechanisms of therapeutic change)?” (Kazdin, 2008, p. 151). In the case of AN, it is unclear what components of treatment influence patient motivation.

1.4.3 Review of Process Research

To date, there is severely limited research examining motivation and psychotherapeutic processes or the non-specific factors of therapy in AN. Non-specific factors are defined as predictors of outcomes that do not pertain to any one specific treatment or theoretical approach (Ackerman et al., 2001). In order to explore these factors of therapy, the American Psychological Association Division of Psychotherapy’s Taskforce, known as the Division 29 Taskforce, attempted to review the evidence regarding empirically supported therapy relationships (Ackerman, et al., 2001; Norcross, 2002).

General aspects of the therapy relationship that were found to be effective in treatment were the therapeutic alliance (the quality and strength of the relationship), cohesion in group therapy, empathy (therapists’ sensitivity towards and ability to

understand patient), goal consensus and collaboration (Norcross & Hill, 2004). Aspects of the relationship deemed promising and probably effective were positive regard, congruence/genuineness, feedback, repair of alliance ruptures, self-disclosure, management of countertransference and quality of relational interpretations (Norcross & Hill, 2004). When tailoring treatment to specific patients, the following factors were considered effective; resistance (minimal therapist defensiveness and paradoxical prescriptions) and functional impairment (longer and more intense therapy for greater patient severity) (Norcross & Hill, 2004).

The Taskforce concluded that relationship related factors were important in treatment (Ackerman, et al., 2001; Norcross & Hill, 2004). In terms of research recommendations, they argued that rigorous qualitative methods be included within standard paradigms (Ackerman, et al., 2001). Research designs needed to extend beyond experimental studies in order to capture the complexity of the dynamic interactions between the patient-therapist dyad (Ackerman, et al., 2001; Norcross & Hill, 2004).

For example, in examining therapeutic alliance in the early stage of CBT for eating disorders, (Waller, Evans, & Stringer, 2012) found that the relationship was strong at the six-session mark. The sample consisted of 44 participants and the relationship was assessed using the Working Alliance Inventory Short Form (WAI-SF; Hatcher & Gillaspay, 2006). The measure yielded three subscales (therapeutic tasks, goals and attachment), with higher scores indicating a greater perceived alliance. The findings suggest that perceived therapeutic alliance was strong, and that the relationship was influenced by interpersonal and emotional aspects of comorbid illness, but not by eating disorder pathology. The alliance did not improve as expected with eating disorder pathology. Though the study was helpful in increasing insight into the factors affecting patients' perception of the therapeutic relationship, the process by which the alliance was

developed or modified was unclear. The inclusion of a qualitative component in such studies may improve upon these findings.

1.4.4 Limitations in Process Research

Specifically, one limitation of process research to date has been the reliance upon quantitative methods, which have tended to confirm existing beliefs regarding the process of therapy or produce confusing results (Elliot, 2012). (Elliot, 2012) has likened quantitative research to a blunt instrument that is ill equipped to deal with the complexities of change in psychotherapy. This gap in knowledge between process and outcome research has been referred to as ‘fundamental ignorance’ about how therapy works (Elliot, 2012). To use Elliot’s (2012) words:

“In the absence of careful prior qualitative research, tightly focused process-outcome research is analogous to poking a long stick into a deep hole; if you do it enough times, eventually you will hit something, but you may still not be sure what it is.”
(Elliot, 2012, p. 70)

Researchers, such as Elliot (2012) and (Rhodes, 2011) call for greater qualitative research to further understand how therapy and change in patients is related. Therefore, greater process research is required to bridge this knowledge gap, and definition of evidence to be used in this process needs to be extended to include qualitative research (Kazdin, 2008; Rhodes, 2011). The section below provides a rationale for using qualitative methodology for this purpose, followed by an overview of the key methodologies utilised in psychology research.

1.5 Qualitative Research

Qualitative research has been highlighted as a viable method of investigation to close the gap between process and outcome research as it allows access to information

that is not traditionally accessible through empirico-analytical methods (Fossey, Harvey, Mcdermott, & Davidson, 2002; Kazdin, 2008; Rhodes, 2011). That is, qualitative research illuminates the subjective experiences of illnesses from the perspective of patients (Usher & Holmes, 1997). It elicits rich and in-depth data, regarding not only human experience, but also the context in which it occurs and the meaning that is attributed to it, which forms the foundation of theory (Charmaz, 2006; Fossey, et al., 2002).

Investigation of the participants' subjective experience is important in the field of clinical psychology as patient related factors play a critical role in the delivery of treatment, perhaps more-so than in other health-related fields. An understanding of the therapy process from the perspective of the patient can provide valuable insight into how treatment is received and what impact it has upon the patient. This can then contribute to the development of a theoretical understanding of the therapy process, which in turn, can inform future clinical practice. Without an understanding of the treatment process from various paradigms, methodologies and perspectives, a limitation is placed on the range and depth of knowledge that can be applied in the therapeutic setting (Higgs & Jones, 2000).

Qualitative research is advantageous in that it allows for exploration of poorly understood phenomenon (Fossey, et al., 2002; Kazdin, 2008; Rhodes, 2011; Strauss & Corbin, 1994). Limited or poor conceptualisations of a particular area of research can limit the growth of knowledge. Traditionally, quantitative research methodologies have been considered the best way of building knowledge (Taylor, Kermode, & Roberts, 2006). However, the positivist, hypothesis-testing methodology, that is dominant in psychology, limits the development of new conceptualisations as it relies upon a prior understanding (Mahrer, 1988). The reflexivity and data driven nature of qualitative research is likely to liberate the researcher to develop novel conceptualisations that may

challenge traditional thinking (Henwood & Pidgeon, 2003; Mahrer, 1988). On a pragmatic level, this advantage can also be attributed to the requirement of smaller sample sizes (e.g. Frankel & Levitt, 2009). This is particularly helpful when recruitment is an issue in the field due to relatively low prevalence rates, such as for AN (Guarda, 2008).

The advantages of qualitative research have been increasingly recognised across a range of fields, particularly clinical psychology (Barbour & Barbour, 2003; Tweed & Charmaz, 2012). The increasing popularity has seen the refinement of standardised research protocols and evaluation criteria (Mays & Pope, 2000), as well as the development of specific methodologies to address various research questions (Creswell, 2007). This includes the development of a number of separate and well defined methodologies, such as Ethnography, Narrative Inquiry, Interpretative Phenomenological Analysis and Grounded Theory (Creswell 2007). These will be briefly outlined below.

1.5.1 Phenomenological Analysis

Phenomenology is appropriate to study the meaning and significance of a particular phenomenon across a number of individuals (Côté & Turgeon, 2005; Creswell, 2007). For example, (S. Williams & Reid, 2010) studied the meaning attributed to experiences of illness and treatment in patients with AN who were ambivalent about change and used pro-anorexia websites to communicate their understanding.

Phenomenological studies are best suited when the research problem involves understanding the common experience of a group of individuals who have lived through a homogenous experience (Creswell, 2007). This method does not typically extend to the development of a theory examining commonalities in processes.

1.5.2 Ethnography

Ethnography is suited to the study of the cultural elements, including the social, cultural and political pressures, which influence a particular phenomenon (Côté & Turgeon, 2005). For example, internet ethnography has been used to investigate the processes that shape identity on pro-anorexia websites (Hammersley & Treseder, 2007). This methodology is appropriate for the study of social norms and rules governing interactions between groups of individuals, with a focus upon the dominant and minority cultures (Holloway & Wheeler, 2010). It tends to require larger samples, and requires group interaction over time to allow for the development of a common pattern of behaviour and language (Creswell, 2007). Therefore, it may not be well suited to study the nuance of interaction between the therapist and patient.

1.5.3 Narrative Inquiry

Narrative inquiry typically involves gathering stories from a number of individuals, identifying and chronologically ordering the meanings of those experiences (Creswell, 2007). For example, (O'Shaughnessy, Dallos, & Gough, 2013) explored, using narrative inquiry, the commonalities and the distinctions between the subjective experiences of women that have or are experiencing AN. As narrative inquiry focuses upon analysing participants stories and reorganising them into various frameworks (Creswell, 2007), it is limited in its ability to identify the nuances of therapeutic processes which impact change. Likewise, the linear nature of stories with the use of causal attributes may place artificial constraints on the therapeutic processes which are to be studied, where the interaction between the therapist-patient dyad is likely to be dynamic.

1.5.4 Grounded Theory Analysis

Grounded theory is an inductive method of research that explores phenomena in-depth, focusing upon the actions, meanings and context, to derive a theoretical

conceptualisation (Glaser & Strauss, 1967; Tweed & Charmaz, 2012) that extends beyond description into explanation (Creswell, 2007). Rather than testing a-priori constructs, grounded theory is emergent; it aims to develop categories to generate theory grounded in the data (Charmaz, 2006; Creswell, 2007; Glaser & Strauss, 1967). It is characterised by a cyclical data collection and analysis process, driven by a process of constant comparison between texts and emerging categories until theoretical saturation is reached (Tweed & Charmaz, 2012). For example, grounded theory has been used to study the process of recovery from the perspective of a recovered patient with AN, with results suggesting that control is a key process (Simmons, 2006).

Emerging from the field of sociology (Charmaz, 2006; Creswell, 2007), grounded theory analysis has been used to study texts (Tweed & Charmaz, 2012) as well as lived human experience (Miles & Huberman, 1994). It is commonly believed that two variations of grounded theory exist; one which derives from the positivist and the other from interpretive school of thought (Charmaz, 2006). However, according to Tweed and Charmaz (2012), the epistemological stance for grounded theory is on a continuum with positivism at one end and constructivist on the other.

The objectivist grounded theory analysis emerges from the positivist school of thought, in which it is assumed that an objective ‘truth’ exists and standardised objective measures can ‘discover’ this (Charmaz, 2006). The researcher is placed in the expert position and must set aside their preconceived notions to examine the data objectively (Charmaz, 2006). This version of grounded theory is characterised by systematic procedures that direct the research process (Creswell, 2007). The theory building occurs in specific, prescriptive ways, with four causally-linked factors being identified: (a) antecedent conditions, (b) the phenomenon itself, (c) strategies or responses to the phenomenon, and (d) the consequences. There is a strong focus upon identifying a singular core process of the phenomena (Charmaz, 2006). The rigidity of the objectivist

grounded theory analysis procedures have been criticised for reducing the paradigm's ability to capture the complexity and layers of human experience (Creswell, 2007).

On the other hand, the constructivist grounded theory takes an interpretivist epistemological position (Creswell, 2007). Here, it is argued that the theory developed is generated through the interaction and the relationship between the researcher, participants and contextual factors (Charmaz, 2006). This approach acknowledges that as researchers attempt to immerse themselves in data, they will remain one step away from the lived experience of the phenomenon. Therefore, the theory developed is the researchers' interpretation of the meaning constructed by participants. As the researchers' values, motives and beliefs may influence the results (Charmaz, 2006), the theory developed is best viewed as a suggestion, or one perspective of the phenomenon. In improving upon objectivist grounded theory analysis, the constructivist position argues for flexibility in the analytical process to improve credibility (Creswell, 2007).

Qualitative Research in AN

To date, there have been numerous studies exploring AN treatment through the patient's perspective. Recently, (Espindola & Blay, 2009) undertook a systematic review of qualitative studies in AN from 1990 to 2005 in which the articles were reviewed, critically appraised and the results metasynthesised. The article identified ten studies that examined recovery in AN alone, and five studies which consisted of a heterogeneous eating disorders sample.

Through their second-order interpretations, the authors identified the process of change through phases of recovery (Espindola & Blay, 2009). These phases were *centred identity in anorexia* where the participants described AN as being a part of themselves, therefore difficult to fight; *self-knowledge* phase during which participants learn about themselves, separate from the illness; *self-acceptance* in which patients' conflicted and

dysfunctional views of themselves are integrated and expectations are established; *determination* in which patients make a commitment to change and; *maintenance* in which changes are consolidated.

The review identified satisfactory affective relations (characterised by acceptance and understanding), application of cognitive/psychological abilities and nutritional knowledge (modification of previous dysfunctional thoughts), increasing vital space (making concrete changes in other domains of one's life) and spirituality, to be important factors that facilitate recovery (Espindola & Blay, 2009). Factors that hindered recovery were found to be fear of change, lack of motivation, ambiguity (about desire to be free of AN), lack of social support, professional rigidity (inflexible and authoritarian therapeutic style) and media influence (Espindola & Blay, 2009).

These second-order categories were then further analysed to derive the third-order categories, which was reconciliation with one's self. This processes included patient's acceptance of AN as an illness, which contributes to the patients' understanding that they are not a mere object of acceptance by others, leading to self-reconciliation (Espindola & Blay, 2009). This meta-category suggests the importance of therapists considering each patient on an individual basis and respecting heterogeneity within the population (Espindola & Blay, 2009).

This review was hampered by some limitations. Firstly, the aggregation of studies that were based upon a homogenous AN as well as mixed eating disorders samples is problematic. This is because of the heterogeneity within eating disorders, with differing outcomes being associated with separate diagnoses, may have diluted the results of the studies examining AN alone. For example, (Ben-Tovim et al., 2001) prospectively followed 220 women diagnosed with an eating disorder and found higher rates of recovery for Bulimia Nervosa (BN) or Eating Disorders Not Otherwise Specified

(EDNOS), than for AN. This suggests that aggregating eating disorders patients may lead to the nuances of recovery, that are specific to AN, being lost.

Secondly, the studies included did not directly explore adult experiences in ongoing outpatient treatment. Of the ten studies exploring AN patient perspectives, four tended to explore recovery from recovered patients views (Hsu, Crisp, & Callender, 1992; Lamoureux & Botorff, 2005; Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2003; Weaver, Wuest, & Ciliska, 2005). Three studies explored AN recovery from the adolescents perspectives (Colton & Pistrang, 2004; Tan, Hope, & Stewart, 2003; Tan, Hope, Stewart, & Fitzpatrick, 2003), one study explored the experience of FBT (Chan & Ma, 2003), one study examined participants views of versions of their AN self (Surgenor, Plumridge, & Horn, 2003), and one study looked at AN and the media (M. Williams, Thomsen, & McCoy, 2003).

The limitations of such studies are that recovery is aggregated across various modalities of treatments, including inpatient and outpatient, resulting in the richer explorations of the relationship between treatment and recovery being lost. Furthermore, the reliance upon perspectives of recovered participants is problematic due to long illness histories, resulting in recall being inaccurate. Moreover, given that shorter illness duration is a good prognostic factor (Steinhausen, 2002), examining the recovery process from adolescent perspectives may not be easily translated to adult experiences. The dearth of research examining participant experiences of treatment, whilst it is ongoing, is a barrier to the field developing treatments that may be more acceptable for AN patients.

Since this review, there have been only a small number of other qualitative studies examining adult patients' experience of treatment. (Higbed & Fox, 2010), using grounded theory methodology, examined AN patients' perception of their illness whilst in treatment. Four key themes identified included (1) making sense of the AN, (2) relationship between AN & the self, (3) the recovery struggle and (4) coping with

treatment. The subtheme of losing the self to anorexia emerged within the theme of relationship between AN and the self, suggesting that patients felt that the AN was in control rather than themselves. Within the recovery struggle, the theme of constant battle emerged, which captured participant's views of AN as a struggle. However, this study explores participants experiences in both inpatient and outpatient treatment, which are two markedly different treatment methods.

(Schoen et al., 2012), using grounded theory methodology, explored the experience of the help-seeking process of 14 college-aged women. The themes that emerged included denial and awareness regarding the illness, feedback as a process that heightened awareness, critical incidents as being a catalyst for seeking help, and the role of negative emotions and attitudes in preventing help seeking behaviour. However, this study included participants with a range of eating disorder diagnoses. Given the heterogeneity within eating disorders, this is a limitation of the study.

A study examining the process of recovery from personal written accounts of people with AN found desire for recovery, professional help, having hobbies and other individuals with an eating disorder as important themes (Hay & Cho, in press). The theme of desire for recovery was identified as being a motivating factor towards recovery that was referred to as the 'turning point' by one patient (Hay & Cho, in press). The subtheme of hope was prominent (Hay & Cho, in press). However, this study examined recovery from the perspective of recovered individuals. For a greater understanding of how psychotherapeutic processes impact recovery, it is necessary for research to focus upon participants still engaged in treatment.

Using narrative inquiry, a recent study examining recovery in eight recovered AN patients, found that there were four phrases; (i) Unready and/or unable to change, (ii) The tipping point of change, (iii) Active pursuit of recovery, and (iv) Reflection and rehabilitation (Dawson, Rhodes, & Touyz, 2012). This study highlighted the importance

of the tipping point which consisted of patients' hitting rock bottom yet experiencing connectedness with others that contributed towards motivation and determination to recover. However, this study examined recovery from the perspective of recovered individuals. For a greater understanding of how psychotherapeutic processes impact recovery, it is necessary for research to focus upon participants still engaged in treatment. Similar to (Hay & Cho, in press), this study too relied on retrospective accounts from patients whom have already experienced recovery.

However, to date, there have not been any studies that examine the processes within therapy that impact motivation from the perspective of AN patients who are currently in the treatment process. The majority of studies examined tend to explore motivation retrospectively following recovery (Dawson, et al., 2012; Hay & Cho, in press). One study explored patient experiences whilst in treatment, the focus of the study was illness perception rather than motivation and therapeutic processes (Higbed & Fox, 2010). Furthermore, there have not been any qualitative studies exploring motivation in standardised settings. The addition of a qualitative component to an RCT would bridge the gap between evidence-based treatment and evidence-based practice.

1.6 Introduction to the Present Study

1.6.1 Rationale and Objective

AN is a serious chronic illness (Beumont & Touyz, 2003) marred by poor recovery rates and high morbidity (Steinhausen, 2002). A key factor implicated in poor recovery rates is the low motivation to recover in patients (Vitousek, et al., 1998). Despite the plethora of treatment developed for AN, there is limited evidence as to the efficacy of these treatments (Bulik, Berkman, Brownley, Sedway, & Lohr, 2007). Furthermore, the current understanding of the 'active ingredients' of treatment, or the psychotherapeutic processes that effect change, are significantly limited (Rhodes, 2011). The process by

which motivation to change interacts with therapeutic processes and treatment components is unknown. Moreover, no previous research has specifically examined processes influencing motivation in AN within the framework of specific, manualised treatments.

Therefore, the objective of this study is to investigate the psychotherapeutic processes implicated in the process of change in motivation for recovery in patients during the early stages of treatment. The study aims were divided into two parts; (i) develop a grounded theory of the motivation change processes in patients, during the early stage of treatment; (ii) isolate particular aspects of treatment which contribute to changes in motivation, including those referred to in treatment manuals as well as processes unique to patient-therapist interactions.

It is hoped that the development of a change processes model would contribute to the area of processes research by extending the field to examine processes in AN treatment. Namely, processes research would provide greater understanding as to how motivation develops and changes throughout treatment, shedding light on the debate as to how motivation in AN should be conceptualised. In the area of AN research, this study would provide much needed insight into which aspects of treatment are helpful and potentially shed light on future directions for treatment development and modification.

1.6.2 Research Questions

Research questions which will be examined include:

1. What has been the patient's experience of treatment in AN?
2. What factors do patients perceive as being most and least helpful in the treatment of AN?
3. Which treatment components were experienced as positive and which as negative?

4. How does motivation develop and change in AN?
5. Which processes within therapy most impacted upon patients' motivation to change?
6. What particular aspects of treatment specifically contributed to changes in motivation, for both the positive and negative?
7. Which particular processes unique to the patient-therapist interaction impacted upon patients' motivation to change, and in which direction?

1.6.3 Methodological Considerations

Ideally, selection of the research method should be determined by the nature of the research questions being asked (Lewis, 2003; Silverman, 2005), with considerations being given to the manner in which data is to be collected as well as the researcher's conceptual framework (Silverman, 2005). However, research design is often a balance between the ideal goal and the constraints of the situation, including time, funding and feasibility (Lewis, 2003). Therefore, striking an appropriate balance is important.

Thus far, the literature review has identified a number of gaps within the current understanding of motivation and treatment for AN. Firstly, it is unclear at present what motivation is. Secondly, it is not clearly understood how motivation alters or changes during the early, critical stages of treatment for AN. The process of change in motivation in AN has not clearly been mapped out. Thirdly, it is also unclear as to which processes in therapy influence motivation to change. In sum, it is unclear how and why motivation changes may occur in therapy.

Prior to developing solutions, it is important to identify the limitations in the field that have been a barrier to bridge this knowledge gap. The limitations of the field have been the use of primarily standardised, quantitative methods to test pre-existing

conceptualisations of motivation change processes. This has been a barrier as data collection and analysis have been limited by researcher assumptions and with the participants' perspective being examined through specific, narrow lenses. Hence, the solution to this problem would need to involve non-traditional research methods, that allow for dominant thinking to be challenged and provide insight into the patients' experiences. Hence, qualitative methods have been considered most appropriate as it is emergent and sourced with rich, in-depth data, hence it liberates the researcher to modify the study design to examine the issues as they emerge, rather than be restricted to engaging in confirmatory studies (Charmaz, 2006).

A range of qualitative research methodologies exist and selection between them needs to be driven by the purpose of the research (Lewis, 2003). Should the purpose of the research be to describe in-depth the subjective experience or to explore its meaning and interpretation, a phenomenological study would be appropriate. If examining the commonalities of the culturally based patterns of interaction and language be the focus, ethnographic studies would be ideal. If the purpose of the study was to examine the life story of individuals or identify the common patterns in individuals' narrative across a range of events over time, narrative inquiry would be suitable. Should the study wish to focus in-depth upon one or a small number of individuals to examine their experience as imbedded in their individual contexts, and to be studied as an example of a phenomenon (Creswell, 2007), a case study approach would be selected.

However, the purpose of the present study is to describe and *explain* the process of change in motivation and the role of psychotherapeutic processes in this dynamic interaction. Hence, the focus here is upon developing an explanatory model of the mechanisms that influence motivation to change in the specific context of early stages for treatment for AN in an ongoing RCT. The aim was to develop a theoretical understanding that was grounded in data and to provide a framework through theory to allow for further

research (Creswell, 2007). The advantage of such a method is that it allows researchers to study a subjective experience and generate a model of that phenomenon through a method of inductive categorization (Glaser & Strauss, 1967). Therefore, grounded theory analysis would be deemed most appropriate. Grounded theory analysis for this purpose is particularly advantageous as it allows for the study of interactions and processes in phenomenon's (Côté & Turgeon, 2005), which in this case, is the treatment process from AN.

As noted above, grounded theory varies on a continuum from the positivist to interpretivist inclinations, which have strong implications for the manner in which the theory is developed and portrayed. Given the multiple perspectives on what constitutes grounded theory analysis, it is important to clarify to the reader the justification of the method. For this present research question, a constructivist grounded theory approach was considered most appropriate as it allowed for flexibility in procedures to empower the data to determine the course of action.

Specifically, compared to objectivist grounded theory, the constructivist approach provides flexibility in research protocol to respond to emerging themes in the data and values multiple processes and perspectives in that it does not prescribe the selection of a single, core phenomenon to be specified. This approach was also chosen as it is consistent with the researcher's world view in taking an interpretivist rather than a positivist approach to knowledge generation. The method's emphasis on researcher reflexivity and transparency in reporting the study process and findings was also valued. Hence, given the study's stated research question, constructivist grounded theory was considered the most appropriate method for investigation. The methodology of the present study will now be outlined.

Chapter 2: Methods

The structure of this section is as follows; first, the research aim will be restated, second, the research process is outlined, beginning from participant recruitment, data collection and analysis, to theory development.

2.1 Brief Statement of Research Aim and Methodology

The study aims were divided into two parts; (i) develop a grounded theory of the motivation change processes in patients, during the early stage of treatment; (ii) isolate particular aspects of treatment which contribute to changes in motivation, including those referred to in treatment manuals as well as processes unique to patient-therapist interactions. Therefore, participants will be recruited following their 10th session in the LEAPOut trial, thus they will have completed two assessment sessions and eight sessions of treatment, either CBT or LEAPOut.

2.2 Participants

In grounded theory analysis, the development of a theory requires rich and comprehensive data (Charmaz, 2006). Therefore, selection of participants was not based upon number; rather the quality of the data was given paramount importance (Côté & Turgeon, 2005). Good sampling is judged on the appropriateness of the participants selected to answer the research question and the adequacy of sampling range, number and data richness (Morse, Barrett, Mayan, Olson, & Spiers, 2002). Theoretical sampling is the specific strategy used to determine the number of participants, and it was related to the concept of theoretical saturation, discussed below. In line with the principles of grounded theory analysis, 16 participants were included in the study, with two participants specifically engaged in member checking. As participants are currently in treatment, and to maintain the double-blind of the RCT, the treatment allocation for each participant will

not be presented. Moreover, the results will be aggregated to prevent any threat to the blinding.

All 16 participants recruited were female. Ten were recruited from Australia, five from the United Kingdom (UK) and one from the United States of America (USA). Due to drop out and missing data, complete data is available for only 14 participants. Seven of the participants were single, six identified themselves as either married or in a live-in relationship, and one participant was separated or divorced. In terms of education, the highest level achieved was undergraduate for nine women, postgraduate for three, Year 10 for one, Year 12 for another and one participant had TAFE equivalent certification. Three participants were students, whilst 69% were employed.

The average age of the participants was 28.09 years ($SD=6.81$), ranging from 18 to 38. The mean age of onset of AN was 17.46 ($SD=7.92$), with diagnosis tending to occur 2.88 years ($SD=2.29$) after onset. The average duration of illness prior to engaging in the LEAPOut trial was 10.09 years ($SD=7.68$).

Mean weight at baseline was 44.65kg ($SD=3.84$), which had increased to 45.61kg ($SD=3.64$) at first assessment. At baseline, mean BMI was 16.25 ($SD=1.01$), which increased to 16.71 ($SD=0.82$) after the first ten sessions of therapy. Of the data available, nine individuals reported improved motivation on the ANSOCQ, with the majority reporting a reduction in their eating disorder pathology on the EDE-Q. Nine individuals also reported a reduction in the compulsivity of their exercise and the actual amount of exercise and activity completed. Majority of participants also reported reductions in distress on the K10 by first assessment. Means and standard deviations of participants' scores at baseline and the ten-week mark are presented in Table 2.1.

Table 2.1.

Means and Standard Deviations of Assessment Measures at Baseline and First Assessment

Measure	T0		T1	
	Mean	(SD)	Mean	(SD)
Weight	44.64	(3.84)	45.61	(3.64)
BMI	16.25	(1.01)	16.71	(0.82)
ANSOCQ	2.55	(0.74)	2.76	(0.78)
EDE-Q Global	3.66	(1.33)	2.98	(1.71)
K10	27.13	(9.78)	24.57	(9.52)
CET Total	15.03	(5.74)	13.02	(6.11)
EPSQ	231.87	296.63	139.41	177.11

Note: BMI = Body Mass Index; ANSOCQ = Anorexia Nervosa Stages of Change Questionnaire Stage Score (Rieger, et al., 2002); EDE-Q = Eating Disorder Examination Questionnaire Global Score (Fairburn & Beglin, 2008); K10 = Kessler 10 Psychological Distress Scale (Kessler et al., 2002); CET = Compulsive Exercise Test (Taranis, Touyz, & Meyer, 2011); EPSQ = Exercise Participation Screening Questionnaire (Davis, Kennedy, Ravelski, & Dionne, 1994)

2.3 Procedure

2.3.1 Ethical Approval

The procedure for recruitment, data collection, analysis and management was kept consistent with the ethical guidelines that governed the study. The research protocols with ethical considerations are outlined below. The documentation regarding ethical approval for the study is presented in Appendix A.

Given that the study was nested within an ongoing, multi-site RCT, ethical approval for the study was sought as an amendment to the pre-existing ethics approval. In Australia, the original ethical approval for the RCT, without the present study, was

approved by the University of Western Sydney Human Ethics Committee (HREC) on 24th February 2010 and the University of Sydney HREC on 6th May 2010. The modification to include the present study was approved by the University of Western Sydney HREC and the University of Sydney HREC on 16th and 28th September 2010, respectively.

A qualitative study had already been included in the application for approval from the UK site. Approval from the National Research Ethics Service Leicestershire, Northamptonshire & Rutland Research Ethics Committee was gained on 22nd April 2010, which was later modified. To achieve the required targets for recruitment, the RCT was extended to the USA with ethical approval being granted by the Institutional Review Board at Weill Cornell Medical College on 19th October 2012. To prevent repetition, information sheets, consent forms and advertising material from Australia only have been included in Appendix A.

Given that participants were recruited from an ongoing treatment trial, it was important to manage the potential for coercion and ensure that participants' involvement in research would not affect the treatment they received. Thus, the participants were approached by the blind assessor of the study, and not the student researcher, to minimise the potential for coercion. The blind assessor was a member of the research team that was not one of the chief investigators, neither therapist nor student researchers. Their primary role was to collect data for the trial by undertaking assessments at various time points during treatment. For this reason, the assessor was blind to the treatment group that the participants had been recruited into. The blind assessor provided information regarding the nature of the study and the risks associated, to allow for informed consent to participate. Upon consent, the participant's details were then provided to the present researcher who contacted the participants to set up an appointment and then undertake the interview. For participants from UK and the USA, to further protect confidentiality,

participant details were not disclosed to the author. Rather telephone interview appointments were set up by administrative staff, based on participants' convenience.

2.3.2 Recruitment

Source

Participants were recruited through the ongoing LEAPOut trial after their 10th session of treatment. This meant patients had presented at two assessment sessions with their therapist and received eight sessions of therapy, either CBT or LEAPOut. Attempts were made for the interview to be held within a week of their 10th session, however at times this was not always possible. Therefore, for a minority of patients, the interview may have been delayed by up to two weeks.

For the trial, participants were recruited through a range of avenues. In Australia, this includes news-media (e.g. newspapers, radio, magazines), relevant websites for clinicians and consumers (e.g. Butterfly Foundation, CEDD, Something Fishy), General Practitioners (GPs), flyers at public eating disorder services (e.g. Browne St, RPA Eating Disorder Service), University psychology clinics (as some had requested this information), and UWS and USYD Media Unit (Appendix A). In the UK, referrals were provided by primary care providers (General Practitioners) in the same NHS health area as the study. In the US, patients were either referred by a clinician or recruited from the inpatient unit affiliated with Weill Cornell Department of Psychiatry. Upon contact with potential participants, a screening and allocation process was undertaken to ensure participants were appropriate for the study. The study inclusion/exclusion criteria and the process will be outlined below.

Inclusion and Exclusion Criteria

Strict and compulsory inclusion and exclusion criteria governed acceptance into the trial. The inclusion criteria stipulated that the participant must be at least 18 years of age, with a primary diagnosis of AN according to the DSM 5 (American Psychiatric Association, 2013). Given that the study focused upon exercise behaviours, it was required that the participants had engaged in some form of exercise behaviour over the previous three months, with the Exercise Participation Screening Questionnaire (EPSQ; Davis, Kennedy, Ravelski, & Dionne, 1994) being used as a screening tool.

Exclusion criteria included a diagnosis of psychosis, bipolar disorder, or current substance dependence. Participants were excluded if they were deemed to be at a high level of risk of suicide and/or medical compromise, or had a BMI below 14, as outpatient care would not be considered appropriate in those scenarios. Concurrent psychological therapy with other health professionals for AN was not permissible.

Screening & allocation process

Initial telephone screening was used to identify potential participants who were then engaged in an initial assessment session, which was undertaken by the blind assessor. The assessment undertaken at this time point was considered the baseline assessment. During the session, once informed consent had been obtained, participants completed a number of measures and had their BMI assessed. To examine primary/comorbid diagnosis and to rule out psychosis and bipolar disorder, patients were engaged in a semi-structured evaluation interview which included a clinical assessment by their therapist and the Mini-International Neuropsychiatric Interview (MINI v6.0; Lecrubier et al., 1998).

Keeping in mind the physical complications associated with AN, the patients were required to undertake a blood test and electrocardiogram to ensure that they were medically fit to engage in outpatient therapy. Patients were encouraged to regularly

consult their GP during treatment. The guidelines for medical assessment and monitoring of the AN patient were in line with international (APA 2006, Mitchell et al., 2000) and the Australian and New Zealand Guidelines (RANZCP, 2005).

Patients who were deemed eligible for the study were then randomised to one of the two treatment groups (LEAPOut or CBT) using Ephron's Biased Coin, a Microsoft Excel Program. The randomisation was stratified by location (Sydney, Leister, New York), subtype of illness (restricting vs binge-eating/purging), whether a participant is on psychotropic medication, and whether or not a participant has had psychotherapy for AN within the previous 12 months. An online program (sealedenvelope.com) was used to allow for group allocation to be communicated to the therapist, whilst keeping the study assessors blind to the treatment group. Participants were also kept blind to the group that they have been allocated to. They were advised that they were receiving alternative forms of CBT, and were informed as to the rationale to maintain their blind. A comprehensive debrief following treatment will undertaken to ensure that participants are aware of the treatment the received.

Following allocation, participants received ten sessions of their treatment, two assessments and eight therapy sessions of either LEAPOut or CBT, prior to the second assessment (T1). It was at this assessment, that the blind assessor approached the participants regarding the present study. Although informed consent for participation in the research interview was already covered by the initial consent form, verbal consent was again sought. Upon agreement, participants' contact details were forwarded to the present researcher to organise the interview.

2.4 Data Collection

2.4.1 Interview Details

Once the participant had been contacted by the researcher, the date, time and location of the interview was determined in collaboration with the participant. Of the 16 participants, three agreed to undertake interviews face-to-face, with the majority selecting telephone interviews for convenience. In cases where participants opted for face-to-face interviews, they were held in the room in which they regularly received therapy sessions, which was located at The University of Sydney.

The interviews were in-depth, semi-structured and individual interviews. The recommendations outlined by (DiCicco-Bloom & Crabtree, 2006) were used. That is, summarising a body of previous research, (DiCicco-Bloom & Crabtree, 2006) posit that there are four stages of rapport building; apprehension, exploration, co-operation and participation.

Thus, the interviews typically began with a brief introduction to the researcher and the study. Verbal consent for the interview and for its recording was again sought. Broad questions followed by prompts that used participants own words were then used stimulate initial discourse and challenge apprehension. Once the participant was sufficiently engaged, exploration was facilitated in the relationship through listening and reflecting. The co-operation phase marked the increasing trust in the relationship whereby the questions could increasingly probe sensitive and intimate aspects of the participants' experiences. Finally, participation in the rapport building stages was often marked by the participant taking on the expert role with comfort and allowing the research to become immersed in the participants' experience. At the conclusion of the interview, participants were thanked for their contribution to the research and were informed that they may contact the researcher at any time should they wish to discuss the study further. Participants were encouraged to ask questions to clarify their understanding throughout the interview process.

It is important to note that despite the level of preparation undertaken to create the interview structure, the actual interviews themselves were generally free-flowing. The advantage of using such a model to guide the development of interview structure is that it sensitised the researcher to the participant's experience as they voluntarily disclosed their most personal experiences with a stranger. This in turn allowed for the development of both broad and specific questions constructed in ways that were respectful, neutral and limited its influence upon data collection, to cater to the developing rapport throughout the interview. The process of development of the initial and subsequent questions used to guide the interview process is presented in the "Developing Interview Questions" section.

2.4.2 Measures

The following measures were used for data triangulation. Participants scores on these measures were presented in the 'Participants' section.

Demographic Data

Data regarding the participants age, education, work status, living arrangements was collected at baseline.

Body Mass Index (BMI)

BMI is an objective measure of the participant's weight to height ratio and provides an convenient indication of adiposity (Williamson, Kahn, Remington, & Anda, 1990). There is a high correlation between BMI and skin fold measures of fatness (Garrow & Webster, 1985). It is calculated by dividing weight in kilograms by height in meters squared.

Eating Disorder Examination-Questionnaire, Edition 6.0 (EDE-Q 6.0; Fairburn & Beglin, 2008)

The EDE-Q is a 36-item questionnaire that assesses disordered eating psychopathology and behaviours in the previous 28 days. It is based on the Eating Disorder Examination (EDE; Cooper & Fairburn, 1987; Fairburn & Cooper, 1993). Using a 7-point Likert scale, it consists of four subscales that assess Shape, Weight and Eating Concern, and Dietary Restraint, with higher scores indicating greater severity of symptoms. A Global Score, which is the mean of the subscale scores, is calculated to provide an overall assessment. The psychometric properties of the scale can be described as robust, with good concurrent and acceptable criterion validity (Beglin & Fairburn, 1992; Mond, Hay, Rodgers, Owen, & Beumont, 2004).

The Anorexia Nervosa Stages of Change Questionnaire (ANSOCQ; Rieger, et al., 2002; Rieger, et al., 2000).

Based on the SoC, this 20-item instrument assesses readiness to change in AN. It consists of three subscales; Weight Gain (readiness to achieve healthy body weight); Eating, Shape and Weight Concerns (readiness to shift the value placed on eating, shape and weight upon self-esteem); and Ego-Alien aspects (readiness improve interpersonal difficulties). Scores range from 20-100, with each item providing a series of statements which respondents must endorse. Responses are scored at 1 for the precontemplation-stage response to 5 for the maintenance-stage response. Participant's stage of change is identified based on the stage score which is the overall mean score across all items, with higher scores indicating greater motivation. The test had demonstrated adequate internal consistency, test-retest reliability and convergent, discriminate, concurrent and predictive validity (Rieger, et al., 2002; Rieger, et al., 2000).

Exercise Participation Screening Questionnaire (EPSQ; Davis, Kennedy, Ravelski, & Dionne, 1994)

Based on the method utilised by (Davis, et al., 1994), physical activity in the previous month was quantified by multiplying weeks x frequency per week x duration per session in half-hour units (1, 2, 3, 4,5) x intensity (1, 2, 3) for each activity, and summing across all activities for the month.

The Compulsive Exercise Test (CET; Taranis, Touyz, & Meyer, 2011)

The CET is a measure of the primary factors implicated in the maintenance of compulsive exercise. The 24-item measure consists of five factors; (1) Avoidance and rule-driven behaviour (continued exercise despite injury or illness), (2) Weight control exercise (exercising for weight and shape reasons), (3) Mood improvement (positive reinforcement component of exercise), (4) Lack of exercise enjoyment (experiencing exercise as a chore and deriving no enjoyment from it), and (5) Exercise rigidity (rigid adherence to a strict and repetitive exercise routine). The participants score statements along a six-point Likert scale from 0 (never true) to 5 (always true). The mean of all subscales yields a total score, with higher scores indicating greater levels of compulsive exercise. It's psychometric properties have been established in a sample of 367 college students (Taranis, et al., 2011).

Kessler 10 Psychological Distress Scale (K-10; Kessler et al., 2002)

This ten-item instrument is an measure of psychological distress and severity across anxiety and mood disorders (Brooks, Beard, & Steel, 2006). It is a widely accepted measure, and has been included in the Australian National Survey of Health and Well-being (Kilkkinen et al., 2007). It was been designed to assess psychological distress in epidemiological studies, and has well established psychometric properties (Kessler, et al., 2002).

Mini-International Neuropsychiatric Interview (MINI; Sheehan et al., 1998)

The MINI is a short, structured diagnostic interview based upon the DSM-IV-TR diagnostic criteria (American Psychiatric Association, 2000; Sheehan, et al., 1998). It was used to rule out bipolar, psychosis and substance abuse diagnoses in recruitment. Of the modules included, suicide, AN, bulimia and personality disorders were not assessed.

2.5 Data Management

Data management was a critical and complex process involving the maintenance of ethical standards across three treatment sites. All paper data has been kept in a locked cabinet in the chief investigator's research offices. All audio recordings and electronic information has been stored on computer files with separate identifying data files and study results data files. Codes are kept on an electronic file with security code password access only to the chief investigator and delegated research personnel. In the present study, participants' quantitative data was de-identified and then provided to the researcher for triangulation through a secure electronic medium. The data was then stored in a secure manner with the qualitative data. To maintain both the participants' and assessors' blind, communication regarding treatment allocation was restricted to clarification by the participant's therapist only. Furthermore, this clarification was sought after the research interview to prevent disclosure.

As stated above, digital recording devices, and in one case an analogue cassette tape recorder, were used to capture the research interviews. The audio recordings were transcribed verbatim by a private transcription service that signed a confidentiality agreement (Appendix A). The transcription was funded by the Postgraduate Research Support Scheme awarded to the researcher from The University of Sydney. Completed transcripts were checked for accuracy by the therapist. This minimised the opportunity for

error in transcription and increased therapist familiarisation with the data. Data not directly relevant to the research, such as introduction to administrative staff prior to engaging in the interview, was deleted for clarity. The interviews were subsequently de-identified through the use of pseudonyms for the participants and in the cases of reference to the therapist by name, the term 'the therapist' was substituted. This was to protect participant confidentiality and to prevent identification of the participant by the research team or therapists themselves. An attempt was made to undertake initial coding as soon as possible to allow the development of further questions as other interview opportunities develop. However, this was not always possible due to time constraints.

For the purposes of data analysis, the researcher had access to all information. This includes the raw data (both audio recordings and qualitative questionnaire responses), demographic details, and de-identified transcripts. The present researcher did not have a pre-existing relationship with the participants, nor did the primary research supervisor.

Maintaining Blinding

Due to the associate researcher's role as chief investigator in the trial as well as her role as a therapist for one participant, discussions between the researcher and supervisors did not involve the specifics of the participants. To maintain the associate supervisor's blinding, individual transcripts and their group allocation were not disclosed. Given the importance of maintaining the blind, the present researcher was unaware of treatment allocation until after the research interview was conducted. This mitigated the risk of the patient becoming aware of their treatment group. In terms of reporting the results, as participants are currently in treatment, and to maintain the double-blind of the RCT, the treatment allocation for each participant will not be presented. Furthermore, to

prevent any breach of blinding, the participants' experiences between the two treatments were not compared.

2.6 Data Analysis

Overview of Grounded Theory Process

Data was analysed using the grounded theory process, in line with strategies adapted from (Charmaz, 2006) and, (Tweed & Charmaz, 2012). The process of data analysis is visually represented in Figure 2.1. Data collection is represented in orange, analytic steps in purple, and strategies for rigour in blue.

Sensitising Concepts/ Theoretical Sensitivity

Coined by (Blumer, 1969), sensitising concepts are used as initial ideas that guide the design of the study and identify initial interview questions. It is developed through the researcher's backgrounds, disciplinary training and familiarity with the research topic and literature. As Charmaz (2006) states, sensitising concepts are useful as a starting point only. Openness and reflexivity are necessary to allow the research to develop and be guided by the data.

Initial Interview Questions and Developing Further Questions

Initial interview questions were based upon the original research questions of the study (DiCicco-Bloom & Crabtree, 2006). This was followed by planned and unplanned probing to uncover details specific to that participant. Given the reiterative nature of qualitative research, the analysis of the data was used to develop further, more specific questions, to understand the phenomenon at a greater level (DiCicco-Bloom & Crabtree, 2006). As understanding of the topic develops, new questions often emerge whilst previous questions may be excluded as they may no longer be necessary (DiCicco-Bloom

& Crabtree, 2006). Samples of some interview questions, in the order as they were developed, are presented in Appendix B.

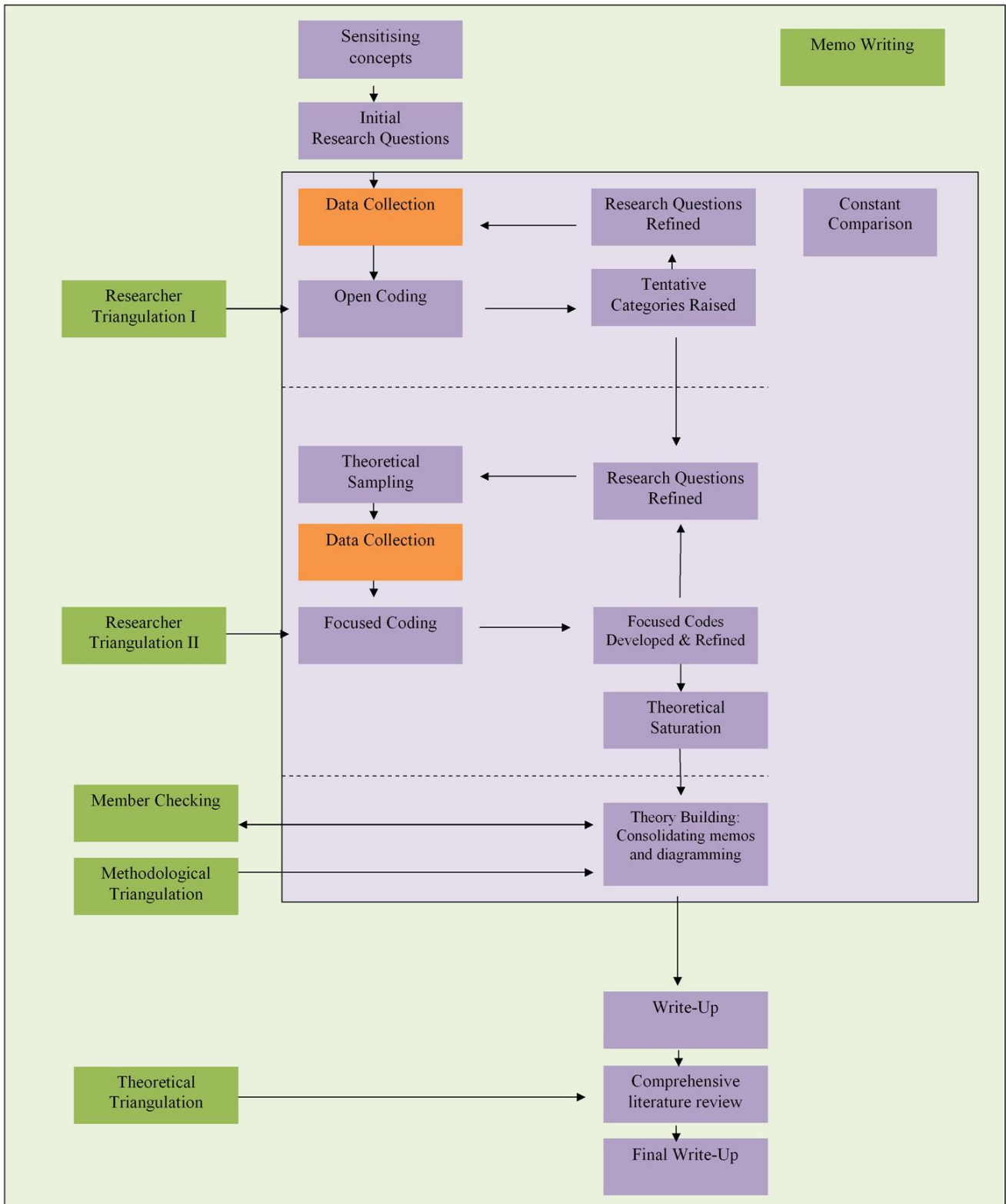


Figure 2.1. Visual representation of the process of grounded theory for this study; Adapted for Charmaz 2006, Tweed and Charmaz 2012

2.6.1 Coding

Overview

The grounded theory analysis process is analogous to that of a pyramid, with the mass of raw data categorised into initial codes being used as foundational building blocks, with focused codes and conceptual categories forming the narrowing body, and the theoretical model of the processes forming the apex (Tweed & Charmaz, 2012). As the pyramid narrows, the categories become increasingly sophisticated with greater interpretation and inductive reasoning being used to form the theory (Tweed & Charmaz, 2012). Following the procedure outlined by Charmaz (2006) and Tweed & Charmaz (2012), the analytic steps undertaken will be described below.

Open Coding

Following familiarisation with the text through repeated readings, open coding was undertaken. Also known as initial coding, it was the process whereby interview transcripts were categorized under labels generated by the researcher that best captured the processes within. As much as possible, labels or codes were derived from the participant's language, known as *in vivo* codes, to allow the theory to remain as close to the actual phenomenon as possible. For the initial four interviews, line-by-line coding was used. This involved every line of the interview being categorised and classified as one unit of data. The intensity of this process was necessary to ensure that the codes generated were grounded in the data rather than relating to the researcher's preconceptions. As recommended by (Charmaz, 2006), questions were asked of the data to guide the coding process. This included asking "What process(es) is at issue here? How can I define it?" and "When, why and how does the process change?" QSR International's NVivo 10, a computer program designed to facilitate qualitative data

analysis was used (NVivo Qualitative Data Analysis Software, 2012). The transcripts were cross coded with the primary supervisor of the project to increase rigour.

Constant Comparison

The constant comparison method is series of analytical and reflexives strategies used to develop the theory (Tweed & Charmaz, 2012). It involves a continual process of comparing and contrasting units of data, codes, categories and concepts between and within one another. Doing so, allows theorists to identify the commonalities within, as well as the differences between, clusters of data. This serves to allow theorists to develop more abstract conceptualisations of the phenomenon. The researcher in this process is required to take a reflexive stance and allow the data to drive the process of induction. It is a reiterative process that continues from initial data collection to write up, as demonstrated in Figure 2.1.

Tentative Categories Raised

Following open coding, the constant comparison method was used to tentatively raise categories (Charmaz, 2006). These categories were used to formulate further research questions, which drove further data collection. The research questions developed were aimed at generating further data regarding a particular aspect of the phenomenon that was not well understood. To fill this understanding, theoretical sampling was employed as a research strategy.

Focused Coding

Focused coding is a process that allows the large volumes of initial codes generated to be synthesised into larger segments of data. It is a selective, driven and analytical process that involves directing the research focus upon the most significant codes. The focused codes were identified by the researcher engaging in constant

comparison to identify significant and frequent segments of data. Clustering of initial codes into a core theme was another method used to identify focused codes. For example, the initial codes generated from the first four transcripts were printed and tacked to a pin board. The constant comparison method was used to cluster the initial codes into larger and more abstract categories, which then became the focused codes. To enhance rigour, the primary supervisor blind coded 25% of the data using the generated focus codes. Disagreements in coding were discussed and used to further refine the codes. Consensus was reached for the majority of codes. Where disagreements were unable to be resolved between the present researcher and primary supervisor, the associate supervisor was consulted who acted as an arbiter for the final code. The tentative focused codes generated were then used to refine interview questions and drive further data collection, until theoretical saturation had been achieved.

2.6.2 Theoretical Saturation

Theoretical saturation is the point at which additional data does not shed new insight into the categories or emergent theory (Glaser & Strauss, 1967). For the present study, this occurred after the 12th interview. Data collection was continued through to the 16th interview to confirm the emergent theory and gather multiple examples of participant's experiences so that it could be well articulated. Data collection was ceased after this point. Theoretical saturation is a point that is subjectively defined and a source of disagreement in the literature (Charmaz, 2006). However it is important that saturation be declared following a thorough exploration of data at an abstract level to ensure that the saturation occurs not due to repetitious events in data, but due to the data no longer identifying different properties of the emergent theory (Charmaz, 2006).

2.6.3 Theory Building

The final stage of data analysis was the development of the emergent theory. A number of different strategies are used during this stage. Theoretical sorting was undertaken by physically sorting the focused codes, memos, interview notes and other research material such that it allowed the creation, testing and refining of theoretical links between the categories. Diagramming was a key tool used in building the present model. Diagramming allowed for a visual representation of the links and associations between various codes. The present study used a variety of mediums to engage in diagramming, including paper and pencil, NVivo (NVivo Qualitative Data Analysis Software, 2012), Microsoft Excel, and by physically adjusting the position of handwritten codes on a pin board. Integration of memos into the above processes was key in allowing researcher reflections and inductive reasoning to be included in the theory construction process.

As mentioned above, Charmaz's (2006) perspective of theoretical sensitivity relates to participants ability to derive a theory out of the data by reflecting, comparing, establishing novel connections and taking a curious stance as to what the data is conveying. The researcher is encouraged to engage with their data in a manner this is free from rigid, mechanical procedures to probe to the core of the phenomenon studied;

“Whimsy and wonder can lead you to see the novel in the mundane. Openness to the unexpected expands your view of studied life and subsequently of theoretical possibilities” (Charmaz, 2006, p. 135).

In line with such guidelines, the present researcher engaged in free-drawing, mind-mapping and charting to derive the present theory. The final model of the theory is presented in Chapter 3, which presents the results of the data analysis.

2.7 Reflexivity and Rigour

Overview

As is the case for quantitative research, it is important that qualitative research too is required to be of a certain standard, such that the research can be trusted (Mays & Pope, 2000; Morse, et al., 2002). Particularly for grounded theory, guidelines regarding rigour of qualitative research are required as it is these guidelines that determine the strength of theory developed. Hence, it is argued that these standards need to specify the processes during the research study which enhance rigour, rather than simply outlining evaluation criteria following write-up (Morse, et al., 2002).

However, this is an ongoing debate in the literature with regards to what constitutes quality research. Traditionally, validity, reliability and generalisability have been the standards applicable to empirical investigations. Yet, the very use of these terms in the constructivist domain has been questioned (Leininger, 1994). However, by shifting the perception of the research methodology from a quantitative/qualitative dichotomy to a continuum, similar to (Morse, et al., 2002), the present author can argue that for all research to be valued and useful, it must demonstrate reliability, validity and generalisability.

Given the differences in nature of knowledge across quantitative and qualitative research methods, what is required are not two different research standards, but rather different research strategies to pursue the standards (Morse, et al., 2002). Therefore, this thesis will aim to bridge the boundaries between well established terms for rigour in quantitative research, whilst respecting the traditions of qualitative research. This has the advantage of providing a common language of communicating diverse research methodologies using a common language, and challenging notions that qualitative research is lacking in rigour. Moreover, the guidelines for rigour presented are in-line with those relevant to qualitative research in general as well as those specified for grounded theory analysis (Chiovitti & Piran, 2003). A description of the criteria for

rigour, with specific strategies that were employed in the present study, are outlined below.

2.7.1 Credibility

Credibility can be defined as the extent to which the participant's experiences and the theory developed are congruent (Pope, Ziebland, & Mays, 2000). It relates to the ability of the theory to capture the phenomenon as accurately and vividly as possible (Chiovitti & Piran, 2003). Guidelines for enhancing credibility which apply to qualitative research in general, as well as those specific to grounded theory analysis are presented below.

Participant Directed

To allow the data to be grounded in the participant's reality, as they perceive it, it is considered important to allow participants to control the direction and content of the investigation. Particularly in the early stages of data collection, it is critical that the therapist exert minimal influence upon participants' responses (DiCicco-Bloom & Crabtree, 2006). This can be done by using broad and open-ended questions, and constructing follow up questions that use the participants' words to prevent contamination. In the present study, it was observed that when discussion regarding the process of change and motivation *during* treatment, participants continually directed the conversation to exploring their experiences of motivation *prior* to treatment. The surprising findings then allowed for a richer and a greater context-imbedded theory of motivation during treatment.

Grounded in Data

To ensure that theory development is imbedded in the data, it is recommended that participant's actual words be used in generating codes (Charmaz, 2006). Doing so

reduced the potential for researcher bias and misinterpretation, and allows the developed theory to be consistent with the actual phenomenon as possible. In saying that, it is considered helpful to explore whether a specific term or jargon used by participants have a consistent meaning or whether it has different aspects. For example, the term “motivated” was repeatedly used by participants but differed in definition, ranging from motivation as desire to motivation as self-efficacy.

Triangulation

Triangulation in qualitative research borrows from a “...surveying metaphor that refers to the geometrical possibility of fixing a point in space by viewing it from two other locations.” (Stiles et al., 2006, p. 61). It is the collection of data through a variety of sources and perspectives to develop a deeper understanding of the data. Methodological triangulation refers to the use of multiple methodologies, such as interviews and direct observation, to study the same phenomenon (Forcano, et al., 2011).

In this study, demographic variables and quantitative measures of their eating disorder pathology have been used as attributes or characteristics of participants to allow for more detailed comparison of themes and modelling of data. It is also a form of data triangulation as it allows for the collection of data through different perspectives, which includes self-report questionnaires, interview questionnaires & objective data from physiological measures, such as weight and height (Forcano, et al., 2011). Similarly, environmental triangulation was undertaken by recruiting participants from Australia, UK and USA. This allowed for the exploration of the same core phenomenon, which was standardised treatments of AN, imbedded in a variety of contexts and cultures. Researcher triangulation, the process of cross-coding with another member of the research team is considered important to ensure rigour in the coding process. Allowing cross-coding contributes to credibility by increasing the reliability of the data and

ensuring that researcher bias is minimised. This was undertaken at two time points, first during the initial coding phase, and the second during the focused coding stage.

Theoretical Sampling

Theoretical sampling was a strategy that was used to further shed light on the emerging categories within the data and to reach theoretical saturation (Charmaz, 2006). The process involved includes the researcher asking questions of their data and identifying areas with limited understanding. Data collection was then undertaken in a goal directed manner to fill those gaps in understanding. Due to the present study recruiting participants consecutively from a clinical trial, it was not possible to recruit participants with differing attributes, or those from other settings. Therefore, research questions were used as a means of developing and saturating categories with data. This process of data collection continued into the focused coding stage of analysis.

Member Checking

Member checking, also known as respondent validation (Mays & Pope, 2000), is a process whereby the results of the study are presented to participants to gain their perspective, with the aim to both increase the validity and credibility of the study or to expand the categories further (Charmaz, 2006; Chiovitti & Piran, 2003). Member checking is considered an important means of ensuring that there is congruence between the theory development and the actual phenomenon as experienced by the participants. The aim is to examine the level to which the researcher's theory of the phenomenon corresponds to the participant's account (Mays & Pope, 2000). It is expected that there will be individual differences in participants' experiences which may not be accurately captured by the global theory (Mays & Pope, 2000). Nonetheless, the process increases

the credibility of the theory, that is the extent to which the theory captures what is actually the case for participants (Chiovitti & Piran, 2003).

In the present study, following saturation being achieved, two participants (Alyssa and Zara) were employed in member checking. The participants were asked if they would be interested in providing feedback on the findings thus far. Following initial rapport building, the study's findings were explained to the participants. They were then asked whether the theoretical model fit with their personal experiences with the illness and treatment process (C. Albas & D. Albas, 1988; D. Albas & C. Albas, 1988; Charmaz, 2006). Of the two participants, both were able to see their experience of illness and treatment within the model presented. However, Zara felt that her experience was limited to a certain point within the model as she reflected that she had not experienced a personal "rock bottom". This information was used to further expand the categories and add depth to the model developed.

Reflexivity

The advantage of qualitative research is that in-depth exploration of, and researcher immersion in the research phenomenon allows understanding of it to be developed in a way that is not otherwise possible (Côté & Turgeon, 2005). However, for the developed theory to be empirically grounded in data, it must be faithful to the actual phenomena, rather than wholly the researcher's perspective. It is inevitable that the researcher and the lens through which they view the data will influence the results. However making implicit assumptions explicit, empowers the researcher to focus upon the data and actively challenge biases, rather than seek information consistent with their views without conscious awareness. In the research process, this is considered important as it allows one to objectively examine the extent to which the researcher's views may have impacted upon the study results. Memo-writing throughout the research process has

been found to be an efficient method of bringing to light these implicit assumptions (Charmaz, 2006). In line with this, the present researcher's own philosophical and conceptual stance of the world will be outlined.

Researcher Reflections

The present researcher is a 26-year-old Australian woman of Indian ethnicity. Whilst carrying out this research, she was completing a doctorate in clinical psychology. She has had no personal experience with eating disorders. Her interest in AN was sparked upon learning of the seriousness of the disorder coupled with the ambivalence to recover, during a series of seminars attended whilst undertaking honours. Given her developing skills as a clinician, she was interested in understanding the illness through the personal experiences of sufferers themselves, contributing towards a growing interest in qualitative research. The author has not had previous experience with qualitative research.

The author's training lent towards a cognitive-behavioural orientation towards understanding AN, though she desired to explore alternate conceptualisations. The completion of a clinical placement in a child and adolescent eating disorders service within a public hospital, delivering Maudsley FBT, helped further develop the author's ideas regarding her epistemological position. The use of multiple perspectives and circular hypotheses in family therapy, matched the therapist's personal values and liberated her to question her own previous conceptualisations of AN. Thus, the epistemological position adopted in this research was constructivist.

2.7.2 Fittingness/Transferability

The fittingness of a qualitative research study is the extent to which the results can be applicable to contexts other than the ones that were studied. In quantitative research, its equivalent would be external validity. Two research strategies have been identified to improve fittingness.

Detailing the Context

The first and most obvious strategy is to clearly specify the details of and the context surrounding the present study. Specifically, participant details, such as demographic and key variables relating to the topic of interest should be spelt out. Likewise, it is important to identify the context of the study, such as where the participants were located and what were the conditions in which they were interviewed. This information will increase fittingness in that it will allow readers to determine for themselves whether the results of the study can be extended to the population at hand. It is for the disconcerting reader to make those judgements, but it is the researcher's job to provide sufficient information to allow informed decisions to be made. These judgements may pertain to the author's proximity to the data and phenomenon, relationship with the participants and the setting, and the potential for biases involved (Côté & Turgeon, 2005).

Level of Theory

In a similar vein, it is important to outline to the reader the level of theory generated. As per Strauss and Corbin (1990), there are two levels of theory; grand and substantive. The former refers to a general theory that identifies universal mechanisms in a phenomenon that has been studied across a diverse range of contexts. The latter relates to a theory that is situated in one specific context only. Specifying the level of theory allows to reader to make informed choice regarding the fittingness of the theory. This is all the more important in health research where clinicians may be required to judge whether the outcomes of research are applicable to their particular patient. The present theory developed was at the substantive level.

Theoretical Triangulation

The second strategy to improve fittingness is to place the results of the study in the context of pre-existing knowledge and literature related to the phenomenon. This is important in that it places the results of the present study within the growing body of knowledge about AN. In practical terms, this may mean identifying similarities in meanings of categories across different fields of psychology, as well as existing literature examine the nature of the relationship between the categories.

However, to prevent an over-influence of pre-existing literature on emerging categories, two separate literature reviews were undertaken. The preliminary literature review was undertaken to allow for theoretical sensitivity, as described earlier. The latter, more comprehensive review was undertaken once the theory had been developed, prior to write-up. This allowed for a deeper understanding of how the results of the present study relate to existing literature whilst minimising the influence of the literature on the developed theory.

2.7.3 Auditability/Dependability

Auditability, akin to replicability in quantitative research, is the extent to which the conclusions are in line with research process, such that should another investigator undertake the analysis using the same methodology, it is highly likely that the conclusions would be similar. For this to occur, it is imperative that the researcher maintain thorough notes on the research process and is able to identify decision points which determined the course of the study.

Memo-Writing

“Informal analytical notes” (Charmaz, 2006, p. 72) written during the qualitative research process are known as memos. Memo-writing is considered important for auditability and credibility of the research process (Chiovitti & Piran, 2003; Tweed and

Charmaz 2012). Writing in grounded theory analysis is used as a way of analysing the emerging categories within the research, exploring the relationships between and making explicit investigator biases that may be influencing the developing theory. It enhances auditability by allowing one to follow the analytic path of the research and identify crucial nodal points in the research. These nodal points may identify a decision to recruit particular individuals for theoretical sampling, or it may identify a shift in which the categories were understood. Memo-writing in the research process is critical as the researcher is considered a tool in the research process; therefore documentation serves as a way of crystallising the internal workings of this tool. Memo writing crystallises the researcher's hunches, thoughts, interpretations and decisions between the start of the data collection to the write-up phase (Tweed and Charmaz 2012

Relying on (Charmaz, 2006) guidelines, in the present study, memos written at the earlier stage of analyses tended to explore the data at hand to identify emerging codes. In the later stages, the memos tended to explore the relationships between categories, compare across categories and, as research progressed, compare the developed model with pre-existent literature. The memo-writing process was kept as unstructured as possible to allow for organic development of ideas. Therefore, modelling, flow-charting, and free-writing were used as strategies.

Chapter 3: Results

As per the aim, the study has resulted in the development of a grounded theory that explains the process of motivation through the experiences of patients with AN. Specifically, the results yielded a change processes model of motivation, and the identification of the processes unique to the patient-therapist interaction as well as components of the manualised treatments that interact with patients' motivation.

Using guidelines from (Anderson, 2010), a discussion of the results with relevant literature has been included within the results section. This is considered common practice and is a means of enriching the results in qualitative research (for example, Burgess, Rhodes, & Wilson, 2013). In typical quantitative tradition, the separation of the literature, methods, results and discussion sections is considered important in delineating possible researcher biases upon findings. From the constructivist perspective, qualitative research is a function of the researcher, their prior beliefs and frameworks, and the data (Charmaz, 2006). The decisions regarding literature review, methodology, theory generated and conclusions drawn are viewed as a construction. Thus the separation of the literature, method, and discussion from results is considered "artificial" (Sandelowski & Barroso, 2002, p. 215).

However, in line with standards of rigour for grounded theory analysis and to minimise researcher influence, the comprehensive literature review and theoretical triangulation was undertaken after the theory had been developed and member checking had occurred. The exploration of previous literature in relation to the developed theory occurred during the write-up stage of research.

The results are presented in five sections; firstly, the model of motivation developed is presented; secondly, the psychotherapeutic processes that influence

motivation are outlined; thirdly, the manualised aspects of treatment that relate to motivation are outlined; and finally, counter-cases are discussed.

3.1 Process of Change

The primary aim of the present study was to develop a grounded theory of the process of change in motivation in patients with AN, in the early stages of treatment. However, to do so, it became apparent from the data that the patients' experiences from prior to treatment needed to be considered to provide a holistic understanding of the change process. That is, when exploring the influence of treatment upon motivation to change, participants would often reflect upon the processes that lead to them choosing to engage in treatment. This process was considered critical to understanding the role of treatment in motivation to change and have been included below.

Results suggest that the process of change in AN can be divided into three broad phases; (i) illness, (2) turning point, (3) recovery. The illness phase was characterised by the participants' sense of being controlled by the AN to the point that they reached their personal "*rock bottom*". The phase labelled turning point encapsulated the shift in participants' motivation such that there was a developing willingness to change. The recovery phase captured participants' active battle in treatment to fight against AN. The model generated will be outlined below. A diagram of the change model is presented in Figure 3.1.

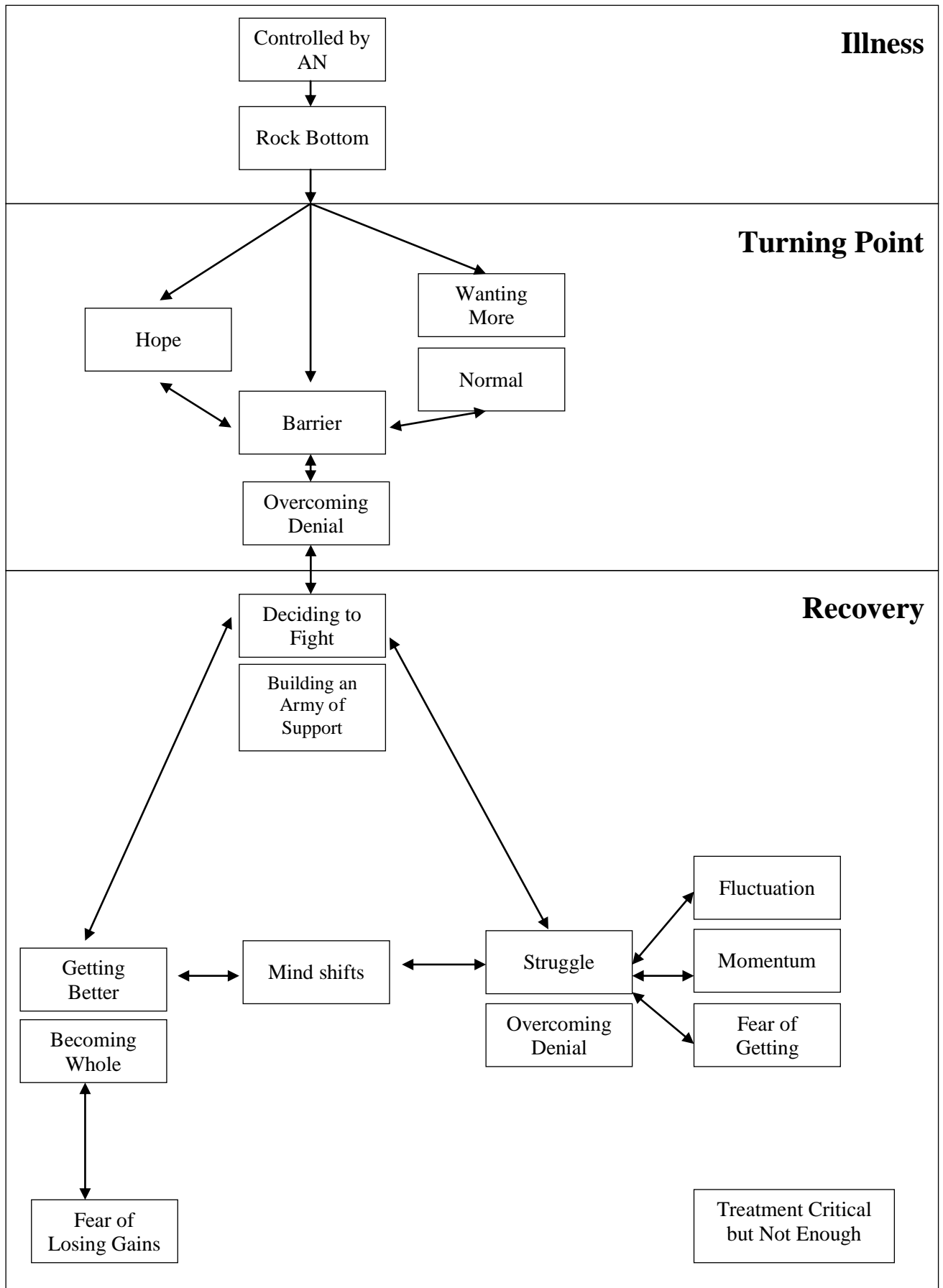


Figure 3.1. Model of the processes of change in motivation

3.1.1 Illness Phase

In discussing motivation during treatment, participants inevitably discussed their illness experiences prior to treatment. The extension of the scope of research to participants' experiences before therapy was surprising. The present researcher anticipated that the results generated would pertain to the process of change relevant to therapy alone. Such unexpected findings are considered important as they demonstrate researcher learning and authenticity in qualitative research (Fossey, et al., 2002). As was the case in the present study, the researcher's views were challenged and expanded through the authentic representation of participants' views (Fossey, et al., 2002).

The first phase of the studied phenomenon was marked by the participants' experience of being governed by the illness, such that their lives became out of control. Here, participants experienced their personal low point, which allowed for the second phase to begin. The processes within this phase are presented in Table 3.1 and outlined below.

Table 3.1

Processes of Change in Motivation in the Illness Phase

Phase	Theme
Illness	Controlled by the AN
	Rock bottom

Controlled by the AN

Specifically, when discussing motivation to recover, the majority of participants reflected upon a time in their life when they felt “*controlled*” by AN. The control was experienced as being pervasive and all encompassing, to the extent that it “*becomes a part of your identity*”. This is congruent with the findings of the meta-synthesis when

'identity centred in AN' was identified as the first phase of recovery (Espindola & Blay, 2009).

Participants described feeling trapped because they "*really can't see a way out*". The distresses of being stuck within the illness often led to a negative self-perception, such as for Chloe who saw herself as a "*waste of space*". Despite the illness's dominance, participants were able to distinguish between themselves and the illness when noticing that they were "*attacked everyday*" by AN and made to "*do all these things that's the complete opposite*" of their values. The sense of being trapped by another entity, namely AN, was captured in Mia's description.

"I sort of was so involved in AN, I couldn't see a way out... I think I was so engulfed by the anorexic thoughts about what was me, I wasn't fighting it anymore, would go with it, so I was just exercising every day, eating rotten food actually that's all I had, like rotten vegetables and that was it. except for the dessert and I got to a point where I was just engulfed and I couldn't even remember who I was and I could feel my body shutting down" (Mia)

The sense of being controlled by AN is parallel to the stage one of recovery described by (Dawson, et al., 2012). The inertia, lack of motivation or lack of perceived ability to fight the illness apparent in this theme is akin to the state of amotivation as described by the SDT (Ryan & Deci, 2000b). Though this theme holds some similarities to the precontemplation stage from SoC (Prochaska, et al., 1992), it differs in that the participants here were able to indicate awareness of the extent of their problem.

Rather than being in denial about the difficulties, the participants appeared to have surrendered to the AN. The lack of motivation to change may partially be attributed to a low self-efficacy (Bandura, 1999) and participants' having an external locus of control (Ryan & Connell, 1989). In line with (Verstuyf, et al., 2012) hypothesis, the lack

of motivation to change may be because the illness had served to fulfil participants' basic psychological needs, albeit in a dysfunctional manner. AN as a maladaptive coping mechanism to satisfy thwarted needs may have been considered helpful in the short-term, which may explain the lack of desire to recover.

Rock Bottom

The control of the AN was described as contributing to a downward spiral which led to participants experiencing a “*rock bottom*”. This was described as the “*lowest*” or “*weakest*” point in their lives where continuing to live with the illness was no longer possible as the suffering was too great. The definition of this suffering varied greatly.

For Isabella, it was the physical deterioration when she “*just woke up in an ambulance, and I was on a drip for like a week, I was unconscious, I couldn't move, I couldn't go to the toilet or anything*”. For Chloe, it was the comorbid low mood, which led to significant suicidal ideation “*All I wanted to do was just die*”. For Amelia, it was that the deterioration prevented her from achieving her goals to study; “*I...hit a wall and I couldn't do it anymore, I just kind of caved in and I found that I couldn't really read or watch films or learn or remember things just like that.*” For Mia, her lowest point was when she lost touch with identity; “*I was so out of touch with my feelings ...perhaps I wasn't even human*”.

It seemed that reaching this point of despair was critical in allowing participants to consider a life without AN. Specifically, reaching this point meant that life could not continue as it was, either due to death becoming imminent or one's regular functioning becoming impossible. This liberated participants to reflect upon their life with the illness. The option of considering a life free from AN became a possibility. The crucial role of experiencing their lowest point prior to contemplating change can be seen in the case of Isla:

“...I felt like I had really hit a wall and, you know, I couldn’t stand staying anorexic and sort of non-functional for the rest of my life. And I was sort of at that point I was thinking I either need to kill myself or get better so that was sort of pushing me towards recovery. But the positivity has really, sort of, helped me find sort of things that I want to get better for, things that I want to do but I can’t do at the moment or previously.” (Isla)

The shift towards considering a life without AN during their weakest moments is akin to the transition towards the contemplation stage of change (Prochaska, et al., 1992). However, this realisation of the desire to live and flourish during the lowest point in one’s life may be better explained by the SDT. From the SDT perspective, the desire to live in the face of adversity it may reflect the innate desire to grow and actualise (Ryan & Deci, 2000b). That the AN may prevent one from achieving their goals can be perceived as thwarting of the need for autonomy and competence. Thus, the growing desire to consider a life without AN may be a means of seeking alternative strategies to satisfy basic psychological needs, with the recovery being considered as a viable option.

Summary

In sum, the first phase of the change process of motivation consisted of the AN having a strong hold on the participants’, with their willingness to change as being low or non-existent. However, as the impact of the illness tended to worsen with participants’ lives being increasingly limited, there was a growing tendency to contemplate a life without AN.

3.1.2 Turning Point Phase

One of the key findings of the study was the emergence of what was referred to as the “*turning point*” in participants’ process of change. It was only after participants’

experienced the worst consequences of the illness, that they were able to experience a turning point, which consisted of a collection of processes that resulted in participants deciding to fight the illness. These processes have been presented in Table 3.2. The turning point encompassed a budding desire to want more in life; to become normal. This required participants to view AN as a barrier to achieve their goals, and come to terms with the seriousness of their condition. For the following processes to occur, participants needed to experience the lowest stage in their illness. The processes that emerged as being critical in experiencing this turning point have been outlined below.

Table 3.2

Processes of Change in Motivation at the Turning Point

Phase	Theme
Turning point	Wanting more
	Normal
	Hope
	Barrier
	Overcoming denial
	Turning point

Wanting More

The majority of women interviewed expressed a budding desire to seek greater happiness, meaning and purpose in their lives, by extending beyond the limits of the illness. Alyssa described this as using therapy to “*increase the size of your bubble or pop it*”. The expression of the desire to grow described by participants appears akin to intrinsic motivation as outlined in the SDT (Ryan & Deci, 2000b). Here, similar to the need for relatedness (Ryan & Deci, 2000b), wanting to reconnect with family was often cited as a reason to recover; “*...my family and my friends...that’s why I want to get better*” (Rose). Similarly, the desire to achieve goals that were incompatible with AN

were also expressed. This included finding love and a partner, having children, completing one's education, getting a driver's licence, and fulfilling one's purpose in life. This can be seen for Chloe, who stated:

"I never used to have a purpose for myself in the world, like I just thought I was a complete waste of space...but about four years ago, I started teaching like lecturing and stuff, and I really really enjoy it. And I think at that point in time I realised that 'ok I finally do have something I can be good at' and...impart with...onto others and make a difference. And that was you know probably another key factor as to why I wanted to get better..." (Chloe)

Participants often described the desire to want more in one's life as coexisting with the AN's demands. As Olivia states, *"there is a eating disorder side that just says being skinny is the only thing that's important in life and then there's that other side of you that says no all these other things are important"*. Interestingly, research suggests that as readiness to recover improves, the value placed upon shape and weight as a determinate of self-esteem decreases, whilst the importance of personal growth increases (Geller, Cassin, Brown, & Srikameswaran, 2009).

Normal

Participants also endorsed a desire for a life in which they were not set apart from family, friends and peers by virtue of being different, sick or abnormal. To achieve this, comparisons with those deemed normal was used to guide behaviour. For example, Mia was able to eat a whole sandwich because she believed that *"that's what normal people do"*.

On the other hand, such comparisons resulted in frustration. For example, Sienna struggled with the structured nature of weekly food challenges because she believed that *"Normal people don't think 'Ok this week I have to buy a donut, I'm going to buy it here;"*

I'm going to buy it with this person." Likewise, perceptions of eating or exercise behaviour being normalised contributed to distress, such as for Amelia who commented, *"when I feel as if I have eaten a normal amount in the day or quite a lot then I find it really hard to eat the next meal..."*

It is important to note that normal does not necessarily indicate the absence of illness, such as for Olivia who really just wanted to *"feel more normal"*. Yet, she felt her ideal situation would be one where she could *"lose three kilos but then not have all the other symptoms so I wanna be like this normal person but still be really skinny and I know that's not possible"*.

This theme tended to remerge at a later stage in treatment process, when participants were able to reflect upon their gains to build towards their sense of being normal. Treatment also tended to contribute to this sense of normalcy. For example, a modification in the definition of what is typical was considered a powerful tool when used by the therapist to normalise participants' experiences. This was seen as the case for Mia:

"...you feel ashamed of what you're saying because you know it's weird for normal people, ok? But then having someone who was obviously sane but also professionally aware and educated in that kind of thing to understand you and give you a genuine, 'O yeah yeah that's normal, that's what the disorder is telling you, that is the disorder, that's not you' ...that really just helped me validate everything that it was me and not the AN sort of thing, and helped me see that that was an illness and not me and reassured me" (Mia)

Hope

Generally, as the desire to want more from life increased, participants described growing hope for recovery. Many used the metaphor of hope as light at the end of the

tunnel. There were times that this hope was strong; *“I might actually make it through this and come out the other side and have a reasonably normal life”* (Isla). At other times, it was rather cautious; *“even if I don’t recover, umm at least have some kind of positive impact”* (Chloe).

For some, the therapy itself raised confidence; *“I feel like by coming to the therapy I will get better”* (Ella). For others, it was specific aspects of treatment, such as the psychoeducation *“...it’s always people telling me, ‘if you get up to a BMI of 19, you know minimum normal, you’ll have you know perfect concentration.’ You know, it’s kind of those things that drive me to kind of provide you know, provide the incentive.”* (Aria)

Hope in this context can be perceived as a belief that one is able to recover. From the literature, this may be akin to the concept of self-efficacy (Bandura, 1999) or competence (Ryan & Deci, 2008), whereby participants believe that their actions will affect the desired change. The need for competence considered a basic psychological need that drives behaviour, and is considered a critical ingredient in instigating change (Ryan & Deci, 2008). Results from the present study support this theory, with only three participants’ accounts indicating an absence of hope. Two of these three participants later dropped out of treatment, see ‘Counter-cases’.

In treatment, optimism and expectation of recovery was often built following successes in therapy. For example, Grace was able to reflect that since engaging in therapy, *“now I have like times where life isn’t s***, life’s pretty good, life will get better.”* Grace was able to say that the journaling required in treatment specifically was helpful for her; *“to go back and just to read through where I was at gives me a greater understanding of where I have been and how far I have come and gives me hope”*. As participants goals for their future became clearer, so did faith that their future could improve. As the discrepancy between what they have and what they were wanting increased, AN became viewed as a barrier to achieving this.

Barrier

The majority of participants described AN as a barrier that prevented them from reaching their full potential; “...*feels like it really holds me back from achieving everything that I wanna achieve and then it also just really messes with your day to day life*” (Olivia). Goals that were blocked by the AN included becoming a good mother (Ava and Chloe), having a functional relationship with one’s partner (Mia), getting through day-to-day life (Amelia and Aria) and being connected with others (Rose). The process of participants viewing the negative aspects of AN can be related to contemplation stage of change which is hypothesised to be marked by the assessment of the pros and cons of change (Prochaska, et al., 1992).

The language describing AN tended to shift with the degree of participants’ recovery. In the early stages, the undercurrent of “*missing out*” was noticeable, whilst in the later stages AN is viewed as negative and unwanted. Treatment had played an active role in shifting the perception of AN from being helpful to being a hindrance. As Amelia stated, “*I couldn’t really do much of it if I was still ill so I guess [the therapist] just kept bringing that up and reminding me why I needed to get better.*” Interestingly, the participant’s views of AN as an obstacle is akin to the existential psychotherapy approach which assumes humans have an innate desire to grow and prosper, which can at times may be hampered by barriers which need to be moved for wellbeing to prevail (Yalom, 1980). The obstacle in this situation being AN. As participants increasingly perceived AN as a barrier, they reported a process of acceptance, in which they were able to come to terms with the reality of their situation.

Overcoming Denial I

Participants described how they were faced with the realities of the serious consequences of AN, which lead them to further consider change. As Grace stated, “*it*

was terrifying... when I admitted to myself that 'yes, you really do have a problem'...I thought I was in control...but I realized that I had no control whatsoever." This process of acceptance is similar to the third-order concept of self-reconciliation identified by (Espindola & Blay, 2009), in their metasynthesis.

The duration of this phase varied between participants. For some, overcoming denial occurred in one moment of time when they were "*shocked*" into facing the seriousness of their situation. For others, the process spanned years as "*it took a very long time, like more than a decade, to want to get better because for the longest time I believed that I would have to live with this for the rest of my life*" (Chloe).

Generally, participants described acceptance occurring at two points; prior to treatment and during. Prior to treatment, patients described experiencing disbelief at being diagnosed with AN or learning the seriousness of their symptoms. For example, Charlotte recalled being informed that "*no day program would accept me because I was too low...and quiet critical*" as being a "*shock*" because she "*just thought like I just needed a bit of a prod along*". As seen in the quote below by Ella, the initial shock often prompted the gathering of courage to decide to fight the AN.

"...quite a shock actually because I didn't believe that I was that bad so it was quite upsetting and emotional but I think I needed to hear that to sort of prompt me"
(Ella)

Not only were participants forced to face the dangerous consequences of continuing to remain sick, but they also came to accept the fact that they needed help and support to recover; "*...it did take me a long time to convince myself that...I can't do this by myself, I do need others' help to better*" (Chloe).

The process of participants accepting the severity of the condition in which they were in, contemplating a life without AN, and coming to value recovery is parallel to

integrated motivation. Integrated motivation is when the performance of an action is viewed as a volitional expression of one's personal values and commitments (Vansteenkiste, et al., 2005). Thus, confrontation of shocking information and reflection upon this may have resulting in the assessment and incorporation of the information into one's sense of self in a manner that is consistent and coherent. For some, that may have meant that learning the severity of their illness may have been confronting as it was perceived as being inconsistent with their sense of self, therefore recovery increasingly became valued and integrated as part of one's identity. For most women, coming to accept the harsh reality of their circumstances was a necessary aspect of reaching the turning point, at which these women developed a desire to heal.

Turning Point

Whilst the theme of wanting more captured the participants' desires to fulfil their potential, turning point captured the transition of that desire into wanting to engage in treatment. Whilst the theme of deciding to fight captured the actions which participants engaged in to want to change, turning point captured the fundamental mental shift which enables actions to be undertaken. It captured that brief but critical space between participants experiencing the lowest point in their lives due to AN and making the conscious decision to fight the illness. Within that space, a series of processes needed to occur to enable participants to challenge the illness.

For instance, for Grace, the experience of the worst part of her life due to AN was liberating in that it gave her the permission to heal by allowing her to come to terms with the reality that her purging was uncontrollable. The lack of control was perceived as an abnormality, "*this isn't right*", which was not desirable. This allowed for motivation to recover to grow:

“I thought that that was rock bottom but then the first two weeks of the study I went further downhill like I lost more weight and then that was when the purging got really really really out of control...that was when I realized that yeah, this isn't right or this behaviour is completely out of control, out of my control, what I thought I was controlling, it was controlling me, well and truly and it had to get to that point like I had to come to that realization before I was going to allow myself to start trying to get better.” (Grace)

Some described the development of the desire to change as a realisation; *“I just realised I don't want to live like this anymore”* (Alyssa), whilst for others, it was a decision; *“I just decided one day”* (Mia). For some, this process was gradual; *“...it's more been kind of a very gradual, difficult, kind of clawing at different possibilities...trying to work out what is it that I need to do and change”* (Aria).

It is important to note that although the processes tended to occur in the order stated, it was not always the case. The reason for the processes being grouped together as a collection is that often the individual processes alone are unable to capture this space, which resulted in a permanent shift of the participant's motivation to change. As the adage indicates, the whole is greater than the sum of the parts.

The turning point phase was considered critical in understanding participants' motivation for recovery during treatment. Generally, the majority of participants tended to engage in most, if not all of these processes. Notably, there were three cases for which this theme, as well as the processes described above, either did not emerge or were qualitatively different to that of others. Two of these three cases dropped out of treatment in the early stages. Though these cases will be discussed later, it highlights that the experience of the turning point was important in building motivation to change. The present theory of change developed may further be enriched through the SDT perspective (Ryan & Deci, 2000b).

Specifically, for motivation to become self-determined, it is necessary for the regulators of the behaviour to become integrated into one's sense of self (Ryan, et al., 2011). It is likely that the turning point marks the integration of the values for recovery into a coherent identity for the majority of participants interviewed. Conditions which are considered need-supportive are suggested to facilitate this process of integration (Ryan & Deci, 2008).

Using this lens, the participants' expressed a wish to seek a fulfilling life beyond the limits of the illness may be considered an expression of desire to be in charge of one's life. Namely, rather than letting the AN be in control, they expressed the desire to be autonomous. In most cases, the participants' individual environments may be considered supportive of this need. For example, many participants expressed a wish to achieve goals that they personally valued, such as finding love, becoming a mother or progressing in their career. Thus, having a partner or the offer of a university course may be seen as facilitators for recovery in that they create opportunities for participants to express their autonomy.

Similarly, participants' desire to be "*normal*" like others may be viewed as an expression of the need for relatedness. The identification of the support of partners, families and friends as reasons to improve suggests that these social networks may satisfy the need for relatedness. Likewise, the hope for recovery may be perceived as the satisfaction of the need for competence, namely, that participants believed that they could modify their behaviour and recover from AN. Integration is the process whereby regulations for behaviour are evaluated and brought into congruence with one's personal values and needs, thereby becoming assimilated with a coherent identity (Ryan & Deci, 2000b). Reconciling with the reality of their present situations (overcoming denial), may then be viewed as the participants' process of integrating the value for recovery into a coherent sense of self.

Thus, the turning point phase may mark the alignment of a number of factors that facilitate the satisfaction of basic needs, which in turn, liberates the individual to incorporate regulations for behaviour change within their personal values and identity. Thereby, the type motivation for recovery shifts from being amotivational, external, introjected or identified, to becoming integrated. In other words, motivation for recovery becomes self-determined.

Summary

In summary, only after experiencing severe consequences of being ill (rock bottom), did participants begin to reflect upon their situations and consider alternate scenarios. It was then, that the desire to have a life that included love, connection and fulfilment grew (wanting more), as did the yearning to have a life like others' (normal). This longing, coupled with the faith that a future free of the burden of AN was possible (hope) contributed to the shift in perspective of AN as a hindrance to their happiness (barrier) rather than a helpful tool. Seeing the extent to which AN prevented them engaging in life, led participants to confront the extent of damage sustained by the illness and the degree of effort required to recover (overcoming denial). This acceptance provided participants with a sense of clarity and lit the flame of desire to change (turning point). It is likely that these processes combined to facilitate motivation for recovery to become integrated and self-determined (Ryan & Deci, 2000b). It was only after the acceptance of their situations, were participants able to consciously choose a life of health (deciding to fight).

3.1.3 Recovery Phase

Following the development of the will to recover, participants described making the decision to recover and enlisting the support of friends, families and the therapists in a

battle against AN. This constant and exhausting battle with symptoms in an effort to recover often lead to a greater appreciation of the extent of their engrained habits with the illness. However, it was through the consistent effort to change that participants experienced shifts in their perceptions which further facilitated change. As the changes were noticed and reflected upon, it contributed to a sense of pride and renewed hope, as well as a feeling of becoming a whole entity separate from the illness. The more the participants were able to reflect upon their improvements, the greater the expressed fear of relapsing to their worst moments. Nonetheless, this further contributed to the determination to fight the illness. The engagement in the struggle to modify behaviours or thoughts was often influenced by fluctuations in both motivation and progress, changes in momentum and fear of losing the comforts that AN provided. In reflecting upon the role of treatment during this recovery phase, participants generally stated that treatment was considered a critical ingredient in driving change, but insufficient without their pre-existing determination to fight. The processes identified in the recovery phase have been listed in Table 3.3, and are outlined below.

Table 3.3

Processes of Change in Motivation in the Illness Phase

Phase	Theme
Recovery	Deciding to fight
	Building an army of support
	Constant struggle
	Overcoming denial
	Mind shifts
	Getting better
	Becoming whole
	Fear of losing gains
	Fluctuation
	Fear of getting better
	Momentum
	Treatment critical but not enough

Deciding to Fight

Either prior to treatment or in the initial stages, participants described the point at which they actively decided to fight the AN. Similar to the preparation stage of change (Prochaska, et al., 1992), this category includes the translation of intention to preparatory behaviours. Alternatively, the decision to change can also be viewed as participants taking responsibility for their recovery process or being self-determined (Ryan & Deci, 2000b). Thus, rather than behaviour modification being regulated by friends, family or health professionals, it suggests that the regulators were the participants themselves.

For some, this process meant the start of seeking treatment to get better; “... *I just put up my hand for everything and the treatment*” (Rose). For others, it included taking steps to improve their symptoms. As Mia describes, “*I just thought.....well, excuse the language, but f*** it. I am just going to order that, a jacket potato with loads of cheese and eat it and see what the worst happens....and then for some reason I did that and it felt really liberating*”. The process of engaging in help-seeking included admitting that help was needed and enlisting the support of others; “*I want to get better. I want to have something approaching a normal life and I obviously can't do it on my own*” (Isla).

The actions engaged in by these participants may have been initiated by others or by the participant themselves. Aria attributed her decision to fight the illness to “*partly encouragement from other people, support from other people and partly knowing that things weren't like how I wanted them to be*”. It is important to acknowledge that this process was not without hesitation or fear, but rather the active decision to push forward despite it.

Building an Army of Support

Similar to the SoC process of helping relationships (Prochaska, et al., 1992), participants described being able to involve significant others in their recovery process has being helpful, if not critical, for progress and motivation. The help provided by others was at times emotional support, such as for Mia who felt *“having people who I loved and family, that motivated me”*, whereas for Aria it was tangible help, *“voluntary drivers come and pick me up... So it’s almost like everyone is making such an effort for me I kind of owe them an obligation in part to do my best to try and get better”*.

The support network often itself became a reason to recovery; *“it’s like you don’t just wanna get better for you but you wanna get better for everyone that’s trying to help you as well”* (Olivia). At times, the relationship with the therapist was the source of support through the recovery process, and has been outlined in the ‘Psychotherapeutic Processes’ section.

The importance of a support network in facilitating recovery is clear in FBT approach to treatment in children and adolescents, which relies upon parents to nurture their child back to health, whilst siblings provide emotional support (Lock & Le Grange, 2012). Similarly, a support network is critical in allowing individuals to feel a sense of belonging and relatedness, a basic psychological need (Ryan & Deci, 2000b). The impact such a support network being lacking can be seen as the case for Ava, where the absence of family support has resulted in pressure and a sense of failure:

“...my family is like when I’d say that I can do it, I can get better they said oh it has happened before, like, you know, this is what you said last time and look at the situation that you have ended up in, sort of like they don’t think you can do it and I find that for me is very demotivating.” (Ava)

Constant Struggle

Participants described that, during the course of treatment, they tended to experience an exhausting and unending battle against the AN and their symptoms. Alyssa describes this as her fight; *“I’ve been you know fighting as best I can. I haven’t let myself go... you know I’ve always been fighting with that”*. Mostly, participants describe this phase as either ‘hard’, ‘difficult’ or ‘scary’. Participants note that it is “emotional”, “time consuming” and “exhausting”. Even attending therapy itself is a struggle. This was partially due to the weekly weigh-ins that were experienced as confronting.

Participants’ described engaging in actions such as establishing appropriate meal and exercise routines, as well as completing in therapy related tasks. For example, Zoe describes the food diary aspect of treatment as, *“you don’t really get to escape from it at all ever like life is exhausting and then when you do have a spare five minutes and you are so exhausted, you just want to lie down but you can’t until you get it documented”*. The sheer enormity of the effort required to recover in AN is captured in metaphor:

“...it’s like saying to somebody who hates exercise that, you know, ‘you can go to Hawaii if you want but you have just got to swim there from Australia’. It sounds like, ‘Well I know why it’s going to be amazing but I don’t really want to swim there, like, how, you know, how painful, how boring, like how terrible would that be’ (Ava)

Whilst the fight for some was with regard to tasks, for others it was the mental aspects of recovery, such as the mental battle between wanting to recover and belief in their own limited self-efficacy; *“I was saying ‘I want to. I want to. But I don’t know if I can. I don’t know if I’d be able to. I am not sure if I’m strong enough to’” (Aria)*. Cognitive challenging, too was an effort as *“...it is scary having to change your thinking and change your...outlook on life and you know just questioning thoughts that you thought were so true for so long ...I’ve been this way since I was 12 you know. It’s like a part of me and it’s like giving up a part of you.” (Alyssa)*. Importantly, the aspects that are challenging were not always consistent and uniform. For example, one can be

comfortable with weight gain but not with another aspects of the illness. The continual wrestle with the illness a source of frustration, as described below.

“...it’s really hard and you also know that you are the only person who can get you better so it’s like you know I have the complete control to stop this and to get rid of the Eating Disorder a hundred percent, like it’s only me that can get better and it’s very frustrating that you know something you control you can’t just switch overnight sort of thing.” (Olivia)

The participants’ determination to persevere despite the scale of the task suggests that these individuals were able to take responsibility for their recovery. This indicates that recovery for these women was motivated autonomously and was self-determined to some degree (Ryan & Deci, 2008). This in line with the argument presented by (Vansteenkiste, et al., 2005), in that greater integrated motivation is likely to facilitate the change process. From the SoC perspective, participants actively pursuing behaviour change would be considered a classic example of the action stage of change (Prochaska, et al., 1992).

Overcoming Denial II

Acceptance of the extent to which AN had taken a hold of them or the level of effort required to recover was similar to the previously discussed initial process of acceptance. Here, therapy played a key role in helping raise awareness of the impact of AN:

“... before I started therapy like I said I was a bit in denial of how extreme my habits had become so I guess I sort of ignored the fact what I was doing to myself and the therapy just made me realize that how much of an impact the AN has had on my life really.” (Ella)

It is important to note that although participants were able to come to terms with one aspect of their illness, they may have continued to deny the seriousness of other aspects. For example, Charlotte did come to terms with the seriousness of the illness and accepting that she needed help; *“I was really worried that I might die before I got to hospital”*. However, she struggled to come to terms with the fact that exercise was harmful rather than helpful, *“... it was too scary not to exercise...”*.

Therapy was noted by many as being an important part of acceptance. This included *“really simple basic...things that my friends can do, you know go out in the evenings.”* Aria identifies the recovery process as one where she is able to come to terms with what she has lost to the illness, such as *“flexibility”*. Aria describes the very process of therapy as *“coming to terms with the fact that okay I can’t...do things that I could before”*. This, again, reflects the third-order category of self-reconciliation identified by (Espindola & Blay, 2009). For some, acceptance was still an ongoing challenge:

“Science says that you have to be fifty two kilos before you are healthy” but *“I think deep down I don’t believe that, I actually think that, you know, I still think that I am healthy at forty five kilos”* (Olivia)

This process of acceptance often contributed to participants experiencing ‘*mind shifts*’ in therapy, which are described below.

Mind shifts

Many participants described experiencing a shift in their views or beliefs towards their symptoms and/or behaviour. These shifts were referred to as *“mind shifts”* or *“light bulb moments”*. These mind shifts ranged from learning to listen to one’s body, expanding the definition of who they are to include their body and the realisation that there is more to life than the eating disorder. These shifts may be attributable to the

participant's themselves, or the therapy, and can be either specific moments or gradual processes. Such was the case for Rose:

"...one of the biggest things that I have realized was what was sort of driving the ED and keeping it fuelled was this really really stupid spontaneous exercise that I had been doing and you know like walking home in the rain because I just had to or walking home with like 500 tins of shopping or baked beans or you know, that's really really heavy so it's kind of giving you extra sort of ammunition to sort of not put on any weight and these things I have consciously stopped and that's a serious mind shift like no way that is ED driving me to do those really stupid things...so these are the mind shifts that have been happening for me" (Rose)

These cognitive changes further contributed to changes in behaviour, which were perceived as gains in treatment. Such cognitive changes are a target of CBT itself, and explicitly outlined as treatment goals in both programs that were trialled (Hay, 2010; La Puma, Touyz, Tranis, & Meyer, 2008; Pike, et al., 2004; Touyz, et al., 2010).

Getting Better

This theme captured participants' ability to reflect upon their success in therapy and notice positive changes in their symptoms and lives. These improvements include feeling in control, reduced compulsive exercise, improved ability to study, reduced distress about weight gain, weight gain, reduced perfectionism, reduced compensatory behaviours, or generally feeling less 'anorexic'. From the SDT perspective, reflecting upon success and receiving positive feedback from the weight scales or the therapist may have contribute towards participants' need for competence (Ryan & Deci, 2008).

For some participants, the changes had had a global positive impact, such as Charlotte who believes her "*life has recovered*", despite her weight "*lagging*" behind. For others, it was the emotional aspect which has resulted in positive changes in the other

domains, such as Isabella who believed “*I am coping with work, I am not stressed, um, I am confident in myself now, I like myself because a lot of those underlying issues have been resolved*”. The ability to reflect upon their progress has been helped through the treatment. For example, Olivia was able to look back through her food diaries and believed that “*I do think that we have made progress, which has been positive.*”

Noticing the positive changes had been helpful in recharging participants to continue to engage in the struggle against their symptoms. The process of reflection was indicated to have helped identify milestones for recovery and build hope.

“*...recovering, getting better, that closer to getting treated, getting over it, this is a chapter in my life, I know it's going to be, I keep saying to my friends you know we are going to laugh about this one day, we do now anyway....*” (Rose)

Becoming Whole

Given that AN was seen as a limiting barrier in one's life, noticing gains in treatment contributed to a sense of becoming a whole entity, separate from AN. Here, participants described being able to reconnect with their former identities. This included joining with their families, friends and greater community, or with their own selves; “*...bits of my personality that I haven't seen in about ten years have shown up*” (Isla).

As some of the participants continued to make gains, they described their focus shifting from just eating and weight alone, to their whole sense of self. For example, Mia stated that she “*started believing in myself...I had forgotten what real life was like, who I was as a person...I actually have a bit of a personality, you know (laughs)*”. Part of this process included others helping participants appreciate their whole beings separate from the illness. As Charlotte was pleasantly surprised to learn, “*rather than at all being*

preoccupied with body image that there is other qualities that people complimenting me to do with who I am as a person”.

However, for some participants, the more they improved in treatment, the greater they feared the risk of relapsing into the most difficult stage of their illness.

Fear of Losing Gains

Participants expressed a fear of regressing to depths of the illness and losing the gains that have been made in treatment. For Grace, with regard to purging, she states “*I am petrified that if I start again that I’ll just get back on that cycle and I won’t be able to get off and I have worked so hard to get off it*”. The fear of losing gains extended to projections made by the participants for the end of the treatment stage, on how progress will be maintained following treatment termination

“One thing I am worried a bit about is when it finishes, then sometimes you can get a bit dependent on things like therapy and you might be a bit cold turkey stopping. Maybe it would be better to stop it gradually, see her once every two weeks or something like that, that might be something to think about” (Isabella)

Participants reported that this fear contributed to greater resolution to continue to challenge the AN symptoms, which further contributed to engagement in the struggle against the illness, experiencing cognitive shifts (mind shifts), noticing gains and becoming whole. This cycle described above, was influenced by three key processes. These are outlined below.

Fluctuation

The willingness to battle the AN symptoms was often reported to be fluctuating. The role of ambivalence in influencing the varying levels is evident in Amelia’s case.

“...for me it was kind of difficult, basically I didn’t know whether I wanted to get better or not... I was just on the borderline of whether I wanted to get better or not because it was just a lot easier to stay as I was and I didn’t want to put on weight and I guess the treatment helped me but I kind of knew I needed to.” (Amelia)

The ebb and flow of motivation, which “*comes in waves*”, was seemingly unpredictable, with Aria pointing out “*I guess you don’t really know going into a session how it is going to work out always.*” The variations tend to occur on a day-by-day basis, “*I still have days now where I don’t want anything to change*” (Grace), though a general trend can be noted “*desire [to recover] is getting stronger*” (Chloe).

Fear of Getting Better

Influencing participant’s engagement in the fight against AN was a fear of change, as it may result in a sense of loss of who they were during the state of illness. For Alyssa, recovering from AN felt like “*like giving up a part*” of herself. For some, the fear of recovery coexisted with the willingness to fight, whilst others were able to openly acknowledge that this fear of change may have negatively impacted recovery.

“I guess in part it is more being scared of change and being afraid of making change...that may have, like, stopped or inhibited my recovery rather than not wanting to get better.” (Aria)

Interestingly, this fear tended to coexist with a desperate desire to heal; “*I found really difficult because I wanted so badly to take responsibility for myself, but I wasn’t sure whether I would be able to.*” (Aria). Part of the fear is attributed to losing control as a coping mechanism. In terms of their day-to-day lives, participants feared a loss of control over eating would equate to a loss of control in all other aspects of their lives. Emotionally, participants feared, this would result in them feeling stranded and without protection. For example, Ella feared that she would lose control over her whole life and

Zara equated loosening the rigidity around food to becoming a failure; “*all of a sudden I’ve been an unemployed person living in a pigsty*”.

The concern regarding recovery for some was anticipated negative evaluation from others regarding their weight and appearance, which related to core beliefs regarding one’s worth. Olivia explains:

“...*then you have to deal with the negative side of that when you start to put on weight like you know where I still feel like myself, will people still like me? Will people still think I am pretty?*” (Olivia)

Momentum

The concept of momentum in therapy is acknowledged by (Fairburn, et al., 2008), who argue that the benefit of time-limited treatment is that it keep patients and therapist focus, and ensures a future-oriented stance in therapy. Similar to fluctuating motivation, the rate of change as experienced by participants tended to impact willingness to struggle against AN.

Generally, participants were able to note that momentum tended to ebb and flow, with Isabella noting that there is “*a little bit of pressure with time*” to improve, yet “*every week varies*”. Some participants felt that the momentum for change was intense at the beginning, and more therapy was needed for greater support. Alyssa notes that “*in the beginning there’s a lot of...changes going on*”, with Amelia commenting that during that period, she wished for twice weekly sessions for “*a bit longer... because sometimes I feel that I need to talk to someone but I have to wait like six days or like, last week the therapist went on holiday so I had in fact almost...well...almost two weeks without seeing her. At the end of the first week, I was like ‘I really wanna see the therapist’*”.

Change occurring at a pace that was controlled and collaboratively determined by the therapist brought a sense of reassurance. As Chloe stated, *“I think that’s one of the really good aspects of this programme is that you don’t go from like 0 to like 90, you go from 0 to maybe 5, then 10, then 15, then 24”*. A strong momentum for change was viewed positively by Isabella who felt building upon her success led to her creating *“this sense of excitement in wanting to get better from these umm smaller challenges or the successful completion of these smaller challenges.”*

Meanwhile, other participants conveyed a sense of ‘stuckness’ with regard to their recovery, with the inertia leading to frustration.

“... you are upset or you sort of feel a bit deflated because you haven’t achieved your goals, you didn’t really achieve them last week or the week before, you haven’t really achieved them any week, you are sort of like, well, it’s sort of like you just come in to come as opposed to like putting in the effort to make things happen.” (Ava)

Similarly, Zara, experienced the ‘stuckness’ of motivation as a permanent state, stated that there is *“... basically a lack of intrinsic motivation”*. The lack of intrinsic or autonomous motivation is likely to account for amotivation or stagnation in treatment (Ryan & Deci, 2008). For some, motivation is impacted by the discrepancy between their desire to get better and hope that it is a possibility; *“I know it’s difficult to put a number on, like my motivation would be 10 if I knew it was possible but I know it’s not definite so I am at probably 5... I knew that I could get better and I would feel happy with myself when I am better and I’d be completely motivated but as of now I have been oscillating back and forth”* (Zoe). Here, the lack of self efficacy or sense of competence can be seen to be negatively influence motivation (Bandura, 1999; Ryan & Deci, 2008).

Ava, Zara and Zoe's experience of the process of change in motivation was dissimilar to that of the majority of the sample. The cases will be discussed below in 'Counter-cases'.

Treatment Critical but Not Enough

Generally, treatment was viewed as an indispensable tool for recovery. For example, Mia felt that she would not "*have managed it without the treatment*". However, the onus upon recovery was often placed back upon the participants themselves; "*it has to be you who does it*" (Zoe).

Many described the treatment as requiring "*self-discipline*" as participants considered themselves to be the agents of change. Consequently, many commented that treatment is "*probably not really suitable for those who are not yet ready to get better*" (Chloe). Not only does this suggest motivation to recover must be pre-existing to enrolling in treatment, but that the motivation must have a certain quality. Ella describes this as reaching the "*right point*" in recovery, whilst Grace views it as reaching a place where one is "*allowing*" themselves to recover.

Summary

Upon having decided to engage in the process of recovery and sourced support from within one's support network and treating team, patients' experiences can be mapped out onto a cycle. This cycle consisted of participants engaging in a fight against symptoms (struggle), including overcoming denial about severity (overcoming denial II), to experiencing cognitive shifts (mind shifts). These changes in perception often was experienced as an improvement by the women (getting better), which contributed to their sense of becoming a whole entity, separate from AN (becoming whole). Reflecting on the positive changes contributed to a fear of losing those changes. Both the fear and the

positive changes themselves then further contributed to strengthened determination to fight the illness and improved social support. However, the cycle tended to be influenced by the constant fluctuation in progress and motivation, the rate of change and fear of losing the security that AN provided. Participants were able to state that their ability to engage in the cycle was facilitated by treatment, but that without their pre-existing determination to recovery, treatment would not have sufficed.

3.2 Psychotherapeutic Processes

The second aim of the study was to explore the nuances of the patient-therapist interaction that influenced participant motivation to recover. The psychotherapeutic processes described here influenced the participants' motivation across treatment. The processes relate to the participants' relationship with the therapist and treatment, as a whole, as well as the perceived attributes of the therapist. The processes are outlined in the following order; professionalism, trust, rapport, non-judgemental, reliable, flexible and collaborative, disconnect and bandaid.

3.2.1 Professionalism

In participating in an RCT, participants were able to reflect upon two important aspects of treatment which was found to particularly helpful; one, the therapists' training and skills, and two, the evidence based treatment itself.

Specifically, the perceived competence of the therapist was an important factor that greatly impacted participants' motivation. The qualities that were valued in a therapist include correct judgement as to "*when to back off and knows when to push*", being "*trained to deal with me*", "*quite organized*", and the therapists' ability to "*actually gives answers*". The participant's positive regard for their therapist's expertise

in the treatment of AN is mirrored in clinical research that suggests that, given the complexity and challenge involved, professionals should receive specific training ((Pike, 1998).

The therapists' ability to manage competing demands in therapy was valued by these women. The ability to balance the need to be firm whilst remaining empathetic to the participants' plight during treatment helped in the development of trust. As summarised by Mia, the therapists are perceived to be "*professionals and helpful but also human*". Similarly, the ability to push for change to the correct degree instilled a sense of respect for the therapists' abilities; "*she's usually dead on with what I can handle and what I can't handle*" (Alyssa). The therapists' ability to be "*insightful*" and "*pick up on things*" that participants felt they "*wouldn't have noticed*" has been perceived as helpful in increase the participants' awareness.

The view of the therapist as being competent and trained tended to increase the level of trust participants are able to place upon the treatment; "*I know that my Mum and Dad and family and friends all tell me that I need to eat more but to hear it from somebody I guess is a professional, it always makes me like 'yeah I do need to get a better diet in order to become healthier'*" (Ella). The therapist's trust in the therapy spurs on the participants, "*she really believes in the research and you know, her work and that shines through.*" (Rose).

The importance of perceived competence in developing trust was particularly visible when participants were not confident about the therapists' competence. For example, in speaking about her therapist, Zoe commented, "*Yeah she is nice. I am not sure how much experience she has... I don't know I just got a bit sceptical when she said that the evidence suggests in my experience you do this, you do that, you can't really, for patients it's kind of helpful doing this but you can't just rely on what works for one is going to help the other.*" (Zoe) The relationship between trust and competence has been

well explored in the medical literature with (Hall, Dugan, Zheng, & Mishra, 2001) concluding that competence is one of the five dimensions of trust in physicians.

Secondly, participants reported that knowing that the treatment they were receiving was evidence-based and empirically promoted faith in the therapy. Isla found the scientific evidence-base for the treatment as being in line with her own values; *“I have to go back to about being a scientist, just needing that sort of proof that they don’t just say this is fairly effective”*. The structured nature of the therapy with its *“solution orientation”* was reported as being valuable as it allowed for a focus upon key issues, such as food or exercise, in the *“now”*. The manualised nature of treatment helped participants feel more *“motivated”* as therapy appeared to be *“really professional and proper”*, in that the sessions were goal oriented and ensured participants were *“going in the right direction”*. The guided and structured nature meant treatment was seen as *“supportive”*.

However, it was acknowledged that evidence based treatment alone was insufficient. As Alyssa put it, *“you can’t just pick anybody for... to work with an anorexic”*. She was able to appreciate the theory-driven nature of the treatment, but attributed its efficacy to the therapist as well; *“it’s not just the models it’s like who’s doing the model as well”*. This suggests that the therapists’ competence is related not just to the treatment techniques but also the therapists’ personal attributes.

Thus, emphasis placed by participants upon having therapists that were seen to be implementing the appropriate treatment techniques in a skilful manner is reflected in recent literature (Barber, Sharpless, Klostermann, & McCarthy, 2007; Fairburn & Cooper, 2011). For example, in a recent review found a positive relationship between therapist competence and treatment outcome (Barber, et al., 2007). (Hersoug, Høglend, Monsen, & Havik, 2000) found a relationship between greater therapist experience and therapeutic alliance. In discussing therapist competence, both the use of correct treatment

techniques and personal attributes of the therapist were emphasised as being important (Barber, et al., 2007; Fairburn & Cooper, 2011).

In the present RCT (Hay, 2010), therapy quality was assessed through integrity checks and therapists were provided supervision for professional development. In line with (Fairburn & Cooper, 2011) argument, there may be merit to greater focus being placed on training and evaluating therapists' competence in treatment delivery to improve quality. The innovative use of role-play based training and assessment scenarios may be a helpful paradigm for this purpose (Fairburn & Cooper, 2011).

3.2.2 Trust

Trust was a theme that resonated with many participants. They valued trust within the therapeutic relationship as it allowed them to share aspects of their experience that they were unable to do so with others; *"I tell the therapist a lot more than I tell my friends and my family about, like, how I feel about food and my weight and my mood and things"* (Amelia). This related to the concept of honesty and equality in the relationship, which is also reflected within medical literature of trust (Hall, et al., 2001). Trust was valued especially more when participants felt they had been unable to share with previous health professionals, such as Chloe who stated trust *"was quite critical because with all the psychologists I've seen in the past that I've never really told them about..."* the difficulties. This trust extends to participants belief in the therapists skills, abilities and judgements. This was evident in Grace's interview, *"I don't know how that's going to work but I am hoping the therapist will be able to show me some strategies so I can do that."*

The therapists' ability to build trust within the therapeutic relationship is considered essential for treatment success (Ackerman & Hilsenroth, 2003). Trust is considered to build upon both the therapists' level of competence and as well as their

ability to build rapport with the patient (Ackerman & Hilsenroth, 2003). In the field of eating disorders, lack of trust between patients and health professionals is often cited as a reason for drop-out (Vandereycken & Devidt, 2010). In the present study, the participants' ability to trust the therapist was often cited as the reason for being to take risks and implement change strategies.

3.2.3 Rapport

The “*rapport*”, connection or “*bond*” between the participants and their therapist was identified as being crucial. It related to the extent that the participants were able to engage with their therapist, “*Her gestures, the way she you know, her body language, the way she has it planned down, honestly happy to see me, um, yeah, it’s really, she is engaging.*” (Rose). Characteristics of the therapist that contributed to the connection included that they were a “*good listener*” and closeness in age; “*think it also helps because she’s like similar to me in age...so sometimes it feels more like just a chat rather than a hierarchical type of relationship.*” (Chloe). This is reflected in the literature with greater therapist warmth and friendliness being associated with higher ratings for the therapeutic relationship (Mohl, Martinez, Ticknor, Huang, & Cordell, 1991). Moreover, greater therapist warmth was also associated with improved treatment outcome and therapist effectiveness (Najavits & Strupp, 1994).

3.2.4 Non-Judgemental

The ability of the therapist to remain non-judgemental was a valuable therapeutic process that allowed participants to build trust in their relationship and experience therapy as “*very safe environment*”. The act of being non-judgemental included the ability to “*listen*” then “*give feedback*”, For Olivia, the therapist was “*really good at never kind of making me feel like I am in trouble*” for failing to complete a homework task. The non-

judgemental stance extended to not only dialogue but non-verbal communication; *“there is no look of judgement there”* (Grace). It is likely that the acceptance that the therapist demonstrated for these women may have, to some degree, satisfied the need for relatedness (Ryan & Deci, 2008).

This safe environment facilitates the building of trust in the relationship where the patient doesn't *“need to feel ashamed with the therapist or embarrassed”* (Grace). This process built upon the perception of the therapist as an *“obviously sane but also professionally aware and educated”* individual that *“just helped me validate everything that it was me and not the AN”* (Mia). This stance helped the participant feel normal; *“I guess she has comforted me by agreeing with me and understanding how I feel because she has met people all the time that have the same feelings as me”* (Amelia). The power of this psychotherapeutic process is best described by Mia below:

“... after so long I am feeling even like a human or worth anything to then to be treated as an equal is like really important I think for me because of AN, I know, for me personally, I didn't think of myself as.....well, I thought lesser than an animal at one point so to then think, oh yeah, no, to be treated as an equal from the beginning which really helped me actually without even realizing how much it did” (Mia)

The participants' experience of the therapeutic relationship as being free of judgements, may relate to the therapists' ability to be empathetic. Namely, the therapists' ability to understand and relate to the participants' experience in a manner that is validating is considered critical in eating disorders (Vitousek, et al., 1998) as well as psychotherapy in general (Ackerman, et al., 2001). In particular, understanding the ego-syntonic nature of the illness as well as the difficulty associated with change is suggested as being helpful for clinicians to build empathy (Vitousek, et al., 1998). However, a recent review of motivation in AN calls for therapists to demonstrate “firm empathy”

(Waller, 2012, p. 9), which involves balancing the need to be understanding with the importance of setting appropriate boundaries in treatment.

3.2.5 Reliable

The sense that participants were able to rely or depend upon their therapist was prominent. This theme related to the availability of the therapist, *“You need that person to talk to and to know that there are there to help you.”* (Alyssa), as well as the level of responsibility they take for your recovery, such as Amelia who was reassured when her therapist stated *“we’ll get you better”*. The therapists’ unwavering confidence with their consistent ability to handle situations boosted participants’ sense of hope:

“I had a few really bad weeks where I sort of thought I can’t keep going, and I called the clinic, and she called me back and calmed me down and gave me a sort plan for what I need to do...to get through the bad periods. And that sort of shows me that she is really there to help me through it and she is always very positive about my chances of making it out of this” (Isla).

There is some literature to support the relationship between therapist consistency and patient views of a positive relationship (Horvath & Greenberg, 1989). However, it is likely that the therapist’s ability to remain available, calm and helpful during crisis situations contributed to participants’ perception of the therapists as competent and built trust in the relationship. Similar to the therapists’ perceived competence and professionalism, the therapists’ dependability during times of crisis was viewed as a personal attribute of the therapist.

3.2.6 Flexible and Collaborative

Similar to previous literature, participants in the present study viewed collaborative practices by their therapist as being helpful in increasing engagement and

adherence in treatment (Geller, 2002). Participants described the therapy as “flexible”, “responsive”, “accommodative” and not “rigid”. Participants felt as if they were working as a team with their therapist, so the gains and the credit and the process were shared. This is evidenced in Isabella’s use of ‘we’; “*the last session was the first time we hit 46 but we have done this so gradually*”. This view persisted despite differences of opinions due to the positive reaction of the therapist; “*we may disagree on some things still but umm she doesn’t harp on those things*” (Alyssa). Specifically, the therapist not taking an authoritarian stance was valued; “*I really like this programme because no one forces you to do things that you don’t want to*” (Chloe).

The importance of the need for control may have related to participants’ desire to feel empowered in their own lives, given the control that AN had taken from them; “*...what I want more than anything else is responsibility and independence...So I guess the thing with the therapy is that it starts letting me take control and make decisions myself*” (Amelia). Creating opportunities for autonomy and allowing participants to decide can improve treatment engagement and reduce dropout, particularly in the early stages of treatment (Vandereycken & Vansteenkiste, 2009). This is reflected in recent literature that suggests that “overall sense of control, positive sense of control, and a positive assertive mode of gaining control were significant predictors of recovery status.” (Nipomnick, 2011)

Furthermore, the participants’ ability to view the program as being flexible and collaborative was particularly important given that both treatments tested during the trial were manualised; “*I don’t really feel as if I am on a program, really.*” (Ava). The flexibility demonstrated by therapists enhanced participants’ sense of worth and allowed them to feel important.

The stated helpfulness of treatment, which was viewed as a collaborative processes, can be understood as the participants’ feeling empowered to assert their

autonomy and remain in control of the change process (Ryan & Deci, 2000b). By remaining autonomy-supportive, it is likely that this treatment was able to facilitate the internalisation of motivation for recovery for some participants.

Not Individualised

On the other hand, there were participants that did not feel as though the treatment was tailored to their specific needs, leading to frustration. Ava felt the handouts were juvenile and Ella felt the treatment was a “*standard package*” that didn’t apply to her situation. Zara and Zoe reported that the treatment was not accommodating to their needs, as both wished to disengage particularly due to the food diary and daily monitoring.

3.2.7 Disconnect

The concept of disconnect in the therapeutic relationship was raised by four participants. The disconnect tended to occur in situations where the participant felt that the treatment process had not been collaborative. For example, Ava was denied access to the data from the accelerometer and felt that it was a waste, as the information would have been critical for recovery. Ava believed that having access to facts would “*remove*” the negative emotions she was experiencing. Furthermore, Ava also did not believe the food diary to be helpful but was informed that it was a compulsory aspect of treatment. Therefore, when she did “*put a lot of time and effort*” into the diary and felt “*it wasn’t then used*”, she experienced frustration.

For Ella, the disconnect stemmed from the fact that the therapist did not remember significant details about her, which led her to feel as though the therapist was not engaged and that treatment was “*pointless*”. Ella stated, “*I feel as though [the therapist] is not always taking in what I am saying if that makes sense and [the therapist]*

would repeat the same question the next week or maybe forgets something that I have said and that makes me sometimes feel as though [the therapist's] not always listening to everything that I say..." However, she was able to say that the disconnect she experienced did not negatively impact her motivation to recover. *"It doesn't really affect my motivation for wanting to get better because [the therapist] encourages me, which I suppose is positive."*

Awkwardness in conversation and long pauses have also been identified in experiencing a sense of disconnect with the therapist. As Sienna described, *"I always kind of find that it's a bit strained in the beginning. It's just like- she's always like "So, how did you go with your eating this week?". Well, it's the same as last.... It feels like it takes a really long time to get the conversation going and I definitely have to initiate whatever I'm going to say or talk about and then its kind of like at the end "here's some hand outs, do you want to read them while your away for the week and maybe work on thinking about this" or whatever it might be."*

Disagreement about the course of treatment too has been linked with experiencing a sense of disconnect with the therapist, leading to poorer progress in treatment. This is well summarised by Zoe, *"since because we have that disagreement about that I kind of have gone a bit more backwards because I have explained to her as well, probably self sabotaging in a way because if you tell me do something that I don't want to do, I often do the opposite,"*.

The different examples of discomfort, disagreement or disconnect identified within the therapeutic relationship may be perceived as ruptures in the therapeutic alliance (Safran, Muran, Samstag, & Stevens, 2001). Therapeutic ruptures are defined as a deterioration or change in the quality of the alliance between the patient and therapist (Safran, Crocker, McMMain, & Murray, 1990). They are an important therapeutic event worthy of further investigation (Safran, et al., 1990) as research suggests that such

ruptures are associated with patients terminating treatment (Samstag, Batchelder, Muran, Safran, & Winston, 1998). On the other hand, repairing such ruptures provides valuable opportunities to disconfirm patients maladaptive cognitions regarding interpersonal interactions (Safran, et al., 1990). In terms of AN, given the ego-syntonic nature of the illness and high ambivalence to recovery, greater investigation into the development and resolution of therapeutic ruptures may be helpful.

3.2.8 Bandaid

A minority of participants expressed disappointment and frustrations at their expectations of treatment not being met. For some participants, the current treatment failed to explore the “*root cause*” of their illness and instead focused upon day-to-day eating and exercise to improve symptoms in the present. This was perceived as a “*bandaid*” solution to a deep and complex problem. As Sienna stated, “*I kind of feel like that is not really treating the cause more kind of like putting a bandaid on symptoms like making sure that you keep eating when I kind of am passed that point in my recovery I think.*” It was a thought that was repeated by Chloe and Isabella, who believed that this exploration was necessary for both closure and a thorough “*solution*” to the “*problem*” that is AN.

The sentiment echoed by Sienna, Chloe and Isabella resonated within the literature which suggests that treatment be tailored the individual in terms of goals (Pike, 1998). In saying that, it is also recommended that treatment focus upon weight restoration, particularly when it is below 75% of normal body weight (Pike 1998). Specifically, it is important for the early stage of treatment to target the eating disorder symptoms rather than the aetiological factors, as the factors maintaining the illness may not always be the same as the factors contributing to its development (Pike, 1998). Thus,

the clinician's position in this situation becomes difficult in terms of balancing the expectations of the patients with the importance of enabling positive change.

3.2.9 Summary

In sum, both the quality of the therapeutic relationship and therapist attributes were identified as being important in facilitating motivation to change. The therapists' competence, ability to demonstrate warmth and empathy, and be dependable was reported as being helpful, particularly in building trust. Participants' indicated that the therapists' ability to be responsive to the participants' needs, as well as the treatment being adaptable to the individual, was important. It is suggested that this might be attributed to a collaborative treatment approach that is autonomy-supportive. On the other hand, treatment being perceived as a bandaid solution to a complex problem and the experience of a therapeutic rupture may have negatively impacted motivation to change.

3.3 Aspects of Treatment

The second aim of the study also included the identification of aspects of the manualised treatments that influenced participant motivation to change. The salient therapy components that were identified by participants in influencing readiness to recover were challenging, externalisation, food diaries, goal setting, psychoeducation and weigh-ins. These treatment tasks have been outlined in detail below.

3.3.1 Challenging Fears

Participants described various challenging exercise used in treatment, which pushed each woman to fight her fears. These challenging tasks were identified as being a source of fear and difficulty, as *"it causes a lot of anxiety having to change"*. However it is acknowledged that *"in the long run it is good"* as it allowed them to identify the

problem and prevented it from being an obstacle in one's life. The challenging tasks were helpful as they contributed to cognitive shifts that boosted motivation in treatment.

Thought challenging exercises allowed Amelia and Charlotte to gain a more realistic perspective. For example, the therapist showed Amelia a normal weight chart and pointed out that she was at the bottom of the normal curve, which *"put things into perspective a little bit"* for Amelia. Similarly, one participant equated not exercising or reducing her exercise behaviour to being lazy, but cognitive challenging by her therapist led her to consider the alternate explanation to her *"black and white thinking"*. That is, she was able to state *that "you can be a very disciplined person but you just don't exercise but you are high achiever and very expert in your field of whatever but its just exercise isn't your thing"*.

Engaging in small, graduated challenges helped develop participant's sense of self-efficacy and contribute to improved hope that *"OK I can change my behaviour"* (Chloe). For example, Olivia was able to overcome her urge to chew then spit out her food through small, gradual challenges; *"what we have tried to do is to really start to focus on little things, little challenges every week so one challenge would be... trying, you know, for the whole day not to do this chewing and spitting thing and then once I was achieving that, getting through a whole day without doing it, then we tried sort of getting through two full days without doing it..."*.

These small successes are highly valued by the participants as it opened up many doors for them, to allow them to have a fulfilling and connected life. This is particularly the case for Isabella who described setting up a homework task with her therapist, whereby she would enjoy a meal at a restaurant with her boyfriend every Wednesday night. She reflects on how this was a dramatically different from what she was previously able to do; *"I couldn't eat out ever, I never ate out, like, that's unheard of, someone else cooking for me and bringing me out my plate, like I don't know what it is or you know"*.

Cognitive challenging and behavioural experiments have been prescribed as part of both the LEAPOut and CBT manual (Pike, Carter, & Olmsted, 2009; Touyz, et al., 2010). Specifically, developing skills in cognitive restructuring are a core aspect of CBT for AN. It involves the identification of a false belief, identifying the evidence supporting and refuting the thought, and reaching a reasoned conclusion based on the weight of evidence. Behavioural experiments are the use of planned experiential activities to test the validity of a false belief and develop alternative and more adaptive thoughts.

To investigate the mechanisms of change in CBT, (Bennett-Levy, 2003) a mixed methods design was employed to investigate the impact of automatic thought records used for cognitive challenging and behavioural experiments upon participants' ratings of belief and behaviour change. The results suggested that behavioural experiments were seen as more efficacious in promoting change as it involved real-world experience rather than cognitive challenging which used identified evidence (Bennett-Levy, 2003). This may partially be attributed to behaviour experiments being more affect-loaded than the logical and rational reasoning processes implicated in cognitive challenging (Bennett-Levy, 2003). Nonetheless, both procedures were found to be equally effective in improving insight into internal processes (Bennett-Levy, 2003). The results of the present study support such empirical findings, as the challenging aspect of both CBT and LEAPOut were found to be helpful in motivating change.

3.3.2 Fighting Anorexia Voices

Participants' use of externalisation (White, 1989), a strategy derived from narrative therapy (White & Epston, 1989), was frequently employed by participants as a means of separating themselves from the illness entity. The separation between the participants and AN was generally found to be helpful. In Mia's case, "*letting me know that the things that I was feeling in my head were the AN and not me as a person*" was

very reassuring. It helped her in *“pushing through all those voices in my head that were telling me that, you know, that ‘I shouldn’t eat, I shouldn’t eat’...”* The exception was Zoe who believed that *“there is no like complete separation between the two”* as she felt that she had been sick for so long that she and the illness were one entity.

Taking an externalising stance empowered participants to take back control. This was well highlighted in Olivia’s case: *“...it’s almost like two people inside your head so you know one is this side where you want a really happy life...but then you have got this sort of kind of Eating Disorder side that says nothing is more important in your life than being skinny ...I definitely don’t believe that anymore and I think that side of me that doesn’t believe that is getting stronger and stronger and the side that does believe there is nothing more important in life than being skinny is getting weaker and weaker.”* (Olivia).

However, this fight was an exhausting battle between the *“two sides”* (Alyssa) that reared its head particularly during meals, *“I know like one part of me knows that just eat and you’ll feel so much better, I am sure you’ll feel better if you just eat, just feed me, but a bigger part of me is saying, no you don’t want to”* (Grace). The fight was won by facts and knowledge to challenge the AN voice, or through the therapist’s support when the battle becomes overwhelming. This battle against the voice of AN was important as it was a fight for authenticity. As Chloe described it, *“mentally you are always giving into someone other than your true self”*, with Mia reporting how therapy helped this process by trying to *“sift through all the thoughts and try and find yourself and find what’s real”*.

Externalisation as a therapeutic technique has been found to be helpful in treating children and adolescents diagnosed with eating disorders (Ellison et al., 2012). It is a key tenant of FBT for eating disorders in such populations (Lock & Le Grange, 2012). In adults, the literature exploring the use of externalisation is limited. However, a recent study, which employed narrative therapy framework for the treatment of depression and

disordered eating in a sample of eight women, found that externalisation was particularly helpful in promoting behavioural change (Weber, Davis, & McPhie, 2006).

The reason that externalisation is considered a powerful technique in eating disorders is that often the use of labels such as the participant being an ‘anorexic’ leads to the individual’s identity fusing with that of the illness (Weber, et al., 2006). In families, externalisation is considered helpful in reducing blame and parental criticism (Ellison, et al., 2012). In adults, it is likely that individuals suffering from AN perceive themselves as a problem, and experience guilt and self-blame as a result (Weber, et al., 2006). Thus externalisation is considered helpful in creating an opportunity for individuals’ beliefs about their illness, which may contribute to their difficulty, to be modified (Madigan & Goldner, 1998).

3.3.3 Food Diary

As part of both the LEAPOut and CBT programs, participants were required to maintain a diary that captured their intake and compensatory behaviours, whilst identifying the situation, thoughts and feelings that occurred during these times. Such monitoring records were designed to increase participants’ insight into their cognitions and emotions, and how that may relate to their eating disorder symptoms. The food diary here was similar to the concept of automatic thought records employed in CBT (Bennett-Levy, 2003).

The participant’s generally tended to view the food diary as a helpful aspect of treatment. It was generally acknowledged that the process took a while to become accustomed to, it was noted that it became easier over time. The diary was valued particularly due to its ability to improve insight. Amelia, for example, stated that it helped her become more *“in tuned to thinking...about food”*, whilst Isabella described how the process of writing in and discussing the diary helped her *“relate my feelings and my*

thoughts to whatever I was doing at that time food wise". Participants also valued the diary in that the process of recording allowed them to gain perspective on their diet and, like Ella, realise that *"it isn't a normal diet compared to healthy people"* so that she could *"increase more in my diet to get a more balanced diet"*. The diary also served as record of progress which became a source of hope for participants.

Conversely, a minority of participants indicated that the food diary had been an unhelpful aspect of treatment. This may be attributed to either the burden of work, in that it as *"time consuming"* and *"annoying"* or the level of fear and discomfort experienced in recording intake. Specifically, Ava struggled with the diary as she felt the process of writing about what she had eaten was akin to *"reliving"* the anxiety she felt when she ate, which she would much rather *"bury deeper"* by engaging in *"distractions"*. This was in direct contrast to the view held by Grace, who embraced the idea of the food diary which facilitated exposure, rather than avoidance, of her emotions. As she describes:

"I think...having to write it down I have to actually sit and sit with it, with the feeling and consider the feeling and accept the feeling whereas if before when I wasn't writing anything down, the urge and the feeling and the desire would come into my head and would linger there for seconds or minutes or however and then be gone whereas the fact that I have to, that I am sitting and writing it I am actually working through it and I am accepting it and allowing myself to feel it." (Grace)

However, the main complaint against the food diary was the fact that it was perceived as a barrier, either because it was not *"normal"* or that recording intake meant *"having to go back that step"*. For example, Mia stated that *"I just want to be normal and this isn't normal, people in the normal world don't like to keep this diary"*. The food diary for Mia was a barrier to her being in touch with her own instincts about her diet.

The results of the present study as similar to that of previous research into daily records in which participants identified avoidance, mediating effect of emotion, being equipped, forgetting, impact and quality of evidence emerged as salient themes (Bennett-Levy, 2003). Specifically, participants reported that records and diaries tended to reduce avoidance of salient thoughts or emotions, or increased awareness that avoidance strategies were being employed. (Bennett-Levy, 2003). The thought record being difficult during the experience of strong emotions was also identified, which also meant that insight gain tended to be at an intellectual rather than emotional level (Bennett-Levy, 2003). Similar to the results of the present study, research suggests that the difficulty of being equipped with the diary, pen and paper and the importance of immediate recording, to prevent forgetting, were highlighted (Bennett-Levy, 2003). Nonetheless, like the participants in the present study, previous research has highlighted the value of diaries and records in increasing insight into the relationship between thoughts, emotions and behaviour (Bennett-Levy, 2003).

In considering the relationship of other therapeutic processes with treatment components, it is likely that the manner in which the food diary was discussed, implemented and reviewed contributed to participants' views of its effectiveness. For example, Mia, who found the food diary to be a barrier to a recovery, was able to negotiate not having to complete it if she was able to continue to gain weight. She found her therapists' response to be supportive of her decision, which contributed to her sense of positivity regarding recovery:

"... they were really encouraging about my decision and supportive of that, and spurred me up more and said 'well, if you prefer to do that, that is even better and it's shown in your weight...that that's worked for you too so we'll support you with that...so that was good.'" (Mia)

The therapists' supportive reaction is likely to have been experienced as autonomy-supportive and further contributed to her self-determined motivation to recover. By contrast, Sienna felt that completing the food diary was "*having to go back that step*", and felt disheartened that she was required to complete it as part of treatment. Thus, both participant characteristics and therapist responses are likely to influence the impact that treatment components have upon recovery.

3.3.4 Goal Setting

Goal setting is an activity that was specified in the treatment manuals for both therapies. Participants were able to identify that the process of setting long-term goals was helpful in allowing them to feel a sense of purpose and a broader perspective in their recovery. For example, Amelia found that by the therapist asking "*if you still have AN, could you still do this?*", she was better able to understand why she need to gain weight. Similarly, Isla found long-term goals helpful in keeping a broader perspective rather than "*getting bogged down entirely in the present*". Knowing that the future without AN brings joy, she was able to transcend the daily struggles with meals, as she described "*I want to go to Italy and you know enjoy the food without worrying about getting fat basically and you know I haven't... partly because of the AN*".

Short-term goal setting too was seen as helpful in providing structure and direction, as well as building momentum for recovery. As Ava described it, "*if you use sprint analogy like a running race or something like that rather than focusing on the finish line which is ten kilometres or ten kilos away, focusing on like ten metres in front of you, fifty metres in front of you or a hundred metres in front of you, you know that when you get to that hundred metres, you are going to like you know get a burst of energy or something like that and then that will get you to the next hundred metres which would be*

great as opposed to trying to run to ten kilometres away and going 'Ahh, yeah I can see it's good out there except, you know, how am I going to get there?'

Literature supports the use of goal setting as a means of prioritising treatment targets and setting up realistic expectations regarding recovery (Pike, 1998). This is considered particularly important for individuals who have a longer duration of illness; therefore the gap between their current and ideal functioning is likely to be larger, leading to unrealistic goals (Pike, 1998). However, the SDT highlights the importance of considering the quality and nature of the goals for recovery (Deci & Ryan, 2000).

Specifically, goals that are targeted towards fulfilling intrinsic needs, such as recovering to reconnect with family and friends, versus for extrinsic purposes, such as recovering so that one can be discharged from hospital, is likely to impact the quality of motivation (Deci & Ryan, 2000). Similarly, the goal orientation is also highlighted as being important in influencing motivation (Deci & Ryan, 2000). For example, if the goal for recovery is consistent with one's sense of self, the goal orientation is suggested to be autonomous. Thus, goal setting in and of itself as a therapy task is likely to be helpful to the extent that the goals identified by the individual are to be expected to be need-satisfying and autonomously oriented (Deci & Ryan, 2000). Linking with the process of change discussed above, the experience of the turning point phase of recovery, with a growing desire to want more from life than what AN can provide, is critical for the treatment component of goal setting to be helpful in bolstering motivation to recover.

3.3.5 Information

Psycheducation was a key aspect of both the CBT and LEAPOut treatment programs. CBT focused upon psychoeducation regarding the nature of AN, the physical impact of starvation and the relationship between body weight and their physical, psychological and mood symptoms. LEAPOut additionally focused on correcting

participants' understanding of healthy exercise levels and educated them on the difference between exercising for health versus compulsive exercise. Such information was found to be highly valued by these participants, who described information as a key tool in their recovery process. This is in line with research that suggests that psychoeducation can play a role in improving readiness to change (Pettersen, Rosenvinge, & Wynn, 2011).

Many participants were surprised at what they had learnt during the course of treatment. As one participant commented, *“you know I consider myself pretty knowledgeable because I have Master's in Nutrition”*, before describing an aspect of the illness she now understands better. Information was considered helpful as it empowered participants to challenge their symptoms. For Amelia, understanding calories helped her see how much she could eat before she would *“balloon”*, which helped her increase her intake. Similarly, Aria understood the connection between her panic-like symptoms and her eating disorder symptoms, which facilitated her decision to gain weight.

The psychoeducation was helpful also in normalising the experience of the illness and the anxiety raised by treatment. For example, Ella understood that *“what I am experiencing throughout the therapy is normal like I will have to experience all of the anxiety and all the emotions that I am feeling to beat the AN, to get well once again. So I guess that keeps me motivated because I know that the feelings that I get like anxiety are sort of what I need to”*. Understanding these links also provides a sense of hope and incentive to improve. As Aria learnt, *“if you get up to a BMI of 19, you know minimum normal, you'll have you know perfect concentration”*. This helped to *“drive”* her to recovery. The ability for information to drive positive behaviour tended to occur even in cases where information was perceived as *“scary”*, as was the case for Amelia who indicated that *“what's kind of helpful is as well kind of the most scary aspects of it so if I didn't put on weight then I'd be like this forever and because I have been diagnosed with*

low bone density that'd just get worse and the therapist said that I could have a vertebral collapse which some people get.”

The information that particularly helped participants understand the link between their cognitive, affective, behavioural and physiological symptoms was an explanation of the (Keys, Brozek, Henschel, Michelson, & Taylor, 1950) study. The impact of understanding the study is well summarised by one patient who stated that; “...*they did this big study on them and none of them had Eating Disorders, they restricted their diet so they lost heaps and heaps of weight and then they started to display all these nutritional symptoms of people having Eating Disorders and she said then when they stopped doing that most of them sort of recovered and went back to normal sort of thing so I know that it's not possible to be super thin and not have an Eating Disorder”*.”

Research suggests psychoeducation regarding the severe health risks associated with emaciation is particularly important to communicate to participants (Pike, 1998). In particular, clearly communicating the impact of starvation upon affective, cognitive and behavioural functioning is important as it provides the rationale for focusing upon weight gain, as weight restoration alone may significantly improve such symptoms (Pike, 1998). This is reflected in treatment models for children and adolescents with AN, where orchestrating a scene that communicates the grave physical consequences of the illness is used as means of motivating the parents to focus primarily upon weight restoration (Lock & Le Grange, 2012). From a motivational perspective, the provision of information is likely to be helpful as it empowers the individual to assess facts and make an informed decision. Thus, facilitating the individual's expression of autonomy in therapy (Ryan & Deci, 2008).

3.3.6 Weigh-Ins

Half the participants described the process of being weighed each week in session as being “*hard*”, “*difficult*” or “*stressful*”. Some were able to understand that it was an important aspect of monitoring for their progress as well as an integral part of data collection for the RCT; “*I know that it’s part of it because I do need to know how my weight is changing and affecting me but I do find it quite hard*” (Ella). Participants were able to anticipate that the process of being weighed and seeing one’s weight increase is likely to lead to distress. The discomfort following weight change was considered to be a barrier to engaging in treatment; “*I think it makes it harder to engage in the therapy when all I am thinking about is how much I have gained or, yeah. It would probably be more helpful to weighing after the therapy really because at least then I’ve got through the therapy and then been weighed so I am sort of concentrating more in the therapy if that makes sense*” (Ella).

The anticipation of being weighed led to distress in the lead up to the session, despite the process being seen as challenging one’s fears, “*it was really scary last time because it had been nearly three weeks, it had been three weeks since I’d been on the scale and I had myself convinced that I’d gained like five kilos, which I hadn’t, I hadn’t gained anything*” (Grace). Isabella describes the extent of agony experienced when watching the weight shift to the next whole number, for example increasing from 44.6 to 45 kilograms, which can be distressing as the barrier of the ‘*safe*’ weight is broken.

Distress associated with weight gain is a hallmark of AN, with an intense fear of weight gain being stipulated within the diagnostic criteria (American Psychiatric Association, 2013). Therefore, the difficulty experienced in becoming aware of one’s weight for these women is not surprising. Rather, the distress participants expressed during the process of being weighed provides insight into the degree of suffering associated with AN. It provides an appreciation for the level of motivation required to continue to change daily habits and fight for weight gain. As discussed in the ‘Process of

Change' section, weigh-ins were another aspect of the relentless struggle that participants engaged in during the recovery phase.

3.3.7 Summary

Results suggest that the manualised components of both the LEAPOut and CBT program, that influenced motivation to change, were challenges, both cognitive and behavioural experiments, externalisation, food diaries, goal setting, psychoeducation and regular weight checks. However, it is excessively simplistic to suggest that the components alone influenced motivation to change. Rather, the manner in which the components were delivered contributed to how therapy tasks were interpreted. The perception of the tasks being implemented in autonomy-satisfying ways was perceived as being helpful.

3.4 Counter-Cases

In addition, it was considered important to include in the study participants whose experience was at odds with or counter to the dominant view that was emerging (Côté & Turgeon, 2005). Such participants were important that they provide another aspect of the phenomena which was equally valid, interesting and important (Côté & Turgeon, 2005; Strauss & Corbin, 1994).

Attending to cases that do not fit the fit the emerging, dominant model is considered an important practice for establishing quality of research (Mays & Pope, 2000). These cases, referred to as “negative” or “deviant” cases in the literature, provide an alternative explanation for the data and serve to further refine the analyses (Mays & Pope, 2000). According to (Côté & Turgeon, 2005), this process is considered “very useful, even essential” (p.73) in research. The exploration of such cases was important in improving credibility of the study in explaining the apparent contradictions within the data (Krefting, 1991).

As the present study explores the deeply personal experiences of vulnerable women suffering from AN, these cases will be referred to as “counter-cases”, rather than “negative” or “deviant” cases, which has negative connotations. Of the 16 participants, three cases in particular could be identified as being counter to or an alternative view of the phenomenon being explored. These are Zara, Zoe and Ava. Importantly, Zara and Ava dropped-out of treatment in the early stages, with quantitative data suggesting poorer outcome in terms of weight and eating disorder pathology. These cases are considered alternative as their experience of AN and the treatment differed significantly to that of other participants. These cases are advantageous as they are able to shed a strong light upon the findings. An explanation as to why these cases were considered ‘counter-‘ or ‘alternative’, and what it contributed to the findings is outlined.

3.4.1 Differences

Zara, Ava and Zoe have been identified as ‘counter-cases’ as their path through the emergent model is markedly different from the majority. These women appeared to not have experienced a turning point in their illness which has spurred on the decision to fight AN. Specifically, it appeared that these women, though they may have experienced a distinct low point in their illness, may have limited motivation to recover as they did not have concrete goals or reasons to improve, or that they lacked the sense of self-efficacy to do so.

The turning point was an important theme that emerged for the majority of women which described a collection of processes that resulted in them viewing their illness in a negative light and the building of desire to fight AN. The counter-cases presented here were noteworthy in that the theme of the turning point did not emerge for two, Ava and Zara. As the development of the willingness to fight required a number of processes to occur, it may be that for these women, some processes may have been

lacking. As suggested by (Mays & Pope, 2000) these two cases shed light on the importance of the turning point as a phase, as without this process, participants struggled to engage in treatment and build towards recovery. This is evidenced in Ava and Zara's dropout from treatment.

Zoe, on the other hand, did describe experiencing a turning point during her illness where she *"realized I couldn't go on, I mean like the sort of living like this till I am sixty is not possible so I have to start something..."*. However, she did not particularly believe that her life or symptoms could improve. She did not have a strong idea of what more she wanted out of life rather than her illness, and was still in denial about the seriousness of her condition. This counter-case provides further support for the grounded theory presented above, in that it highlights the importance of all these processes co-occurring for participants to reach an effective tipping point, where recovery is valued more than the illness.

Specifically, one key difference between these women and the majority were that they were not able to identify concrete reasons to get better. Whilst other women were able to say that they wanted more in life, including a partner, children, that job or career, these three women did not have a clear goal in mind. For example, Zoe had a very vague idea as to what was motivating her to engage in treatment. When asked how life would look like without AN, she stated, *"I don't know, just being enjoying life really"*. Zara, on the other hand, did not believe that life without AN would be any different; *"I think my life without AN would be the same as it is now but I would just be bigger."* The illness was not perceived as a barrier to her engaging in life.

Similarly, Ava stated that she lacked reasons to engage in healthy eating and exercise behaviours and improve. This is contrasted with another time in her life when she was able to improve without the support of health professionals as she had a happy living arrangement, a good job and a satisfying relationship with her boyfriend, which

motivated her to stay healthy. She was motivated to maintain a healthy weight and stay out of the hospital so that she could lead an active, fulfilling life with her partner. However, these reasons to improve were no longer present.

Consequently, for these women, AN then is not seen as a barrier to engaging in life. Whilst the theme of AN as a barrier did not emerge, Zoe, Zara and Ava actively denied that AN prevented them from achieving what they want. Rather, they felt AN was an effective coping mechanism that allowed them to remain in control. Therefore, there was a fear of recovery as eradicating AN was equivalent to being left out of control and helpless. As Zara stated, *“I don’t have... something specifically that I want that I can’t get because I have AN”*.

Qualitative differences between the majority and the counter-cases emerged in the way the concept of hope was discussed. For example, Zara tended to refer to hope in the past tense, stating that *“when I first started treatment I was very hopeful that I would umm be happier.”* For Zoe and Ava, hopelessness was expressed. Zoe’s hopelessness related to the chances of recovery, *“realistically I don’t think I can get better”*, as well as ever experiencing happiness, *“I can’t really see myself being happy even without the Eating Disorder”*.

Given the positive views these women held about their illness, the theme of overcoming denial regarding the seriousness of the illness was absent from their data. Zara, for example, was unable to grasp the seriousness of her condition given her low weight as she stated, *“I would estimate I would spend a lot more time than other people thinking about food or shape or weight or whatever. But that’s my way. It’s been my way for so long now. It’s just a habit”*. Interesting, two of these women, Ava and Zara, explicitly denied ever having experienced a personal rock bottom or low point during their illness. Zoe, on the other hand, described reaching a point in her life where she

would participate in assisted suicide if she could to escape the exhaustion and distress associated with suffering from AN.

As a consequence, Zoe, Zara and Ava's discourse lacked evidence of a willingness and determination to rid themselves of AN. That is, the theme of deciding to fight was absent from their transcripts. Rather, Zara was actively resistant to the strategies discussed in treatment, "*I rarely challenge thoughts.*" The closest example of one of these women deciding to fight the illness would be Zoe's comment that "*so even though I may not think that it's gonna help me, you have to try it.*" This suggested that she was engaging in the therapy seemingly for the sake of trying, without the deeper level motivation which was demonstrated by other women, suggesting her motivation may be introjected (Ryan & Deci, 2000b). Zoe's surface-level compliance with treatment can be contrasted with the possibly integrated motivation displayed by Rose, "*I was just ready mentally in my head I knew that it was time to get help and I did*", which suggests her actions were self-determined (Ryan, et al., 2011).

Zoe, Zara and Ava's reluctance to engage in treatment was reflected in their discourse which suggests that they struggled with the guilt and shame associated with not completing therapy tasks, whereas for the majority of participants, the struggle they experience was with the difficulty of actually completing a task. For example, Zara described attending therapy as an obligation to her daughters and to model appropriate behaviours, but found herself having to talk herself into attending sessions regularly. Both Zara and Zoe struggle with extent to which therapy itself is straining. Zara found this surprising; "*I thought it would be easy, I thought I'd be good at it like I was before and I suspected it would cause me little or no hardship personally...to make whatever changes were required.*" Zoe commented that, "*I just wish you could take a pill and you are better*". Ava provided an eloquent analogy to explain how engaging in the struggle to improve is like for her:

“Yeah, yeah it’s like you can see that the destination is amazing like, you know, it’s like saying to somebody who hates exercise that, you know, ‘you can go to Hawaii if you want but you have just got to swim there from Australia’. It sounds like, ‘Well I know why it’s going to be amazing but I don’t really want to swim there, like, how, you know, how painful, how boring, like how terrible would that be’” (Ava)

In terms of the therapeutic processes, each of these three cases has the theme of disconnect in common. Specifically, Zoe, Zara and Ava have all experienced a rupture in the therapeutic relationship or experienced a disconnected alliance with their therapist. For Ava, it was when the therapist did not spend sufficient amount of time on the food diary which she had worked very hard, despite finding it a challenge. For Zara, disconnect in the relationship was experienced when she felt the therapist’s stance that Zara needed to increase her weight by ten kilograms was extreme, given that she *“never really considered that anyone would expect me to put on weight.”* Zoe experienced disconnect when the therapist was unwilling to allow Zoe to discontinue completing a food diary, an experience which she states has impacted her progress; *“since because we have that disagreement about that I kind of have gone a bit more backwards”*.

3.4.2 Explanation of Differences

An explanation as to why Zoe, Zara and Ava were different to the other participants was conducted. An analysis of their attributes was undertaken to explore the patterns. No apparent pattern emerged that differentiated these three participants and the other participants. The counter-cases ranged from 22 to 39 years of age, with no apparent pattern in terms of the ethnicity, level of education, or employment status. Similarly, no outstanding pattern in quantitative variables was identified as relating specifically to the counter-cases. All three participants were treated by one therapist, but that therapist did have three other participants who did fit the emergent model and had substantial

improvements. Interestingly, all three cases had durations of illness that were greater than seven years. However, other participants such as Alyssa, Charlotte, Chloe, Isabella and Olivia also had similar or greater duration of illness.

It appears that the reason for the difference in how the above three cases to experienced AN and early treatment can be attributed to the difference in their experiences prior to treatment, as described. As the model suggested, the experience of the turning point phase was critical in allowing participants to develop the motivation or willingness to improve their symptoms. From the perspective of the SDT, these participant's motivation to engage in treatment appears to be extrinsic, in that they are in treatment to achieve the goal of fulfilling an obligation or avoid hospitalisation (Ryan & Deci, 2008). Within that, Zoe, Zara and Ava's motivation may be classified as introjected regulation in that each of these women wishes to improve so that they may be viewed as a better mother, or to keep their friends and family happy (Ryan & Deci, 2000b). For example, Ava was driven by desire to avoid the guilt and shame of being ill and not improving; *"I knew that every time I'd be visiting my immediate family, they are just so disappointed that this is so unfair, because I wasn't going forward, I wasn't getting better"*.

This is in contrast with the majority of women described above whose motivation to engage in treatment and recovery was self-determined (Ryan & Deci, 2000b). Given that the majority admit to engaging in treatment, not for the sheer joy of therapy, but rather to achieve a desired outcome, their motivation too appears to be extrinsic (Ryan & Deci, 2000b). However, it appears to be qualitatively different, in that the actions taken to improve in treatment are viewed as an expression of their own violation or willingness. As Aria stated, *"I am always someone that's been able to do anything that I've set my mind to"*. This indicated that their type of motivation may be classified as integrated regulation, in that their actions are self-determined and recovery is assimilated into a

cohesive view of their identity (Ryan & Deci, 2000b). Therefore, the desire to struggle through challenging tasks is regulated internally and because they *want* to rather than feel like they *need* to.

Furthermore, in line with the SDT, the cases of Zoe, Zara and Ava indicated the thwarting of basic psychological needs which need to be facilitated to allow extrinsic motivation to become integrated with oneself. For example, Ava and Zoe's disconnect with their therapist and limited support from their families, which suggests a thwarting of the need for relatedness. Experiencing a secure attachment with significant others and a sense of belonging within one's social network has been shown to lead to greater internalised regulation (Ryan, Still and Lynch, 1994).

Likewise, competence is another primary psychological need that appears to be satisfied in these three cases. Ava describes recovery as having to swim alone from Sydney to Hawaii, Zoe doesn't believe that treatment will be helpful and Zara is unable to see a life in which she is in control but not eating disordered. Improved sense of competence or self-efficacy has been shown to both improve intrinsic motivation and facilitate integrated regulation.

Furthermore, autonomy is important in allowing one to exercise their free will and facilitates a sense of competence (Ryan & Deci, 2000b). To do so, one must understand the deeper meaning and purpose of their action and then chose to perform it. It is likely that the disconnect these three women experienced with their therapist contributed to a sense of impaired autonomy which further led to the experience of treatment and improvement as being externally regulated rather than integrated regulation. Alternatively, the lack of self-determined motivation may have negatively influenced their interactions with, and perceptions of, the therapist.

Chapter 4: Discussion

The structure of this chapter is as follows; (1) the objectives for, and results of, the study will be summarised, (2) the clinical implications of the finds will be discussed, (3) the theoretical implications will be outlined, (4) the limitations will be reviewed, (5) directions for future research will be suggested. Lastly, the study's conclusions will be presented.

4.1 Overview of the Current Study

Anorexia Nervosa (AN) is classified as one of the most serious and chronic psychiatric illnesses (Beumont & Touyz, 2003). Despite the plethora of treatment developed for AN, there is limited evidence as to the efficacy of these treatments. Current guidelines for the treatment of AN state that it is “extremely difficult to draw general conclusions about the efficacy of specific treatment options for AN” (RANZCP, 2005, p. 618). The generally poor outcome for AN can partially attributed to low motivation to recover (Vitousek, et al., 1998). Consequently, a number of treatments or supplements to treatment have been developed to address the low motivation to change in AN (Waller, 2012).

However, it is still unclear as to how motivation to change in AN is developed or influenced by treatment. The active ingredients of therapy or the psychotherapeutic processes that influence motivation are not well understood. Therefore, what is needed is a systematic analysis of what processes in therapy influence patients' motivation to change. The currently ongoing RCT, comparing LEAPOut enhanced CBT with CBT alone, provided a unique opportunity to examine the motivation change process across manualised outpatient treatment (Hay, 2010).

Therefore, the objective of this study was to investigate the psychotherapeutic processes implicated in the process of change in motivation to recover in patients during the early stages of treatment. The study aims were divided into two parts; (i) develop a grounded theory of the process of change in motivation in patients, in the early stage of treatment; and (ii) isolate particular aspects of treatment which contribute to changes in motivation, including those referred to in treatment manuals as well as processes unique to patient-therapist interactions.

In line with the first aim of the study, a grounded theory of the process of change in motivation in AN patients, in the early stage of treatment, was developed. The emergent model consisted of three key phases. The first phase, illness, captured participants' sense of being controlled by AN to the extent that they reached the lowest point of their lives. The second phase, turning point, described a period of time in which multiple processes co-occurred that resulted in the participants developing the will to change. This involved a budding desire to seek a fulfilling and normal life, that was free from illness, a shift towards viewing AN as a hindrance towards achieving this, hope that the future will be better and coming to a point of acceptance regarding their illness. The third phase, recovery, described the processes within treatment that translated the will to recover into determination and active participation in the change process. This included participants investing in support networks, engaging in the relentless battle against their symptoms, and experiencing mental breakthroughs before being able to reflect upon improvements. Factors such as fluctuations in progress and motivation, momentum and fear were identified as impacting upon participants' efforts to change.

However, three participants were identified as 'counter-cases' as their experience of AN and treatment, in terms of motivation to change, was markedly different to that of others. Specifically, these participants did not experience the turning point like the majority of the sample. That two of the three participants dropped out of treatment

suggests that the experience of the turning point is significant for recovery in AN. The theoretical and clinical implications of this finding will be discussed later.

As per the second aim, the psychotherapeutic processes implicated as being relevant to motivation were therapist professionalism, non-judgemental approach, reliability, and ability to be collaborative and flexible. In terms of the relationship, trust, rapport, disconnect and perceptions of the treatment as a bandaid were identified. The aspects of treatment that were isolated as impacting upon motivation to change were challenging fears, externalisation, food diaries, goal setting, information and weigh-ins.

4.2 Discussions of Theoretical Implications

The findings of the present study contribute to an area of much needed research in AN. The structure of this section is as follows; firstly, the change process model will be discussed with regard to the SoC and the SDT, secondly, the theoretical implications of the psychotherapeutic processes and treatment components will be discussed.

4.2.1 Change Processes Model

The change process model developed in the present study captures the change in participants' motivation from the point at which recovery was not considered to active engagement in treatment. The results suggest that the current understanding of motivation, based primarily upon the SoC model, is limited. Rather, the application of the SDT in AN is warranted.

Transtheoretical Stages of Change Model (SoC; Prochaska, et al., 1992)

Specifically, the present model lends limited support to the SoC. From the model developed, it can be inferred that the illness phase was akin to precontemplation, the process of deciding to fight was similar to the preparation stage of change and the constant struggle being similar to action. However, similar to previous findings, the

present model did not lend support to the linear sequence of phases outlined in the SoC nor was the model able to clearly define the boundaries between the stages (Sutton, 2001; West, 2005; Wilson & Schlam, 2004).

According to the proponents of SoC, the contemplation stage is defined as a phase at which recovery is considered, whilst preparation involves the engagement in limited behaviours towards change (Prochaska, et al., 1992). In the present study, Charlotte recalled approaching day hospital programs in the process of considering change and preparing for recovery. On the other hand, Rose stated that she approached treatment centres once she had made the decision and committed to recovery. In both situations, the participants' behaviours were identical, namely, seeking treatment. Based on the behaviour alone, it is unclear what stage of recovery would apply at those points. The boundaries between the stages are particularly hard to define given that the contemplation stage of change is characterised by intent to change, though not actual behavioural changes (Prochaska, et al., 1992). The SDT, on the other hand, is better able to distinguish between behaviours by conceptualising both the quantity and quality of motivation (Vansteenkiste, et al., 2005).

Moreover, the SoC posits that the process implicated in the transition between the preparation and action is self-liberation (Prochaska, et al., 1992). Self-liberation is defined as the process of choosing or committing to change (Prochaska, et al., 1992). From the current model, the participants' descriptions of deciding to fight the illness may be considered akin to the self-liberation process. However, the identified process seems more descriptive than explanatory. In the present study, the factors contributing the participants being able to commit to change were theorised. The turning point phase described the various processes that tended to co-occur, which resulted in participants being able to choose recovery. The identification of a range of processes occurring prior to commitment to treatment, and that these processes have not been explicitly accounted

for by the SoC occurring, mirrors previous research which suggests that the SoC fails to account for how the commitment to change translates into actual behavioural change (Armitage, et al., 2004).

Although the current change process model developed does include phases, or stages, it differs from the SoC in important ways. Firstly, the theory developed is at the substantive level. The aim was to explore participants experience within a specific treatment trial in AN, thus the theory developed aspires to do just so. Unlike grand theories that are developed to identify universal mechanisms and allow for greater generalisation (Strauss & Corbin, 1990), here, no such claim is made.

Secondly, unlike the SoC, the present findings acknowledge that it is possible to be in multiple phases simultaneously. That is, participants may have experienced a turning point in terms of their desire to recover, but may still be controlled by their the urge to chew and spit, for example. Within the cycle in treatment, it was possible for participants to experience a mind shift about their exercise behaviour but still be struggling to change their views of weight-gain. This is in line with the recent interpretations of SoC in eating disorders where specific behaviours are assessed separately, in terms of stage of change (Rieger, et al., 2002; Rieger, et al., 2000).

In sum, the present study lends limited support to for the application of the SoC within the field of AN. Limitations of the model highlighted through the emergent theory include the unclear definition regarding boundaries, that the processes did not necessarily occur in the linear fashion hypothesised and that the model tended to be more descriptive than explanatory. The complexity of motivation change processes in this ego-syntonic illness requires a theoretical conceptualisation that is able to provide both descriptive and explanatory power.

Self-Determination Theory (SDT; Ryan & Deci, 2000b)

The present study lends support to the theoretical application of the SDT to AN. The development of motivation, as depicted in the model presented, lends support to the notion that the development of autonomous, self-determined motivation is critical for treatment engagement and recovery. The psychotherapeutic processes identified as being helpful in motivating recovery, support the notion that the need-satisfaction for autonomy, competence and relatedness tends to enhance motivation (Ryan & Deci, 2008; Vansteenkiste, et al., 2005). Furthermore, components of treatment that were deemed as being the active ingredients of therapy, tended to have variable impacts upon participants recovery process. The interaction between the components with how they were delivered supports the hypothesis that need-satisfying treatments facilitated self-determined motivation (Ryan & Deci, 2008; Vansteenkiste, et al., 2005). These factors will be presented in detail below.

Firstly, the results of the present study support the types of motivation identified in the SDT (Ryan & Deci, 2000b). The current participants varied in the extent to which changing specific behaviours was an expression of their own personal values. For some, recovery was consistent with their personal goals, such as to become healthy enough to bear children. For others, recovery was not considered personally important, thus treatment attendance was for the sake of obligation and was driven by guilt and shame. It indicates that the type of motivation regulating the recovery process ranged from integrated to introjected, respectively (Ryan & Deci, 2000b). Similarly, the descriptions of the AN being a controlling entity, which participants felt unwilling or unable to change is akin to the state of amotivation as depicted by the SDT.

Secondly, the change processes model developed, supports the concept of integrated motivation, as posited by the SDT. Specifically, the turning point was a phase in which participants articulated their growing desire to change, and the recovery phase

marked the active engagement in cognitive and behavioural modification process. In SDT terms, it may be viewed as the point at which the value for recovery became integrated, and the change process became internally regulated. The processes identified as occurring during this phase may be conceptualised as being need-satisfying, thereby facilitating the integration process.

For example, the participants' growing desire to want more from life than what AN could provide may be viewed as the expression of the innate human tendency to grow and flourish. In SDT terms, this refers to intrinsic motivation (Ryan & Deci, 2008). The desire to be the same as others may represent the need to feel connected to others, specifically the need for relatedness (Ryan & Deci, 2000b). Hope that one can have a future without AN may be better, may be the expression of belief that one's able to control their lives, namely competence and autonomy (Ryan & Deci, 2000b). Thus, these processes identified in the model may represent a growing desire for, or the participants learning alternative methods to, satisfy basic psychological needs. Participants coming to terms with the reality of their situation may represent the process by which recovery becomes aligned with participants' personal values and becomes integrated within their identity. Thus, the SDT is able to provide a theoretical explanation for how the processes identified in the change processes model may contribute to growing motivation to engage in treatment.

However, it is important to note that the SDT does not explicitly stipulate the mechanisms by which an externally regulated goal becomes integrated. That is, although the factors contributing to integration are identified, cognitive processes by which this occurs is unclear. For example, in the present model, reflection upon one's situation was indicated as occurring during the time when participants came to accept their diagnosis and began to consider change. Further investigation on the mechanisms contributing to integration is required, with reflection a likely candidate for research.

Thirdly, the recovery phase of the emergent model also endorses the application of the SDT in the field of eating disorders. From the model, participants' decision or commitment to change can be viewed as an expression of their personal willingness and determination to change. Furthermore, the participants' willingness to continue in the struggle against the illness can be best understood as an expression of their autonomy. The positive impact of noticing improvements relates to the concept of competence. The use of support networks to aid recovery is accounted for by the SDT in terms of participants' fulfilling the need for relatedness.

In sum, change is considered a difficult process, particularly in the case of AN, an ego-syntonic illness (Vitousek, et al., 1998). The present study provided insight into the exhausting, difficult and relentless nature of this change, as aspect of recovery which is well documented in previous research (Dawson, et al., 2012; Higbed & Fox, 2010). Despite the difficulty, some participants were willing to persevere whilst others were unable or unwilling to do so. Within the present study, the distinguishing factors between the two groups of participants were their experiences of the illness prior to engaging in treatment, which may have contributed to motivation to recover becoming integrated with their sense of self. Moreover, the differences in the quality of motivation of the participants may be conceptualised in terms of motivation types, according to the SDT (Ryan & Deci, 2000b).

Thus, this discussion does not intend to simplify a complex phenomenon. Rather, within the complexity of the unique accounts of sixteen women suffering from AN and being engaged in the early stages of treatment, gaining broad theoretical understanding is critical improving treatment options for this serious illness (Beumont & Touyz, 2003). The substantive grounded theory developed in the present study lend support to the SDT's account for motivation in AN, as postulated by (Vansteenkiste, et al., 2005).

4.2.2 Psychotherapeutic Processes

The therapeutic processes identified as influencing motivation to change, from the patient perspective, are in line with previous recommendations in field of eating disorders (Pike, 1998; Treasure & Ward, 1997; Vitousek, et al., 1998). Some of the processes identified in the present study are parallel to the clinical method advocated by MI. Specifically, the therapists' ability to remain accepting of patients' experiences and to respect their autonomy was common across the present findings and MI literature (Miller & Rollnick, 2002).

Theoretically, however, the importance of the processes identified can to some extent be understood through the SDT. Specifically, the need for therapist acceptance, warmth, empathy, trust and rapport may be attributed to participants' need for relatedness. Arguably, when the needs for relatedness and belonging were met, participants were more likely to report that it had positively impacted their change process. Understandably then, disconnect within the relationship is likely to have been experienced as either a rejection or as alienation, which may have hampered motivation to change.

Similarly, the need for the therapist to take a collaborative and flexible stance in treatment may reflect participant need for autonomy. By allowing participants to control aspects of the change processes, such as the rate of change, it is likely that patient autonomy was facilitated. Thus, the internalisation of the value for recovery may have been supported. Conversely, disagreement upon the goals of therapy and the manner in which change would be regulated may have been perceived as autonomy-thwarting. For example, the therapist insistence upon the food diary when the participant viewed it as unnecessary may have acted as an external regulator for the behaviour. The SDT posits that in such scenarios, integration of the value for recovery is less likely to occur (Ryan & Deci, 2000b).

4.2.3 Aspects of Treatment

The components of the manualised treatments that were identified as being helpful in facilitating motivation and change were food diary, challenging fears, goal setting, information, weigh-ins, and fighting AN voices. The theoretical implications of these identified components will be discussed.

Given that both treatments were based upon the CBT model, the core treatment components identified in the present study as influencing motivation were daily food records, information, weigh-ins, and challenging tasks. The aim of the daily food diary was to increase participants' insight into the relationship between thoughts, feelings and behaviours, particularly in relation to food (Pike, et al., 2004; Touyz, et al., 2010). The expectation is that increased insight is likely to facilitate cognitive challenging.

Likewise, the provision of information in both treatment programs served to increase awareness and facilitate cognitive restructuring. For example, information from the (Keys, et al., 1950) study challenged participants belief that they could remain underweight yet symptom free. Similarly, the provision of information regarding healthy exercise levels in LEAPOut (Touyz, et al., 2010) was with the aim of correcting misconceptions and maladaptive thoughts. Both daily food records and psychoeducation served to increase insight and awareness, to facilitate cognitive restructuring.

Challenging tasks involved either behavioural experiments or cognitive restructuring exercises that aimed at modifying dysfunctional beliefs (Pike, et al., 2004; Touyz, et al., 2010). Weigh-ins served as behavioural experiments for some participants in challenging their beliefs that regulated eating patterns would result in significant weight-gain. According to the CBT model, it is expected that modification of erroneous beliefs is likely to result in behavioural changes. Qualitative responses of the present sample support this theory. In sum, the findings support the theoretical conceptualisation

of AN in cognitive-behavioural terms and the utility of CBT-based treatments for this illness

Participants use of externalising strategies, a strategy derived from narrative therapy (White & Epston, 1989), was helpful in reducing distress. By separating their identity from that of AN, participants were able to attribute distressing cognitions and behaviours to the illness. This served to reduce distress and empowered participants to fight the illness. Similar to the findings in FBT research (Ellison, et al., 2012), the present study supports the notion that externalisation is an effective means of reducing blame and distress.

4.3. Discussion of Clinical Implications

4.3.1 Change Processes Model

The clinical implications of the model of change developed is upon the role of treatment in fostering the motivation to recover in AN. From the emergent model, it appears that self-determined motivation is required for change in treatment to occur. In cases where autonomous motivation was either limited or lacking, change was not noted by participants nor was treatment perceived as being particularly helpful. The model suggests that motivation to recover tends to emerge prior to treatment engagement and, for motivation to develop, a number of key processes need to occur. These processes, such as experiencing the lowest point in their lives and viewing AN as a barrier to achieving a fulfilling life, are personal and unlikely to be replicated in a treatment settings. Thus, although treatment may sustain and build motivation to recover, it appears that treatment may play a small role in generating the willingness to change.

Active treatment aimed at cognitive and behavioural change, then, is probably best suited to those that are motivated, namely ready, willing and able to change (Miller & Rollnick, 2002). Though this may draw parallels with the matching hypothesis of the

SoC (Prochaska, et al., 1992), it differs in that it is argued that treatment is not sufficient in generating motivation to change. Without participants taking responsibility for recovery, such treatment is unlikely to be helpful. Rather, continuing to deliver such change-based treatments to individuals that are not motivated to change is likely to increase the sense of hopelessness.

Given the serious nature of AN (Beumont & Touyz, 2003), withdrawal of treatment is not recommended, yet the developed model speaks to the wisdom of respecting patient autonomy. One potential solution to this clinical blind is the application of the recovery model in AN (Anthony, 1993). The recovery model stipulates that the control and responsibility for recovery be placed upon the shoulders of the patient (Frese, Stanley, Kress, & Vogel-Scibilia, 2001). The definition of recovery, however, is modified such that it allows for individuals to lead a satisfying and fulfilling life within the confines of the illness (Anthony, 1993). Thus, treatment is used as a way of working with patients' motivations and improving quality of life, without necessarily aiming for remission. Given the medical complications associated with malnutrition in AN (RANZCP, 2005), this model may not be applicable to acute patients. However, for chronic patients, this model may be helpful.

4.3.2 Psychotherapeutic Processes

In terms of therapeutic processes, there has been much research investigating the non-specific aspects of treatment (Ackerman, et al., 2001). The present study lends support to the notion that aspects of the therapeutic relationship (Ackerman, et al., 2001) as well as therapist attributes (Ackerman & Hilsenroth, 2003) influence participant experience of treatment, and qualitative accounts of motivation.

In terms of the relationship, the factor of trust was identified as being important in the current study. The therapists' ability to build trust was considered important in

allowing participants' to take risks and try alternative strategies during change process. Within the literature, trust in the therapeutic relationship has been well studied (Ackerman, et al., 2001), and in the field of eating disorders, has been identified as being important in improving engagement (Vandereycken & Devidt, 2010). In terms of clinical practice, the present study further lends support for a focus upon building a strong therapeutic alliance marked by trust, particularly in the early stages of treatment for AN.

In terms of therapist attributes, the results suggest participants viewed therapist professionalism, and their ability to be non-judgemental, collaborative and reliable, as helpful factors in the motivation process. Specifically, participants' perceptions of the therapist as a specialised, trained and competent professional was important in building trust within the relationship. The perception of the therapist as a competent individual was built through the therapist's ability to make accurate judgement calls, communicate expert knowledge and have insight into participants' experiences. As per the literature (Pike, 1998), the results suggest that therapists working in AN should receive specialist training to enable to manage the unique challenges of AN, an ego-syntonic disorder (Vitousek, et al., 1998).

Given the level of shame, guilt and blame participants experience for being ill with AN (Skårderud, 2007), the therapists' ability to remain empathetic, warm and validating is critical (Vitousek, et al., 1998). In the present study, the participants' responses suggest the therapists' efforts to normalise participants' experience of AN by attributing distressing symptoms to the diagnosis, was particularly helpful. The clinical implications of this finding are that a strong focus upon creating safe, empathetic and validating space within treatment is likely to increase engagement, reduce distress and improve motivation to change.

Similar to the non-judgemental stance, the therapists' ability to maintain a collaborative stance, and to resist the urge to take on an authoritarian stance, was highly

valued by participants. This is echoed in previous research in eating disorders (Geller, 2002). It may be that by taking a collaborative approach and not enforcing recovery through external controls and consequences may place the responsibility for recovery upon the patient. The removal of external controls is likely to increase autonomous motivation to recovery, as hypothesised in the SDT (Ryan & Deci, 2008). The inverse of being accommodating, as perceived by participants, led to frustration and a sense that treatment was not applicable to their situations. The importance of sharing the responsibility of change with the patient has been well articulated by (Waller, 2012). Given that the present study was nested within an RCT investigating manualised therapies, the participants' perceptions of treatment being flexible and individualised is interesting. It suggests that the ability to remain responsive and collaborative in treatment is based upon the therapists' approach rather than the treatment itself.

Finally, the reliability of the therapist was valued by patients as it contributed to the perception that the therapist was a competent professional and improved trust in the relationship. It suggests that in the treatment of AN, the therapists' ability to provide consistency and stability, particularly in the face of a crisis, is likely to positively impact the therapeutic relationship.

On the other hand, lack of goal consensus and limited rapport was identified by participants as negatively impacting upon motivation. It is acknowledged that the therapist may be in a bind here as focus upon weight restoration is critical for recovery (Pike, 1998), yet may not be a priority for participants (Guarda, 2008). Thus, both goal consensus and limited bond in the relationship is likely to be experienced as a rupture in the therapeutic alliance. Thus, a modification of therapist expectations and definition of recovery, based upon the recovery model (Anthony, 1993), may aid in achieving goal consensus for chronic patients.

4.3.3 Aspects of Treatment

The findings of the present study support the continued implementation of CBT for AN. However, the results suggest that it is not only the treatment itself that is identified by participants as influencing motivation, but the manner of delivery also.

Specifically, psychoeducation, challenging tasks, food diaries, goal setting and weigh-ins are helpful components of the treatment to the extent that they are implemented in a manner that communicates warmth, empathy, respect and collaboration. The participants' ability to negotiate changes within the treatment program, such as the discontinuation of the food diary, communicates the therapists' respect for patient autonomy. When the identified treatment components are implemented in ways that are need-supportive, they are deemed as having a positive impact upon recovery, from the participants' perspective. When aspects of the treatment perceived as being externally regulated, for example when the task of challenging fear foods is perceived as being monitored and regulated by the therapist, it is viewed as being unhelpful. This is in line with the SDT, which posits that self-determined motivation is facilitated through autonomy-supportive environments with limited external controls (Ryan & Deci, 2000b).

Supportive of previous literature, the present findings argue that both correct treatment techniques and therapist skills are critical in supporting a positive therapeutic relationship and motivation to change (Barber, et al., 2007; Fairburn & Cooper, 2011). The therapists' ability to deliver treatment in a competent manner that respects the therapeutic alliance has been associated with improved treatment outcome (Barber, et al., 2007). Thus, in AN treatment, the utilisation of evidence-based treatments in combination with guided evidence-based practice is likely to yield positive results.

4.4 Discussion of Limitations

The present study was based upon interviews conducted with sixteen women who had been suffering from AN and were in the early stages of treatment within an RCT. Though the sample was consistent in terms of diagnosis, they were heterogeneous in terms of their experience of illness, as well as level and quality of motivation. The analyses aimed to develop a theory, grounded in the interview data, that both described and explained the experiences of these sixteen women. To this end, the scope of the study may be regarded as small and transferability limited.

In line with standards for rigour in qualitative research (Charmaz, 2006), attempts have been made to account for the context within which the theory was developed to improve transferability. For example, it was outlined that the present theory was developed following interviews with women undertaking either LEAPOut or CBT as part of an RCT that was conducted across three continents. Moreover, it was specified that the level of the developed theory was substantive, in that the theory attempts to account for the experiences of these sixteen women in this particular trial only. Universal mechanisms of influencing this phenomenon have not been identified. However, theoretical triangulation, as a means of relating present findings to previous literature, has been used to demonstrate the applicability of core concepts to other areas of AN treatment and research.

The present theory developed, identified a large proportion of women who labelled themselves as being motivated to recover, and were able to reflect upon gains in treatment after only a mere ten sessions. The optimistic result of the present study may be attributed to either the sample or the study design. Specifically, given that the trial was for adults, required voluntary participation, was available for free and had a rigorous selection process prior to treatment beginning, may have served to screen for participants that were less motivated. Thus the sample may have had greater motivation at baseline

than in other studies, such as those investigating inpatient programs (Wade, et al., 2009), where participation may not be voluntary . Secondly, as the study was conducted in the early stages of treatment, with participants having completed two assessment sessions and eight sessions of either LEAPOut or CBT, the optimistic results may reflect the initial eagerness to change that motivated participation in the RCT. Nonetheless, this provided a unique opportunity to study the motivation change process in a field where research is often hampered due to low prevalence (Guarda, 2008).

Given that the study was nested within an ongoing RCT that compared two treatments, LEAPOut and CBT, a comparison of participants' experiences between the two therapies may have been helpful. To prevent any threat to blinding, as the trial is currently ongoing, such comparisons were not undertaken. Following the conclusion of the trial, an analysis of the differences may be warranted.

Traditionally, there is bias in the field regarding telephone interviews as they remove non-verbal cues during data collection (Novick, 2008). In the present study, the heavy reliance upon phone interviews was for participants' sense of comfort and safety when discussing their journey through treatment, and to improve rapport (Morrow, 2005). However, research suggests that data yielded through telephone interviews does not differ significantly from that of face-to-face interviews (Sturges & Hanrahan, 2004). Rather, telephone interviews have the advantage of greater convenience and privacy for the participants, which may improve disclosure (Sturges & Hanrahan, 2004).

The current study investigated participant's experience of treatment retrospectively, calling for participants to recall their experience of treatment over ten sessions. Thus, the study was able to identify macro-level therapeutic processes that emerged from participants' recall, such as trust. However, in order identify the micro-level processes within therapy, the exploration of participant experiences would need to occur in close proximity to therapy sessions and directed such that there would be a

greater focus upon the nuances of therapy. Such research would provide more specific guidelines regarding evidence-based practice, and may allow for the development of clinical guidelines that guide therapists' in-session decision-making. Potential methodologies for this purpose are discussed in the 'Future Research Directions' section. Nonetheless, the identification of broad therapeutic processes is helpful providing general guidelines for clinical practice.

Given the dearth of literature exploring participant experience of treatment and its' impact upon motivation, the present study aimed to focus upon the patient perspective. The advantage of such methodology is that it allows insight into the subjective experience of the recipients of treatment, in an illness that is notoriously treatment resistant due to its ego-syntonic nature (Vitousek, et al., 1998). However, exploring the therapists' perspective of the same phenomenon may have been helpful for triangulation and in further developing insight into how the therapist-patient dyad may influence motivation.

4.5 Future Research Directions

Several directions for future research have been identified through this study. Firstly, the importance of exploring participants' experiences prior to treatment in understanding motivation has been highlighted. It is suggested that future research, using a prospective study design, follow participants' illness journey to identify the factors that contribute to the development of autonomous motivation to recover. A qualitative study design is likely to be most helpful in such exploratory investigation. The advantage of a prospective design would be that it would allow for a context-imbedded insight into how motivation to change in AN is developed, with minimal influence of memory biases. This is all the more important for understanding which processes contribute to participants experiencing a tipping point (Dawson, et al., 2012) in their motivation, and how these processes lead to motivation to recover becoming integrated and self determined. For

example, it may be that reflection is implicated in the integration process. Such research would provide further insight into how intention to change translates to behavioural changes in AN.

Secondly, given that the presents study contributed to an understanding of the macro-level processes that impacted motivation to change, research that explores the nuances of interaction within therapy are more likely to provide a richer insight into how therapeutic processes impact motivation to change. Interpersonal Process Recall (IPR; Kagan, Krathwohl, & Miller, 1963) has been acknowledged as a helpful means of exploring conscious-yet-unspoken experiences within therapy (Rhodes, 2011). A typical IPR application involves recording a therapy session that is viewed by the participant, alongside the research interviewer (Larsen, Flesaker & Stege, 2008). The administration of such an interview post-therapy sessions is likely to yield to the identification of minutiae within interactions, such as pauses (Levitt, 2001) and non-verbal cues (Fraenkel, 1983), that effect motivation and change.

Thirdly, given the narrow scope of the present study, interviewing a larger number of individuals, across a variety of treatment contexts would contribute to a greater understanding of what works best, for whom and when. It is unlikely a one-size-fits all approach to treatment would be effective in AN. Therefore, a broader qualitative base of knowledge may provide an opportunity to develop an understanding of the differences between groups, and pave the way for later testing through quantitative means. Moreover, extending the present findings through triangulation of outcome and follow up data may be helpful in bridging the gap between process and outcome research.

Finally, given that the current theoretical conceptualisations of AN is limited, greater attempts at consolidating understanding of motivation may be helpful. This calls for further systematic reviews to synthesis the empirical research into motivation. Furthermore, the applications of theories of motivation from other fields in psychology in

the area of eating disorders is likely to be helpful. Specifically, the SDT offers strong potential to expand the current understanding of motivation in AN. Using quantitative methodology, the testing of the key tenets of the model in AN populations may be fruitful.

4.6 Conclusions

The experience of illness and treatment, and the process of motivational change in women suffering from AN is complex. The events and experiences occurring prior to engagement in treatment have a significant impact upon motivation to recover in treatment. Particularly, the experience of the lowest point of the illness with a growing desire to have a life beyond the limits of AN may contribute to the development of a determination to fight the illness. Therapeutic processes, such as trust and collaboration, and treatment strategies, including challenging and psychoeducation, supported the change process

The therapeutic processes and the aspects of treatment identified are similar to those found in previous quantitative and qualitative research. The findings provide further guidance into evidence-based practice in treatment for AN. In particular, the importance of supporting autonomy, competence and relatedness is highlighted.

The change process model developed draws parallels with previous qualitative findings, and contributed to further support for the application of the SDT in the area of AN treatment and research. The model draws to the forefront the debate regarding the role of treatment in enhancing motivation to change in AN. It recommends the application of the recovery model to AN treatment.

Research examining AN patients' motivation to engage in treatment and change is limited, thus this study contributes to a field where research improving patient outcomes is critical. Moreover, the present study contributed toward much needed

research in evidence-based practice and process research. In the area of AN, the findings have provided indications for improved theoretical conceptualisation of the motivation change process and have highlighted the therapy-related factors that facilitate change.

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Appendix A: Ethics Documents

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Original Ethical Approval from the University of Western Sydney HREC

From: Kay Buckley
Sent: Wednesday, 24 February 2010 4:22 PM
To: Phillipa Hay
Subject: HREC Approval H7732

Notification of Approval

24 February 2010

Email on behalf of the UWS Human Research Ethics Committee

Dear Phillipa

I'm writing to advise you that the Human Research Ethics Committee has agreed to approve the project.

TITLE: Taking a LEAP forward in the treatment of Anorexia Nervosa: A randomised controlled Trial

The Protocol Number for this project is H7732. Please ensure that this number is quoted in all relevant correspondence and on all information sheets, consent forms and other project documentation.

Please note the following:

- 1) The approval will expire on **31 December 2014**. If you require an extension of approval beyond this period, please ensure that you notify the Human Ethics Officer humanethics@uws.edu.au prior to this date.
- 2) Please ensure that you notify the Human Ethics Officer of any future change to the research methodology, recruitment procedure, set of participants or research team.
- 3) If anything unexpected should occur while carrying out the research, please submit an Adverse Event Form to the Human Ethics Officer. This can be found at http://www.uws.edu.au/research/researchers/ethics/human_ethics/human_ethics_adverse_event_end_of_project_report
- 4) Once the project has been completed, a report on its ethical aspects must be submitted to the Human Ethics Officer. This can also be found at http://www.uws.edu.au/research/researchers/ethics/human_ethics/human_ethics_adverse_event_end_of_project_report

Finally, please contact the Human Ethics Officer, Kay Buckley on (02) 4736 0883 or at k.buckley@uws.edu.au if you require any further information.

The Committee wishes you well with your research.

Yours sincerely

Associate Professor Janette Perz,
Chair, Human Research Ethics Committee

Kay Buckley
Human Ethics Officer
University of Western Sydney
Locked Bag 1797, Penrith Sth DC NSW 1797
Tel: 02 47 360 883
http://www.uws.edu.au/research/ors/ethics/human_ethics

Modification from the University of Western Sydney HREC

Andreea Heriseanu

From: Kay Buckley
Sent: Thursday, 16 September 2010 3:32 PM
To: Phillipa Hay
Cc: Andreea Heriseanu
Subject: RE: Amendment to project protocol H7732

Dear Phillipa

Notification of approval for an amendment to an existing project detailed in your recent emails. The HREC Chair is satisfied with the responses to the issues raised in relation to the proposed amendment and therefore the amendment approval is granted.

H7732

Please ensure that you notify the Human Ethics Officer of any future change to the research methodology, recruitment procedure, set of participants or research team.

At the completion of the project, please submit a report on its ethical aspects to the Human Ethics Officer (humanethics@uws.edu.au). This can be found at http://www.uws.edu.au/research/ors/ethics/human_ethics/human_ethics

Please don't hesitate to contact me on (02) 4736 0883 or at k.buckley@uws.edu.au if you have any further questions.

regards

Kay

Kay Buckley
Human Ethics Officer
University of Western Sydney
Locked Bag 1797, Penrith Sth DC NSW 1797
Tel: 02 47 360 883
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Original Ethical Approval from the University of Sydney HREC



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6 May 2010

Prof Stephen Touyz
School of Psychology
Transient Building - F12
The University of Sydney
Email: stephen.touyz@sydney.edu.au

Dear Professor Touyz

I am pleased to inform you that the Human Research Ethics Committee (HREC) approved your protocol entitled "**Taking a LEAP forward in the treatment of anorexia nervosa: A randomized control trial**" at its meeting held on **4 May 2010**.

Details of the approval are as follows:

Protocol No.: 12660
Approval Period: May 2010 to May 2011
Authorised Personnel: Prof Stephen Touyz
Prof Phillipa Hay
Dr Caroline Meyer
Dr John Arcelus
Dr Sloane Madden
Dr Ross Crosby
Dr Kathleen Pike

Approved Documents:

Recruitment Advertisement, Version 1 February 12 2010
Participant Consent Form, Version 1 February 12 2010, updated
Participant Information Statement, Version 1 February 12 2010, updated
EDE-Q
SF-12 QUALITY OF LIFE Survey
K-10
Anorexia Nervosa Stages of Change Questionnaire
Client Satisfaction Questionnaire
The Compulsive Exercise Test (CET)
Attitude to Exercise
Reasons for Exercise
Exercise Beliefs Questionnaire
Eating Disorder Examination (Edition 16.0D)
Padua Inventory – Washington State University Revision

The HREC is a fully constituted Ethics Committee in accordance with the National Statement on Ethical Conduct in Research Involving Humans-March 2007 under Section 5.1.29.

Human Ethics Secretariat:
Ms Portia Richmond T: +61 2 8627 8171 E: portia.richmond@sydney.edu.au
Ms Patricia Engelmann T: +61 2 8627 8172 E: patricia.engelmann@sydney.edu.au
Ms Kala Retnam T: +61 2 8627 8173 E: kala.retnam@sydney.edu.au

ABN 15 211 513 464
CRICOS 00026A



The approval of this project is conditional upon your continuing compliance with the National Statement on Ethical Conduct in Research Involving Humans. A report on this research must be submitted every 12 months from the date of the approval or on completion of the project, whichever occurs first. Failure to submit reports will result in withdrawal of consent for the project to proceed. Your report is due by **31 May 2011**.

Special Condition/s of Approval

1. Please forward contact details for co-researchers when they become available.
2. Please forward ethics approval for the UK study when it becomes available

Chief Investigator / Supervisor's responsibilities to ensure that:

1. All serious and unexpected adverse events should be reported to the HREC within 72 hours for clinical trials/interventional research.
2. All unforeseen events that might affect continued ethical acceptability of the project should be reported to the HREC as soon as possible.
3. Any changes to the protocol must be approved by the HREC before the research project can proceed.
4. All research participants are to be provided with a Participant Information Statement and Consent Form, unless otherwise agreed by the Committee. The following statement must appear on the bottom of the Participant Information Statement: *Any person with concerns or complaints about the conduct of a research study can contact the Deputy Manager, Human Ethics Administration, University of Sydney on +61 2 8627 8176 (Telephone); + 61 2 8627 8177 (Facsimile) or ro.humanethics@sydney.edu.au (Email).*
5. You must retain copies of all signed Consent Forms and provide these to the HREC on request.
6. It is your responsibility to provide a copy of this letter to any internal/external granting agencies if requested.
7. The HREC approval is valid for four (4) years from the Approval Period stated in this letter. Investigators are requested to submit a progress report annually.
8. A report and a copy of any published material should be provided at the completion of the Project.

Please do not hesitate to contact the Ethics Office should you require further information or clarification.

Yours sincerely

Associate Professor Ian Maxwell
Chair
Human Research Ethics Committee

Modification from the University of Sydney HREC

----- Forwarded Message

From: Portia Richmond <portia.richmond@sydney.edu.au>

Date: Thu, 30 Sep 2010 13:20:09 +1100

To: Stephen Touyz <stephen.touyz@sydney.edu.au>

Cc: <smad0566@mail.usyd.edu.au>, Paul Rhodes <p.rhodes@sydney.edu.au>

Subject: HREC No. 12660 Taking a LEAP forward in the treatment of anorexia nervosa: A randomized control trial

Dear Professor Touyz

Title: Taking a LEAP forward in the treatment of anorexia nervosa: A randomized control trial (Ref. No. 12660)

Your request to modify the above application was considered by the Executive Committee of the Human Research Ethics Committee (HREC) at its meeting on 28 September 2010. The modification has been approved as attached.

The following researchers have been added under "Authorised Personnel" on your project:

- Shilpa Madiwale

- Dr Paul Rhodes

The Committee had no ethical objections to the modifications and has approved the protocol to proceed.

Provision of the above also meets the first condition of approval (i.e. contact details for co-researchers) as outlined in original approval letter.

Further to Katy Wilson's email of 24 August 2010, please forward the outstanding Special Condition of Approval for the project, being:

- Ethics approval for the UK study when it becomes available.

Please also ensure that the current University of Sydney logo is used on the Letter Acknowledging Voluntary Withdrawal, however you do not need to resubmit this for approval.

18/10/2010

Please do not hesitate to contact Research Integrity (Human Ethics) should you require further information or clarification.

Yours sincerely

Human Research Ethics Committee

PORTIA RICHMOND | Ethics Administration Officer

Office of Ethics Administration

THE UNIVERSITY OF SYDNEY

Jane Foss Russell Building G02 | The University of Sydney | NSW | 2006

T +61 2 8627 8171 | F +61 2 8627 8177

E portia.richmond@sydney.edu.au <<mailto:portia.richmond@sydney.edu.au>> | W <http://www.usyd.edu.au/ethics/>

<<http://www.usyd.edu.au/ethics/>>

CRICOS 00026A

This email plus any attachments to it are confidential. Any unauthorised use is strictly prohibited. If you receive this email in error, please delete it and any attachments.

----- End of Forwarded Message

18/10/2010



National Research Ethics Service

Leicestershire, Northamptonshire & Rutland Research Ethics Committee 1



1 Standard Court
Park Row
Nottingham
NG1 6GN

Telephone: 01158839425
Facsimile: 01159123300

22 April 2010

Dr Jon Arcelus
Consultant and Honorary Senior Lecturer in Eating Disorders Psychiatry
Leicestershire partnership NHS Trust
Eating Disorders Service
Brandon Unit
Leicester General Hospital
LE5 4PW

Dear Dr Arcelus,

Study Title: Taking a LEAP forward in the treatment of Anorexia Nervosa: A randomised controlled trial
REC reference number: 10/H0406/25

The Research Ethics Committee reviewed the above application at the meeting held on 09 April 2010. Thank you for attending to discuss the study together with Dr Caroline Meyer.

Ethical opinion

Discussion:

- You clarified that a minimum of 60 participants will be recruited with an aim to recruited 200 altogether.
- You confirmed that all assessments will be conducted by assessors blind to the treatment group.
- You explained that the reason for limiting participation to age 18 and above is because the Eating Disorders Service does not accept patients under the age of 18.

The researchers left the room.

Decision

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

This Research Ethics Committee is an advisory committee to East Midlands Strategic Health Authority.
The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England.

The Committee has not yet been notified of the outcome of any site-specific assessment (SSA) for the non-NHS research site(s) taking part in this study. The favourable opinion does not therefore apply to any non-NHS site at present. I will write to you again as soon as one Research Ethics Committee has notified the outcome of a SSA. In the meantime no study procedures should be initiated at non-NHS sites.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>. Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

Other conditions specified by the REC

The Committee gave a favourable opinion of the application with additional conditions:

1. The information sheet requires a minor amendment – under 'what will happen if I do take part' – the word 'need' at the end of the paragraph should be changed to 'we would like'.
2. The consent form should include tick boxes next to each question.

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Covering Letter		17 March 2010
REC application	42574/106598/1/834	15 March 2010
Protocol		01 November 2009
Participant Information Sheet	1	18 February 2010
Participant Consent Form	1	18 February 2010
GP/Consultant Information Sheets	1	18 January 2010
Investigator CV		16 February 2010
CV - Caroline Meyer		
Letter from funder		08 October 2009
Referees or other scientific critique report		14 July 2009
Flowchart	1	17 March 2010

Questionnaire: The EDE-Q		
Questionnaire: SF-12 Quality of Life Survey		
Questionnaire: K-10		
Questionnaire: Anorexia Nervosa Stages of Change Questionnaire		
Questionnaire: The Compulsive Exercise Test (CET)		
Questionnaire: Attitude to Exercise		
Questionnaire: Reasons for Exercise		
Questionnaire: Exercise Beliefs Questionnaire		
Questionnaire: Padua Inventory - WSUR	B© 1996	

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

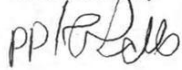
The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/H0406/25	Please quote this number on all correspondence
--------------------	---

With the Committee's best wishes for the success of this project,

Yours sincerely



Dr Carl Edwards
Chair

Email: rinat.jibli@nottspct.nhs.uk

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments

"After ethical review – guidance for researchers"

Copy to: Sponsor /R&D office for NHS care organisation at lead site -
Leicestershire Partnership NHS Trust

Ethical Approval from Weill Cornell Medical College, USA



Weill Cornell Medical College

Rosemary Kraemer, Ph.D.
Director, Human Research Protections Programs
Division of Research Integrity
Research and Sponsored Programs
407 East 61st Street, RR110
New York, New York 10065

Telephone: 646-962-8200
Email: rkraeme@med.cornell.edu

October 19, 2012

Evelyn Attia, MD

Submission Type: New Response to Issues
Protocol Number: 1205012397
Risk Level: Minimal Risk
Protocol Title: Taking a LEAP forward in the treatment of Anorexia Nervosa: A randomized controlled trial

Dear Dr. Attia:

The Institutional Review Board has conducted an expedited review of your response to the modifications required letter issued on **September 18, 2012** regarding the abovementioned protocol.

The protocol and its relevant documents stand approved for the following period:

Consent Form
Flyer
Medical Clearance Letter
HIPAA Authorization form

Approved: October 15, 2012

Expires: June 10, 2012

Please do not hesitate to contact the IRB office staff if you have any questions or need assistance in complying with the terms of this approval.

Sincerely,

A handwritten signature in cursive script that reads "Rosemary Kraemer".

Rosemary Kraemer, Ph.D.
Director, Human Research Protections Program

Please note the following important information about this approval:

- **Billing Compliance:** This approval is contingent upon continued adherence with institutional billing compliance policies.
- **Immediate Reporting:** Investigators must follow the Immediate Reporting Policy at http://weill.cornell.edu/research/research_integrity/institutional_review_board/irb_adv.html
- Failure to comply with IRB directives within specified time frames may result in federally mandated penalties, up to and including suspension or termination of IRB approval and mandatory reporting to the Federal government.
- **Human Gene Transfer:** If this is a human gene transfer protocol, it is a term and condition of IRB approval that the principal investigator obtains Institutional Biosafety Committee (IBC) approval of all amendments prior to initiation, reportable adverse events as per WCMC policy, and annual reports as per M-I-C-3 of the NIH Guidelines for Research

Involving Recombinant DNA Molecules. View the IBC website at http://weill.cornell.edu/research/research_integrity/ibc.html or contact ibc@med.cornell.edu if you require assistance in complying with these requirements.

- **Other reporting:** The reporting requirements of various regulatory bodies may differ with regard to both what must be reported and when. You are responsible for acquainting yourself with and abiding by all applicable federal and state regulatory reporting requirements.
- **Changes to this protocol:** If you want to change this research in any way or if any unanticipated hazardous conditions emerge affecting the rights or welfare of the human subjects involved in it, you must submit an amendment detailing these changes to the IRB for review and approval prior to implementing those changes. If the CTSC is used, the changes must also be submitted to the Translational Research Advisory Committee (TRAC). It is your responsibility to obtain approval for any such changes prior to initiating them.
- **Continuing approval:** You will receive a reminder via email for continuing review of this protocol in advance of the expiration date. The continuing review forms must be filed with the IRB sufficiently early to permit timely review and approval if the project is to continue beyond the period for which it was approved. Please note, no study related activities can continue beyond the WCMC IRB expiration date, including subject recruitment, enrollment, intervention and data analysis.
- **If your research study involves human tissues:** In addition to IRB approval, Section 4.4 of the hospital By-Laws “**Specimens Removed During Resectiv e Surgery**” requires that all specimens removed during surgical diagnostic procedures that will be used for research must be approved by Pathology Service. Information about Pathology review can be found online at http://www.med.cornell.edu/research/for_pol/forms/Pathology_Review_Instructions.pdf
- **If the IRB is requiring that you obtain informed consent from subjects:** The signed IRB approved consent forms must be kept in the subject’s hospital chart. If the subject has no New York Presbyterian Hospital chart, you are responsible for retaining such signed forms in your research files.
- **Information about the WCMC IRBs:** The Weill Cornell Medical College (WCMC) Institutional Review Board (IRB) is constituted as required by the Federal Office for Human Research Protections (OHRP). WCMC holds a Federalwide Assurance (FWA) with OHRP. The FWA number is FWA00000093. The WCMC IRB is registered on that FWA. The registration number for the IRB is: IRB #1 IRB00000952; and IRB #2 IRB00004327. Should you need additional information about the terms of the WCMC FWA or the WCMC IRB, please refer to http://weill.cornell.edu/research/research_integrity/institutional_review_board/index.html
- Note that new federal legislation took effect April 7, 2008. (<http://grants.nih.gov/grants/guide/notice-files/NOT-OD-08-033.html>), requiring that all peer-reviewed journal articles resulting from NIH supported research be deposited in PubMed Central, the NIH free digital archive of biomedical and life sciences journal literature, and be made publicly available within twelve months of publication. The Library and RASP have prepared general information which you can see at: <http://library.med.cornell.edu/FacPub/nihpolicy.html>
- The International Committee of Medical Journal Editors (ICMJE) has established a requirement that all clinical trials be entered in a public registry before the onset of patient enrollment as a condition of consideration for publication. Additional information may be found at <http://clinicaltrials.gov/> and at http://www.icmje.org/clin_trialup.htm Please contact the Protocol Registration System (“PRS”) administrator by e-mail at octa@med.cornell.edu to set up a PRS user account to register new and ongoing investigator-initiated clinical trials. The e-mail should contain the PIs full name, department, phone number and e-mail address.

Human Research Ethics Committee
Office of Research Services



Participant Information Sheet (Medical)

Project Title: Taking a LEAP forward in the treatment of anorexia nervosa: A randomized control trial.

Who is carrying out the study?

Professor Phillipa Hay (Psychiatrist, University of Western Sydney)
Professor Stephen Touyz (Psychologist, University of Sydney)
Assoc Professor Caroline Meyer (Psychologist, University of Loughborough, UK)
Dr John Arcelus (Psychiatrist, Leicestershire Eating Disorders Service)
Dr Sloane Madden (Psychiatrist, University of Sydney)
Dr Ross Crosby (Health Statistician, University of North Dakota)
Professor Kathleen Pike (Psychologist, Columbia University)

You are invited to participate in a study conducted by Professor Phillipa Hay, Chair of Mental Health, School of Medicine, University of Western Sydney.

What is the study about?

The purpose is to investigate an enhanced psychotherapy for anorexia nervosa. Anorexia nervosa is a serious mental illness that is associated with high levels of disability and psychological distress. Many people fail to recover fully with current therapies. Dr Meyer and her colleagues in Loughborough (England) have developed an enhanced form of cognitive behaviour therapy (CBT) which is an evidence based talking therapy for anorexia nervosa. The therapy addresses more specifically some features of eating disorders symptoms that have been found to be important in recovery (or not) from anorexia nervosa and similar eating problems.

The aim of the research is to determine if the enhanced CBT gives additional benefits over the standard CBT.

What does the study involve?

If you have anorexia nervosa and if outpatient psychotherapy is suitable for you, and if you agree, you will be randomly allocated to either 34 sessions of standard or enhanced CBT on a weekly basis with a registered psychologist. Each session will last for 50 minutes. Prior to the commencement of the treatment, you will be asked to attend an interview, complete a series of questionnaires and undertake a medical examination and blood tests. The questionnaires will be re-administered again after 16 weeks of treatment, at the end of treatment and three and six months after the end of treatment. The interview and questionnaires will ask you about your eating habits, thoughts around body image, how your general health and well-being is, other psychological problems such as depression and anxiety and how you think about the role of therapy at this time in your life.

CBT is an active treatment aimed at restoring weight and normal eating habits by challenging underlying beliefs and thoughts through specific strategies. It includes

providing education about eating disorder topics, giving advice about restoring normal nutrition, establishing a regular eating pattern, and reducing extreme weight control behaviours such as dietary restriction, purging and/or driven or compulsive exercise. A further focus is to address more general dysfunctional thoughts and beliefs such as low self-esteem. It also includes time to consider relapse prevention and prepare for the ending.

How much time will the study take?

You will be asked to attend a screening interview. During this interview, you will receive an explanation of the study procedures and will be asked to give written informed consent. You will then be required to fill out questionnaires as well as undertake an interview (as described above). Your height and body weight will be measured. You will also be asked to attend your family doctor and undergo a routine physical examination and a number of blood tests. The medical examination and blood tests are considered part of good medical practice and would be recommended even if you were not participating in this study. The blood tests are necessary to ensure your physical well-being can be monitored. When blood is taken, your doctor will need to collect 20 mls of blood (approximately 4 teaspoons) from a vein in your arm. If the results indicate cause for concern, this will be discussed with you and appropriate treatment will be offered. You will be required to have further medical examinations throughout the duration of the study to ensure that you are not medically compromised.

You will be randomly allocated to either 34 sessions of CBT or enhanced CBT on a weekly basis. 'Randomly allocated' means that an independent professional will assign you to one of the treatments and you have an equal chance of being assigned to either treatment (like tossing a coin). These therapy sessions will be audio-taped with 10% of these sessions analysed by an expert involved in this study to ensure the highest quality of treatment. Before and after therapy you may be asked to wear a pedometer like device to measure your physical activity for four days. This device is a small box that is attached to your clothing and is not painful or harmful.

The assessment interview and questionnaires together will take around 2-3 hours and 1-2 hours on each occasion after that.

In addition, Ms Shilpa Madiwale will be involved in the analysis of the audio tape recordings of the therapy sessions. This forms part of her Clinical Doctorate program at the University of Sydney. She will be supervised by Dr Paul Rhodes. Following the tenth treatment session, you may be invited to take part in an individual interview of 1 hour duration and/or a further 3 hour extended interview at the University of Sydney. A movie ticket will be given to the participants taking part in these interviews.

This is an international study and the data analysis will be undertaken in Sydney. However, all data will be fully de-identified and stored securely. No information that can lead to you being identified will leave the University of Western Sydney.

Will the study benefit me?

The study aims to further medical knowledge and may improve future treatment for anorexia nervosa, however it may not directly benefit you. You will receive an evidence-based psychological treatment which will be administered by trained and supervised psychologists following published procedures in manuals.

Adults who have anorexia nervosa are able to participate. You must not be suffering from psychosis, mania or substance abuse or be currently engaged in

psychotherapy. Furthermore you will need to confirm that you do not intend to move beyond commuting distance from the study site for the next 10 months.

Will the study have any risks?

The risk of psychological and/or physiological harm associated with this study are not high. You will be treated by a registered and closely supervised psychologist who has undertaken specific training in these psychological treatments. Should you become either psychiatrically or medically unwell during the study, you will be referred to the appropriate medical specialist or psychiatrist. Blood collection can be painful and bruising may occur. A local anaesthetic may be used by your doctor to numb pain.

How is this study being paid for?

The study is being sponsored by the National Health Medical Research Council of Australia.

Will anyone else know the results? How will the results be disseminated?

All aspects of the study, including results, will be confidential and only the researchers will have access to information on participants 'except as required by law'.

Can I withdraw from the study?

Participation is entirely voluntary: you are not obliged to participate and - if you do participate - you can withdraw at any time without giving any reason. Whatever your decision, it will not affect your medical treatment or your relationship with medical staff in any way, now or in the future.

Can I tell other people about the study?

Yes, you can tell other people about the study by providing them with the chief investigator's contact details. They can contact the chief investigator to discuss their participation in the research project and obtain an information sheet.

What if I require further information?

When you have read this information, Andreea Heriseanu will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact Professor Phillipa Hay, Psychiatrist, 0412330428 or 02 98524668.

What if I have a complaint?

This study has been approved by the University of Western Sydney Human Research Ethics Committee. The Approval number is 7732.

If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Office of Research Services on Tel 02-4736 0883 Fax 02-4736 0013 or email humanethics@uws.edu.au.

Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome. If you agree to participate in this study, you may be asked to sign the Participant Consent Form.

The information sheet is for the participant to keep and the consent form is retained by the researcher.

Human Research Ethics Committee
Office of Research Services



Participant Consent Form

Project Title: Taking a LEAP forward in the treatment of anorexia nervosa: A randomized control trial.

I,....., consent to participate in the research project titled "Taking a LEAP forward in the treatment of anorexia nervosa: A randomized control trial".

I acknowledge that:

I have read the participant information sheet and have been given the opportunity to discuss the information and my involvement in the project with the researcher/s.

The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction.

I consent to being randomly (by chance) allocated to one of the two therapies, to the audio-taping of therapy sessions, and to undertaking regular medical review with my doctor of choice.

I understand that my involvement is confidential and that the information gained during the study may be published but no information about me will be used in any way that reveals my identity.

I understand that I can withdraw from the study at any time, without affecting my relationship with the researcher/s now or in the future.

Signed: _____

Name: _____

Date: _____

Return Address:

Participant Information Sheet (University of Sydney)



THE UNIVERSITY OF
SYDNEY

School of Psychology
Faculty of Science

ABN 15 211 513 464

Professor Stephen Touyz
Professor of Clinical Psychology

Room TR167
Transient Building (F12)
The University of Sydney
NSW 2006 AUSTRALIA
Telephone: +61 2 9351 2646
Facsimile: +61 2 9351 2984
Email:
stephen.touyz@sydney.edu.au
Web: <http://www.usyd.edu.au/>

Taking a LEAP forward in the treatment of anorexia nervosa: A randomized control trial.

PARTICIPANT INFORMATION STATEMENT

You are invited to take part in a research study into **Taking a LEAP forward in the treatment of anorexia nervosa: A randomized control trial.**

The purpose is to investigate an enhanced psychotherapy for anorexia nervosa.

Anorexia nervosa is a serious psychological illness that is associated with much distress and many difficulties for people living with the illness. Many people do not get better with current therapies. Dr Meyer and her colleagues in Loughborough (England) have developed an enhanced form of cognitive behaviour therapy (CBT), which is a psychotherapy or talking therapy for anorexia nervosa. CBT in anorexia nervosa treatment focuses on how people think about eating, weight and shape and what they do about them (e.g. diet to lose weight). The therapy we are testing in this study has been enhanced by focussing more on some features of anorexia nervosa that have been found to be prevent people getting better from anorexia nervosa.

The aim of the research is to find out if the enhanced therapy gives additional benefits over the standard therapy.

The study is being conducted by Professor Stephen Touyz (Professor and Head of Clinical Psychology) and his colleagues:

Professor Phillipa Hay (Psychiatrist, University of Western Sydney)
Assoc Professor Caroline Meyer (Psychologist, University of Loughborough, UK)
Dr John Arcelus (Psychiatrist, Leicestershire Eating Disorders Service)
Dr Sloane Madden (Psychiatrist, University of Sydney)
Dr Ross Crosby (Health Statistician, University of North Dakota)
Professor Kathleen Pike (Psychologist, Columbia University).

If you agree to participate in this study, and if you have anorexia nervosa and if outpatient psychotherapy is suitable for you, you will be randomly allocated to either 34 sessions of standard or enhanced CBT on a weekly basis with a registered psychologist. 'Randomly allocated' means that an independent professional will assign you to one of the treatments

Taking a LEAP forward in the treatment of anorexia nervosa: A randomized control trial.

Version 2 - 24 August 2010

Page 1 of 3

and you have an equal chance of being assigned to either treatment (like tossing a coin). Each session will last for 50 minutes.

Prior to the commencement of the treatment, you will be asked to attend an interview. During this interview, you will receive an explanation of the study procedures and will be asked to give written informed consent. You will then be required to fill out questionnaires as well as undertake an interview (as described above). Your height and body weight will be measured. You will also be asked to attend your family doctor and undergo a routine physical examination and a number of blood tests conducted by your doctor or at a pathology service on his/her referral. The medical examination and blood tests are considered part of good medical practice and would be recommended even if you were not participating in this study. The blood tests are necessary to ensure your physical well-being can be monitored. When blood is taken, your doctor will need to collect 20 mls of blood (approximately 4 teaspoons) from a vein in your arm. If the results indicate cause for concern, this will be discussed with you and appropriate treatment will be offered. You will be required to have further medical examinations throughout the duration of the study to ensure that you are not medically compromised. You will need to attend at the University of Sydney Clinical Psychology Building Camperdown for 2-3 hours for first assessment and then weekly for 50 minute sessions for about ten months.

In addition, Ms Shilpa Madiwale will be involved in the analysis of the audio tape recordings of the therapy sessions. This forms part of her Clinical Doctorate program at the University of Sydney. She will be supervised by Dr Paul Rhodes. Following the tenth treatment session, you may be invited to take part in an individual interview of 1 hour duration and/or a further 3 hour extended interview at the University of Sydney. A movie ticket will be given to the participants taking part in these interviews.

CBT is an active treatment aimed at restoring weight and normal eating habits by challenging underlying beliefs and thoughts through specific strategies. It includes providing education about eating disorder topics, giving advice about restoring normal nutrition, establishing a regular eating pattern, and reducing extreme weight control behaviours such as dietary restriction, purging and/or driven or compulsive exercise. A further focus is to address more general dysfunctional thoughts and beliefs such as low self-esteem. It also includes time to consider relapse prevention and prepare for the ending. The therapy sessions will be audio-taped with 10% of these sessions analysed by an expert involved in this study to ensure the highest quality of treatment. Before and after therapy you may be asked to wear a pedometer like device to measure your physical activity for four days. This device is a small box that is attached to your clothing and is not painful or harmful.

All aspects of the study, including results, will be strictly confidential and only the investigators named above and their supervised research offices will have access to information on participants, except as required by law. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

While we intend that this research study furthers medical knowledge and may improve treatment of anorexia nervosa in the future, it may not be of direct benefit to you.

Participation in this study is entirely voluntary: you are not obliged to participate and - if you do participate - you can withdraw at any time. Whatever your decision, it will not affect your medical or psychological treatment or your relationship with medical or mental health staff.

You may stop an interview at any time if you do not wish to continue, the audio recording will be erased and the information provided will not be included in the study.

Taking a LEAP forward in the treatment of anorexia nervosa: A randomized control trial.

Being in this study is completely voluntary and you are not under any obligation to consent to complete the questionnaires or interview. Submitting a completed questionnaire is an indication of your consent to participate in the study. You can withdraw any time prior to submitting your completed questionnaires.

When you have read this information, Professor Touyz, Dr Madden or their Research Officer will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact Professor Touyz 9351 2646.

Any person with concerns or complaints about the conduct of a research study can contact the Deputy Manager, Human Ethics Administration, University of Sydney on +61 2 8627 8176 (Telephone); +61 2 8627 8177 (Facsimile) or ro.humanethics@sydney.edu.au (Email).

This information sheet is for you to keep.

Taking a LEAP forward in the treatment of anorexia nervosa: A randomized control trial.

Version 2 - 24 August 2010

Page 3 of 3

Consent Form (University of Sydney)



School of Psychology
Faculty of Science

ABN 15 211 513 464

Professor Stephen Touyz
Professor of Clinical Psychology

Room TR167
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The University of Sydney
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PARTICIPANT CONSENT FORM

I,[PRINT NAME], give consent to my participation in the research project

TITLE: Taking a LEAP forward in the treatment of anorexia nervosa: A randomized control trial.

In giving my consent I acknowledge that:

1. The procedures required for the project and the time involved (including any inconvenience, risk, discomfort or side effect, and of their implications) have been explained to me, and any questions I have about the project have been answered to my satisfaction.
2. I have read the Participant Information Statement and have been given the opportunity to discuss the information and my involvement in the project with the researcher/s.
3. I understand that I can withdraw from the study at any time, without affecting my relationship with the researcher(s), health care practitioners, or the University of now or in the future.
4. I understand that my involvement is strictly confidential and no information about me will be used in any way that reveals my identity.
5. I understand that being in this study is completely voluntary – I am not under any obligation to consent.
6. I understand that I can stop an interview at any time if I do not wish to continue, the audio/video recording will be erased and the information provided will not be included in the study.

7. I consent to:

Taking a LEAP forward in the treatment of anorexia nervosa: A randomized control trial.

Page 1 of 2

- i) Audio-taping YES NO
- ii) Receiving Feedback YES NO
- If you answered YES to the "Receiving Feedback Question (iii)", please provide your details i.e. mailing address, email address.

Feedback Option

Address: _____

Email: _____

Signed:

Name:

Date:

OUTPATIENT TREATMENT FOR ANOREXIA NERVOSA

An outpatient treatment study is currently being offered to people over 18 years of age with anorexia nervosa. The study is being funded by the National Health and Medical Research Council (PG 634922). It involves expert researchers and clinicians in the field of eating disorders from around Australia and the U.K.

The study is testing a promising new therapy for anorexia nervosa. People in the study will be randomly (that means by chance) allocated to an established therapy or an extension of the therapy with some new elements. Both will consist of 34 outpatient sessions.

For more information please contact:
Ms Andreea Heriseanu at the University of Western Sydney,
Phone: 02 4620 3726 Email: treatmenttrials@uws.edu.au

Transcription Confidentiality Agreement

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Taking a LEAP forward in the treatment of anorexia nervosa: A randomized control trial

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CONFIDENTIALITY AGREEMENT

Transcription Services

I, MUHAMMAD AMBER SAJJAD, transcriptionist, agree to maintain full confidentiality in regards to any and all audiotapes and documentation received from Shilpa Madiwale related to her study on A qualitative study of early treatment motivation in Anorexia Nervosa: Comparing LEAP enhanced mCBT-AN to mCBT-AN alone.. Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews, or in any associated documents;
2. To not make copies of any audiotapes or computerized files of the transcribed interview texts, unless specifically requested to do so by Shilpa Madiwale;
3. To store all study-related audiotapes and materials in a safe, secure location as long as they are in my possession;
4. To return all audiotapes and study-related documents to Shilpa Madiwale in a complete and timely manner.
5. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audiotapes and/or files to which I will have access.

Transcriber's name (printed): MUHAMMAD AMBER SAJJAD

Transcriber's signature: *Muhammad Sajjad*

Date: 09.07.2013

LEAP Chief Investigators:

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Appendix B: Sample Interview Questions

1. How would you describe the treatment you received?
2. What did you find helpful?
3. What did you find unhelpful?
4. What effect did treatment have on your motivation to change?
5. Which particular aspects most influenced your motivation to change?
6. What aspects of treatment are you find quiet easy?
7. What aspects of treatment are you find quiet hard?
8. Can you describe you relationship with your therapist?
9. Are there any particular aspects of your relationship with the therapist that you found helpful?
10. Are there any particular aspects of your relationship with the therapist that you found not as helpful?
11. What sorts of thing has the therapist done with you in sessions that have been most helpful to make you want to get better?
12. If there was anything you could have done to try and improve the treatment, what would it be?
13. Is there any other information that you wanted to pass on that you thought might be really helpful for this research? Is there anything that we might be missing?
14. Did the realisation that you had lost control over the AN occur at a certain point, or was it a gradual realisation?
15. What would have happened if you had the opportunity to get into treatment earlier than you did?

16. What is this point and can you describe what it is like to be there? Have you been there? Is it just something that you reached once or is it something that you keep going through?
17. What is it that makes you want to get better?
18. What would it mean for you to have a life without anorexia? What would that look like?
19. What keeps you going?
20. Have you found yourself perhaps trying to overcome your denial at any aspect during treatment?
21. Have there been any times during treatment that you've perhaps experienced something like a mind-shift?
22. Have you ever had that light bulb or "aha" moment in therapy?

Appendix C: Interview Transcripts

Table C.1 List of Interview Transcripts and Types

Pseudonym	Type
Alyssa	Member Checking
Amelia	Data Collection
Aria	Data Collection
Ava	Data Collection
Charlotte	Data Collection
Chloe	Data Collection
Ella	Data Collection
Grace	Data Collection
Isabella	Data Collection
Isla	Data Collection
Mia	Data Collection
Olivia	Data Collection
Rose	Data Collection
Sienna	Data Collection
Zara	Member Checking
Zoe	Data Collection

Note. CD of transcripts in PDF format is attached to the back cover of this thesis.