Expanding the Concept of Motivation to Change: The Content of Patients’ Wish to Recover from Anorexia Nervosa

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ABSTRACT
Objective: Motivational approaches to anorexia nervosa (AN) have mainly concerned motivational quality and quantity. We investigated the content of patients’ wish to recover.

Method: Eighteen women, aged 18–39, with AN were interviewed in depth using a phenomenological study design. Interviews were tape-recorded, transcribed, and analyzed using the QSR-N*Vivo software program.

Results: Four motivational content areas characterized informants’ wishes to recover: “Sense of vitality” (e.g., joy, concentration, spontaneity, energy); “Sense of autonomy” (e.g., choosing to recover, new methods of mastery, self-determination); “Sense of insight” (e.g., awareness, seeing nuances, limitation of goals, self-knowledge); and “Negative consequences” (e.g., loss of future, costs to own children, feeling sick or thin, social costs, physical costs).

Conclusion: Our sample of AN patients’ motivation to recover may be described using three dimensions: content, quality, and quantity, and may also include motives with no behavioral intention. Sustained therapeutic success may rest upon the therapist’s ability to identify and ally with the patient’s motives to recover. © 2008 by Wiley Periodicals, Inc.

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Introduction
Strong, but ambivalent, hesitance toward recovery is a major challenge in the treatment of anorexia nervosa (AN).1–3 Several motivational issues have been studied in this population, including factors facilitating recovery,4–6 the recovery processes,5,7 decisional balance scales,8,9 and motivational assessment.10,11 The content or motives that drive AN patients’ wish to recover, however, is still lacking. The purpose of this article is to enrich and expand the concept of AN patients’ “motivation to change” by systematically exploring the meanings which patients refer to in their wishes to recover.

The motivational approaches in the field of AN are based on different conceptualizations of motivation. The most frequently cited theoretical framework is the Transtheoretical Model of Change (TMC).12,13 This model delineates five stages of change: precontemplation (not thinking about change); contemplation (thinking about change); preparation (intention to change soon); action (actively making changes); and maintenance (working to prevent relapse).12,13 The TMC thereby provides a framework for conceptualizing the development and change in strength of motivation, i.e., quantities of motivation.

Vansteenkiste and colleagues14 present an alternative approach to motivation in the field of eating disorder (ED) by addressing how motivation to change occurs. They introduce Self-Determination Theory (SDT),15,16 where “controlled motivation” is distinguished from “autonomous motivation.” “Controlled motivation” includes “external motivation” (e.g., expectations, rewards, and punishments administered by the patients’ environment) and “introjected motivation” (e.g., guilt, shame, anxiety, and internal compulsion). In contrast, “autonomous motivation” includes “identified motivation”...
patients. To facilitate recognition and evoke the intrinsic motivation. Therefore, the critical question is not to what extent the patients are at a particular stage (cf. TMC), but rather why they are at a particular stage and where the motivation is located, i.e., qualities of motivation.

AN patients tend to be highly ambivalent about change. Many clinicians therefore find it difficult to establish a robust working alliance with these patients. To facilitate recognition and evoke the patient’s autonomous motivation, knowledge about the specific motivational content is critical in the treatment of these patients. Here, the word content refers to the specific themes that inspire the patient’s motivation to change. We suggest that a comprehensive framework of motivation to change requires data not only about the strength (quantity) and locus (quality) of motivation, but also about these specific themes that motivate the patients to change (content).

The concepts of content, quality, and quantity of motivation are not completely independent of one another, because no assessment of quality or quantity may occur without any reference to content. But neither the TMC, nor the SDT, have yet addressed content specifically as a key feature either of patients’ motivation to change or their wish to recover.

Motivation to change implies an intention—weak or strong—to change one’s behavior. However, AN patients may at the same time both wish to recover and be highly resistant to change their behavior. Therefore, we suggest that assessment of motivation in these patients should include not only their motivation to change, but also their different wishes to recover which do not necessarily imply a behavioral intention. The purpose of this study has been to systematically explore the contents which AN-patients themselves claim motivate them to wish to recover.

Method

Participants

Informants were 18 women aged 18–39 years (mean 27.2 years) treated for AN within the past 2 years at three clinical institutions in Norway. At the time of the interview, nine were outpatients, seven were inpatients, and two had completed treatment within the past two years. Mean BMI at the time of the interview was 17.2 (range 14.2–21.7). Two informants reported having had a BMI of 12 and 14, respectively, and would not report their BMI at the time they were interviewed. Mean duration of AN was 7.6 years (range 2.5–25 years) and mean time in treatment was 4.2 years (range 1–12 years).

Setting and Procedure

A phenomenological, descriptive, qualitative study design with Grounded Theory elements was used. To maximize study validity, a two-phase study design was used. First, an exploratory study on a sample of 18 AN patients similar to the sample described above was conducted. The purpose of this study was to describe a wide range of experiences associated with living with AN. One class of experiences identified in this study related to the recovery process. The current study builds upon these data by following up with in-depth-interviews focusing specifically on these experiences.

Patients were informed about the study by their therapist or by one of the first three authors and were provided with written information about the study, including a description of the purpose and procedure. Each voluntary interview lasted between 90 and 120 min and was audiotaped and transcribed verbatim.

Data collection occurred using an “Experience interview,” which is a semi-open, informant centered and strategic conversation, derived from communication theory. After first hearing the purpose of the study described, some informants spoke spontaneously about their experiences of recovery. If this did not occur, the interviewer used open questions, such as “What do you think when I say ‘Recovering from AN’?” The interview guide provided specific prompts and probes to stimulate discussion. Patients’ narratives and responses to the interviewer’s probes drove the order and context in which themes and queries emerged. The interviewer brought up issues that were not touched upon spontaneously by the interviewee. In this way, the interview guide worked as a checklist of issues, rather than as a list of questions mechanically structuring the course of the interview. Interviewers encouraged patients’ to pursue and elaborate upon themes using “open instructions” (“Go on...”), “delayers” (“Let’s come back to that a little later”), “backtrackers” (“You mentioned your treatment...”), “personal emphases” (“How was that for you?”), “references to interviewer’s impression” (“How terrible!”), and frequent use of verbal (“Yeah”) and non-verbal (smiling) “facilitators.”

Patients were provided with a graph, and asked to draw a line indicating how their wish to recover had varied over the course of their life with AN. The graph was...
used to help informants relate to their wish to recover over time. The x-axis corresponded to time, from “start of AN” to “today,” and the y-axis indicated the strength of the patient’s wish to recover, from “weak” to “strong.” There were no units on either axis.

Data Analysis

The verbatim-transcribed interviews were analyzed by means of the software program QSR-N*Vivo. Each text was explored using open thematic coding according to the “bottom-up principle.” In this process, each full text is divided into excerpts according to the essence of meaning, which is coded, labeled, and entered into the database based on semantic and contextual analysis. For example, a larger text excerpt (e.g., “… [text omitted] … But if I eat, I get much more energy to think I will recover … [text omitted] …”) was divided into its essence of meaning (e.g., “Eating gives energy to recover”), coded, and then labeled under a content construct (e.g., “Experience of energy”). All content constructs that were not associated with a wish to recover were excluded. The remaining content constructs were sorted into higher-order constructs (e.g., “Sense of vitality”) that most parsimoniously accounted for the content. Following semantic analysis, tests for coherence and contrasts, each content construct and higher-order content construct was given a tentative definition with reference to the essence of meaning for all relevant original text excerpts.

All constructs were validated against the original text using confirmatory and selective coding and following the “top-down principle.” In this process, each higher-order content construct (e.g., “Sense of vitality”) that was generated through the open coding was applied to each full text excerpt and checked for its essence of meaning. The purpose of this “backward translation” was to ensure that the generated construct definitions fit with the original text, to detect possible overlap between constructs, and to determine whether further refinements were needed (e.g., more precise conceptualization, elaboration). For instance, the applicability of the potential higher-order construct “Sense of vitality,” referring to the content constructs of “Joy,” “Concentration,” “Spontaneity,” and “Energy” was checked by semantically reanalyzing and recoding all text excerpts that contained descriptions of joy, concentration, spontaneity, and energy.

Results

Patients approached recovery themes from different angles during the interview: by spontaneous questions about what the interviewer meant by recovery; descriptions of their conflicts about recovering; concrete descriptions of situations in which they had felt a wish to recover; or through the ways they described their course of recovery from AN. All patients spoke of wishes to recover one or several times during the course of their AN. Their wishes to recover varied from strong to weak. This variation was expressed in the interviews, and illustrated by patients’ graphs indicating the strength of their wishes to recover. No patients drew a straight line, which would have indicated a steady wish to recover. The patients also reported disparity in terms of behavioral consequences. Some described wishes to recover as triggering dramatic changes in the AN behavior. On the other hand, some patients described no behavior changes associated with these wishes:

Carrie: “I had such horrible chest pain, that I thought I was gonna die that day. That was a turning point. I was faced with reality. Then I pulled myself together.”

Ivy: “Even if this flash of motivation is there, it’s never enough.”

Liz: “I wanna recover, but I don’t manage to do everything I should do. I don’t want to put on any more weight.”

These wishes to recover were referred to as different motivations. By condensing all the text excerpts where the informants referred to a wish to recover, we were able to differentiate between 16 subconstructs of motivational content. These 16 subconstructs of content could be further sorted into four logically relatively independent constructs: “Sense of vitality,” “Sense of autonomy,” “Sense of insight,” and “Negative consequences” (Table 1).

In this section, we describe the four main constructs, their subconstructs, and the number of informants reporting each construct. Because every

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<th>Higher-Order Content Constructs</th>
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Note: The table represents an overview of the higher-order content constructs and their subconstructs identified in the study.
The interview was tailored interactively to the individual informant, and no construct was predefined; the numbers should not be used to indicate distribution of the constructs in the sample. Rather, we report the number of patients (in parentheses following the construct) whose interviews reporting led to the inference of a given construct. We illustrate the subconstructs through excerpts from interviews. Because of space constraints, our presentation condenses the interview excerpts. Yet our changes in length attempt to avoid interfering with the individual’s style of phrasing or emotional attunement. Information that could possibly reveal any informant’s identity has been removed.

**Sense of Vitality (n = 7)**

Sense of vitality is based on four subconstructs labeled “Joy,” “Concentration,” “Spontaneity,” and “Energy.”

“Joy” refers to the experiences of being happy and glad when engaging in an activity or being together with people. Traveling, exercising or being at parties exemplifies what they could enjoy partaking in. This filled them with enthusiasm, happiness, and fulfillment.

Ivy: “I get nearly euphoric when I’m in those situations. Going out and traveling does me good, ’cause then I get that extra get-up-and-go or enthusiasm. I’m having fun and this makes me think: I don’t wanna do this any more. Period!”

“Concentration” conveys experiences of focused attention, interest, and engagement. This could occur when the informants read a good book or studied at school. The concentration was associated with a positive feeling which could make them wish to recover.

Interviewer: “And how would you describe it when you feel this desire to recover?”

Vivian: “Then I get very focused on things I wanna do, what I can do, and that life can be pretty okay.”

Interviewer: “When do you feel like that?”

Vivian: “When I’ve been together with other people and had a good time, or when I’ve read something exciting or discovered something new.”

Interviewer: “What do you think then?”

Vivian: “That I shouldn’t let these things run my life any more.”

“Spontaneity” implies an experience of impulsivity when engaging in an unplanned situation or activity. Being spontaneous could make the informants feel glad and vital. Impulsively accepting an invitation to a party or suddenly changing their decision about what they were going to eat could make them feel good about themselves and could lead to wishes to recover.

Ivy: “If I’m in a good mood, then I can splurge and eat something extra or enjoy food a lot more. There are ups and downs. So if I’m better, that has something to do with my motivation. Then my motivation gets an extra boost.”

“Energy” involves an experience of surplus strength and energy. This feeling of surplus strength could be associated with an individual managing to eat food. The eating gave them energy, and increased the feeling of being able to struggle against AN. Such an experience could fuel a wish to recover.

Liz: “Eating also gives you energy. That’s what made me eat several times. If I start throwing up, I don’t have the energy to fight against the eating disorder. But if I eat, I have much more energy to believe that I can recover.”

**Sense of Autonomy (n = 13)**

Sense of autonomy is based on the subconstructs “Choosing to recover,” “New methods of mastery,” and “Self determination.”

“Choosing to recover” refers to the experience of being a person with responsibility for one’s own life; of being agentic. Informants could meet other people who confronted them directly with their need to make an active choice about their own recovery. Such people could be their doctor, therapist, family members, and others whom informants trusted. These experiences could foster the realization that the interviewee had responsibility for their own lives and that recovery depended on their personal choices.

Annie: “It was mostly my doctor, I guess, who contributed to make that decision. When I returned, I lost even more weight. My doctor said that I soon had to choose: ‘Either you have to recover and apply for treatment, or you have to deal with this on your own, or you have to wait till I hospitalize you.’”

Interviewer: “So it was like you got different alternatives?”

Annie: “Yeah. I got these choices from my doctor and then I realized, that maybe I had to do this on my own . . . that it was time to do something.”

“New methods of mastery” refers to feelings of strength, willpower, and mastery informants experienced when they found new ways of handling challenges of life. Such challenges could involve changing old anorectic habits, including eating a kind of food that had previously been “off limits.”
Signs of change in these old, enduring, habits could lead to new feelings of willpower and strength.

Interviewer: “Do you ever feel any closer to recovery?”

Joanna: “Yeah, if I have this plan in my head and don’t just have the same patterns of reactions as I’ve always had.”

Interviewer: “You said, ‘plan in your head’?”

Joanna: “I have this plan of what I’m going to eat and how I’m going to handle things. If I start thinking a lot of negative thoughts, then I try to forget it all or get involved in something else so I won’t think about it any more. It feels good if it works.”

“Self determination” refers to experiences of having the right to have one’s own will, independent of other people’s explicit wishes. This could be expressed as informants’ disagreement with health care personnel and their family members about the recommended treatment regimen. Disagreements with other people could lead to a patient’s recognition of her need to stand alone and follow her own will.

Hilda: “So then I discharged myself from the hospital, ‘cause I didn’t want to be there. But then I set myself up against all the others. And then I knew that I wanted to do this on my own. And I knew that I could do so, but I had to find the willpower to do it.”

Interviewer: “So to find your way out of the disorder, you had to find that willpower, right?”

Hilda: “Yeah, this was actually the first time I felt like I really wanted to recover.”

Sense of Insight (n = 12)

Sense of insight is based on four subconstructs labeled “Awareness,” “Seeing nuances,” “Limitation of goals,” and “Self knowledge.”

“Awareness” refers to experiences of individuals becoming more clear in their thinking about managing their lives. The informants realized that their bodies needed more nourishment to work well or that a life with AN could be a miserable life. It could also imply that the individual’s underlying logic of how and when to eat now did not match her understanding about how a life should be lived.

Greta: “I have a couple of good friends that I talk with a lot, and I really like that, because it gives me new drive. ‘Yeah, now I’m gonna take this thing by the horns!’”

Interviewer: “What is it that can give you this new drive?”

Greta: “Well, then I figure out myself as I’m sitting talking about it, that it sounds totally strange why I can’t just get healthy. Why do I let this so utterly run my life? So when I’m sitting talking about it with other people it’s like: ‘Yes, now I’m going home and I’ll pull myself together.’”

“Seeing nuances” involves experiences of no longer recognizing oneself, or people around oneself, and seeing the world as black or white. The informants may have struggled to find out whether they were inhibited or vital. Accepting oneself as a person with varied characteristics was then associated with the wish to recover. The patients now realized that bad periods often pass and that life is complex.

Interviewer: “Can you explain why you’re here today (pointing at the upper part of the graph she has drawn) and not there (pointing at the lower part of the graph)?”

Suzannah: “I had a lot of thoughts about dying and getting away from everything. Today those thoughts aren’t there anymore, because today, even if it’s tough sometimes, I see that you don’t actually need to be on top of things all the time to be liked or to be successful.”

“Limitation of goals” refers to lowering one’s ambitions. This lowering would include accepting not being best in everything or that the individual would not always fully carry out her plans. Instead of starting to eat a normal amount of food, the informants might gradually increase their amount of food in the attempt to recover. This could give them the experience of acceptance for lowering their self-expectations, which might then drive their wish to recover.

Cindy: “Now I’m just going to do one thing at a time and see what happens. I’ll try to accept that things don’t need to be perfect. It’s when I came to this clinic I first started to think this way in terms of goals . . . to look at the main goal.”

Interviewer: “And the main goal is?”

Cindy: “The main goal is to be healthy . . . the others are subgoals.”

“Self knowledge” includes experiences of understanding oneself better. Being able to know better who they were, their needs, what they liked, and which experiences had been significant in their lives, could make them feel more content about themselves.

Liz: “But for me, to get well is also a lot about thoughts and feelings. It is to become independent. To trust yourself, I believe, is the alpha and omega in the eating disorder. To find my intrinsic value, my existential place in the world. Then I don’t need to focus on what other people think of me, whether they think I’m fat or thin . . . as long as I’m OK with whom I am.”
Negative Consequences (*n* = 16)

“Negative consequences” is based on the five subconstructs “Loss of future,” “Cost to own children,” “Feeling sick or thin,” “Social cost,” and “Physical cost.”

“Loss of future” refers to fear of losing one’s future plans for life. The informants wanted to become educated, work, or settle down with their own family. Because of their AN, these dreams were difficult to achieve. A patient could feel tired, sad, and depressed, and she could then see her feeling of having a miserable life as unbearable and unacceptable.

Joanna: “Sometimes my motivation is stronger, then it weakens, and then I get to where I can’t go on like this; then I get more motivated and then it fades again.”

Interviewer: “What happens when you think it cannot go on like this?”

Joanna: “It’s more that I think it’s getting worse, I know that things can’t be any better. It’s like I cannot imagine a future living with an eating disorder.”

“Cost to own children” includes being concerned about the effect of AN on one’s own children. Informants having children would worry about how their condition affected their children.

Interviewer: “What happened here (pointing at the upper part of the graph)?”

Olivia: “That’s when my daughter was born. Then I realized that I had to do something.”

“Feeling sick or thin” refers to the patient becoming frightened upon realizing she is suffering from a serious illness. Other people expressing their worry about the patient’s health could alert her to the fact that she suffered from a worrisome disease. In turn, this would evoke her anxiety about her condition and underly her wish to recover.

June: “I feel he is [her psychiatrist] right there with me. He listens to me and I believe what he says. So every time I came out of the consultation I thought to myself: Okay, I’m sick. I’m going to recover, now I have to pull myself together.”

“Social cost” implies the experience of loneliness because of AN. Because these women were preoccupied with what to eat and when to eat, they had much less time to make new friends and be with friends and family. They missed their social life and felt depressed and lonely.

Annie: “When you haven’t been eating for a long period of time, you don’t function very well. That’s logical. Physically, I didn’t have any energy to go to work or meet friends . . . I didn’t have any energy at all. I didn’t want to do anything. I was really depressed. So then I thought, I have to try at least, ‘cause I don’t want the rest of my life to be like this.”

“Physical cost” refers to fearing the bodily effects of AN. Recognizing and thereby facing the risks of developing osteoporosis, infertility, metabolism difficulties, or heart arrhythmia due to AN, some informants became scared. They could develop these pathological conditions, be informed about them, or meet other people who already struggled with them. Such experiences with the physical sequel to AN, could terrify them and drive their wish to recover.

Greta: “Right now I’m very motivated. It’s been several years since I’ve been this motivated. I moved from one apartment to another, was renovating nonstop, forgetting to eat or just not eating. I felt something inside me . . .”

Interviewer: “What did you feel?”

Greta: “A sort of anxiety when I was breathing and all, when it started to affect my inner organs, then . . . Well, for the first time I felt scared in connection with this disorder, ‘cause I never felt scared like that before.”

Conclusion

Our study contributes to the literature on motivation in patients with anorexia nervosa (AN) in several ways. First, in addition to quality and quantity of motivation, we expand the concept of motivation to address what makes AN patients wish to recover. This study uncovers four broad constructs, which may underly their wishes to recover. Second, the results suggest that AN patients might experience both a wish to recover during the course of their illness and that this wish—in terms of content—may vary both within and between patients. This is consistent with previous research indicating that AN patients’ wish to recover tends to fluctuate. Third, we have shown—as suggested by the Transtheoretical Model of Change (TMC)—that AN patients may wish to recover even though they have no intention to change their behavior. Our investigation adds to the AN literature by framing the content of these AN patients’ wish to recover in their own language, rather than in terms of predefined categories, e.g., precoded interview forms and questionnaires. In this way, by using a phenomenological study design, this study provides groundwork for more definitive quantitative studies.

To our knowledge, this is the first study to systematically explore what—in terms of themes—
inspire AN patients to wish to recover. The differentiation between thinking about change and being ready to change behavior (viz. contemplation vs. action) is one of the basic contributions from TMC research.\textsuperscript{12,13} However, although previous studies have mainly addressed patients’ motivation to change (e.g., Refs. 3, 7, and 24), this study examined what could make AN patients’ wish to recover. Therefore, we did not differentiate between contents with an intention—weak or strong—to change behavior (e.g., putting on weight) and contents with no such intention (e.g., become happy and healthy without gaining weight). Consequently, contents associated with a weak, fragile, and diffuse wish to recover were also described in this study. We found that in some cases, the informants seemed to keep and nourish their wish to recover secretly. The contents associated with wish to recover, could in these cases seem more like fantasies or dreams than like motivation to change. Yet, although further exploration is needed, many of these fantasy-like wishes seem to us to be “autonomously motivated.”\textsuperscript{14} In that case, working motivationally with the content of such fantasies may in the long run be a better investment in achieving sustainable change, than attempting to change anorectic behavior in patients whose motives are of “controlled motivation.”\textsuperscript{14}

As stated by several authors, to be sustained, the alliance between patient and therapist must rest on the patients’ own autonomous motives and values.\textsuperscript{3,26} Indeed, “patient factors,” such as motivation, have been shown to make the greatest contribution to the therapeutic alliance.\textsuperscript{27} To stimulate patient motivation is challenging for the clinician because, as shown in this study, AN patients’ wishes to recover may be weak, highly ambivalent and/or fluctuating.\textsuperscript{1–3} Understanding the subjective contents that drive the patient’s wish to recover, is therefore essential in motivational work with AN patients. This study provides the clinician with knowledge which may serve as a guide when examining the patient’s personal and unique motives either to wish to recover or to change—and by addressing this, grounding the therapeutic alliance on the patient’s own autonomous motivations.

Because AN patients may both wish to recover and simultaneously be highly resistant to change their behavior,\textsuperscript{1–3} further study is needed to address whether some contents are more strongly associated with motivation to change than are others. More knowledge is also needed to understand how content, quality and quantity of motivation are related and possibly interact. A challenge for further research would therefore be to combine traditional measures of the quality and quantity of motivation to change, with a focus on content. One way to achieve this would be to use qualitative statements as collected in this study as items in a short multidimensional pencil-and-paper test of motivational content. Ratings made on these items by a suitable group of patients, could then be subjected to factor analysis. Such a procedure could work as a quantitative verification of the constructs arrived at qualitatively in this study. The resulting questionnaire could then work as a tool to study the relationships between content, quality and quantity of motivation, and become a clinically highly relevant supplement to the TMC-based methods now used to assess readiness to change in ED (e.g., Refs. 10, 11).

There are limitations to this study. We have uncovered, described, and conceptualized different qualities of experience among Norwegian women with AN. We have not tried to count their distribution in this or other populations, and generalizability to other samples are unknown. Our study was also restricted to AN, so the generalization of study findings to a wider spectrum of ED is not known. Further research is also needed to determine how subdiagnosis of AN and co-morbidity may have influenced the results. Our two-phase design using separate samples of similar size strengthens the validity of this study, but it does not rule out the need for additional quantitative verification of the four content constructs (e.g., factor analysis). To assure that the informants had sufficient experience to be able to reflect upon the questions they were asked, we oversampled patients with relatively long career with AN. This may limit generalizability of the conclusions to younger women in a more acute phase of their AN. Neither do we know if any individual patient’s concept of recovery was colored by prior treatment experiences, treatment failures, and duration of the illness and the relative chronicity of the illness, including possible refractoriness to change despite adequate treatment. There is, however, nothing in the results to indicate such eventual skewed motivational attributions and, although experienced patients were oversampled, this was to some degree compensated for by including in the total sample a reasonable variety in duration of illness, treatment, and types of treatment. The interview format used in this study was designed specifically for this study to give structure to the data collection without shaping the informant’s report, and the informants were repeatedly told that the interview would address their experiences with “wish to recover.” Yet, we cannot completely exclude that some interviewee’s perceptions
and other verbal responses may have been inadvertently shaped by the interview protocol and/or interviewer.

In summary, our study revealed the contents of AN patients’ wish to recover. Four main motivational constructs were found. In searching to develop a comprehensive framework of motivation, we suggest that AN patients’ motivation be assessed by means of three relatively independent dimensions, namely: the themes (e.g., vitality, autonomy, insight, negative consequences), locus (e.g., SDT: autonomous versus controlled motivation), and strength (e.g., TMC: action stage), corresponding respectively to content, quality, and quantity of motivation. We also suggest that such a comprehensive model should include wishes to recover that do not necessarily imply a behavioral intention. Accordingly, we have substituted the often used term “motivation to change” with the new term, “wish to recover.” As already noted, the content, quality, and quantity of motivation are not strictly independent dimensions. Clinically and conceptually, however, these dimensions comprise three very different and highly relevant aspects of AN patients’ treatment motivation. In this regard, our study represents another step towards a more holistic model of treatment motivation.

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