RESEARCH ARTICLE

Reluctance to Recover in Anorexia Nervosa

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Abstract

Objective: Reluctance to recover may explain poor treatment outcome and high dropout and relapse rates in the treatment of anorexia nervosa (AN). This study systematically explored what AN patients describe as interfering with their wish to recover.
Method: Two independent samples of women with AN (total $N = 36$) were interviewed in-depth using a phenomenological study design. Interviews were tape recorded, transcribed and analysed using QSR-NVIVO7 (QSR International, Melbourne, Australia) software.
Results: Seven core obstacles were found to interfere with informants' wish to recover as follows: (i) 'perceiving judgements'; (ii) 'feeling stuck'; (iii) 'feeling distressed'; (iv) 'denying AN'; (v) 'eating'; (vi) 'gaining weight'; and (vii) 'appreciating the benefits'.
Conclusion: The wish to recover is an autonomously based, fundamental motivational requirement for becoming ready to change. Understanding factors that contribute to this wish adds to the clinician's toolbox in motivational work with AN patients.

Keywords
eating disorder; ambivalence; resistance; motivation to change; treatment

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Published online 9 February 2011 in Wiley Online Library (wileyonlinelibrary.com) DOI: 10.1002/erv.1097

The recovery process in anorexia nervosa (AN) is associated with a complex set of factors including the patient's environment, the patient's personality and the treatment that is offered (Garrett, 1997; Keski-Rahkonen & Tozzi, 2005; Matusek & Knudson, 2009; Nilsson & Hägglöf, 2006; Noordenbos & Seubring, 2006; Pettersen & Rosenvinge, 2002; Tozzi, Sullivan, Fear, McHenzie, & Bulik, 2003; Vanderlinden, Buis, Pieters, & Probst, 2007). A major challenge is the patient's motivation, as many AN patients show a reluctance to recover (Geller & Drab, 1999; Vansteenkiste, Soenens, & Vandereycken, 2005). This may stem from patients perceiving their core symptoms as attractive (Nordbø, Espeset, Gulliksen, Skårderud, & Holte, 2006; Serpell, Treasure, Teasdale, & Sullivan, 1999; Vitousek, Watson, & Wilson, 1998). This has been hypothesized to produce ambivalence about change (Vitousek et al., 1998), high rates of treatment avoidance (Rosenvinge & Kuhlefelt-Klusmeier, 2000), dropout (Mahon, 2000; Wallier et al., 2009), relapse (Fichter, Quadflieg, & Hedlund, 2006; van Son, van Hoeken, van Furth, Donker, & Hoek, 2010) and poor treatment outcome (Fairburn, 2005; van Son et al., 2010). Both the reinforcing and egosyntonic quality of the symptoms and their corollary reinforcement may account for the reluctance to recover (Nordbø et al., 2006, 2008; Vitousek et al., 1998). However, the strong reluctance to recover from a serious illness like AN has prompted many researchers to study motivational processes in AN (Vansteenkiste et al., 2005). In this study, we address a fundamental aspect of AN patients' motivation to recover, namely, why patients who have AN may not wish to recover.

The Transtheoretical Model of Change (TMC) provides a means for describing patients' motivation for change (Prochaska, 1994; Prochaska, Redding, & Evers, 2002). According to the TMC, patients may wish to recover even though they have no immediate intention to change their behaviour (e.g. 'contemplation'); that is, wishing to recover is regarded as primary to any decision about change or readiness to change. Such wishes to recover may vary greatly: from weak, rudimentary and fantasy-like (appearing only in glimpses with no actual intention to act) to those that are strong and persistent (Nordbø et al., 2008). Drieschner, Lammers, and van der Staak (2004) defined the concept of treatment motivation in terms of engagement. These authors suggest that there is a need for clearer conceptualization of motivation and emphasis on the importance of distinguishing between the concepts of motivation and desires or wishes (Drieschner et al., 2004). Wishes typically come from within and are autonomously driven. According to the Self-Determination Theory (SDT) (Deci & Ryan, 1985, 2000), such autonomously driven motivation is crucial in achieving

sustainable change, even though they may be weak and short lived (Vansteenkiste et al., 2005).

In order to understand the dynamics of recovery in AN, several research have studied recovery, relapse, dropout, psychosocial functions of symptoms and decision processes of patients who have decided to change their behaviour. For instance, recovery has been associated with a number of factors including social support, self-acceptance, body satisfaction, developing new identity, spirituality, community involvement, internal motivation, maturation, own family and type of therapy (Garrett, 1997; Keski-Rahkonen & Tozzi, 2005; Matusek & Knudson, 2009; Nilsson & Hägglöf, 2006; Noordenbos, 1992; Pettersen & Rosenvinge, 2002; Tozzi et al., 2003). Relapse has been linked to low tolerance of unpleasant feelings, low self-esteem, lack of structure, identification with the disorder, lack of social support, need for control, interpersonal conflicts and negative treatment experiences (Cockell, Zaitsoff, & Geller, 2004; Darcy et al., 2010; Federici & Kaplan, 2008). Dropout has been related to high impulsivity, low cooperativeness, absence of depression, low perceived freedom, low readiness to change dietary restriction, lack of trust and patients' experiencing treatment as being too difficult (Eivors, Button, Warner, & Turner, 2003; Fassino, Abbate Daga, Pierò, & Rovera, 2002; Geller, Drab-Hudson, Whisenhunt, & Srikameswaran, 2004; Vandereycken & Devidt, 2010; Wallier et al., 2009).

In addition, the psychosocial functions of AN have been addressed in several studies (Nordbø et al., 2006, 2008; Serpell et al., 1999; Vitousek et al., 1998; Williams & Reid, 2009). Serpell et al. (1999) asked AN patients to write a letter to 'AN as a friend' and to 'AN as their enemy'. The perceived benefits included feeling protected, gaining a sense of confidence and feeling different. Similarly, Nordbø et al. (2006) identified eight different psychological meanings that patients attribute to their AN: feeling secure, avoiding negative emotions, having mental strength, feeling self-confident, having a new identity, eliciting care, communicating difficulties and fulfilling a death wish.

A few authors have attempted to conceptualize and measure ambivalence to change. For example, the Pros and Cons of Anorexia Scale includes six items reported by patients to be benefits of AN: feeling safe, more attractive, avoiding menstruation and pregnancy, increased fitness, communicating emotions and feeling special (Gale, Holliday, Troop, Serpell, & Treasure, 2006; Serpell, Teasdale, Troop, & Treasure, 2004). Correspondingly, the decisional balance scale includes benefits associated with self-control, self-esteem enhancement, perfectionism and accomplishment of needs (Cockell, Geller, & Linden, 2002, 2003).

Together, these studies suggest that a number of events, situations and processes influence patients' wish to recover. Previously, we have conducted a study that specifically asked AN patients what made them wish to recover, irrespective of whether or not they actually had the intention to change (Nordbø et al., 2008). No study has yet asked AN patients specifically about what makes them not wish to recover. In order to address this question, we have conducted a comprehensive in-depth analysis using a semi-open, informant-centred and interactive interview format in which we invited AN patients to reflect upon what makes them not wish to recover.

Methods

Participants

The informants were 36 women aged 18–39 years (mean 26.5) treated for AN (APA, 1994) within the past 2 years at four clinical institutions in Norway. At the time of the interview, 23 of the informants were outpatients, 11 were inpatients and 2 had completed treatment. The mean of the lowest reported body mass index (BMI) while having AN was 13.6 (range 8–17), mean duration of AN was 8.8 years (range 1–25 years), and mean time in treatment was 5.1 years (range 0.50–14 years). One informant was unable to report her lowest BMI. The sample size was defined by criteria of data saturation according to Strauss and Corbin (2008): new informants were included until three subsequent interviews had been conducted without essential, new information being added. When 36 informants were interviewed, the criteria of data saturation were fulfilled.

Design

A phenomenological, descriptive, qualitative study design (Moustakas, 1994) with elements of grounded theory was employed (Strauss & Corbin, 2008). Because the aim was to identify the patients' subjective experiences, we based the design on a 'patient as expert' perspective, which means that the patients were considered as experts on their own experiences. The study is part of a larger research project on patients' experiences of living with and being treated for AN (Nordbø et al., 2006, 2008; Espeset, Nordbø, Gulliksen, Skarderud, Geller, & Holte (In press)). Data were collected in two steps. Step 1 consisted of a comprehensive and wide-angled exploratory study on a sample of 18 AN patients. The purpose of step 1 was to explore a range of experiences that patients may have living with AN and to determine topics for more thorough investigation. In step 2, we addressed a selection of themes that had been identified in step 1 in greater depth. One theme was what motivated their wish to recover. Step 2 built upon the experiences that were identified in step 1 and was conducted on a new sample of 18 AN patients. The aim of step 2 was restricted to collecting detailed, in-depth descriptions of the feelings and reasoning underlying AN patients' wishes to recover or to not recover.

Setting and procedure

Informants were told about the study by their therapist or by one of the first three authors. They were provided with written information about the study, which included a description of the purpose and procedure. Each interview was voluntary and lasted between 90 and 120 minutes. The interviews were tape recorded and transcribed verbatim.

Data collection was conducted by means of the 'experience interview' (Holte, 2000), which is a semi-open, informant-centred, strategic conversation format that is derived from communication theory (Littlejohn, 1999). The interview strategy in steps 1 and 2 diverge. In step 1, an open interview strategy was used. An interview guide was used as a framework, and motivation to recover was one of several themes explored. The findings from the step 1 interviews were used to plan and construct the step 2 interviews. A focused interview strategy for

step 2 was used. The interview guide in step 2 provided more detailed prompts and probes to stimulate reflection specifically and exclusively on themes associated with motivation to recover. In both steps 1 and 2, the interview guide worked as a checklist of issues rather than as a list of questions that mechanically structured the course of the interview. For further details of the interview procedure, see Nordbø et al. (2006, 2008).

Data analysis

The verbatim transcribed interviews were analysed using the software program QSR-NVIVO7 (QSR International, Melbourne, Australia; Fraser, 1999). Each of the 35 texts was explored using an open thematic coding according to the 'bottom–up principle' (Strauss & Corbin, 2008). In this process, each full text was divided into excerpts according to its essence of meaning, which was coded, labelled and entered into the database according to semantic and contextual analysis. For example, a larger text excerpt (e.g. '. . . [text omitted]. . . But then as I am sitting down to eat, all motivation disappears. . . [text omitted]. . .') was divided into its essence of meaning (e.g. 'eating lessens my wish to recover'), coded and then labelled under a content construct (e.g. 'eating'). All content constructs that were not linked to a wish to recover were excluded. Following semantic analysis, each content construct was given a tentative definition with reference to the essence of meaning for all relevant original text excerpts and was tested for coherence and contrasts.

All constructs were validated against the original text using confirmatory and selective coding and following the 'top-down principle' (Strauss & Corbin, 2008). In this process, each content construct (e.g. 'eating') 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 overlaps between constructs and to determine whether further refinements were needed (e.g. more precise conceptualization and elaboration). For example, the applicability of the potential construct 'eating' that referred to the informants' opinion that eating interfered with their wish to recover was checked by systematically re-analysing and recoding all the text excerpts that contained descriptions of eating as a barrier for wishing to recover. The coding was supervised by the last author. Disagreements were solved by discussion and consensus.

Results

All the informants said that they had wished to recover from their AN. In most cases, this wish had fluctuated in intensity, from no wish at all to a strong wish. The wish to recover also varied in duration; some had only experienced it as a short glimpse or glimpses, whereas others had had long periods with a constant wish to be free of living with AN. All but two of the informants could attribute decreases in their wishes to recover to one or several specific preceding conditions.

By condensing 265 text excerpts that contain a description of an event, situation, state or process that the informants identified as decreasing their wish to recover, we were able to identify 23 subconstructs representing sources that deflate the informants' wish to recover. These 23 subconstructs were sorted further into seven logical, relatively independent, higher-order constructs. Because the purpose of this study was to explore the patients' own perception of what could interfere with their wish to recover (not to test preconceived concepts), the seven constructs are based on a bottom–up analysis, reflecting patients' own descriptions and representing variations in content in terms of events, situations, states or process.

The following are the seven constructs: (i) 'perceiving judgements'; (ii) 'feeling stuck'; (iii) 'feeling distressed'; (iv) 'denying AN'; (v) 'eating'; (vi) 'gaining weight'; and (vii) 'appreciating the benefits'. For transparency reasons, we report in parentheses both the number of text excerpts upon which each construct was based and the number of informants whose interviews led to the inference of a given construct. Because each interview was tailored interactively to the individual informant and constructs were not predefined, the numbers should neither be used to indicate distribution of the constructs in the sample or population nor be confused with the validity of the construct.

In the text describing the single constructs, each sentence refers to one or several experiences reported by the informants. The informants' wording has been used whenever possible. Each construct has been illustrated by excerpts from the interviews. Because of space constraints, the extracts have been edited, yet not in a way that interferes with the individual's style of phrasing or emotional colouring. Information that might possibly reveal the informant's identity has been removed.

Perceiving judgements ($n = 14$, text excerpts = 21)

'Perceiving judgements' refers to a diminished wish to recover when AN patients are exposed to other people's expressed or unexpressed opinions about them. Many of the informants described themselves as extremely sensitive to other people's opinion about them. Meeting others could be associated with certain tension. People's utterances about the informants' appearance or weight could significantly affect the informants' wish to lose more weight. The term 'other people' refers to partners, friends, family members, therapists, doctors or others whose opinion the informants value. The expression of relief by these people if the informant gained weight could evoke fear of losing other people's concern and thereby reduce the wish to recover. Also, the absence of people's opinions could trigger decreases in such a wish. For instance, a therapist or parent who did not express worry about the informant's body weight could make the informant conclude that she had gained weight. Facial expressions, body language and behaviours could be over-analysed and misinterpreted leading to the AN patient believing that others thought that she had gained weight. In this way, the informants receive 'proof' of their fear of being 'too big' and had a reason to keep losing weight.

Irene: Family and friends, they don't need to say anything, it could be that they react or I feel they react. . . If I haven't seen them in months and I know I've lost weight, I thoroughly analyse their expressions and check out what they are looking at. Sometimes I think, 'Uh-oh, because they don't say anything, maybe they think I'm too big?'

Other people's expectations of future plans for the informant could also decrease their wish to recover. This included

descriptions of what the informants believed others wanted for them such as completing studies, getting a good job or beginning a family. Experiencing friends and family wanting these things for the informants could evoke fear of failure.

Hilda: I'm sick and tired of hearing, 'Hilda, you need to recover quickly, you have such a potential! Think of everything you can do and everything you can become.' And I feel like shit. I'm not good at anything, except starving myself. I think there are so many expectations or pressure. If I recover, everything I'm to become, help! It is almost as: Do I dare to recover?

Feeling stuck (*n* = 29, text excerpts = 68)

'Feeling stuck' refers to an experience where recovering from AN seems impossible and where the feeling of hopelessness drains the wish to recover. Several of the informants expressed disillusion as they described their wish to recover. They did not know how they could change. Life without AN felt distant; it was difficult for them to believe that a healthy life was possible. The only way that they could imagine being without AN was if a miracle, or some sort of spontaneous change in which they were suddenly, inexplicably healthy, occurred. Some of the informants had had AN for many years. A few of them described a growing despair that increased along the course of AN.

Irene: I have had this for such a long time. For so many years, it's not easy to keep up one's spirit. The years blend into each other and each year becomes worse than the one before it—at least not better. I'm just getting older, and everything is just the same. So if I think about it, I feel powerless, because I don't feel there is anything I can do. I can't understand what I could do to become better.

Other informants had little faith that recovery was possible regardless of the duration of AN. Thoughts about food, body and exercise were so dominant that a life without it seemed like utopia. They did not have an alternative way of living their lives or different strategies for handling difficult feelings. The lack of other types of goals or meaningful goals in life made them feel indifferent, hopeless and powerless.

Heidi: To have something to live for has been actualized now in this period as I try to change and recover. Because, what am I going to live for then? That has been very difficult and that's why I haven't managed to give up my eating disorder.

Being distressed (*n* = 20, text excerpts = 47)

'Being distressed' refers to a decreased wish to recover when experiencing a state of sadness, uneasiness and misery regardless of what triggered it. The informants spoke about depression, anxiousness and anger. Such a condition could be a persistent or recurrent emotional state. In some cases, the feelings could be linked to specific occurrences such as experiencing failure, not meeting one's own expectations, moving to a new place, ending a relationship or losing a person close to them. In addition, informants who had experienced sexual abuse or sexual abuse attempts associated these experiences with emotional distress and a lowered wish to recover. Some informants spoke about aching feelings that were not specifically linked to an event. Even where the informant could point to different negative incidents in their life or in a period of their life, the overwhelming experience in these cases seemed not to be the antecedent event but the misery that ensued.

Interviewer: . . . so your motivation weakened?

Vivian: Yeah. And then it just continued. My living condition was difficult, I was on sick leave, I felt bad, my boyfriend and I broke up. . . small things or big things, I'm not sure what to call it. . . but it made it impossible for me to keep my motivation up or want to recover. The feeling that everything is so horrible that I could just as well bury myself in the eating disorder. Just wanting to resign from the world and. . . being alone with the food.

Moreover, many of the informants did not know why they felt depressed, anxious or angry. However, the state in itself was associated with a decreased wish to recover. Often, the informants said 'Then I had a bad day', 'I felt sad for no reason' or 'then I was just in a bad mood'. Many also described loneliness, which for some occurred whether they were with other people or not.

Mette: If I have a bad day, my mood is bad. First I feel more and more disgusting, everything around me becomes more and more of a drag. . . usually it ends up with me getting a fit of rage. I hide under the duvet and want to be away from everything. Of course it's difficult to imagine that I will recover when I'm having one of those bad days because then everything is just horrible.

Denying AN (*n* = 14, text excerpts = 29)

'Denying AN' refers to not acknowledging the presence of AN and therefore not seeing that there is anything to recover from. Some of the informants were convinced that they did not have AN. They did not feel sick or did not experience themselves as having an eating disorder. Instead, they said that they felt better than at any other time in their life. They denied the fact that they fulfilled the criteria for AN. In the interview, severely underweight informants questioned that they were informants because they believed that they did not fulfil the criteria for AN. These informants did not want to recover from AN. For many of the informants, a state of denial had characterized the first phases in the course of AN. In this phase, they did not want to or were unable to admit that they were unhealthily preoccupied with food, body and weight.

Pauline: To begin with I didn't really realize that I was ill. So the wish to recover. . . I didn't really have any.

Although the desire to keep losing weight was not defined as a difficulty, some informants acknowledged other problems, such

as feeling depressed, abusing laxatives or having general 'eating troubles'.

Rita: When I started treatment here, it wasn't an eating disorder, it wasn't anorexia, it was a 'tablet problem'—laxative tablets. I wanted to get rid of this, without putting on weight. I remember meeting the other girls here, one thinner than the other, and I thought, 'Poor people!' And then it appeared to be me who was the one who was most sick. . . I don't think it was until that episode when I collapsed that I knew, 'I'm an anorectic, I'm sick, and I need help'.

Eating (*n* = 14, text excerpts =25)

'Eating' refers to reduction in the wish to recover while relating to food. There were two prominent events that the informants highlighted as triggering a diminished wish to recover. One of these involved eating. Unlike 'feeling distressed', in which distress deflated the wish to recover independent of what triggered it, eating was a specific trigger that deflated the wish to recover. According to some informants, specific situations where they had to deal with food could in itself interfere with the wish to recover. They could wish to recover, but as soon as they were about to eat, the wish to recover disappeared. The informants expressed difficulties in understanding why they reacted this way and found it frustrating. Merely thinking about food (such as what to eat and when to eat), unexpectedly being exposed to food, eating or having eaten seemed to deflate their wish to recover.

Interviewer: Do you ever have any kind of wish to recover?

Susan: Yeah, I do. But it just disappears so quickly. Half an hour before a meal I could think, 'Susan, you're gonna make this'. But then as I am sitting down to eat all motivation disappears.

Other informants explained why they found it difficult to relate to food. It could make them miserable because they saw it as a failed attempt to lose weight. Relating to food could also make them become focused on themselves, which they wanted to avoid. They feared becoming obsessed or being perceived as a greedy person. Another reason was that they felt that they did not deserve food. Some said that having food in their stomach could make them feel restless and vulnerable.

Heidi: I don't want to live like this for the rest of my life. But something happens when I eat. It feels as my thighs immediately expand. I know it isn't possible but. . .

Interviewer: But that is how you feel.

Heidi: Yeah, physically. It is difficult. I feel rotten. . . and become very restless. Others have noted that my legs actually are shaking, something I wasn't aware of myself.

Gaining weight (*n* = 16, text excerpts = 28)

'Gaining weight' refers to a diminished wish to recover following weight gain. The informants found it very difficult to put on weight. When they realized that they had gained weight, by means of a scale or clothes that had become too small, their wish to recover was lessened. Like relating to food, gaining weight seemed to be a specific trigger that in itself lessened the wish to recover. As with relating to food, many informants could not explain how gaining weight diminished their wish to recover. Gaining weight seemed in itself to be so devastating that they talked about it distinctively as a separate barrier for wishing to recover.

Tina: I haven't managed to let AN go. I haven't dared to put on weight because I'm afraid to lose control of the weight gain. That's what's difficult. Regardless if I'm 35 kilos, 38 kilos, or 32 kilos, to gain one kilo has been equally difficult.

Other informants described what weight gain made them feel; they became overwhelmed by emotions and felt 'ugly', 'disgusting', 'fat' or 'ghastly'. Typically, the descriptions were bodily such as 'Gaining weight makes me feel sick', and they illustrated this in the interview by means of facial expressions and gestures that expressed aversion. For some informants, such feelings could be so overwhelming that they became preoccupied with washing themselves. They could feel 'filthy' and 'dirty'.

Mette: I am afraid of putting on weight. I am afraid of what I have experienced earlier as I gained weight—how disgusting and awful I felt. It is almost like I get sick of myself and can't get away from myself. It feels terrible.

Appreciating the benefits (*n* = 27, text excerpts = 47)

'Appreciating the benefits' refers to a decreased wish to recover as the positive sides of living with AN are given more importance than the negative ones. Having AN could evoke positive feelings such as the feeling of security or the feeling that there is meaning and purpose in life. Being extremely undernourished could make them feel 'high' or like they were new, better, successful people. They felt the benefit of the support and care that they received from family, friends, therapists and others. If they failed in other areas of life, such as in school or relationships, AN was a protected area in which they succeeded. Recovery would mean losing these benefits of AN.

Ann: I feel this diagnosis is a sort of net beneath me. If I fail or make a fool of myself, it catches me, the anorexia catches me. So if anything goes wrong I could use the anorexia to show that I'm good at something, that I manage something, or have control. So I'm afraid to completely recover because then I won't have any safety net.

The informants also talked about the negative consequences of AN, in that the presence of the positive sides exceeded the negative sides. Some of them described experiences of the

beneficial consequences through the whole course of AN. Other informants only had such experiences early in the course of AN.

Grete: Now I could blame the anorexia. I would lose having something to blame. I don't know. . . I believe I'm gaining more then I'm losing.

Discussion

In this study, we aimed to discover what makes AN patients not wish to recover from their illness. We approached this by regarding the patients as experts and interviewing them extensively about their reluctance to recover. Seven core obstacles were identified that decrease the AN patients' wish to recover: 'perceiving judgements'—when they are exposed to other people's expressed or unexpressed opinions about them; 'feeling stuck'—when recovery from AN seems impossible and hopelessness takes over; 'being distressed'—when they are in a state of sadness, uneasiness and misery, regardless of what triggered it; 'denying AN'—when they do not acknowledge they have AN and, hence, they feel there is nothing to recover from; 'eating'—when they think about food such as what to eat and when to eat, are unexpectedly exposed to food or have eaten; 'gaining weight'—when they realize an increase in their body weight (e.g. when weighing themselves on a scale or when they begin to outgrow their clothes); and 'appreciating the benefits'—when the positive aspects of living with AN outweigh the negative aspects.

These findings contribute to the literature on AN patients' motivation in several ways. First, existing evidence emphasizes that in order to be successful, treatment of AN requires that the patient wants to change her or his anorectic behaviour (Geller & Drab, 1999; Geller, Cockell, & Drab, 2001; Geller, Zaitsoff, & Srikameswaran, 2005). It is therefore suggested that clinicians assess the readiness of the patient to change (i.e. 'How motivated is the patient?'). The TMC (Prochaska, 1994; Prochaska et al., 2002) provides a theoretical model for such assessment (Geller & Drab, 1999; Geller et al., 2001; Rieger et al., 2000). Other evidence emphasize the need to question the quality of the patient's motivation to change (i.e. 'How is the patient motivated?') (Vansteenkiste et al., 2005). The SDT (Deci & Ryan, 1985, 2000) provides a theoretical model for such assessment by addressing, among other things, whether the patient's wish to recover is autonomously driven or driven by more external sources (Vandereycken & Vansteenkiste, 2009; Vansteenkiste et al., 2005). Our approach supplements this by suggesting that the clinicians also explore the thematic reasons that attract and detract patients to recover (i.e. 'What is the source of motivation for the patient?'). Recently, we categorized four sources that attract AN patients to wish to recover: when they experience a sense of vitality, a sense of autonomy, a sense of insight or certain negative consequences of having AN (Nordbø et al., 2006). The current study completes this by providing knowledge about what detracts AN patients from wishing to recover.

Second, 'motivation to change' is a frequently used concept to capture the AN patient's readiness for change (Vansteenkiste et al., 2005). As laid out in the TMC, such readiness may vary from not thinking about change ('precontemplation'), intending to change but being ambivalent (contemplation), planning to change but not knowing how (preparation), making change (action) and sustaining the change (maintenance) (Prochaska, 1994; Prochaska et al., 2002). Fundamental to this development, however, is that each individual has a potential for a wish to recover. As noted, motivational theorists have called for a clearer conceptualization of motivation and emphasized the importance of distinguishing between the concepts of motivation and desires or wishes (Drieschner et al., 2004). Our approach supplements the studies on motivation to change (Cockell et al., 2002; Geller & Drab, 1999; Vansteenkiste et al., 2005) by addressing what influences the patients' wish to recover, regardless of whether they intend to act on their wish or not.

Third, the idea that AN patients tend to appreciate their symptoms in spite of the seriousness of their condition is supported by several researchers (Cockell et al., 2002; Geller & Drab, 1999; Nordbø et al., 2006; Rieger et al., 2000; Williams & Reid, 2009). This tendency has been suggested to explain the AN patients' use of pro-anorexic websites as well as treatment relapse and dropout (Williams & Reid, 2009). By working as an internal rather than a social reinforcer, it is hypothesized that the positive value of the AN symptoms constitutes a significant contribution to the maintenance of AN (Garner & Bemis, 1982; Vitousek et al., 1998). The current study adds to this by establishing a direct subjective link between AN patients' positive experiences of their symptoms, as described in previous studies, and the patients' reluctance to recover. This is consistent with the idea that the core obstacles that we have identified in this study may work as mechanisms that contribute to maintain AN. However, further research is needed to test this hypothesis.

Fourth, this study points out that reluctance to recover is not restricted to the perceived benefits of the disorder, as previous studies might indicate (Nordbø et al., 2006; Vitousek et al., 1998). The reluctance to recover may also be fuelled by the negative sides of the disorder such as continuous dependency on other people's judgements and vulnerability to various kinds of food exposure, eating and gaining weight. These may instil hopelessness and resignation in AN patients, which in turn weaken their wish to recover. In older patients with a long AN career, such negative experiences may even be more important demotivators than the values that make the illness attractive.

A patient's wish or lack of wish to recover may play a crucial role in the recovery dynamics because it is internally based and autonomously driven (cf. SDT) (Vandereycken & Vansteenkiste, 2009; Vansteenkiste et al., 2005). Threats to this wish may therefore be regarded as threats to the recovery process. For instance, Darcy et al. (2010) found that a lack of a sense of volition in engaging in treatment was related to poor motivation among former AN patients. Indeed, several studies have indicated that the patients' motivation to change is an important factor in the process of recovery (Espíndola & Blay, 2009; Federici & Kaplan, 2008; Geller, 2002; Keski-Rahkonen & Tozzi, 2005; Tierney, 2008).

In order to fully understand the recovery processes in AN, however, we need to apply multiple sources of knowledge. This also includes studies on the psychosocial functions of the

symptoms, the individual's social context and the factors that influence treatment decisions, relapse and dropout (e.g. Cockell et al., 2004; Darcy et al., 2010; Garrett, 1997; Serpell et al., 1999; Tozzi et al., 2003; Vandereycken & Devidt, 2010; Vanderlinden et al., 2007). Among the factors found to play a significant role in the dynamics of recovery are improved self-esteem, improved body experiences, development of new identity, spirituality, community involvement, recovery as a work in progress, treatment experiences, supportive relationships, tolerance of negative emotions and own family (Federici & Kaplan, 2008; Garrett, 1997; Keski-Rahkonen & Tozzi, 2005; Matusek & Knudson, 2009; Nilsson & Hägglöf, 2006; Vanderlinden et al., 2007). A recent review of the patients' perception of important factors in the treatment of AN also include factors that seem to limit recovery (Espíndola & Blay, 2009). Among these are fear of change, ambivalence, lack of social support, professional rigidity, media influence and lack of motivation. This indicates that to recover from AN is a complex process in which the wish to recover is only one of a larger set of factors. A research challenge that follows from this is to find out what specific impact patients' wish or not wish to recover has, relative to all the other factors, on the overall dynamics of recovery from AN.

This study has several clinical implications. Establishing a therapeutic alliance with patients who feel they benefit from their AN symptoms is extremely challenging (Skårderud, 2007; Vitousek et al., 1998). Although AN may be associated with positive functions such as mental strength, self-confidence and identity (Nordbø et al., 2006; Vitousek et al., 1998), these difficulties can appear in the very beginning of the treatment. This is indicated by the current research where we found that some patients denied having AN and therefore meant that they had nothing to recover from. Lack of internal motivation to recover may lead to premature termination of the treatment or to patients being in treatment for other reasons than to recover from AN, for example, to please own family or partner (Vandereycken & Vansteenkiste, 2009; Vitousek et al., 1998). An additional reason for an AN patient to be in treatment may be to address anxiety or loneliness—not to terminate their weight-reducing behaviour (cf. 'appreciating the benefits'). Furthermore, therapeutic exploration of the individual sources of motivation or lack of motivation may be particularly challenging because AN patients may have difficulties in verbalizing emotions (cf. alexithymia) (Taylor, Bagby, & Parker, 1997). Even though the interviews in this study were conducted in a highly facilitating atmosphere, some of the informants could give only meagre descriptions of their feelings. When exploring patients' wishes, clinicians must therefore take into account possible difficulties in verbal emotional expression.

By providing several specific thematic reasons for not wishing to recover from AN, these findings may help clinicians identify their patients' reasons for avoiding treatment, dropping out, relapsing and poor treatment outcome. For example, as found in this study, some patients seem to experience a direct link between 'eating' and 'gaining weight', respectively, and a deflation of their wish to recover. When this is the case, motivational work focusing on these issues will likely be of great benefit. In contrast, a patient whose mood is contributing to her wish to recover will benefit from treatment focusing on relieving affective difficulties. By exploring not only the patients' level of motivation for change but also the factors that contribute to the patients' wish to recover, the clinician may ensure that the treatment does not turn into a 'pseudotreatment' in which the patients comply with treatment primarily to please important others (Vandereycken & Vansteenkiste, 2009; Vitousek et al., 1998).

Further research may utilize qualitative statements from this study, our former study (Nordbø et al., 2008) and similar studies on what attracts and detracts patients from wishing to recover to develop a formal assessment tool. Such a questionnaire might help pinpoint a patient's wish to recover or lack thereof and work as a supplement to existing assessment tools of patients' motivation to change (Cockell et al., 2002; Geller & Drab, 1999; Rieger, Touyz, & Beumont, 2002; Serpell et al., 2004). Such a procedure could also work as a quantitative validation of the constructs arrived at in this qualitative study. However, development of an assessment tool should never be regarded as a substitute for treating the patients individually or replace the need for an individual exploration in each single patient.

There are limitations to this study. Further research is needed to determine how subdiagnoses of AN and co-morbidity with other disorders may influence the results. In addition, our sample was restricted to young, ethnically Norwegian women. Therefore, the generalizability to other samples is unknown. Although our two-phase design, utilizing two separate samples, may strengthen the validity of this study, it does not rule out the need for additional quantitative verification of the seven content constructs. To ensure that the informants had sufficient experience to reflect on the study questions, we oversampled patients with relatively long careers of AN. This may limit the generalizability of the conclusions to younger women in a more acute phase of AN. The informants were recruited from diverse treatment institutions and had experienced therapists from a variety of theoretical orientations. Yet, we cannot rule out that therapy may have influenced their use of language, descriptions of experiences and interpretation of interview questions. The coding was supervised closely by the last author. This does not exclude that authors' bias may have influenced the data analysis (e.g. skewed coding of the informants' barriers to recovery). Despite these limitations, the design used in this study ensures a certain degree of authenticity of the identified barriers regarding wishes to recover.

Acknowledgements

This research is in collaboration with Modum Bad Research Institute, to whom the authors are indebted for their contribution in preparing the project and practical arrangements of the data collection. The project is supported by a grant awarded by the Norwegian Foundation for Health and Rehabilitation through The Norwegian Council for Mental Health and by the Research Council of Norway. Additionally, we thank Dr Øyvind Rø for his comments on this article.

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