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Motivational versus Directive Interventions in the Treatment of Eating Disorders: Adolescents’ Perspectives

by

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Abstract

Few studies have examined readiness and motivation for change in adolescents with eating disorders, or the effectiveness of motivational interventions in this population. **Purpose:** To examine the perceptions of adolescents' with eating disorders toward written descriptions of motivational and directive interventions in relation to engagement in treatment, and how these perceptions relate to adolescents' own readiness and motivation for change. To explore factors that adolescents with eating disorders identify as important in influencing engagement in therapy. **Methods:** Thirty-nine female adolescents recruited from eating disorder programs participated in this research. Participants were interviewed using hypothetical vignettes depicting motivational and directive interventions, and the Readiness and Motivation Interview (Geller & Drab, 1999). Participants were also asked a number of open-ended questions to explore factors they feel would be related to engaging adolescents in treatment. **Results:** Adolescents reported that in comparison to the directive interventions they would be significantly more likely to trust, agree on goals for therapy, have confidence in their ability to change, feel included in decisions made about their treatment, and find the interventions more helpful with the therapists in the motivational vignettes. Less ambivalence around changing eating disorder symptoms was associated with less favorable ratings of the directive vignettes. Participants generated a number of factors that they felt would influence engagement in treatment. **Discussion:** Implications for practice with adolescents with eating disorders will be discussed.
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Chapter I

Introduction

Eating disorders are disabling illnesses primarily affecting women. These disorders drastically impair the quality of life of those inflicted and are often associated with cognitive impairment, medical complications and in some cases death (e.g., Fisher et al., 1995; Kinder, 1997; Ratnasuriya, Eisler, Szmuckler, & Russell, 1991). Despite these difficulties, women with eating disorders, particularly anorexia nervosa, are notoriously ambivalent towards change and resistant to treatment (Vitousek, Watson, & Wilson, 1998). As such, treatment refusal, drop out, and relapse are common phenomenon in eating disorders (e.g., Mahon, 2000; Pike, 1998). The ambivalence and resistance to treatment found in this population has been attributed to the egosyntonic nature of eating disorders symptoms (Vitousek et al., 1998). That is, individuals with eating disorders have reported that their symptoms have a valued function in their lives.

Recently, a treatment approach has been developed based on several of the principles of Motivational Interviewing (MI; Miller & Rollnick, 1991), and is referred to as Motivation Enhancement Therapy (MET). MET focuses on resolving individual’s ambivalence and increasing their motivation to change (Miller & Rollnick, 1991; Treasure & Ward, 1997). From the perspective of MET, strategies and techniques therapists adopt to help individuals recover from an eating disorder will not be effective without a strong working alliance (Geller, Williams, & Srikanth, 2001; Treasure & Ward, 1997). The stance of the MET therapist is considered central to developing an alliance with individuals with eating disorders. Specifically, therapists should express interest and curiosity in clients’ experiences, avoid making assumptions about clients’
thoughts or feelings, and maximize client responsibility for change (Geller, Williams, et al., 2001).

Although research suggests that MET may be efficacious for the treatment of adults with eating disorders (e.g., Feld, Woodside, Kaplan, Olmstead, & Carter, 2001; Geller, Hastings, Goodrich, Zaitsoff, & Srikameswaran, 2000; Treasure et al., 1999), the utility of MET with adolescents has not yet been examined. This is unfortunate as eating disorders typically develop during adolescence, and furthermore ambivalence may be particularly salient in this age group (Fisher, Schneider, Burns, Symons, & Mandel, 2001). It has been hypothesized that MET may be efficacious with adults with eating disorders because it reduces resistance, foster the development of a strong therapeutic alliance, and enhances clients' confidence in their ability to change and their responsibility for change (Geller, Williams, et al., 2001).

It is not known whether adolescents with eating disorders will align with therapists who adopt a motivational approach, and the extent to which this approach will influence adolescents' confidence in their ability to change and enhance their feelings of control regarding change. Therefore, it is necessary to examine adolescents' perceptions of these variables in relation to MET and other more commonly encountered directive treatment interventions. However, before this treatment model can be implemented with adolescents, a better understanding is needed of how adolescents with eating disorders think about their readiness and motivation to change, and perceive treatment approaches that incorporate the principles of MET.

As such, there are three purposes to the proposed research. Using an analogue design, the first purpose of this study is to examine differences between adolescents' with
eating disorders perceptions of interventions that involve a motivational approach or a directive approach in relation to alliance, feelings about change, and overall treatment effectiveness. The second purpose of this research is to examine whether adolescents’ own readiness and motivation for change is related to their perceptions of the vignettes depicting motivational and directive therapeutic interventions. The third purpose of this research, using open-ended questions, is to explore what adolescents’ perceive to be important aspects of interventions that impact their ability to develop an alliance with their therapist, have confidence in their ability to change, and contribute to the overall effectiveness of interventions.

**Eating Disorders in Adolescents**

Eating disorders categorized in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000) include Anorexia Nervosa (AN), Bulimia Nervosa (BN), and Eating Disorder Not Otherwise Specified (EDNOS). The primary characteristics of AN include restricted eating, severe weight loss, an intense fear of gaining weight, feelings of self-worth based on shape and weight, and amenorrhea (American Psychiatric Association, 2000). Individuals with BN also base their self-esteem on shape and weight however they are not necessarily underweight. BN is characterized by frequent binge eating followed by the use of compensatory behaviors such as restricting dietary intake, vomiting, over exercising or abusing laxatives (American Psychiatric Association, 2000). Individuals with EDNOS display severe eating pathology, however they do not meet the full diagnostic criteria for AN or BN (American Psychiatric Association, 2000). It has been suggested that children and adolescents with eating disorders may have a slightly different clinical presentation than
adults with eating disorders. For instance, in one study, compared to adults, adolescents presenting for treatment at an eating disorders clinic were more likely to receive a diagnosis of EDNOS than AN or BN (Fisher et al., 2001). However, adolescents with EDNOS or subclinical eating disorders have been shown to report similar levels of psychological distress as those adolescents who meet the diagnostic criteria for AN or BN (Bunnell et al., 1990). Given these findings, participants in the proposed study will include individuals with a diagnosis of AN, BN, or EDNOS.

Although it is believed that there are a number of different developmental pathways that may contribute to the onset of disordered eating (Bulik, 2002), it is rare to see eating disorders in children and woman over 40 (American Psychiatric Association, 2000). With respect to BN, the average age of onset is between late adolescence and early adulthood, typically before age 25 (Woodside, & Garfinkel, 1992). For AN the average age of onset is 17 years, however, this mean may actually mask bimodal peaks at 14 and 18 years (American Psychiatric Association, 2000; Thelen, Lawrence, & Powell, 1992). Furthermore, prepubescent children are even less likely to exhibit symptoms of BN than AN (Lask & Bryant-Waugh, 1993; Woodside & Garfinkel, 1992). Therefore, based on the average age of onset, it seems that the transitions from childhood to early adolescence and late adolescence to early adulthood, may represent periods of risk for the development of eating disorders (Bulik, 2002).

Given that eating disorders typically have their onset during adolescence, treatment approaches that match adolescents' stage of development are important if care providers wish to intervene at the onset of the disorders (e.g., Smolak & Levine, 1996; Vohs et al., 1999). Unfortunately, few treatment approaches have been developed
specifically to meet the needs of adolescents, with the notable exception of family therapy (le Grange, 1999).

Typically therapies developed for use with adults are slightly modified and assumed to be suitable for use with adolescents (Gore, Vander Wal, & Thelen, 2001). Moreover, there are only a few randomized control trials examining the efficacy of treatments for adults with eating disorders (Gore et al., 2001; Pike, 1998), and the majority of these studies have focused almost exclusively on the efficacy of Cognitive Behavioral Therapy or Interpersonal Therapy for adults with BN (Gore et al., 2001). Furthermore, the treatment studies that have been conducted estimate that although approximately 30% of individuals receiving treatment for an eating disorder fully recover and 30% partially recover, an additional 30% exhibit no marked improvement at follow-up (e.g., Pike, 1998; Strober, Freeman, & Morrell, 1997). Thus, there are a limited number of studies examining the efficacy of treatment for adults with eating disorders and the results of these studies suggest that at least one third of clients who remain in treatment do not recover. The outcome of individuals with eating disorders who either do not present for treatment, or who drop out of treatment is not known, however, it has been suggested that there is a high probability that these individuals may suffer from chronic eating disorders (Geller, Williams, et al., 2001).

The high rates of resistance to treatment, attrition, and relapse in the eating disorders have been attributed, in part, to the lack of understanding of the ambivalence towards change that these individuals experience, and the disregard for these issues in current treatments (e.g., Geller, Williams, et al., 2001; Vitousek et al., 1998). As such, research has focused on understanding the perceived costs and benefits associated with
having an eating disorder, assessing individuals' readiness and motivation to change, and finally developing and examining treatment approaches that include resolving individuals ambivalence as a necessary component of treatment.

Perceived Costs and Benefits of Eating Disorders

In order to understand the ambivalence associated with change in individuals with eating disorders, and treatment non-responsiveness in this population, the function that eating disorder symptoms may have in the lives of those with the disorders have been examined (Cockell, Geller, & Linden, 2002-a; Serpell, Treasure, Teasdale, & Sullivan, 1999). In one study, individuals with AN were asked to write two letters, one to anorexia their friend and one to anorexia their enemy (Serpell et al., 1999). The themes that emerged from the analysis of these letters reflected the mixed feelings which individuals with AN have about their symptoms. That is, although a number of themes emerged reflecting the negative aspects of the disorder (i.e., costs), a number of other themes emerged reflecting the positive functions of the disorder (i.e., benefits). Specifically, examples of perceived costs of the disorder included, constant thoughts about food, feeling taken over, health concerns, and damage done to personal relationships (Serpell et al., 1999). For instance, to illustrate how AN makes her feel taken over one participant wrote, “there are times when I think you’ve engulfed me and when people look at my body, they don’t see me any more, only you” (Serpell et al., 1999, p. 181). In contrast, examples of perceived benefits of the disorder included feeling looked after or protected, gaining a sense of control, and feeling special (Serpell et al., 1999). To illustrate how AN makes her feel special, one participant wrote, “You make me feel special by making me different. You give me something that none of my friends or family have” (Serpell et al.,
1999, p. 180). Thus, the experience of having AN, and presumably other eating disorders, involves a complex experience of perceived benefits and costs (Serpell et al., 1999). Given that individuals perceive benefits associated with their disorder, it seems reasonable that they would be resistant to changing.

Using the themes that emerged from these letters a self-report questionnaire measure the Pros and Cons of Anorexia Nervosa scale (P-CAN; Serpell, 2000) was developed and validated for use with adolescents and adults with AN (Serpell, 2000; Serpell, Neiderman, Howarth, Emmanueli, & Lask, 2003). The complex experience of the costs and benefits associated with AN was further supported using the P-CAN. Specifically, in adolescents with AN, significant correlations were found between the pro and con sub-scales of the P-CAN as well as between the different pro and con sub-scales. This suggests that high scores on pro sub-scales are not simply associated with low scores on con sub-scales and vice versa (Serpell et al., 2003). Furthermore, adolescents and adults with AN had similar scores on the P-CAN suggesting that younger individuals also experience mixed feelings about their eating disorder symptoms (Serpell et al., 2003).

In addition to examining the Benefits (pros) and Burdens (cons) associated with AN, a second measure, the Decisional Balance (DB), incorporates a third factor namely functional avoidance (Cockell, Geller, & Linden, 2002). The functional avoidance factor reflects mechanisms through which AN provides a way to avoid dealing with aversive emotions, challenges, and responsibilities (Cockell et al., 2002). With respect to treatment, one study using the DB, found relationships between the complex experience of the perceived burdens and benefits of AN and readiness for change (Cockell, Geller, & Linden, 2003). That is, compared to individuals who were resistant to changing,
individuals who were thinking about making changes reported more disadvantages associated with AN (i.e., higher Burdens) and more insight regarding how AN provides a means to avoid (i.e., higher Functional Avoidance). Interestingly, the perceived Benefits of AN were not related to individuals' readiness and motivation for change. That is, even if an individual was actively engaged in recovery they did not report differing level of Benefits associated with AN in comparison to those who were resistant to change (Cockell et al., 2003). These findings suggest, therapeutic experiences focusing on understanding the mechanisms through which the eating disorder results in perceived costs and benefits might be helpful in treating individuals with eating disorders. Furthermore, developing alternative processes for gaining the same benefits (i.e., a sense of control) may be an important part of recovering from an eating disorder. This measure has not been used with adolescents, therefore how younger individuals conceptualize the benefits, burdens, and means of avoidance that the eating disorder might serve is not clear.

Assessing Readiness and Motivation for Change

Related to the pros and cons associated with symptoms, the Transtheoretical Model of Change (TMC) provides a framework for understanding change in treatment-resistant individuals (DiClemente & Prochaska, 1985; Prochaska, Velicer, DiClemente, & Fava, 1988). The TMC conceptualizes change as occurring through a series of stages including precontemplation, contemplation, preparation, action, and maintenance (Prochaska, DiClemente, & Norcross, 1992; Prochaska et al., 1992). Individuals in precontemplation do not view their behavior as a problem. For example, a woman with AN who is in precontemplation would not consider her low weight to be a problem, and
consequently would resist the suggestion to gain weight. Conversely, individuals in contemplation are seriously thinking about changing their symptoms, but have not committed to change (Prochaska et al., 1992). A client that is debating whether or not to enter a residential treatment program, but who has not yet committed to starting treatment, exemplifies an individual in contemplation. Individuals in preparation have committed to change and are working out strategies for changing (Prochaska et al., 1992). For example, a woman with BN that is in preparation may be trying to determine what would be helpful for her during times when she is at risk for bingeing. Individuals in action are actively working at changing their problem behavior (Prochaska et al., 1992). An individual with AN who is working at following a prescribed meal plan would be considered in ‘action’. Finally, in maintenance, significant changes have been made to minimize the problem behavior and individuals are working to maintain the changes made in order to avoid relapse (Prochaska et al., 1992). During maintenance, individuals with eating disorders may focus on maintaining changes made to their eating such as having three meals and two snacks each day. Recently, a number of measures have been developed to assess individuals with eating disorders readiness and motivation to change (Geller & Drab, 1999; Gusella, Butler, Nichols, & Bird, 2003; Jordon, Redding, Nicholas, Treasure, & Serpell, 2003; Rieger et al., 2000).

In the first, the Anorexia Nervosa Stages of Change Questionnaire (ANSOCQ) was developed to assess the stage of change of individuals with AN (Rieger et al., 2000). The ANSOCQ assesses individuals’ stage of change across five dimensions: body shape and weight, eating behaviors, weight control strategies, emotional difficulties, problematic personality characteristics, social difficulties, and treatment issues.
Individuals are asked to select the stage of change that best describes their attitude or behavior for each of the five dimensions (Rieger et al., 2000). To assess the predictive validity of the ANSOCQ, 71 individuals diagnosed with AN enrolled in a lenient refeeding program completed the measure several times throughout their treatment (Rieger et al., 2000). ANSOCQ scores were related to participants’ weight gain during the first 4 weeks of treatment. Therefore, individual’s self-reported readiness and motivation to change appears to be an important predictor of symptom reduction.

Although the ANSOCQ was not validated specifically for use with adolescents with AN, younger participants were included in the study. Interestingly, for adolescents, but not adults, ANSOCQ scores were related to a measure of socially desirable responding (Rieger et al., 2000). A number of different possible explanations could account for this finding. First, compared to adults, adolescents may have been more concerned that their responses would not be kept confidential. For example, younger individuals who were not ready to change may have been concerned that their responses would be shared with their parents. Thus, they may not have felt free to answer openly and honestly. Furthermore, compared to adults, some adolescents may have been more concerned about others opinions of them, and therefore have felt more inclined to answer desirably (Manley & Leichner, 2003; Steinberg, 1996). Alternatively, the relationship between socially desirable responding and adolescents’ ANSOCQ scores could have been a spurious finding and therefore requires further investigation.

Several characteristics of the second measure developed to assess readiness for change in the eating disorders, the Readiness and Motivation Interview (RMI; Geller & Drab, 1999) might reduce the tendency for adolescents to give socially desirable
responses. The RMI is a semi-structured symptom specific interview assessing readiness for change in the eating disorders. Based on the principles of motivational interviewing, RMI assessors are trained to adopt an open, curious, nonjudgmental stance and to express interest in all aspect of individuals' thoughts and feelings about change including both the parts of individuals that do and do not want to change (Geller & Drab, 1999). Given the stance of the RMI assessors, adolescents may feel comfortable to respond openly and honestly, thereby minimizing the tendency to give socially desirable responses.

During the interview, participants explore their readiness and motivation to change each of the diagnostic symptoms of the Eating Disorders Examination (EDE; Cooper & Fairburn, 1987) that they are experiencing. That is, after symptom severity information is assessed using the EDE questions, individuals explore their readiness and motivation to change each particular symptom (e.g., fear of weight gain, restricting, etc.; Geller & Drab, 1999). More specifically, the RMI assesses the extent to which individuals are actively working at changing (action), seriously thinking about changing (contemplation), and not wanting to change (precontemplation) each of their eating disorder symptoms. Interviewees are asked to describe the percentage of themselves that is in each of the three stages such that the sum of the three stages totals 100% (Geller & Drab, 1999). In this way, individuals do not categorize themselves into a single stage of change, instead they describe a profile of readiness to change each symptom. It is not uncommon for individuals to describe a part of themselves as being in each stage. For example, a client may describe that 40% of herself has been actively working at eating more (action) while the other 60% has wanted to continue restricting (precontemplation). Symptom profiles are averaged across four symptom categories: cognitive, restriction,
binge, and compensatory strategies. Global scores assessing mean readiness scores across all of an individual’s eating disorder symptoms are also calculated (Geller & Drab, 1999). RMI restriction precontemplation scores have been shown to predict enrolment in symptom-reduction treatment, dropout from residential care, degree of symptom change in treatment, and relapse 6 months following program completion (Geller, Cockell, & Drab, 2001; Geller, Zaitsoff & Srikameswaran, 2001). Thus, individual’s readiness and motivation to change appears to have meaningful implications for the treatment of adults with eating disorders.

The RMI has not been validated for use with adolescents. Therefore, it is not clear how their responses on this interview would compare with adults reports. However, the stance of the assessor (i.e., understanding, non-judgmental, and curious) might be particularly conducive to working with adolescents as it may reduce their tendency to give socially desirable answers. Furthermore, in contrast to the questionnaire format of the ANSOCQ, the semi-structured nature of the interview enables the assessor to answer any questions adolescents may have about the meaning of specific questions, and discuss and help adolescents clarify their feelings about change during the interview. Therefore, in the proposed study the RMI will be used to assess adolescents’ readiness and motivation to change.

Overall, research has shown that adults and adolescents with eating disorders are attached to their symptoms and view these symptoms as fulfilling a number of functions. Furthermore, adults with eating disorders are typically ambivalent about change. Therefore, it seems reasonable to apply therapeutic strategies with adults with eating disorders that focus on understanding and resolving this ambivalence. Although limited
research has examined ambivalence in adolescents with eating disorders it suggests that therapeutic strategies that focus on resolving ambivalence might also be helpful with this population. However, before these approaches should be incorporated into treatment programs, further research is needed to clarify how adolescents conceptualize change, and perceive therapeutic strategies that incorporate a motivational approach.

Motivational Enhancement Therapy

It has been suggested that a number of implicit assumptions underlie traditional psychological practice, and that these assumptions contribute to the treatment resistance in eating disorder populations. Firstly, there is often the assumption that clients presenting for treatment understand that they have a problem, are distressed, and have a wish to resolve this problem. Secondly, it is often assumed that it is the role of the care provider to give information or practical help that will lead to the resolution. However, the first set of assumptions is rarely accurate in work with individuals with eating disorders, where it is common for individuals to be referred for treatment against their wishes by concerned family members or friends. This disparity between the wishes and beliefs of clients, those making the referral, and care providers has been implicated as one of the causes of the strong resistance to treatment found in this population (Treasure & Schmidt, 2001).

One therapeutic approach that was specifically developed for work with ambivalent, treatment resistant populations is Motivational Interviewing (MI). Specifically, MI is an intervention that was developed to help individuals resolve their ambivalence and reach a decision to change (Miller & Rollnick, 1991). Fundamental to this approach is the belief that lasting change is unlikely to occur until individuals can
resolve their ambivalence (Miller & Rollnick, 1991). A large body of research has supports the utility of MI in other difficult to engage populations such as alcohol and drug users (e.g., Bien, Miller, & Tonigan, 1993; Miller, Benefield, & Tonigan, 1993). For instance, a review of two dozen randomized trials reported that in comparison to waiting list controls, problem drinkers receiving brief motivational interventions had better outcomes, and, in fact, had a comparable outcome to problem drinkers who received more extensive interventions (Bien et al., 1993). Recently, the principles of MI have been incorporated into therapies for the treatment of eating disorders (Geller, Williams, et al., 2001; Killick & Allen, 1997; Tantillo, Nappa Bitter, & Adams, 2001; Treasure & Ward, 1997; Vitousek et al., 1998). In the area of eating disorders, therapy based on the principles of MI is typically referred to as Motivational Enhancement Therapy (MET).

Fundamental to MET is the belief that ambivalence is an expected and understandable experience for individuals thinking about behavior change (Miller & Rollnick, 1991; Killick & Allen, 1997; Vitousek et al., 1998). That is, clients will likely be able to see both good and bad things about their current behaviors and the idea of changing them. Furthermore, motivation is not believed to reside within an individual but instead is conceptualized as resulting from an interpersonal process, which in the context of therapy, resides between the therapist and the client (Miller & Rollnick, 1991). As such, a strong therapeutic alliance is a necessary condition for resolving ambivalence, enhancing motivation, and facilitating change. Therefore, a strong care provider-client relationship is considered an essential and central characteristic of MET (Geller, Williams, et al., 2001).
One strategy for reducing resistance and building alliance involves avoiding what has been labeled the confrontation-denial trap (Miller & Rollnick, 1991). “In this trap, the counselor takes responsibility for the pro-change side of the client’s conflict, and the client is left to defend the status quo (Miller & Rollnick, 1991, p. 66).” For example, a therapist might try to convince a client that her low weight is a problem because it is jeopardizing her health, this leaves the client to deny that her weight is a problem and argue that obesity is actually a greater health risk. “By taking responsibility for the ‘problem-change’ side of the conflict, the therapist elicits oppositional ‘no-problem’ arguments from the client” (Miller & Rollnick, 1991, p. 66). Furthermore, if the person is ambivalent about the topic being discussed this reaction may be particularly strong (Miller, 1983). In order to avoid this type of interaction therapists need to avoid making the assumption that clients view their symptoms as a problem, and instead ask open ended questions and express curiosity regarding the client’s feelings about her symptoms or behaviors (Geller, Williams, et al., 2001).

Within eating disorders, therapists learning MET are trained to avoid making any assumptions about how the client is thinking or feeling, because assumptions are believed to impede the development of the therapeutic alliance with individuals with eating disorders (Geller, Williams, et al., 2001; Vitousek et al., 1998; Ward & Treasure, 1997). For example, according to this model therapists should not assume that an individual with AN who is losing her hair or experiencing chest pains will view these health complications as a reason to gain weight. Similarly, if an adolescent with AN does not appear engaged in therapy, a therapist should not assume that it is because she is resistant to gaining weight. Although research has shown that individuals with eating disorders
are both attached to and value their eating disordered symptoms, it has also been suggested that the motives and functions of the eating disorder symptoms differ across individuals (Vitousek et al., 1998). Vitousek et al. (1998) suggest that:

At every stage of treatment, therapists should be scrupulous in their avoidance of statements that sound omniscient or presumptuous (“All anorexics feel that way”, “Like other bulimics, I’ll bet you…”), and liberal in their use of phrases that emphasize individuality (“Everyone is different, I don’t know what it is like for you…”) (p. 401).

Instead of imposing their own thoughts and beliefs, therapists are trained to use reflective listening which involves clarifying and amplifying the client’s own experience and meaning (Miller & Rollnick, 1991).

Several reasons have been suggested to explain the potential negative impact of therapist assumptions on clients’ readiness for change. First, individuals with eating disorders have identified their symptoms as a means for feeling special and as giving themselves a sense of identity (Serpell et al., 1999). Therefore, if therapists make assumptions about clients’ thoughts and feelings, based on their experience working with other individuals with eating disorders, this could threaten clients’ sense of self and means of feeling special (Vitousek et al., 1998). Second, if therapists assume that clients should view their symptoms as problems that need to be changed, although the client does not actually feel this way, it can reinforce negative opinions that they already hold of themselves (Vitousek et al., 1998). That is, if clients perceive a discrepancy between their own feelings and their therapists’ wishes or opinions, this discrepancy can leave clients feeling poorly about themselves and confused as to why they do not view their
symptoms as a problem that should be changed. Third, when therapists voice their assumptions about client’s experiences, it may prevent both the client and clinician from discovering and understanding the personal underlying meaning of clients’ experiences (Miller & Rollnick, 1991; Geller, Williams, et al., 2001). Specifically, from a MET perspective, one of the therapists’ roles is to elicit self-motivational statements from the client. By supporting the client to generate these statements, her motivation to change will likely be more internally driven, enhancing their sense of control and commitment to change (Miller & Rollnick, 1991). Although these explanations for the negative impact of therapist assumptions on clients readiness for change, resistance to treatment, and the therapeutic alliance seem reasonable, clients perceptions of the impact of therapist assumptions on their motivation to change, engagement in treatment and the therapeutic alliance needs to be examined.

Motivational Enhancement Therapy in the Treatment of Eating Disorders

MET with Adults. Three studies were found that examined the efficacy of MET in the treatment of adults with eating disorders (Feld et al., 2001; Treasure et al., 1999). In the first, the efficacy of 4 sessions of MET was compared to that of 4 sessions of CBT for individuals with BN (Treasure et al., 1999). Across groups, the mean age of participants was 28 years and the mean body mass index (BMI) was 25. MET was shown to be as effective as CBT in reducing participants binge eating (Treasure et al., 1999). Since CBT is considered to be one of the most validated approaches in treating individuals with BN (Gore et al., 2001), this result supports the efficacy of MET in this population (Treasure et al. 1999). Of participants in this study, 90% were considered to be in contemplation and 10% were considered to be in action. No participants were
found to be in precontemplation. Therefore, all the participants in this study acknowledged a desire for change. As MET was developed to assist people resolve ambivalence and enhance their motivation, more robust findings for the efficacy of MET may have been found if participants in precontemplation had been included in the study (Miller & Rollnick, 1991). Furthermore, this study did not include adolescents with eating disorders or adults with AN. Future research, including younger participants who are in each of the stages of change, is therefore necessary.

In the second study, a pretreatment MET group was evaluated (Feld et al., 2001). The group consisted of 4 one hour long weekly sessions, the purpose of which was to increase participants’ motivation to change (Feld et al., 2001). Although 38 individuals were recruited for this study, only 19 participants attended each of the weekly sessions and completed the research protocol. Of the participants included in this study, 12 individuals met the DSM-IV criteria for AN, 4 for BN, and 3 for EDNOS (Feld et al., 2001). Participants completed the URICA (McConaughy et al., 1989), a measure of stage of change adapted from the substance abuse literature, at the pre-assessment and at the post-assessment. Three Likert scales, designed to assess motivation to change, were completed at the beginning of each weekly session. Using these Likert scales, motivation was shown to increase between sessions 1 and 3 and 1 and 4. Participant’s URICA action scores increased significantly from pre to post, while their precontemplation and contemplation scores did not change (Feld et al., 2001). Furthermore, over the course of treatment participants reported an increase in self-esteem. Although the lack of a control group and small sample size limit the conclusions of this
study, it offers preliminary support for the utility of MET with adults with eating disorders.

Further support for the efficacy of MET with adults with eating disorders comes from a third study that used an analogue design to examine clients’ perspectives on the acceptability and expected outcomes for motivational and directive interventions (Geller, Brown, Zaitsoff, Goodrich, & Hastings, 2003). Specifically, written clinical vignettes depicting commonly encountered client-care provider interactions were developed by experienced care providers. For each vignette, two care provider interventions were written; one depicting a standard directive protocol and one that incorporated motivational principles. Key components of the motivational intervention included the care provider taking a curious and interested stance, and avoiding making assumptions about the client’s experience of the problem and feelings about recovery (Geller et al., 2003). Pilot testing found that the vignettes were realistic and represented actual interactions between clients and care providers. After reading each vignette, participants were asked to describe the extent to which they viewed the intervention as client-focused, helpful, and acceptable. Participants were also asked to rate the likelihood that they would follow through with care provider recommendations and remain in treatment with the care provider if they were the clients in the interaction.

Fifty-five adults with eating disorders with a mean age of 26.4 years participated in this study, and their dominant stage of change was precontemplation. A principle component factor analysis revealed, that the extent to which clients rated the interventions as client-focused, helpful, and acceptable were highly correlated with each other (Geller et al., 2003). As such, a total client-focused-acceptability score was
computed by summing across the three ratings. Across all participants, compared to
directive vignettes, motivation vignettes had higher client-focused-acceptability ratings,
and clients reported that they would be more likely to follow through with
recommendations and remain in treatment with care providers in the motivation vignettes
(Geller et al., 2003).

Participants’ stage of change was shown to interact with their perceptions of the
different types of interventions. Previous research using the RMI has demonstrated that
RMI restriction precontemplation scores are related to clinical outcomes such as
symptom change and treatment drop out (Geller, Cockell, & Drab, 2001). Therefore, in
order to examine the relationships between clients’ readiness and motivation to change
and their reactions to the vignettes, two groups were formed by splitting the participants
on their restriction precontemplation scores (i.e., individuals who are and are not ready to
make changes to their restriction). There were no differences between the high and low
restriction precontemplators on any of the ratings for the motivational vignettes.
However, compared with low restriction precontemplators, high restriction
precontemplators rated the directive vignettes as lower on client-focused-acceptability,
and reported that they would be less likely to follow through with care provider
recommendations (Geller et al., 2003). Therefore, those individuals who are not yet
ready to make changes to their restriction are particularly sensitive to directive
interventions. Given that these are also the individuals that are more likely to decline
treatment, drop out from treatment, and make less progress while in treatment (Geller,
Zaitsoff, et al., 2001), interventions that engage these participants are particularly needed.
Overall, these studies suggest that MET may be an efficacious treatment for adults with eating disorders. No studies were found that examined MET in adolescents with eating disorders.

**MET with Adolescent Populations**

The majority of the studies reviewed in this paper have used adult samples. Unfortunately, comparable research has not been conducted with adolescents. Given that eating disorders typically have their onset during adolescence (American Psychiatric Association, 2000), and that a longer duration of illness is negatively related to outcome (Fisher et al., 1995; Pike, 1998), it is important that future research examines the applicability of MET in adolescent samples. However, before treatment programs utilizing MET with adolescents with eating disorders can be developed, adolescents conceptualizations of their readiness and motivation to change, and their perceptions of a MET approach need to be examined. There are however a number of reasons to suggest that MET might be a useful approach in working with adolescents with eating disorders. Specifically, MET has been shown to be effective with other treatment resistant adolescent populations (e.g., Colby, Monti, Barnett, & Rohsenow, 1998; Monti et al., 1999; Woodruff, Edwards, Conway, & Elliott, 2001), components of MET may foster the development of a strong therapeutic alliance, and MET matches many developmental issues pertinent to adolescence. Thus preliminary studies should examine these constructs in adolescents with eating disorders.

**MET with other Treatment Resistant Adolescent Populations** The limited research that has been conducted on the efficacy of MI in the treatment of adolescents with other problem behaviors has yielded promising results (e.g., Colby et al., 1998; Monti et al.,
1999; Woodruff et al., 2001). For instance, in one study forty adolescent smokers (mean age = 16.1 years) being treated at a hospital emergency room were randomly assigned to receive a motivational intervention or brief advice (i.e., provided with information of the effects of smoking and advised to quit). One week following the intervention, the percentage of participants that reported being abstinent from cigarettes for the motivational and brief advice groups were 20% and 10%, respectively. Although this between group difference was not significant, it represent a small to medium effect size ($h = .28$; Colby et al., 1998). In a second study, the potential efficacy of an internet-based virtual world chat room for smoking cessation was examined (Woodruff et al., 2001). In that study, 26 adolescents between the ages 13 years to 18 years participated in seven 1-hour intervention chat sessions during which the therapists utilized many of the principles of motivational interviewing. At the 1-month follow-up, participants reported significant changes in quitting, amount smoked, and intentions to quit (Woodruff et al., 2001). Given that there was no control group in this study, it is difficult to conclude that these findings are due to the intervention, however, there was a low attrition rate and adolescents rated the program positively (Woodruff et al., 2001). Thus, in combination the limited research that has been conducted examining the efficacy of motivational interventions with adolescents supports the utility of this approach. Furthermore, this research suggests that adolescents rate these interventions positively.

**Therapeutic Alliance.** The quality of the relationship between therapists and their clients has been described as a central factor in understanding treatment outcome (Horvath & Symonds, 1991). In support of this view, a meta-analysis of 24 studies examining the relationship between therapeutic alliance and treatment outcome found
that clients' perception of the therapeutic alliance was positively related to outcome (Horvath & Symonds, 1991). Furthermore, this relationship did not appear to be a function of the duration of treatment, the sample size in the studies, or the type of therapy practiced (Horvath & Symonds, 1991). Although the majority of studies examining therapeutic alliance have used adult participants, the relationship between therapeutic alliance and treatment outcome in adolescent populations has also been established (e.g., Diamond, Liddle, Hogue, & Dakof, 1999; Eltz, Shirk, & Sarlin, 1995; Green et al., 2001; Kroll & Green, 1997). For instance, in one study, the therapeutic alliance of psychiatrically hospitalized adolescents and their therapists were examined over the course of the adolescents' admissions. Those adolescents who did not develop strong alliances with their therapists over the course of treatment tended to have the poorest outcomes (Eltz et al., 1995). Although, the relationship between therapeutic alliance and treatment outcome has not been examined in adolescents with eating disorders, in adults with eating disorders premature treatment drop out from an inpatient program was related to a poorer therapeutic alliance within the first three weeks of treatment (Gallop, Kennedy, & Stern, 1994). Key components of a healthy therapeutic alliance that have been identified include clients viewing their therapist as trusting and supportive and as working on goals that are important to the client (Horvath & Luborsky, 1993).

There are a number of reasons to believe a MET approach may be helpful in developing a strong therapeutic alliance with adolescents with eating disorders (e.g., DiGiuseppe, Linscott, & Jilton, 1996; Miller & Rollnick, 1991). Specifically, the stance taken by the therapist in MET is characterized as supportive and nonjudgmental, furthermore the therapist is trained to use reflective listening to resolve resistance and to
build an alliance. Adolescents in a peer group counseling program developed to reduce smoking identified non-judgmental social support as helpful in enhancing their ability to cope with problems (Carty et al., 2000). This stance can be contrasted with a directive or confrontational approach in which therapists confront their clients, encouraging them to accept that they have a problem, and gives direct advice as to how to remedy the situation. In other treatment resistant populations, experimental studies have demonstrated that a confrontational therapist approach leads to client non-compliance, whereas a client-centered approach leads to compliance (Miller, Benefield, & Tonigan, 1993; Patterson & Forgatch, 1985). For instance, in one study problem drinkers were randomly assigned to receive one session of either directive-confrontational counseling or client-centered counseling. The extent to which therapists confronted the client predicted clients’ level of drinking at the follow-up assessment one-year later (Miller et al., 1993). Although not examined empirically, clinical writing on child and adolescent psychotherapy suggests using similar non-directive, supportive, reflective strategies in order to build a therapeutic alliance with younger individuals (DiGiuseppe et al., 1996).

In addition to the role of the therapist stance, agreement on the goals or tasks for therapy between therapists and clients has also been shown to predict clients’ perceptions of the therapeutic alliance (Treasure et al., 1999). Specifically, the more therapists and clients agree on the tasks for therapy the stronger the therapeutic alliance (Horvath & Luborsky, 1993). For example, in one study with adults with BN, the extent to which clients reported agreement between themselves and their therapist on the tasks to be carried out and the goals to be achieved in therapy was related to decreases in bulimic symptomatology (Treasure et al., 1999). It is emphasized in MET that the therapist and
client work together on the problems that are identified by the client (e.g., Geller, Williams, et al., 2001; Miller & Rollnick, 1991). For example, if an adolescent with AN reports that she is having difficulties with her peer relationships, these difficulties would be an appropriate focus of therapy. Compared to research with adults, the relationship between agreement on the goals and tasks of therapy and the development of a strong therapeutic alliance has received less attention with adolescents. However, because younger individuals may be particularly sensitive to having others’ goals imposed on them, task agreement may be a salient component of therapeutic alliance with this age group (DiGiuseppe et al., 1996; Tober, 1991, chp. 18).

A third component of MET that might enhance the therapeutic alliance with adolescents with eating disorders is the therapists expressed interest in both the clients perspective of the pros and the cons of behaviors, and therapists avoidance of assumptions about client experiences (Miller & Rollnick, 1991). Adolescents might be especially sensitive to control issues, by expressing interest in all aspects of a clients behavior, therapists might assure the client that their goal is to understand the clients’ experience as opposed to dominating/controlling the client (Meeks & Bernet, 1996). Therefore, MET might be useful in working with adolescents with eating disorders because it may foster the development of a strong therapeutic alliance, which in turn may lead to positive treatment outcomes. Research examining the extent to which adolescents view MET interventions as conducive to building a therapeutic alliance is needed.

Developmental Considerations. Several of the fundamental principles of MET appear to tap ideas that may be particularly pertinent to adolescents’ stage of development. Specifically, one of the principles of MI is a focus on enhancing self-
efficacy (Miller & Rollnick, 1991). Given that adolescents with eating disorders have been shown to have low self-esteem (e.g., Brooks-Gunn, 1989; Leung, Schwartzman, & Steiger, 1996), they may have a limited belief in their ability to make changes to their eating disorder symptoms (Treasure & Ward, 1997). Moreover, these deficits may inhibit adolescents from attempting to make changes to their symptoms (Treasure & Ward, 1997). That is, if clients feel they will be unsuccessful at changing they might be less likely to try. Furthermore, enhancing clients’ confidence in their ability to change may be a necessary prerequisite to increasing motivation for change (Miller & Rollnick, 1991, p.34). These deficits in self-esteem may, in part be related to adolescents’ realistic perception that they do not have a lot of control over decisions that are made regarding their treatment (Tober, 1991, chp 18). A therapeutic approach such as MET, that focuses on enhancing feelings of efficacy and control, by including client’s opinions in treatment decisions (Miller & Rollnick, 1991), therefore might be particularly helpful in the treatment of adolescents with eating disorders.

Therapists using MET also emphasize that there is no single correct answer to complex questions, and that thinking for oneself will likely be more beneficial than conforming to the others’ opinions. Although these emphases are likely important when working with all adolescent clients (Rush & Nowels, 1994), they may be particularly important when working with adolescents with eating disorders as these clients may be anxious to please others and look for external verification (Thompson & Sherman, 1989; Vitousek, 1996). Furthermore, adolescents are at a time in their development when their cognitive abilities are such that they are able to hold abstract thoughts and can reflect on and understand that different perspectives can be seen for each situation (Meeks &
Bernet, 1996; Menna & Cohen, 1997). Therefore, MET matches adolescents’ stage of cognitive development in that it supports abstract thinking about clients’ experiences, and emphasizes that people often have mixed feelings about change.

Previous research has demonstrated that adolescents with eating disorders are attached to and value their symptoms (Serpell et al., 2003). Thus treatment approaches that focus on alleviating symptoms without replacing them with alternatives means for fulfilling their valued functions might be unsuccessful with this group. From a motivational perspective, addressing the function that symptoms fulfill in clients’ lives is a central focus of therapy, as is resolving clients’ ambivalence. Furthermore, although adults with eating disorders have been shown to be resistant to change, it has been suggested in clinical reports that adolescents with eating disorders may demonstrate even higher levels of resistance to treatment (Fisher et al., 2001). Whether or not these differences truly exist is an empirical question, however, until such research is conducted examining adolescents’ perceptions of treatment approaches that focus on resolving ambivalence is a necessary step in developing new interventions for adolescents with eating disorders. Treatment approaches developed for adults are not always developmentally appropriate for younger individuals. MET appears to be an appropriate match for adolescents stage of development.

In order to examine whether using MET with adolescents with eating disorders might be a useful therapeutic intervention, relationships between adolescents’ perceptions of this approach and constructs related to treatment outcome need to be examined. Two process variables that have been related to outcome include the therapeutic alliance and clients’ confidence in their ability to change. Furthermore, clinical writing suggests that
using MET may be an effective method of fostering the development of a strong therapeutic alliance and building confidence in clients’ ability to change (e.g., Digiuseppe et al., 1996; Geller, Williams, et al., 2001; Miller & Rollnick, 1991). However, these relationships need to be explored in adolescents with eating disorders.

**Purposes of the Present Study**

From a MET perspective, in order to clarify the functions of symptoms, and to understand how clients are feeling about changing, therapists need to express curiosity and interest in each client’s experiences (Geller, Williams, et al., 2001; Miller & Rollnick, 1991). When using this strategy, therapists avoid assuming they know the functions of clients symptoms, or clients’ readiness status regardless of their experience working with other individuals with eating disorders. However, the effect of making assumptions regarding clients’ ambivalence about change, and the function of their symptoms on the therapeutic alliance, and on clients confidence in their ability to change have not been examined in adolescents with eating disorders. Although, MET may be a promising new approach in the treatment of adolescents with eating disorders, given the discussed differences between adolescents and adults with eating disorders, before an extensive clinical trial is implemented, adolescents’ reactions and perceptions to this approach should be examined.

As such, a number of written vignettes depicting commonly encountered client-therapist interactions have been developed for use in the proposed study. There are two components of each vignette, namely, a description of a situation between a therapist and an adolescent with an eating disorder, and a response to the situation from the therapist. For each situation, two therapist responses were developed; one in which the therapist
response is consistent with a motivational approach and one in which it is not. For the motivational responses, therapists are nonjudgmental and express interest and curiosity in the client’s experiences (motivational condition). In contrast, for the non-motivational responses, therapists make an assumption about the extent to which the client is ready to change or the extent to which the client views a symptom as a problem, and direct the intervention accordingly (directive intervention). Adolescents with eating disorders will listen to audio recordings of each vignette and be asked to imagine that they are the adolescents in the vignettes. After listening to each vignette, participants will be asked a number of questions. First, two questions will be asked to assess the relationship between using a motivational or a directive approach when working with adolescents with eating disorders and the development of a strong therapeutic alliance. Specifically, participants will be asked to rate the extent to which they would trust the therapist described, and the extent to which they feel there would be agreement between themselves and the therapist on goals for therapy. Similarly, participants will be asked two questions to examine differences between the two approaches on adolescents’ self-efficacy and sense of control in therapy. That is, participants will be asked to rate the extent to which the intervention would influence their confidence in their ability to change, and the extent to which they feel they would have input into treatment decisions if they were in therapy with the therapist described. Finally, participants will be asked to rate the extent to which they feel the intervention described would be effective in working with adolescents with eating disorders.

Research has also shown that therapist factors that are not necessarily specific to a particular type of intervention, such as therapist warmth and caring (i.e., non-specific
therapy factors), may also be related to therapy outcome (e.g., Chatoor & Krupnick, 2001; Creedy & Crowe, 1996; Kottler, 1991). This suggests that it may not be particular strategies that therapists implement that lead to client change, but instead the characteristics of the therapists. To examine whether participants’ ratings of the two types of interventions were due to the operationalization of the therapeutic approach (e.g., avoidance of assumptions for the motivational vignettes) or due to their perceptions of the therapists as differing on non-specific therapy factors, participants will be asked to rate how warm and caring they find each of the therapists.

Using an analogue design, the first purpose of this study is to examine adolescents with eating disorders’ perceptions of motivational and directive intervention in relation to the development of the therapeutic alliance, their confidence in their ability to change, their sense of control in therapy, and their views on effectiveness of the interventions. It is hypothesized that adolescents will feel more able to trust and agree on goals for therapy with the therapists described in the motivational vignettes than in the directive interventions. Similarly, it is hypothesized that compared to the directive vignettes, adolescents will report a greater sense of confidence in their ability to change, and feel they would have more input into treatment decisions in response to the motivational vignettes. Finally, it is hypothesized that compared to adolescents’ ratings of the directive vignettes, adolescents will rate the motivational vignettes as describing a more effective intervention. Therefore, it is expected that overall the motivational vignettes will be rated more favorably than the directive vignettes on each of the dependent variables. In addition, it is hypothesized that these relations will remain even after controlling for participants’ ratings of therapist warmth and caring.
The second purpose of this study is to examine the relations between participants' readiness and motivation for change and their perceptions of the motivational and directive interventions. Based on previous research demonstrating the predictive validity of RMI restriction precontemplation scores, participants scores on this variable will be used to assess the relations between adolescents' readiness status and their perceptions of the two types of vignettes. Given the preliminary nature of this research, the relationship between individuals overall readiness and motivation for change and their perceptions of the two types of vignettes will also be examined. With respect to the motivational vignettes, it is hypothesized that there will be no relationships between participants’ readiness to change their restriction or their overall readiness and any of the dependent variables. In contrast, for the directive vignettes it is hypothesized that there will be significant relationships between participants’ readiness to change restriction and their overall readiness. Specifically, it is hypothesized that the less ready participants are to change, the less favorably they will rate the directive vignettes on each of the dependent variables. Thus, it is expected that the motivational vignettes will be rated favorably by participants across the stages of change. In contrast, although overall directive vignettes will be rated less favorably than the motivational vignettes, it is expected that this effect will be particularly pronounced in those individuals who are not ready to change.

The third purpose of this study is to gain a better understanding of adolescents' thoughts and feelings about the different interventions in relation to the different dependent variables. That is, based on previous research it is assumed that the hypothesized relationships between adolescents’ perceptions of the vignettes and the outcome measures will be due to the different stances adopted by the therapists in the
vignettes. However, it is important to understand how adolescents interpret these interventions. Therefore, following the quantitative ratings of the vignettes, participants will be asked five open-ended questions. Participants will be asked to discuss factors that they believe influence their ability to trust a therapist, agree on goals for therapy with therapists, feel included in decisions made about their treatment, have confidence in their ability to change, and the overall effectiveness of interventions. It is expected that participants’ responses to these open-ended questions will clarify what aspects of therapeutic interventions adolescents with eating disorders perceive to be related to the development of the alliance, confidence in their abilities to change, and the overall effectiveness of interventions. The relations between participants’ readiness for change and their responses to the open-ended questions will also be examined.
Chapter II

Method

Development and Selection of the Vignettes

In order to assess adolescents’ perceptions of motivational and directive interventions, a number of hypothetical vignettes depicting commonly encountered therapist-client interactions were developed for use in this study. Each vignette had two components, namely, a description of a situation between a therapist and an adolescent with an eating disorder, and a response to the situation from the care provider. In order to manipulate the independent variable (i.e., motivational vs. directive interventions), two care provider responses were developed for each situation, one in which the care provider response was consistent with a motivational approach and one in which it was directive. The motivational responses were developed such that therapists were nonjudgmental and expressed interest and curiosity in clients’ experiences, and avoided making assumptions. In contrast, therapists in the directive responses, made an assumption about the extent to which the client was ready to change, or the extent to which the client viewed a symptom as a problem, and directed their intervention accordingly.

Pilot Testing. To examine the extent to which the vignettes described realistic therapist-client interactions, and the extent to which the independent variable was successfully manipulated (i.e., a motivational vs. directive response), 3 psychologists with expertise in eating disorders read and gave feedback on the vignettes. In addition 7 adolescents with eating disorders participated in a pilot study. After giving consent to participate, adolescents completed a demographic questionnaire, listened to audiotapes of the vignettes, and were asked a series of follow-up questions. Specifically, after each
vignette participants were asked to rate the extent to which they felt the vignettes described a realistic interaction between a therapist and an adolescent with an eating disorder. Furthermore, in order to assess whether the independent variable was successfully manipulated, participants were then asked to rate the extent to which they felt the therapist in the vignettes made any assumptions about the client’s thoughts or feelings. Each of these questions was rated on 5-point Likert scales in which higher scores indicated that the scenarios were realistic and assumptions were made by the therapist (see Appendix C). To select the final set of 10 vignettes (5 pairs of motivational and directive vignettes) the mean scores on each of the pilot questions were examined. Those vignettes with the lowest realistic ratings and for which the independent variable was not successfully manipulated were eliminated. Vignettes that received a mean realistic rating less than 3.5, and directive vignettes with an assumption rating less than 3.5 were eliminated. Motivational vignettes with an assumption rating greater than 2.5 would have been eliminated however, the highest assumption rating for the motivational vignettes was 2.29. Therefore, no vignettes were eliminated based on this exclusion criterion. Within each pair of vignettes (i.e., one scenario and two responses) if either the directive or the motivational vignette met the exclusion criteria both vignettes were eliminated in order to conduct the proposed repeated measures analyses.

The mean age of the participants in the pilot study was 16.00 (SD = 2.00) years and the mean body mass index (BMI) was 20.77 (4.14). Two participants met DSM-IV criteria for anorexia nervosa – restricting subtype (AN-R), 1 met criteria for bulimia nervosa (BN), and 4 met criteria for eating disorder not otherwise specified (EDNOS).
The mean realistic and assumption ratings for each of the vignettes are included in Table 1.

Three pairs of vignettes (scenario 3, 4, and 6) met the exclusion criteria and were therefore eliminated from data collection. In one of the pairs of vignettes the directive intervention received too low a realistic rating, where as in the other two excluded vignettes the therapists in the directive interventions were not rated as making sufficient assumptions and therefore the independent variable was not adequately manipulated.
Table 1. Mean ratings for the vignettes piloted

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<tr>
<th>Scenario</th>
<th>Realistic Rating</th>
<th>Assumption Rating</th>
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<td>M</td>
<td>SD</td>
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<tr>
<td>Scenario 1</td>
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<td>Motivational</td>
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<td>.79</td>
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<td>Scenario 2</td>
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<tr>
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<td>Directive</td>
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<td>.90</td>
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<td>.49</td>
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<tr>
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<td>.79</td>
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<td>.49</td>
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<tr>
<td>Directive</td>
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<td>.82</td>
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</table>

*Note.* *vignettes excluded after pilot testing
Participants

Thirty-nine females under the age of 19-years with a current or past Diagnostic and Statistical Manual – IV – TR (American Psychiatric Association, 2000) diagnosis for an eating disorder participated in this study. Given that the majority of adolescents presenting at eating disorders programs are females, males were excluded from the study. To maximize variability in participants’ readiness and motivation to change and experiences in therapy, participants were recruited from several treatment centers, and were at various stages of treatment. Participants were recruited from eating disorders treatment programs at British Columbia Children’s Hospital (BCCH; n=7, 17.9%) and St. Paul’s Hospital (SPH; n=1, 2.6%) in Vancouver, British Columbia (BC), North Delta Mental Health Centre (NDMH; n=9, 23.1%) in Surrey, BC, Alberta Children’s Hospital (ACH; n=16, 41.0%) in Calgary, Alberta, and the Teen Health Centre (THC; n=1, 2.6%) and the Bulimia and Anorexia Nervosa Association (BANA; n=5, 12.8%) in Windsor, Ontario.

Some individuals were recruited at their intake assessment, whereas others were inpatients, outpatients, or individuals who were receiving follow-up treatment. With respect to current treatment experiences, 29 participants (55.8%) reported that they were in individual therapy, 16 participants (30.8%) reported that they were in group therapy, 28 participant (53.8%) reported that they were being monitored by a physician for reasons related to their eating disorder, 10 participants (19.2%) reported that their family was in therapy, 5 participants (9.6%) reported that their parents were attending a support group, and 20 participants (38.5%) reported that they were seeing a dietician. Ten
participants were in intensive hospital based day treatment programs. With respect to
current diagnoses, 7 (17.9%) participants met diagnostic criteria for AN-R, 8 (20.5%) met
criteria for AN-BP, 5 (12.8%) met criteria for BN, 15 (38.5%) met criteria for EDNOS, 2
(5.1%) had no current eating disorder diagnoses. Diagnostic information was not
available for 2 (5.1%) participants. One of the individuals with no current diagnoses had
a past diagnosis of AN-R and the other had a past diagnosis of EDNOS.
The mean age and BMI of participants were 16.24 (SD=1.47) years and 19.06 (SD=2.41),
respectively. The mean socioeconomic status according to the Hollingshead (1975)
rating system was 1.72 (SD=1.02), indicating middle to upper socioeconomic status.
When asked to indicate their ethnicity the majority of the participants indicated that they
were Caucasian (n= 36), one participant indicated that she was Asian-Canadian, and two
participants endorsed the "other" category. In both cases one of the participants' parents
was Caucasian while the other was from another ethnic group.

Procedure

Participants were told about the study by care providers at their eating disorder
treatment program, if clients indicated that they would be interested in participating in the
study they were contacted by a research assistant to arrange a time to meet. Potential
participants and their parents were encouraged to discuss the study before deciding
whether or not to participate. It was stressed that their decision would not affect their
ongoing treatment, and also that participants could withdraw from the study at any stage
without explanation. Parental and adolescent consent was obtained for all participants
under 18 years of age, and adolescent consent was obtained for all participants who were
18 years old.
At the beginning of the assessment, the written consent form was reviewed with participants and their parents, the research assistant addressed all of the participants concerns and then obtained written consent (see Appendix A).

After agreeing to participate, participants were interviewed using the hypothetical vignettes and the Readiness and Motivation Interview (Geller & Drab, 1999). Responses were audiotaped and transcribed to allow for coding of the open-ended questions. Participants were then asked to complete a series of questionnaires assessing demographic information, eating disorder symptoms, the pros and cons of their eating disorder, internalizing and externalizing feelings and behaviors, and socially desirable responding (see Appendix B). Completion of the tasks took approximately two hours. In order to minimize the tendency for participants to respond in a socially desirable way, immediately before beginning the interviews the research assistant reviewed confidentiality ensuring participants that information shared in the assessment would not affect their treatment in any way. Furthermore, during the vignettes the interviewer asked open-ended questions and expressed interest and curiosity in all of the clients’ thoughts and feelings. After completing the interviews and questionnaires, participants were thanked for their time, and any questions they had were answered. If participants indicated interest in receiving feedback their email address was recorded and a summary of the findings will be sent to them after the study has been completed.

Measures

Vignettes. Adolescents in the study listened to audiotapes of the 10 vignettes selected from the pilot testing, and were asked to imagine that they were the adolescents in the interactions. The same persons voice was used to make each of the audiotapes.
After listening to each vignette, participants were asked to answer a number of questions on 5-point Likert scales. Specifically, adolescents were asked to rate the extent to which they would trust and agree on goals for therapy with the therapists (i.e., alliance). They were also asked to rate the extent to which the therapists’ responses would influence their confidence in their own ability to change, and how included they would feel in decisions made about their treatment with each of the therapists. Finally, participants were asked to rate how helpful they felt each therapist response would be for adolescents with eating disorders (i.e., effectiveness). Higher scores reflect greater trust, agreement on goals, confidence, inclusion in decisions, and overall helpfulness. Perceptions of the different interventions in relation to its effect on alliance (e.g., trust and agree on goals), participant confidence in their ability to change and sense of inclusion in treatment decisions, and the overall effectiveness of the intervention was examined. Scores on each of the questions was examined to determine whether total Trust, Agreement on Goals, Self Confidence, Input in Decisions, and Effectiveness scores could be computed for both the motivational and the directive vignettes (see preliminary analyses in the results section below). In order to examine the role of non-specific therapy factors, participants also were asked to rate on 5-point Likert scales the extent to which they found the therapists in the vignettes warm and caring. Higher scores indicated greater warmth and more caring. (See Appendix D)

After completing the quantitative ratings of the vignettes, participants were asked a number of open-ended questions. These questions explored factors participants identified as important in influencing the extent to which they would trust and agree on goals for therapy with a therapist, feel confident in their ability to change and included in
decisions made about their treatment. Finally, adolescents were asked to discuss things that a therapist could say or do that would be helpful or unhelpful for adolescents with eating disorders (see Appendix D for the open-ended questions to be used for data collection).

Using a random sample of responses, a coding system was developed for each of the open-ended questions (i.e., Trust, Agreement on Goals, Confidence in Ability to Change, Input in Decisions, and Effectiveness). The transcript of 5 randomly selected responses was read by two independent raters (SZ and RM) and coded for content. Codes were then grouped thematically into categories. The raters then discussed each of the categories they had developed, and decided on a final list of categories to use for coding each open-ended question.

A coding manual was developed for each of the open-ended questions that included a list of the category names and their defining features (see Tables 9, 11, 13, 15, and 16). Participant’s responses to each of the open-ended questions were then coded with the relevant coding system. Each category was rated as present or absent.

Reliability Coding. A research assistant was trained to code the data to assess the reliability of the coding system. Training involved reading the training manual and discussions of the categories including examples with the researcher. In addition, 10 transcripts were randomly selected and coded independently by the two raters using the coding scheme. Discrepancies were discussed, and when necessary categories were collapsed or additional rules for deciding between categories were added to the coding instructions. Finally, the remainder of the open-ended responses were coded by the researcher, and a random sample (n = 5) of these was coded by the research assistant to
assess the reliability of the coding system. The percentage of agreement between the two raters for the Trust, Agreement on Goals, Confidence in Ability to Change, Input in Decisions, and Effectiveness questions were 80%, 88.2%, 93.3%, 100%, and 84%, respectively. Cohen's kappas for Trust, Agreement on Goals, Confidence in Ability to Change, Input in Decisions, and Effectiveness for the reliability check were .74, .84, .91, 1.00, and .82, respectively.

**Analyses.** For each open-ended question, after each category had been coded as present or absent the proportionate usage of each category was calculated. For example, if a participant had 3 of 6 categories rated as present, the proportionate usage of each of these categories would be .33 (i.e., 1/3 of their response was focused on this category). Categories that were not rated as present received a proportionate usage score of 0. Arcsine transformations were conducted on the proportionate usage data to correct for non-normality of the data.

**Readiness and Motivation Interview (RMI; Geller & Drab, 1999).** The Readiness and Motivation Interview (RMI; Geller & Drab, 1999) is a semi-structured symptom specific interview assessing readiness for change in the eating disorders. For each symptom of an eating disorder, the extent to which participants are in precontemplation, contemplation, and action is established. For each participant, RMI precontemplation, contemplation, and action scores total 100. If participants are actively working at changing a symptom the extent to which they are working on change for themselves vs. for others (e.g., internality) is also assessed. Global and symptom domain (i.e., restriction, cognition, bingeing, and compensatory behaviors) scores are calculated. The RMI has been shown to have high inter-rater reliability and internal consistency
(coefficient alphas ranging from .63-.84). The construct validity of the RMI has also been established (Geller, Cockell, et al., 2001). Specifically, RMI scores have been shown to predict enrolment in symptom-reduction treatment, dropout from residential care, degree of symptom change in treatment, and relapse 6 months following program completion (Geller, Cockell, et al., 2001; Geller, Zaitsoff, et al., 2001). As such, RMI global and restriction domain scores were used to describe participants' ambivalence, and to assess the relationship between adolescents' ratings of the vignettes and their readiness and motivation for change (see Appendix E).

**Demographic Questionnaire.** Participants were asked to provide their age, height, weight, and ethnicity. Weight and height were used to determine BMI (calculated using the following formula: weight (kg)/height(m)^2). In order to calculate the socioeconomic status of the participants using the Hollingshead Four-Factor Index (Hollingshead, 1979), participants were asked to describe their mother's and father's highest level of education and occupation (see Appendix B). Scores can range from 1 to 5, with lower scores reflecting higher socioeconomic status. Participants were asked to indicate the types of therapy they had been involved in, the list of therapies presented included individual, group, nutritional, school counseling, hospitalization, and family therapy. Participants also were asked if they were being monitored by a physician for reasons related to their ED, and whether their parents were attending a support group.

**Eating Disorders Inventory-2** (EDI: Garner, 1991). The EDI-2 is a 91 item self-report measure of eating disorder symptoms. In completing the measure participants answer a number of questions about their shape, weight, and eating on a 6-point scale ranging from never to always. The EDI-2 has 11 sub-scales, three of which namely,
Drive for Thinness (DT), Bulimia (B), and Body Dissatisfaction (BD) were used in this research to describe the severity of participants' eating disorder pathology. The EDI has a reading level of fifth grade (Williamson et al., 1995). Extensive psychometric support for this instrument and norms for adolescents are available in the treatment manual (Garner, 1991; see Appendix B).

Youth Self-Report (YSR; Achenbach, 1991). The YSR is a 112 item self-report questionnaire that assesses adolescents’ interests, feelings, and behaviors. The YSR has been used extensively in research and clinical settings with adolescents between the ages 11 and 18-years. The YSR total problem score, and the internalizing and externalizing sub-scale scores were used in this research to describe participants’ symptomatology in addition to their eating disorder. The YSR has high test-retest reliability (r = .86 for the total problem scale) and high internal consistency (alphas ranging from .89-.95 for the selected scales). The YSR also has good criterion validity as it has been shown to distinguish between adolescents who have and have not been referred to mental health professionals. (Achenbach, 1991; see Appendix B).

Pros and Cons of Anorexia Nervosa (P-CAN: Serpell et al., 2003). This 50-item questionnaire assesses individuals’ perceptions of the benefits (pro subscales) and costs (con subscales) associated with anorexia nervosa, and has been validated with adolescents with eating disorders. In adolescents, the subscales of this measure have high internal consistencies (ranging from .73-.97), and adequate item-total correlations (ranging from .40-.89; Serpell et al., 2003). Scores on the P-CAN range from −2 (disagree strongly) to +2 (agree strongly). P-CAN scores were used to describe the extent to which
the subset of participants with anorexia nervosa in the study value and are attached to their symptoms (see Appendix B).

**Marlowe-Crowne Social Desirability Scale – Short Form (Reynolds, 1982).** The short form of the Marlowe-Crowne Social Desirability Scale is a self-report measure developed to examine social desirability as a response tendency. The measure consists of 13 questions which participants rate as true or false. Scores on the short form of the measure are highly correlated with scores on the standard 33 item Marlowe-Crowne Social Desirability Scale, and the reliability of the short form has been established (Reynolds, 1982). This measure was used to examine participants’ tendency to give socially desirable responses (see Appendix B).
Chapter III

Results

Preliminary Participant Analyses

To assess whether data could be pooled across participants with different diagnoses, a series of Analyses of Variances (ANOVAs) were conducted to compare participants with different diagnoses on age, BMI, SES, EDI and YSR subscale scores (see Table 2). As expected, in comparison to participants with BN and EDNOS, those with AN had significantly lower BMIs. Similarly, participants with BN had significantly higher EDI bulimia scores than participants with AN, EDNOS, and no current diagnoses. Finally, in comparison to participants meeting criteria for an ED diagnoses, participants with no current diagnoses had significantly lower EDI Drive for Thinness scores. Across diagnoses, participants did not significantly differ on age, SES, EDI body dissatisfaction, or any of the YSR subscale scores.
<table>
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<th>P</th>
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<td>17.30 (1.37)</td>
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<td>16.53 (1.36)</td>
<td>16.20 (1.38)</td>
<td>16.29 (1.38)</td>
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|                  | 5.9 ( ) |                    |                     |              |              |              |
|                  | 5.02    | (3, 32)            |                     | 18.2 (1.90)  | 18.70 (3.57) | 17.80 (1.33) |
|                  | 2.0    | (3, 32)            |                     | 1.6 (3.6)    | 1.36 (0.50)  | 1.36 (3.71)  |
|                  | 2.33    | (3, 32)            |                     | 2.23 (3.31)  | 2.33 (2.59)  | 2.33 (3.31)  |
|                  | 20.58   | (2.15)             |                     | 20.58 (2.15) | 20.58 (2.15) | 20.58 (2.15) |
|                  | 16.00   | (0)                |                     | 16.00 (0)    | 16.00 (0)    | 16.00 (0)    |
|                  | 16.53   | (1.36)             |                     | 16.53 (1.36) | 16.53 (1.36) | 16.53 (1.36) |
|                  | 16.20   | (1.38)             |                     | 16.20 (1.38) | 16.20 (1.38) | 16.20 (1.38) |
|                  | 16.29   | (1.38)             |                     | 16.29 (1.38) | 16.29 (1.38) | 16.29 (1.38) |

Note. * = p > .05, ** = p < .01, *** = p < .001. Differences represent statistically significant group differences.

Table 2. Demographic Information and Eating Disorders Inventory—2 (EDI-2) and Youth Self-Report (YSR) scores across diagnostic categories.
To determine whether the data could be pooled across sites, a series of between site comparisons were conducted. As there was only one participant recruited from both St. Paul’s Hospital and the Teen Health Centre, they were included in the samples from the other centers in the same city, namely BCCH and BANA. ANOVAs were conducted to compare participants from each of the sites on age, BMI, SES, EDI, and YSR subscale scores. ANOVAs revealed significant site differences on the EDI bulimia (F = 3.03, p<.05, h = .22), body dissatisfaction (F = 4.63, p<.01, h = .30), and drive for thinness (F = 3.39, p<.05, h = .24) subscales. Firstly, in comparison to participants from NDMH, participants from ACH and BCCH had significantly lower EDI bulimia scores.

Secondly, in comparison to participants from BCCH and NDMH, participants from ACH had significantly lower body dissatisfaction scores. Finally, in comparison to participants at all other sites, participants from ACH had significantly lower drive for thinness scores. Thus, overall participants from ACH seemed to report the fewest eating disorder symptoms at the time of the assessment. There were no significant differences between sites on participants’ age, BMI, SES, and YSR subscale scores.

Given that there were few significant differences between participants meeting criteria for differing diagnoses other than those expected based on the DSM-IV-TR criteria, and between participants recruited from different centers the entire sample was collapsed into one group for further analyses. Mean Eating Disorders Inventory – 2 (EDI) and Youth Self-Report (YSR) subscale scores for the entire sample (N=39) are displayed in Table 3. Median Pros and Cons of Anorexia Nervosa (P-CAN) scores for participants meeting diagnostic criteria for AN-R or AN-BP are displayed in Table 4. Mean RMI global and RMI restriction precontemplation, contemplation, and action subscale scores
are displayed in Figures 1 and 2. Mean RMI global and restriction internality scores for those participants with RMI action scores greater than zero are displayed in Figure 3.
Table 3. **Mean Eating Disorders Inventory – 2 (EDI-2) and Youth Self-Report (YSR) scores of participants**

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<tr>
<td>Drive for Thinness</td>
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<td>Body Dissatisfaction</td>
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<td>(8.89)</td>
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<td>Bulimia</td>
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<td>(4.44)</td>
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<td><strong>YSR</strong></td>
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<td>Total Problems</td>
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<td>Internalizing</td>
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<td>Externalizing</td>
<td>55.14</td>
<td>(10.17)</td>
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Table 4. **Median Pros and Cons of Anorexia Nervosa Scores for adolescents with anorexia nervosa (n=14)**

<table>
<thead>
<tr>
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</thead>
<tbody>
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<td>Pro Subscales</td>
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<td>Safe/Structured</td>
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<td>Appearance</td>
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<td>Fertility/Sexuality</td>
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<tr>
<td>Special</td>
<td>.60</td>
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<td>Fitness</td>
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<tr>
<td>Communicate</td>
<td>1.0</td>
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<td>Con Subscales</td>
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<td>Trapped</td>
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<tr>
<td>Guilt</td>
<td>1.40</td>
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<tr>
<td>Hatred</td>
<td>.67</td>
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<tr>
<td>Stifles Emotions</td>
<td>.60</td>
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</table>
Figure 1. Mean RMI Restriction precontemplation, contemplation, and action scores.

The standard deviations for precontemplation, contemplation, and action scores were 32.82, 16.17, and 30.81, respectively. Precontemplation, contemplation, and action scores total 100 for each participant.
Figure 2. Mean RMI Global precontemplation, contemplation, and action scores. The standard deviations for precontemplation, contemplation, and action scores were 23.07, 11.54, and 23.71, respectively. Precontemplation, contemplation, and action scores total 100 for each participant.
Figure 3. Mean RMI Restriction and Global internality scores. Participants only receive an internality score if their action score is greater than zero.
Purpose I. Comparison of Adolescents’ Ratings of Trust, Agreement on Goals, Self Confidence, Input in Decisions, and Effectiveness between the Motivational and Directive Vignettes

Preliminary Analyses. In order to determine whether responses to each of the vignettes could be collapsed to yield total mean scores for motivational and directive interventions on each of the dependent variables (e.g., Trust, Agreement on Goals, Self Confidence, Input in Decisions, and Effectiveness) a number of preliminary analyses were performed. Specifically, two repeated measures ANOVAs, one for the motivational vignettes and one for the directive vignettes, were conducted for each dependent variable (e.g., Trust, Agreement on Goals, Self Confidence, Input in Decisions, and Effectiveness) and the realistic rating. For the motivational vignettes, none of the ANOVAs reached statistical significance, suggesting that for each dependent variable participants responded similarly to each of the motivational vignettes. However, for the directive vignettes each of the ANOVAs was statistically significant, suggesting that there was variability in participants’ responses within this set of vignettes. Inspection of the pairwise comparisons suggested that participants were responding differently to directive vignette number 5. As such, vignette number 5 was eliminated and the repeated measures ANOVAs were conducted again. There were no significant differences in scores on any of the dependent variables for the motivational vignettes or on the Trust, Agreement on Goals, Self Confidence, and Input in Decisions ratings for the directive vignettes. The only ANOVA to reach statistical significance examined differences in overall effectiveness ratings for the directive vignettes ($F(3, 111) = 2.84, p<.05$). As a result of these analyses, scenario 5 was eliminated from further analyses. Total mean Trust,
Agreement on Goals, Self Confidence, Input in Decisions, and Effectiveness scores were computed for the motivational and the directive vignettes by calculating a mean score for each of the dependent variable across scenarios 1, 2, 7, and 8.

**Purpose 1 analyses.** In order to assess whether the motivational vignettes were rated more favorably than the directive vignettes on each of the dependent variables a series of repeated measures t-tests were conducted. To control for type I errors an alpha level of .01 was used to test for significance. Results from these analyses are shown in Table 5. The motivational vignettes were rated more favorably than the directive vignettes on each of the dependent variables. Thus, in comparison to participants’ responses to the directive vignettes, participants’ reported that they were more likely to trust and agree on goals for therapy with the therapists, feel more included in decisions made about their treatment, and have greater confidence in their ability to change in response to the motivational vignettes. Moreover, in comparison to the directive vignettes, participants’ rated the motivational vignettes as significantly more helpful for adolescents with eating.
<table>
<thead>
<tr>
<th>Treatment</th>
<th>Confidence Interval</th>
<th>p Value</th>
<th>M (SD) ( p \leq 0.05 )</th>
<th>M (SD) ( p &gt; 0.05 )</th>
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<td>Carting Warmth</td>
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<td>4.66</td>
<td>4.23 (5.69)</td>
<td>3.97 (6.27)</td>
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<tr>
<td>Factors</td>
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<td>4.23 (4.72)</td>
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<td>6.17</td>
<td>6.0 (7.72)</td>
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<td>4.65 (7.72)</td>
<td>3.97 (6.27)</td>
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</table>

Table 5. Comparison of ratings between the motivational and directive vignettes.
To assess the relations between participants' tendency to provide socially desirable responses and their readiness status and ratings of the vignettes, a series of correlations were conducted between Marlowe-Crowne total scores and RMI scores and ratings on each dependent variable for the motivational and directive vignettes. There were no significant relationships between Marlowe-Crowne scores and any of the RMI scores (p > .25) or any of the ratings of the dependent variables for the motivational vignettes (p > .07). However, a number of significant correlations were found between Marlowe-Crowne scores and ratings of the dependent variables for the directive vignettes (see Table 6). In each case, the tendency to give socially desirable responses was associated with more favourable ratings on the dependent variables for the directive vignettes. Thus, ratings of the dependent variables for the directive variables may be inflated due to some participants' tendency to give socially desirable responses.
Table 6. Correlations between Marlowe-Crowne scores and ratings of the vignettes

(n=36)

<table>
<thead>
<tr>
<th></th>
<th>Motivational Vignettes</th>
<th>Directive Vignettes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>-.15</td>
<td>.39*</td>
</tr>
<tr>
<td>Agree on Goals</td>
<td>-.30</td>
<td>.52**</td>
</tr>
<tr>
<td>Included in Decisions</td>
<td>-.15</td>
<td>.26</td>
</tr>
<tr>
<td>Confidence</td>
<td>.10</td>
<td>.40*</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>-.24</td>
<td>.50**</td>
</tr>
</tbody>
</table>

*Note. * = p < .05, ** = p < .01*
Controlling for Non-specific Therapy Factors. In order to examine the influence of non-specific therapy factors on participants' responses on each of the dependent variables, a series of repeated measures Analyses of Covariances (ANCOVAs) were conducted. For each dependent variable two ANCOVAs were conducted. One in which therapist warmth was entered as the covariate, and one in which therapist caring was entered as the covariate. For all the ANCOVAs, vignette type (e.g., motivational vs. directive) was the independent variable. Therapist warmth and caring were significant covariates in each ANCOVA (p < .01), suggesting that participants' ratings of each of the non-specific therapy factors and the dependent variables were related. However, even after controlling for therapist warmth, there were still significant differences between the motivational and the directive vignettes on each of the dependent variables (for trust (F(1,36) = 7.95, p<.01), agree on goals (F(1, 36) = 14.35, p<.01), included (F(1,36) = 17.93, p<.001), and helpfulness (F(1,36) = 21.81, p<.001), respectively), except for client’s confidence in their ability to change (F (1, 36) = 3.41, p>.05). Similarly, after controlling for therapist caring, the Agree on Goals, Inclusion in Decisions, and overall helpfulness ANCOVAS still revealed significant differences between the motivational and the directive vignettes, F(1,36) =8.34, p<.01, F(1, 36) = 11.49, p<.01, and F(1,36) = 15.3, p<.001, respectively. There were no significant differences between the motivational and directive vignettes on trust or confidence in ability to change after controlling for therapist caring (F(1, 36) = 3.09, p>.05 and F(1, 36) = 1.05, p>.05, respectively).

In summary, in comparison to therapists in the directive vignettes, after controlling for the variance accounted for by participants' ratings of therapists level of
warmth and caring, adolescents with ED report that they would still be more likely to agree on goals for therapy, feel more included in decisions, and that the interventions are more helpful with the therapists in the motivational vignettes.

**Purpose 2. Relationships between Adolescents’ Readiness Status and their Ratings of Therapeutic Alliance, Self-Efficacy, and Effectiveness of the Motivational and Directive Vignettes**

It was expected that within the directive and motivational vignettes, participants’ scores on the Trust and Agreement on Goals scales, and the Confidence in Ability to Change and Input in Decisions scales would be highly correlated. In order to assess whether the scales could be collapsed into a total Therapeutic Alliance score and a total Self-Efficacy score for the motivational and directive vignettes, two correlations were performed for each type of vignette. The first correlation was between participants’ scores on the Trust and Agreement on Goals scales and the second correlation was between participants’ scores on the Confidence in Ability to Change and Input in Decisions scales. An apriori decision was made that if the correlations were greater than .70, participants scores on the Trust and Agreement on Goals scales would be averaged yielding total Therapeutic Alliance scores for the motivational vignettes and for the directive vignettes. Similarly, participants’ scores on Confidence in Ability to Change and Input in Decisions scales would be averaged yielding a total Self-Efficacy score for each vignette type. The total Therapeutic Alliance and Self-Efficacy scores were to be used to examine the relationship between participants’ readiness status and their perceptions of the vignettes. Although all correlations were significant (p<.015) the only correlation greater than .70 was within the directive vignettes, between Trust and Agree
on Goals (see Tables 7). Therefore, total Therapeutic Alliance and Self-Efficacy scores were not computed. Instead, relationships between participants’ scores on each of the dependent variables and their readiness and motivation to change were examined independently.
Table 7. Correlations for Therapeutic Alliance and Self-Efficacy scales for the motivational and directive vignettes

<table>
<thead>
<tr>
<th></th>
<th>Motivational Vignettes</th>
<th>Directive Vignettes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Trust</td>
<td>Confidence</td>
</tr>
<tr>
<td>Agree on Goals</td>
<td>.45**</td>
<td></td>
</tr>
<tr>
<td>Included in Decisions</td>
<td>-</td>
<td>.40**</td>
</tr>
</tbody>
</table>

Note. ** = p < .01, *** = p < .001

A series of partial correlations were performed to explore the relations between participants’ responses on each of the dependent variables and their readiness and motivation for change, after controlling for the tendency to give socially desirable responses. Specifically, RMI global and RMI restriction domain scores were correlated with mean Trust, Agreement on Goals, Confidence in Ability to Change, Input in Decisions, and Effectiveness scores for both the motivational and directive vignettes. Marlowe-Crowne total scores were partialed out of the correlations. Within the motivational vignettes, after controlling for the tendency to give socially desirable responses, there were no significant relationships between participants’ RMI scores and any of the dependent variables (p > .05). A number of significant correlations were found between RMI scores and the dependent variables for the directive vignettes (see Table 8). Specifically, there was a significant positive correlation between RMI restriction precontemplation scores and effectiveness ratings. That is, the more a person reported that they did not want to increase their dietary intake or gain weight, the more helpful
they rated the therapist responses in the directive vignettes. RMI global precontemplation scores were positively correlated with trust, agreement on goals, and the overall effectiveness of the interventions. That is, the more a participant reported that they were not intending to change their eating disorder symptoms, the more likely they were to trust and agree on goals for therapy with the therapist in the directive vignettes, and the more helpful they rated the therapist responses in these vignettes. In addition, RMI global action scores were negatively correlated with the extent to which participants reported they would trust the therapists, agree on goals for therapy with the therapists, and the overall effectiveness of the interventions. That is, the more a participant reported that they were actively working at changing their ED symptoms, the less likely they were to trust and agree on goals for therapy with the therapist in the directive vignettes, and the less helpful they rated the therapist response in these vignettes.
Table 8. Correlations between ratings of the directive vignettes and RMI scores, controlling for Marlowe-Crowne scores

<table>
<thead>
<tr>
<th>RMI Restriction</th>
<th>Directive Vignettes</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Trust</td>
<td>Agree on Goals</td>
<td>Included in Decisions</td>
<td>Confidence</td>
<td>Effectiveness</td>
</tr>
<tr>
<td>Precontemplation</td>
<td>.33</td>
<td>.29</td>
<td>.30</td>
<td>.22</td>
<td>.39*</td>
</tr>
<tr>
<td>Contemplation</td>
<td>-.05</td>
<td>.05</td>
<td>-.16</td>
<td>-.09</td>
<td>-.16</td>
</tr>
<tr>
<td>Action</td>
<td>-.32</td>
<td>-.33</td>
<td>-.23</td>
<td>-.18</td>
<td>-.32</td>
</tr>
<tr>
<td>RMI Global</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Precontemplation</td>
<td>.48**</td>
<td>.37*</td>
<td>.24</td>
<td>.31</td>
<td>.40*</td>
</tr>
<tr>
<td>Contemplation</td>
<td>-.07</td>
<td>.03</td>
<td>-.06</td>
<td>-.06</td>
<td>-.09</td>
</tr>
<tr>
<td>Action</td>
<td>-.43*</td>
<td>-.36*</td>
<td>-.21</td>
<td>-.27</td>
<td>-.35*</td>
</tr>
</tbody>
</table>

* Note: * = p < .05, ** = p < .01
Purpose 3. Exploring Adolescents' Thoughts and Feelings about the Different Interventions in Relation to the Different Dependent Variables

Development of the coding scheme

Analyses of the responses to the open-ended questions were used to increase awareness about the factors that the participants perceived to be important aspects of therapist-client interactions in developing the therapeutic alliance, fostering confidence in adolescents' ability to change, and offering effective interventions for adolescents with eating disorders. The number of participants endorsing each category for each of the open-ended questions are listed in Tables 9, 11, 13, 15, and 16. Pearson's correlations between the proportionate usage of each category and RMI global and restriction scores were conducted for each open-ended question.

Trust. When asked to discuss factors that would influence the extent to which they would trust a therapist, the most frequently endorsed category was Genuine Concern followed by Making Assumptions, Confidentiality, Acceptance, Personal Disclosure, and finally Synchrony.

There was a significant positive relationship between the Confidentiality category and RMI global precontemplation scores (see Table 10). That is, the less ready a person was to change their ED, the more likely they were to focus on issues of confidentiality when discussing factors that would influence their ability to trust a therapist.
Table 9. Coding of the open-ended trust question

<table>
<thead>
<tr>
<th>Category</th>
<th>Defining Features</th>
<th>Frequency (% of Sample Endorsing Category)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidentiality</td>
<td>• Maintaining or breaking confidentiality, particularly relevant with respect to sharing information with parents, but can include breaches in confidentiality between staff.</td>
<td>15 (38.5)</td>
</tr>
<tr>
<td>Acceptance</td>
<td>• Demonstrating acceptance of client by being calm and non-judgmental</td>
<td>15 (38.5)</td>
</tr>
<tr>
<td></td>
<td>• Showing interest in parts of client that does not want to change.</td>
<td></td>
</tr>
<tr>
<td>Genuine Concern</td>
<td>• Listening to the client,</td>
<td>29 (74.4)</td>
</tr>
<tr>
<td></td>
<td>• Emphasizing that you are there to help the client.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Giving genuine encouragement.</td>
<td></td>
</tr>
<tr>
<td>Making Assumptions</td>
<td>• Asking the client how they feel or for their opinions.</td>
<td>23 (59.0)</td>
</tr>
<tr>
<td></td>
<td>• Avoid assuming that you know how the client feels.</td>
<td></td>
</tr>
<tr>
<td>Personal Disclosure/Shared Experience</td>
<td>• Demonstrating that you can relate to the client's experience.</td>
<td>14 (35.9)</td>
</tr>
<tr>
<td></td>
<td>• Demonstrating expertise working with clients with eating disorders.</td>
<td></td>
</tr>
<tr>
<td>Synchrony</td>
<td>• Being in synchrony with the client's readiness for change (e.g., not suggesting steps that are “too big”, asking personal questions too soon).</td>
<td>11 (28.2)</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td>----------------</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dispersive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal</td>
<td></td>
<td></td>
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<tr>
<td>Assumptions</td>
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<td></td>
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<tr>
<td>Making</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concern</td>
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<td></td>
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<tr>
<td>Genuine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acceptance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confidentially</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 10. Correlations between Trust categories and RMI scores
Agreement on Goals. With respect to factors that would influence the extent to which participants felt they would agree on goals for therapy with a therapist, the most frequently endorsed category was Synchrony followed by Client Input, Judgmental/Assumptions, Respect, Information, Trust, and finally Formalize Long Term Goals.

Correlations between participants’ RMI Restriction and global scores and each of the categories for Agree on Goals are displayed in Table 12. The more participants reported that they were actively working at increasing their dietary intake, the more likely they were to focus on the importance of synchrony between the therapist and the client in order to agree on goals for therapy with a therapist. The more participants reported that they were thinking about changing their eating disorder, the more likely they were to focus on the importance of having information about eating disorders and nutrition, when discussing factors that would influence their willingness to agree on goals for therapy with a therapist. With respect to the importance of formalizing the long-term goals for therapy in relation to agreement on goals, the more participants reported that they were actively working on changing their eating disorder and increasing their intake, the more likely they were to focus on this category. Conversely, the more participants reported that they were not ready to change, the less likely they were to focus on the need for formalizing long-term therapy goals when trying to agree on goals for therapy with a therapist.
<table>
<thead>
<tr>
<th>Category</th>
<th>Defining Features</th>
<th>Frequency (% of Sample Endorsing Category)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Synchrony</td>
<td>• Match between client and therapist with respect to timing of goals and the pace of therapy</td>
<td>25 (64.1)</td>
</tr>
<tr>
<td>Information</td>
<td>• Health risks and physical consequences of not changing (e.g., bone loss)</td>
<td>6 (15.4)</td>
</tr>
<tr>
<td></td>
<td>• Nutritional information</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• General information on ED</td>
<td></td>
</tr>
<tr>
<td>Judgmental/Assumptions</td>
<td>• Making comments on client’s progress with a evaluative or judgmental component</td>
<td>20 (51.3)</td>
</tr>
<tr>
<td></td>
<td>• Making assumptions about how the client is the thinking or feeling</td>
<td></td>
</tr>
<tr>
<td>Respect</td>
<td>• Demonstrating interest in client’s feelings in general</td>
<td>17 (43.6)</td>
</tr>
<tr>
<td></td>
<td>• Understanding the client’s perspective</td>
<td></td>
</tr>
<tr>
<td>Client Input</td>
<td>• Seek client’s opinion and agreement on goals</td>
<td>24 (61.5)</td>
</tr>
<tr>
<td></td>
<td>• Involved in joint planning</td>
<td></td>
</tr>
<tr>
<td>Formalize Long Term Goals</td>
<td>• Discuss the process of therapy and the long term goals</td>
<td>3 (7.7)</td>
</tr>
<tr>
<td>Trust</td>
<td>• Being able to trust the therapist</td>
<td>5 (12.8)</td>
</tr>
<tr>
<td></td>
<td>10'</td>
<td>0'</td>
</tr>
<tr>
<td>-------</td>
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<td>-------</td>
</tr>
<tr>
<td>3.4</td>
<td>3.4</td>
<td>4.0</td>
</tr>
<tr>
<td>3.4</td>
<td>4.0</td>
<td></td>
</tr>
<tr>
<td>6.0</td>
<td>1.4</td>
<td>4.0</td>
</tr>
<tr>
<td>6.0</td>
<td>1.7</td>
<td>3.0</td>
</tr>
<tr>
<td>2.0</td>
<td>2.4</td>
<td></td>
</tr>
<tr>
<td>1.8</td>
<td>1.8</td>
<td>2.7</td>
</tr>
</tbody>
</table>

Note: \[ d = 0.05, \] \( d = \) * * \( d = 0.1 \)

<table>
<thead>
<tr>
<th>Trust</th>
<th>Goals</th>
<th>Long Term</th>
<th>Formalize</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavioral Input</th>
<th>Respect</th>
<th>Assumptions</th>
<th>Judgment</th>
<th>Information</th>
<th>Synchrony</th>
</tr>
</thead>
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<table>
<thead>
<tr>
<th>Precompliance</th>
<th>Completion</th>
<th>Action</th>
<th>Precompliance</th>
<th>Action</th>
<th>Internally</th>
<th>RMI Global</th>
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</thead>
<tbody>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 12: Correlations between agree on goals, calzegoes and RMI scores

Motivational vs. Directive Interventions 71
Confidence in ability to Change. Regarding factors that would influence participants' confidence in their ability to change, the most frequently endorsed category was Support followed by Judgmental/Assumptions, Patience, Examining Consequences of Not Changing, Providing Change Strategies, Nothing, and Regaining Control.

Correlations between participants' proportionate usage of each of these categories and their RMI restriction and global scores are displayed in table 14. The more participants' reported that they were contemplating increasing their intake, the more likely they were to focus on the importance of regaining control, as an important factor in influencing their confidence in their ability to change. Conversely, the more participants reported that they did not want to change their intake, the less likely they were to focus on regaining control as a factor that would influence their confidence in their ability to change. Lastly, the more participants reported that they were thinking about increasing their intake, the more likely they were to focus on the impact of examining the consequences associated with not changing their ED as factor that would influence their confidence in their ability to change.
Table 13. *Coding of the open-ended confidence in ability to change question*

<table>
<thead>
<tr>
<th>Category</th>
<th>Defining Features</th>
<th>Frequency (% of Sample Endorsing Category)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nothing</td>
<td>• View confidence as an internal state that is not influenced by others</td>
<td>7 (17.9)</td>
</tr>
<tr>
<td>Support</td>
<td>• Demonstrating belief in client’s ability to change, provide a sense of hope</td>
<td>32 (82.1)</td>
</tr>
<tr>
<td></td>
<td>• Show <em>genuine</em> concern</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide encouragement, acknowledge positive changes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide readings that are self-reflective, or motivational (e.g., others recovery stories)</td>
<td></td>
</tr>
<tr>
<td>Regaining Control</td>
<td>• Let client’s make decisions</td>
<td>6 (15.4)</td>
</tr>
<tr>
<td></td>
<td>• Have client’s generate goals</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• When safe, encourage client’s to engage in normal activities (e.g., recreational activities)</td>
<td></td>
</tr>
<tr>
<td>Providing Change Strategies</td>
<td>• Providing alternatives if first attempts are not helpful</td>
<td>7 (17.9)</td>
</tr>
<tr>
<td></td>
<td>• Provide client’s with strategies</td>
<td></td>
</tr>
<tr>
<td>Patience</td>
<td>• Avoid setting time limitations</td>
<td>15 (38.5)</td>
</tr>
<tr>
<td></td>
<td>• Take small steps</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Set manageable goals</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Avoid magnifying slips</td>
<td></td>
</tr>
<tr>
<td>Judgmental/Assumptions</td>
<td>• Making evaluative statements (can include judgmental facial expressions)</td>
<td>26 (66.7)</td>
</tr>
<tr>
<td></td>
<td>• Making assumptions about the client’s thoughts or feelings</td>
<td></td>
</tr>
<tr>
<td>Examining Consequences of Not Changing</td>
<td>• Discussing the cons of not making changes</td>
<td>9 (23.1)</td>
</tr>
<tr>
<td>Item</td>
<td>1.15</td>
<td>0.10</td>
</tr>
<tr>
<td>------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>1.16</td>
<td>1.15</td>
<td>0.29</td>
</tr>
<tr>
<td>1.04</td>
<td>1.05</td>
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<td>1.07</td>
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<td>0.18</td>
</tr>
<tr>
<td>1.18</td>
<td>0.16</td>
<td>0.34</td>
</tr>
</tbody>
</table>

Table 14. Correlations between confidence categories and RMI scores

Movemental vs. Directive Interventions 74
Input in Treatment Decisions. The most frequently endorsed category related to factors that would influence participants' sense of being included in decisions made about their treatment was Control/Power, followed by Caring, Consider Client Readiness, and finally Provide Choice. No significant relations were found between participants' proportionate usage of the categories developed for this question and RMI Restriction or global scores.
<table>
<thead>
<tr>
<th>Category</th>
<th>Defining Features</th>
<th>Frequency (% of Sample Endorsing Category)</th>
</tr>
</thead>
</table>
| Client Input/Control/Power | • Make goals together  
                         • Ask for client input on goals, include in conversations  
                         • Avoid being rigid, and dictating goals  
                         • Emphasize that change is their choice and they have the power to make decisions  
                         • Be open-minded | 33 (84.6) |
| Consider client readiness | • Be considerate of client’s thoughts about changing  
                         • Consider client comfort with goals  
                         • Do not set goals that client’s perceive as too ambitious | 15 (38.5) |
| Provide Choice         | • Together, generate a number of options on how to change | 9 (23.1) |
| Caring                | • Demonstrate that you are interested in the client and that you care | 18 (46.2) |
Effectiveness. With respect to factors that would be helpful for adolescents with eating disorders, the most frequently endorsed category was Alliance, followed by Client Involvement, Assumptions, Support, Judgments, Unrealistic Goals, and finally Provide Information.

Correlations between participants’ proportionate usage of each of these categories and their RMI restriction and global scores are displayed in table 17. The more participants reported that they were not ready to increase their intake, the more likely they were to focus on the importance of client involvement as a helpful aspect in therapy. The more participants reported that they were thinking about increasing their intake, the more likely they were to focus on the helpfulness of obtaining nutritional and health information. The more participants reported that they were working on changing their ED symptoms for themselves (as opposed to for others), the less likely they were to focus on the importance of client involvement, and the more likely they were to focus on the helpfulness of support and a non-body focus in therapy.
<table>
<thead>
<tr>
<th>Category</th>
<th>Defining Features</th>
<th>Frequency (% of Sample Endorsing Category)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance</td>
<td>• Demonstrate interest in person, not just their ED</td>
<td>35 (89.7)</td>
</tr>
<tr>
<td></td>
<td>• Express interest and demonstrate understanding of client’s feelings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Demonstrate Credibility (discuss interest in ED, and training)</td>
<td></td>
</tr>
<tr>
<td>Client Involvement</td>
<td>• Emphasize client choice (i.e., to change)</td>
<td>25 (64.1)</td>
</tr>
<tr>
<td></td>
<td>• Provide choices</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Present change as an experiment</td>
<td></td>
</tr>
<tr>
<td>Unrealistic Goals</td>
<td>• Goals that are too big, or too fast</td>
<td>16 (41.0)</td>
</tr>
<tr>
<td>Assumptions</td>
<td>• Regarding thoughts/feelings, what they need to do to change</td>
<td>19 (48.7)</td>
</tr>
<tr>
<td>Support</td>
<td>• Demonstrate a belief in client’s ability to change</td>
<td>19 (48.7)</td>
</tr>
<tr>
<td></td>
<td>• Provide encouragement to keep <em>trying</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Offer support</td>
<td></td>
</tr>
<tr>
<td>Judgements</td>
<td>• Expressing disappointment</td>
<td>18 (46.2)</td>
</tr>
<tr>
<td></td>
<td>• Magnifying slips</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Good for you!</td>
<td></td>
</tr>
<tr>
<td>Provide Information</td>
<td>• Nutritional Information (i.e., what is a “normal” amount of food)</td>
<td>5 (12.8)</td>
</tr>
<tr>
<td></td>
<td>• Health Information</td>
<td></td>
</tr>
<tr>
<td>Non-body Focus</td>
<td>• Avoid focusing exclusively on shape, weight, or food related issues</td>
<td>13 (33.3)</td>
</tr>
<tr>
<td></td>
<td>0.43</td>
<td>0.13</td>
</tr>
<tr>
<td>--------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>Non-body Information</td>
<td>2.00</td>
<td>0.15</td>
</tr>
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<td>Provide Judgments</td>
<td>0.60</td>
<td>0.80</td>
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<td>0.13</td>
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<td>Alliance</td>
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<td>2.60</td>
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Note: * \( p < 0.05 \)

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<th>Confirmation Action</th>
<th>Preconfirmation Action</th>
<th>Action Internality</th>
<th>RMI Global</th>
<th>RMI Restriction</th>
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Table 1.7. Correlations between helpful categories and RMI scores

Motivational vs. Directive Interventions
Chapter IV

Discussion

Summary of Findings

Adolescents with eating disorders are commonly described as resistant to treatment. As such, it has been suggested that a motivational therapeutic approach could be an effective strategy for engaging and treating this population. However, this is one of the first studies examining readiness and motivation for change in adolescents with eating disorders, and the potential utility of a motivational treatment approach with this population. Adolescents in this study were highly ambivalent about changing their eating disorder. That is, participants commonly reported that a part of them was in each of the stages of change. However, the highest stage of change score averaged across all symptoms was precontemplation. On average, participants reported that there was a large part of themselves (approximately 50%) that was not intending to make changes to their eating disorder symptoms. Despite these high levels of precontemplation, nearly all participants reported that there was at least a small part of themselves that was actively working to decrease their symptoms. Interestingly, if participants were working at making changes to their eating disorder symptoms, the majority of the work they were doing was for themselves (approximately 70%) as opposed to for other people such as parents, friends, or therapists.

Purpose 1. Comparison of Adolescents’ Ratings of Trust, Agreement on Goals, Self Confidence., Input in Decisions, and Effectiveness between the Motivational and Directive Vignettes
Findings from the current study support the potential utility of a motivational therapeutic approach with adolescents with eating disorders. Overall, adolescents reported that they would be more likely to trust, agree on goals for therapy, feel included in decisions made about their treatment, and have greater confidence in their ability to change with the therapists in the motivational vignettes, in comparison to those in the directive vignettes. In addition, in comparison to the directive vignettes, adolescents rated the motivational vignettes as more likely to be helpful for adolescents with eating disorders. There were no significant relationships between the tendency to give socially desirable responses and adolescents’ readiness and motivation for change, or their ratings of the motivational vignettes. However, the tendency to provide socially desirable responses was related to more favourable ratings of the directive vignettes. Therefore, ratings of the directive vignettes may be inflated if they were influenced by participants desire to respond in a socially desirable way. If this were the case, participants’ preference for the motivational vignettes over the directive vignettes might be greater than that described in this study.

In addition to differences between the two types of interventions due to specific techniques or strategies adopted by therapists in the vignettes, adolescents’ perceptions of non-specific therapy factors within the vignettes could have influenced their ratings of the dependent variables. Adolescents’ perceptions of therapist warmth and caring were related to their ratings of the dependent variables. However, adolescents appear to have rated the motivational vignettes more favorably than the directive vignettes for additional reasons other than their perceptions of the therapists in these vignettes as being more warm and caring.
Purpose 2. Relations between Adolescents’ Readiness Status and their Ratings of Therapeutic Alliance, Self-Efficacy, and Effectiveness of the Motivational and Directive Vignettes

The transtheoretical model of change suggests that individuals may react differently to various types of interventions depending on their stage of change (Prochaska et al., 1992). In the present study, there were no significant relationships between adolescents’ readiness and motivation for change and their ratings of the motivational vignettes. In contrast, several relationships were found between adolescents’ readiness and motivation for change and their ratings of the directive vignettes. Overall, the more adolescents reported that they were working on changing their eating disorder (i.e., higher RMI global action scores) the less favorably they rated the directive interventions on trust, agree on goals, and overall helpfulness. Conversely, the more adolescents reported that they did not want to change their eating disorder (i.e., higher RMI global precontemplation scores) the more favorably they rated the directive vignettes on trust, agree on goals, and overall helpfulness.

Purpose 3. Exploring Adolescents’ Thoughts and Feelings About the Different Interventions in Relation to the Dependent Variables

Given the preliminary nature of this research, adolescents were asked a number of open-ended questions to assist in clarifying factors that they identify as important in influencing the extent to which they would trust therapists, agree on goals for therapy, have confidence in their ability to change, and feel included in decisions made about their treatment. In addition, they were asked to discuss the most helpful or unhelpful things therapists could say or do for adolescents with eating disorders. Participants were able to
generate a number of factors related to each of the questions. Demonstrating a genuine concern for their clients was the most frequently discussed factor related to adolescents' ability to trust their therapists. With respect to agreement on goals, the most commonly generated response involved the importance of synchrony between the client and the therapist both in terms of the timing of goals and the pace of therapy. The majority of adolescents identified therapist supportiveness as a factor that would influence their confidence in their ability to change. Examples of supportiveness included demonstrating a belief in client's ability to change and a genuine concern for client's well being. Therapists' ability to provide clients with control or power was the most frequently generated factor related to adolescents' feeling of inclusion in decisions made about their treatment. This encompassed therapist factors such as being open-minded and flexible. Finally, nearly every adolescent reported that the therapeutic alliance was an essential component of helpful interventions. Factors identified as contributing to the development of the alliance included therapists demonstrating an interest in clients as people, not simply as an eating disorder, and expressing interest and understanding in client's feelings.

A number of significant relations were found between adolescents' readiness and motivation for change and the extent to which they focused on various factors in response to the open-ended questions. The more adolescents reported that they did not want to change their eating disorder the more likely they were to discuss the importance of confidentiality as a factor that would influence their ability to trust a therapist and the importance of the therapeutic alliance for helpful interventions, and the less likely they were to focus on the role of client control as a factor that influences their confidence in
their ability to change. The more participants reported that they were contemplating making changes, the more likely they were to focus on the importance of being provided with health information both in terms of their ability to agree on goals for therapy and the overall helpfulness of interventions. In addition, these adolescents were more likely to focus on the importance of regaining control in treatment decisions and in their day to day lives when discussing factors that would influence their confidence. The more participants reported that they were actively working at changing, the more likely they were to focus on the importance of synchrony between the therapist and client, and awareness of the long term process of therapy, as important factors influencing the extent to which they would agree on goals for therapy. The more adolescents reported that they were working on changing for internal versus external reasons, the more likely they were to focus on the importance of a non-body focus in therapy, and the role of therapist assumptions as influencing the helpfulness of interventions. These adolescents were also less likely than those adolescents who were working at changing for external reasons to focus on the role of the therapeutic alliance with respect to the helpfulness interventions.

**Participant Characteristics**

Participants were recruited from a number of different eating disorder treatment centers and had different diagnoses. As expected, few differences in participants’ ambivalence or levels of eating disorder and psychiatric symptom severity were found between centers or across diagnoses. At each of the sites, including the hospital inpatient programs at ACH and BCCH, there was a significant portion of adolescents with a diagnosis of eating disorder not otherwise specified. A number of atypical symptom presentations contributed to the high proportion of EDNOS diagnoses. For example,
some adolescents reported engaging in purging but not bingeing, and other adolescents did not endorse cognitive symptoms such as fear of weight gain. This finding is consistent with the literature where it has been suggested that approximately 50% of young people presenting for eating disorders treatment do not meet the DSM-IV criteria for anorexia nervosa or bulimia nervosa (Nicholls, Chater, & Bryant-Waugh, 2000; Robin, 2003). There are a number of possible explanations for this finding. Firstly, young people with eating disorders may be referred for treatment by parents or caregivers before their symptoms are severe enough to meet the diagnostic criteria for AN or BN (i.e., they are not a low enough weight, or they are not binging 2x a week). Secondly, the diagnostic criteria may not adequately capture the essence of disordered eating in younger individuals (Nicholls et al., 2000). In the current study, there were few differences between adolescents with EDNOS, AN, and BN in terms of levels of ambivalence and eating disorder or psychiatric symptom severity. There was also a wide diversity in symptom presentation in the EDNOS group. Together these findings suggest that the adequacy of the DSM-IV eating disorder criteria for younger individuals deserve further exploration (Nicholls et al., 2000). In one study, the inter-rater reliability of eating disorder diagnoses based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994) criteria and a more behaviorally focused classification system developed by therapists working at a children and adolescent program was compared (i.e., the Great Omron Street (GOS) criteria). The inter-rater reliability values (kappa) using DSM-IV and the GOS criteria were 0.636 and 0.879, respectively (Nicholls et al., 2000). Therefore, it has been suggested that the DSM-IV diagnostic criteria be modified for young people with disordered eating in such
a way that greater emphasis is placed on physical and behavioral symptoms, and less emphasis is placed on cognitive symptoms (Nicholls et al., 2000).

With respect to readiness for change, adolescents expressed a great deal of ambivalence around changing their eating disorder. Although, the dominant stage of change score was precontemplation, suggesting that many adolescents reported that they were not ready to change their eating disorder symptoms, most adolescents reported that there was a part of them that was thinking about, or working at making some changes to their eating disorder. In addition, adolescents with anorexia endorsed a number of pros and cons associated with their eating disorder. With respect to the pros of their eating disorder, adolescents reported that it provided them with a means of communicating their distress to others, a sense of security or structure, improved their appearance, alleviated concerns regarding their sexuality, and made them feel special. At the same time they also acknowledged that their eating disorder made them feel trapped, guilty about the worry it causes others, stifled their emotions, and that they hated their eating disorder. Unfortunately, there was no comparable measure of the pros and cons of BN or EDNOS. However, informal discussions with these adolescents suggested that they also recognized that there were both positive and negative factors associated with their eating disorder. Thus, a distinction needs to be made between adolescents simply not wanting to change their eating disorder, and not knowing how to change their eating disorder or needing something to replace the positive aspects of the disorder instead of simply removing the symptoms. These findings provide empirical support for many of the assertions made in clinical writings on the potential utility of motivational interventions with this population (e.g., Treasure & Schmidt, 2001; Vitousek et al., 1998). For example, as suggested by
Vitousek et al., 1998 therapists could support adolescents in developing their sense of competence in areas of life other than their eating disorder in order to provide them with alternative healthy means for feeling special. Supporting adolescents through the process of understanding their ambivalence and helping them to generate alternative methods of having their needs met may be helpful in working with this population.

Despite the ambivalence adolescents reported, if they were working at making changes to their eating disorder the majority of the work they were doing (approximately 70%) was motivated by internal as opposed to external reasons. This finding could suggest that although parents can sometimes force their children into treatment they will only actively work at making changes if they are motivated to do so for themselves. Alternatively, this finding could reflect a unique experience related to adolescence as a stage of life. That is, many adolescents appeared hesitant to acknowledge that they would do something because someone else had told them too. This appeared different than in adult populations where clients often acknowledge making changes for their partners or families, and give the impression that they feel it would be selfish to report that the majority of the work they are doing is for themselves. Given the importance of control that is often associated with adolescence, encouraging young people who are thinking about making changes to do it for internal reasons may be a nice match with their stage of life.

**Motivational versus Directive Vignettes**

Adolescents rated the motivational interventions more favorably than the directive interventions on each construct assessed. In addition, the majority of these preferences remained even after controlling for their perceptions of the therapists in the motivational
vignettes as more warm and caring. Thus, consistent with previous research with other
treatment resistant groups such as adolescents who smoke (e.g., Colby et al., 1998) or
have substance abuse problems (e.g., Barnett et al., 2002), motivational interventions
seem to be perceived by adolescents with eating disorders as an acceptable therapeutic
approach. Specifically, this research suggests that the stance of therapists using this style
of interacting may be conducive to developing an alliance with this difficult to engage
population.

There are a number of possible explanations for adolescents’ preference for the
motivational vignettes. In discussing factors related to each of the constructs assessed,
therapists making assumptions about their thoughts or feelings, or feeling judged was
consistently mentioned by adolescents as having a negative impact on therapy. Thus, as
hypothesized, the lack of assumptions in the motivational interventions may have
contributed to their preference for these vignettes. Alternatively, given that the use of
assumption was part of the manipulation of the independent variable, the vignettes
themselves may have primed adolescents to discuss this factor. However, recent research
utilizing the principles of motivational interviewing with adolescent mothers has shown
that health care workers often base their interventions on the assumption that these
pregnancies are unintended, and that adolescents are motivated to prevent pregnancy
(Cowley, Farley, & Beamis, 2002). However, in one study approximately half of the
adolescents who were from low socioeconomic status homes and who had never been
pregnant were ambivalent or had positive feelings about becoming pregnant (Cowley &
Farley, 2001). In another study, pregnant teenagers were asked why they had not used
contraception and many of adolescents reported that they had wanted or did not mind
becoming pregnant (Stevens-Simon, Kelly, Singer, & Cox, 1996). Thus, there appears to be a subset of adolescents that are at least ambivalent about the idea of becoming a mother. Researchers in this area have suggested that traditional clinic based interventions that focus on methods of preventing adolescent pregnancies may not be adequate for those adolescents who desire to have a baby because they are based on the “taken-for-granted” assumption that these pregnancies are unintended. In addition, they have suggested that motivational enhancement therapy might be helpful with this population due to its explicit focus on examining ambivalence (Cowley et al., 2002). Together, these findings suggest that further research is needed to identify caregiver assumptions about adolescents with eating disorders and the effects of these assumptions on the efficacy of interventions.

As an alternative explanation for adolescents’ preference for the motivational interventions, many adolescents discussed the importance of feeling in control over their treatment and recovery. They acknowledged that they did not like the therapists in the directive vignettes telling them what they should do without first addressing or validating their own thoughts about changing. When asked to discuss factors that she thought would be helpful in her treatment one adolescent responded:

“Letting you make, kind of, the plans and stuff... Kind of, um asking you where you want to go with this and just never really deciding anything without kind of, like, feeling out the situation first. Um, you know, not saying “OK, we’re gonna, we’re gonna do this today and this is what we’re going to work on and blah, blah, blah” because, you know, you could’ve been having a really great few sessions and now you feel like crap and you don’t want to do that anymore. I think, um, that it should always, kind of, you, the therapist should always kind of, like, ask the patient where they want to go and, um, and if they’re not, if they’re not saying “Well, you know it’s good if you plan to eat more” then um, I mean ‘cause then the patient can feel like “Wow, they don’t, they don’t even care about how I feel”. But, um, if they say “Well, you know, what do you think you wanna do about it? Like how do you feel about this?” then at
least you feel “Well, ok I do have a say in, in, you know, how I want to get better.” So, you know, it’s, it’s a trust thing again. I can feel more in charge and more like I’m doing it instead of, you know, another doctor trying to treat me.”

This quote demonstrates the passion that some of these adolescents felt regarding their need for control and the resistance that could arise if therapists push too hard for change. The motivational approach involves asking client’s how they are feeling and if appropriate developing a plan of action collaboratively (Miller & Rollnick, 1991). Therefore, adolescents may have rated the motivational vignettes more favorably because they felt a greater sense of control or involvement in therapy with these interventions.

Social Desirability, Readiness for Change, and Directive Interventions

Adolescents with eating disorders are often described as eager to please others (Bruch, 1973), therefore the tendency to provide socially desirable responses was assessed. Adolescents receiving treatment for their eating disorder may feel pressure from family, friends, and caregivers to appear ready and willing to change. In a previous study that included adolescents with anorexia nervosa, stage of change information assessed using a questionnaire was related to the tendency to offer socially desirable responses. (Rieger et al., 2000). In the current study, there were no relations between the tendency to offer socially desirable responses and adolescents’ reports of their readiness for change as assessed using the RMI. The stance of the RMI assessor may account for this discrepancy in findings. Specifically, the RMI assessor begins the interview by stating that they are interested in gaining a better understanding of how each individual is feeling about changing their eating disorder, and that they are interested in both the parts of individuals that do and do not want to change. In addition, they emphasize that the
interview is confidential and that regardless of how adolescents respond during the interview it will not effect their treatment. Incorporating these components into interventions when possible may facilitate open discussions regarding clients’ feelings about change. In turn, these discussions may serve to engage adolescents in treatment, and allow therapists to provide interventions that match each client’s readiness for change.

Adolescents’ ratings of the motivational vignettes were not related to the tendency to offer socially desirable responses. In contrast, the tendency to give socially desirable responses was related to more favourable ratings of the directive vignettes. Thus adolescents with eating disorders who are eager to please others may appear to be engaged in directive interventions, however there may be limited movement towards recovery or even premature termination of therapy with these interventions. In discussing how being pressured or told to change in combination with her desire to please others was unhelpful in her recovery one adolescent explained:

“It’s the whole expectation thing. If you think someone has expectation of you, you’ll try to live up to them whether you can or not. Like, if it means, being someone you’re not, feeling something you don’t really feel, if that’s how you think someone wants you to feel you’ll do it, you’ll like, you’ll like put on a mask to be that person to them, live up to those goals when really that’s not really helping anything because everything that was there is still there, and now there is more on top of it… You feel more scared and you feel more “Oh no, I’ve done this and if I turn back and say I can’t do this then I’m going to get in so much trouble and everything is gonna have failed”.

This particular adolescent had prematurely left an intensive day treatment program against the advice of her care providers and parents. Thus, in contrast to a more directive intervention, motivational interventions that encourage open dialogues about clients’ feelings about change, and includes them in treatment decisions instead of telling them
what to do would likely be helpful for adolescents who have a need to please others because it appears to decrease their need to provide socially acceptable responses. This finding provides one possible explanation for the high rates of drop out and treatment failure in more traditional eating disorder treatments that focus primarily on symptom reduction (Geller, Williams, & Srikameswaran et al., 2001). In addition, this finding suggests that length of treatment may be need to be extended because clients may first need to explore their ambivalence and the function of their symptoms before making changes toward recovery (Vitousek et al., 1998).

**Readiness for Change and Ratings of the Directive Vignettes**

In comparison to adolescents who were actively working at changing their eating disorder, adolescents who were not ready to change rated the directive vignettes as more helpful, and the therapists in these vignettes as more trustworthy and caring. This relation is contrary to that reported in a similar study with adults with eating disorders. In that study, participants who were highly ambivalent about change rated directive vignettes less favorably than participants who were ready for change (Geller et al., 2003). These contradictory findings could reflect developmental differences. For instance, adolescence is often a stage in life where individuals are negotiating between a desire for independence and a reliance on caregivers (Meeks & Bernet, 1996; Steinberg, 1996). Adolescents, in particular those with eating disorders, might be struggling with issues of separation and concerns over the prospect of becoming an adult and having to make independent decisions (Bruch, 1973). Thus, adolescents, particularly those in distress, may feel comforted by adults who take a more directive approach, and may therefore interpret this approach as appropriate and caring.
Alternatively, these findings could be related to the combination between adolescents’ ambivalence about changing, their perception of being forced into recovery, and their self-efficacy. In the current study, it was expected that adolescents’ perception of being included in decisions made about their treatment would be highly related to their confidence in their ability to change. Although related, the strength of the association was less than expected. In addition, some adolescents expressed doubt in the ability of adolescents with eating disorders to make healthy choices if they were placed in full control of their own recovery. If adolescents believe they are going to be forced into recovery, are ambivalent about changing, and do not feel confident in their ability to reduce their symptoms it may initially feel better for these adolescents to make external attributions regarding the process of change. In contrast, adolescents who were actively working on change reported that the majority of the changes they were making were motivated by internal as opposed to external reasons. In contrast to motivational interventions, the directive interventions may allow for external attributions thereby contributing to ambivalent adolescents’ more favourable ratings of these vignettes, in comparison to the ratings of motivated adolescents.

Open-ended Questions Clarify Relations between Adolescents’ Readiness and Ratings of the Directive Vignettes

Findings from the open-ended questions suggest additional possible explanations for the relations between client readiness and their perceptions of the directive interventions. Adolescents’ who were least ready to change were most likely to focus on relationship or alliance variables, and least likely to focus on the importance of regaining control as useful aspects of therapy. These adolescents were also more likely to rate
therapists in the directive vignettes as more caring ($r = .33, p < .05$) than those adolescents who were ready to change. These adolescents may feel more in control of their eating because they are not planning on changing, and thus are looking for emotional support from their therapist. The controlling nature of the directive interventions therefore might not be as threatening for these adolescents. Alternatively, in comparison to adolescents who are ready for change, these adolescents may be so distressed by their symptoms that they are more comfortable with others taking over control of the recovery process.

Participants who were actively working at changing expressed interest in discussing the long-term process of therapy, and focused on the importance of synchrony between the therapist and client with respect to size and timing of goals. Together, these findings could suggest that control issues may be particularly relevant to adolescents with eating disorders who are working at changing their symptoms in that they want to know what the proposed end point of therapy will encompass, and do not want change to happen too quickly. Adolescents who are making changes to their eating disorder may feel that they are losing their sense of control by giving up their eating disorder and therefore feel a need to be in control of the recovery process. Alternatively, these adolescents may feel that they have demonstrated that they can make responsible choices and therefore feel entitled to more control or involvement in the process of recovery. Either of these explanations could account for their dissatisfaction with the directive interventions. With respect to treatment, these findings suggest that therapists treating adolescents who are in action may find emphasizing client's control over the process of recovery helpful in continuing to engage the teen in therapy.
Although interesting, the relations between adolescents’ readiness and their rating of the directive vignettes need to be interpreted in the context of the overall finding in which across stages of change, participants rated the motivational vignettes more favorably than the directive vignettes. In summary, across varying levels of readiness and motivation for change, in comparison to directive interventions, motivational interventions may be more effective for adolescents with eating disorders.

**The Transtheoretical Model of Change and Responses to the Open-ended Questions**

Relations between participants’ readiness and motivation for change and their endorsement of the different categories in response to the open-ended questions provide initial support for the applicability of the Transtheoretical Model of Change (TMC; Prochaska et al., 1992) to adolescents with eating disorders. According to the TMC, individuals at different stages of change utilize different processes of change. For example, individuals who are in contemplation are likely to be engaging in the process of change labeled self-reevaluation. This process of change involves examining how one feels about oneself with respect to the problem (Prochaska et al., 1992). In this study, adolescents who were contemplating change were more likely to focus on information gathering, and examining the consequences of changing or not changing, as useful characteristics of therapy. As a second example, individuals who are in precontemplation are likely to be engaging in the process of change labeled dramatic relief. That is, individuals who report that they are not intending to change are often engaged in experiencing and expressing their feelings (Prochaska et al., 1992). In this study, adolescents who were in precontemplation often focused on alliance variables such as therapists expressing interest and demonstrating understanding of client’s feelings as
helpful aspects of interventions. These findings offer preliminary support for the utility of matching interventions to participants’ readiness and motivation for change.

Limitations

There are number of limitations in the current research. Most notably, the analogue nature of the study limits the generalizability of the findings. However, given the preliminary nature of this research an analogue design is an appropriate and cost effective method of exploring adolescents’ thoughts and feelings regarding motivational interventions. The relatively small sample of participants in each of the diagnostic groups limits the conclusiveness of the between group comparisons of symptomatology and readiness for change. In addition, it was not possible to examine differences in adolescents’ perceptions of the different vignettes across diagnostic groups. It is possible that adolescents with different diagnoses may vary in their perceptions of the effectiveness of different types of interventions.

Implications for Practice

A number of implications for therapists working with adolescents with eating disorders can be drawn from this research. Firstly, these finding suggest that therapists working with adolescents with eating disorders should avoid making assumptions about their client’s thoughts and feelings about the extent to which they view their symptoms as a problem, or their readiness and motivation for change. Even therapists or programs that choose to utilize a more directive therapeutic approach could avoid making these assumptions. In fact, in comparison to their reaction to therapists making assumptions about their thoughts or feelings, participants appeared to have less resistance to being directed as to how to change. For example, in one vignette the frequency of the
adolescent's vomiting had increased and the therapist assumed that the adolescent felt awful and asked her to think of ways to decrease her vomiting. Participants' commonly explained that the intervention would have been acceptable if the therapist had first asked the client how she was feeling about the increase in vomiting, and if the client confirmed that she was distressed. Secondly, this research suggests that issues related to the desire to please others may be central for many adolescents with eating disorders. The stance adopted by the RMI assessors and the therapists in the motivational vignettes appeared to minimize the tendency to provide socially desirable responses. Specifically, both the assessor and the therapists expressed interest in hearing and understanding clients' thoughts and feelings regardless of whether they were for or against change, acknowledged that clients' may have mixed feelings, and did not communicate any expectations of the clients. Thirdly, this research suggests that interventions for adolescents with eating disorders may need to be tailored to match adolescents' readiness for change. Overall, it seems that adolescents in precontemplation may benefit from therapeutic experiences that are primarily supportive and that focus on development of the therapeutic alliance. Issues related to confidentiality may be particularly salient for this group. Adolescents who are thinking about making changes to their eating disorder may respond to interventions that are psychoeducational, and that emphasize client choice or control over the process of change. Finally, therapists treating adolescents who are actively working at recovery may want to be cautious about pushing clients too hard as these adolescents may be particularly sensitive to issues related to the synchrony between their personal goals and the goals of others.
Conclusions & Future Research

Given the support for motivational interventions found in this study, future research is needed to examine the efficacy of this treatment approach with adolescents with eating disorders. Adolescence presents a unique stage of development where many aspects of life change relatively rapidly (Steinberg, 1996). For instance, during adolescence there is typically a movement towards independence from parents and caregivers, enhanced cognitive abilities that allow for abstract thought, and increased emphasis on peer relationships (Steinberg, 1996). Thus, motivational therapeutic approaches which focus on enhancing client’s confidence and responsibility for change and encouragement of complex thought appear to be an appropriate match for adolescents’.

This research also suggests that the balance between adolescent responsibility for change, and parents or caregivers taking charge or implementing guidelines is deserving of further investigation. Specifically, although the directive interventions were rated less favorably than the motivational vignettes, these interventions were rated as moderately acceptable, and adolescents identified some positive aspects associated with these interventions. For instance, some adolescents discussed how they were not sure if they would be able to make changes if they were left in complete control over decisions made about their treatment, and therefore liked some of the suggestions made by therapists in the directive vignettes. Other adolescents reported that they would find it reassuring to have someone else take responsibility and guide them to recovery due in part to their difficulty in making decisions, and the guilt they would feel if they chose to eat more. Research on adherence to treatment in adolescents with asthma, and the stages of change
in adolescents with substance abuse problems suggests that teens, parents, and caregivers need to share the responsibility for adolescents’ adherence to treatment and recovery (Barnett et al., 2002; Walders, Drotar, & Kercsmar, 2000). Specifically, in comparison to children, adolescents with asthma have been shown to be less likely to adhere to their treatment regimens. Caretaker over estimations of the level of adolescent involvement in their own asthma care have received empirical support as one possible explanation for the decrease in adherence in this age group (Barnett et al., 2002 & Walders et al., 2000). In adolescents admitted to an emergency department due to an alcohol related injury, anticipation of negative consequences from parents and having penalties for breaking family drinking rules were predictive of advancement through the stages of change in the three months following the assessment (Barnett et al., 2002). Therefore, future research is needed to examine the optimal balance between client and caregiver responsibility for change in adolescents with eating disorders, and how best to implement guidelines for recovery.

Current treatment approaches are typically downward extensions of therapies developed for adults (Gore et al., 2001). Moreover, the majority of the diagnoses in the diagnostic and statistical manual were developed and researched largely with adults (Nicholls et al., 2000). However, over the course of conducting the current research, a number of factors that may be unique to adolescence emerged as important areas to consider in treatment and future research with youth. For example, many adolescents discussed the challenges they had with their peer culture, families, and identity. They discussed their struggle to recover in a peer culture that, from their perspective, places a great deal of emphasis on shape and weight related issues. This struggle appeared similar
to that identified by adolescents who smoke, where the high prevalence of smoking in peer groups has been identified as one factor that makes quitting smoking difficult (Carty et al., 2000). Adolescents also acknowledged the challenge of developing an identity due in part to their unique position between childhood and adulthood, where they had the power to control some areas of their life but not others, and the desire to at times be a child while at others an adult. Finally, they reported feeling that friends and family members did not understand their difficulties. In addition, and consistent with previous reports (Nicholls et a., 2000; Robin, 2003), close to half of the adolescents in this study were diagnosed with EDNOS in part because many did not fit the typical presentations of anorexia or bulimia nervosa. Thus, in order to improve the standard of care for this population, there is a need for the development of treatment paradigms and classification systems that adequately capture the experiences associated with this stage of life.
References


*Australian and New Zealand journal of mental health and nursing, 5*, 84-89.


Appendix A – Parent and Adolescent Consent Forms
CONSENT TO PARTICIPATE IN RESEARCH
READINESS AND MOTIVATION TO CHANGE IN YOUNG PEOPLE WITH
EATING DISORDERS – Parent or Guardian Version

Thank you for taking the time to read this information. You are being asked for your
permission to allow your daughter (under the age of 18) to participate in our study. The
research is being conducted by Shannon Zaitsoff and Dr. Rosanne Menna from the
Department of Psychology, at the University of Windsor, and by Dr. Josie Geller from
the Eating Disorders Program at St. Paul’s Hospital (in Vancouver, BC). Results from
this research will contribute to Shannon’s Master’s thesis. The study is being conducted
at the Bulimia Anorexia Nervosa Association in Windsor, and at Eating Disorders
programs at St. Paul’s Hospital, British Columbia Children’s Hospital, and Alberta
Children’s Hospital. Please take time to read the following information carefully and ask
us if there is anything that is not clear or if you would like more information. Take time
to decide whether or not you wish for your daughter to participate.

If you have any questions or concerns about the research, please feel free to contact
Shannon Zaitsoff at (519) 253-3000, ext. 2219 or Dr. Rosanne Menna in Windsor Ontario
at (519) 252-3000, ext. 2230. You may also contact Dr. Josie Geller in Vancouver BC at
(604) 682-2344, ext. 62472.

Purpose of the study.
The first aim of the study is to explore adolescents with eating disorders thoughts and
feelings about changing their eating disorder symptoms. The second aim of the study is
to examine whether these thoughts and feelings about changing are related to their
perceptions of different treatment experiences.

Why is the study being done?
Previous research with adults with eating disorders has shown that people often have very
mixed feelings about changing their eating disorder symptoms this has led to the
development of new treatments for adults with eating disorders. We do not know whether
adolescents with eating disorders have similar thoughts and feelings about changing as do
adults. It is important to know this so that we can gain a better understanding of how
adolescents recover from eating disorders. This would enable us to provide the best
possible treatment to our clients.

How is the study being done?
If your daughter participates in this study, she will be asked to complete an interview,
five questionnaires, and answer question about hypothetical scenarios. We would like to
tape record these interviews, but they can still participate even if you (or her) do not want
the interviews to be taped. It will take approximately two hours to complete both the
interviews and the questionnaires. Participants will not be paid for participating in this
study. If you would like a summary of the findings from this research they will be mailed
to you approximately six months after completion of the project.
Will taking part in this study be kept confidential?

Only research staff directly involved in the study will have access to the information collected, and we will not put daughter’s name on any of their questionnaires or tapes. Tapes will be erased after the research is completed.

What are the possible benefits and risks of taking part?

By taking part in the study your daughter may experience the benefit of identifying and clarifying her feelings about treatment or recovery. There are no known risks to participating in this study, however, participants may experience strong emotional reactions to some of the questions asked. Participants can decide not to answer any questions they do not want to answer and still remain in the study. Participants can also decide to stop participating at any time.

Does my daughter have to take part?

Your daughter does not have to participate in the study if you do not want them to and you do not have to give a reason. If you decide not to allow your daughter to take part, or if they withdraw from the study at any time, this will not affect their treatment in any way. The investigator may withdraw your daughter from this research if circumstances arise which warrant doing so.

This study has been reviewed and received ethics clearance through the University of Windsor Research Ethics Board. If you have questions regarding your rights as a research participant, contact:

Research Ethics Co-ordinator  
University of Windsor  
Windsor, Ontario  
N9B 3P4  
Telephone: 519-253-3000, #3916  
Email: ethics@uwindsor.ca

Please ask the researcher any questions you like about this project, before you decide whether or not to allow your daughter to join in.

I understand the information provided for the study “Readiness and Motivation to Change in Young People with Eating Disorders”. My questions have been answered to my satisfaction and I have received a copy of this form.

I, __________________________ have read and understand this consent form and give permission

(parent/guardian print full name)

for __________________________ to participate in this study.

(print daughter’s name in full)

Signature/ relationship to participant  
Date
Please check:
☐ I agree to have my daughter’s interviews audio-taped.
☐ I do not want to have my daughter’s interviews audio-taped.

☐ I would like to receive a summary of the research findings.

In my judgement, the parent/guardian is voluntarily and knowingly giving informed consent for their daughter to participate in this research study.

______________________________  ________________
Signature of Investigator               Date
CONSENT TO PARTICIPATE IN RESEARCH
READINESS AND MOTIVATION TO CHANGE IN YOUNG PEOPLE WITH EATING DISORDERS – Adolescent Version

Thank you for taking the time to read this information. You are being asked to participate in a research study being conducted by Shannon Zaitsoff and Dr. Rosanne Menna, from the Department of Psychology, at the University of Windsor, and by Dr. Josie Geller from the Eating Disorders Program at St. Paul’s Hospital (in Vancouver, BC). Results from this research will contribute to Shannon’s Master’s thesis. The study is being conducted at the Bulimia Anorexia Nervosa Association in Windsor, and at Eating Disorders programs at St. Paul’s Hospital, British Columbia Children’s Hospital, and Alberta Children’s Hospital. Please take time to read the following information carefully and ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to participate.

If you have any questions or concerns about the research, please feel free to contact Shannon Zaitsoff at (519) 253-3000, ext. 2219 or Dr. Rosanne Menna in Windsor Ontario at (519) 252-3000, ext. 2230. You may also contact Dr. Josie Geller in Vancouver BC at (604) 682-2344, ext. 62472.

Purpose of the study.
The first aim of the study is to explore adolescents with eating disorder thoughts and feelings about changing their eating disorder symptoms. The second aim of the study is to examine whether these thoughts and feelings about changing are related to their perceptions of different treatment experiences.

Why is the study being done?
Previous research with adults with eating disorders has shown that people often have very mixed feelings about changing their eating disorder symptoms, this has led to the development of new treatments for adults with eating disorders. We do not know whether teens with eating disorders have similar thoughts and feelings about changing as do adults. It is important to know this so that we can gain a better understanding of how adolescents recover from eating disorders. This would enable us to provide the best possible treatment to our clients.

How is the study being done?
If you volunteer to participate in this study, we would ask you to complete an interview, five questionnaires, and answer questions about hypothetical scenarios. We would like to tape record your responses, but you can still participate even if you do not want the interviews to be taped. It will take approximately two hours to complete the tasks. You will not be paid for participating in this study. If you would like a summary of the findings from this research they will be mailed to you approximately six months after completion of the project.
Will my taking part in this study be kept confidential?

Only research staff directly involved in the study will have access to the information collected and we will not put your name on any of your questionnaires. If you agree to have your interviews audio-taped your name will not be put on the tape and it will be erased after the research is completed.

What are the possible benefits and risks of taking part?

By taking part in the study you may experience the benefit of identifying and clarifying your feelings about treatment or recovery. There are no known risks to participating in this study, however, you may experience strong emotional reactions to some of the questions asked. You can decide not to answer any questions you do not want to answer and still remain in the study. You can also decide to stop participating at any time.

Do I have to take part?

You do not have to participate in the study if you do not want to and you do not have to give a reason. If you decide not to take part, or to withdraw from the study at any time, this will not affect your treatment in any way. Also, you may remove your data from the study if you decide you no longer want to participate. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

This study has been reviewed and received ethics clearance through the University of Windsor Research Ethics Board. If you have questions regarding your rights as a research participant, contact:

Research Ethics Co-ordinator
University of Windsor
Windsor, Ontario
N9B 3P4

Telephone: 519-253-3000, #3916
Email: ethics@uwindsor.ca

Please ask the researcher any questions you like about this project, before you decide whether to join in.

I understand the information provided for the study “Readiness and Motivation to Change in Young People with Eating Disorders”. My questions have been answered to my satisfaction. I have read and I understand this consent form and would like to participate in this study. I have been given a copy of this form.
Please check the following:

☐ I agree to have my interviews audio-taped.
☐ I do not want to have my interviews audio-taped.
☐ I would like to receive a summary of the research findings.

________________________________________
Name of Participant.

________________________________________   ______________
Signature of Participant                       Date

In my judgement, the subject is voluntarily and knowingly giving informed consent to participate in this research study.

________________________________________   ______________
Signature of Investigator                      Date
Appendix B – Questionnaires
Teen Background Information Questionnaire

1. When is your birthday? Please give the month, day, and year (example, June 3, 1986)
   My birthday is ________________.

2. How old are you in years? (example: I am 16 years old.)
   I am _______ years old.

3. What grade are you in?
   ___ Grade 6
   ___ Grade 7
   ___ Grade 8
   ___ Grade 9
   ___ Grade 10
   ___ Grade 11
   ___ Grade 12
   ___ Finished high school

4. What race or ethnicity do you most identify with?
   ___ Caucasian
   ___ Black
   ___ Hispanic
   ___ Asian/Pacific
   ___ Native
   ___ Other

5. Are your parents _________?
   ___ Married
   ___ Divorced
   ___ Separated
   ___ Living together
   ___ Remarried
   ___ None of the above
6. What is the highest level of education your mother completed?

___ Less than 7 years
___ Some junior high school (e.g., Grade 7, 8, 9)
___ Some high school (e.g., Grade 10, 11, 12)
___ Graduated from high school or equivalent high school diploma
___ Some college or university
___ Graduated from college or university
___ Other ______________________

7. What is the highest level of education your father completed?

___ Less than 7 years
___ Some junior high school (e.g., Grade 7, 8, 9)
___ Some high school (e.g., Grade 10, 11, 12)
___ Graduated from high school or equivalent high school diploma
___ Some college or university
___ Graduated from college or university
___ Other ______________________

8. Is your mother currently employed?

___ yes
___ no

What is/was your mother’s occupation? ______________________

9. Is your father currently employed?

___ yes
___ no

What is/was your father’s occupation? ______________________
David M. Garner, Ph.D.

DIRECTIONS

Enter your name, the date, your age, sex, marital status, and occupation. Complete the questions on the rest of this page. Then turn to the inside of the booklet and carefully follow the instructions.

Name ___________________________ Date ___________________________

*Age _______ Sex _______ Marital status _______ Occupation ___________________________

___________________________________________

A. *Current weight: _______ pounds

B. *Height: _______ feet _______ inches

C. Highest past weight excluding pregnancy: _______ pounds
   How long ago did you first reach this weight? _______ months
   How long did you weigh this weight? _______ months

D. *Lowest weight as an adult: _______ pounds
   How long ago did you first reach this weight? _______ months
   How long did you weigh this weight? _______ months

E. What weight have you been at for the longest period of time? _______ pounds
   At what age did you first reach this weight? _______ years old

F. If your weight has changed a lot over the years, is there a weight that you keep coming back to when you are not dieting? __ Yes ___ No
   If yes, what is this weight? _______ pounds
   At what age did you first reach this weight? _______ years old

G. What is the most weight you have ever lost? _______ pounds
   Did you lose this weight on purpose? ___ Yes ___ No
   What weight did you lose to? _______ pounds
   At what age did you reach this weight? _______ years old

H. What do you think your weight would be if you did not consciously try to control your weight? _______ pounds

I. How much would you like to weigh? _______ pounds

J. Age at which weight problems began (if any): _______ years old

K. Father's occupation: ____________________________

L. Mother's occupation: ____________________________
INSTRUCTIONS

First, write your name and the date on your EDI-2 Answer Sheet. Your ratings on the items below will be made on the EDI-2 Answer Sheet. The items ask about your attitudes, feelings, and behavior. Some of the items relate to food or eating. Other items ask about your feelings about yourself.

For each item, decide if the item is true about you ALWAYS (A), USUALLY (U), OFTEN (O), SOMETIMES (S), RARELY (R), or NEVER (N). Circle the letter that corresponds to your rating on the EDI-2 Answer Sheet. For example, if your rating for an item is OFTEN, you would circle the O for that item on the Answer Sheet.

Respond to all of the items, making sure that you circle the letter for the rating that is true about you. DO NOT ERASE! If you need to change an answer, make an “X” through the incorrect letter and then circle the correct one.

1. I eat sweets and carbohydrates without feeling nervous.
2. I think that my stomach is too big.
3. I wish that I could return to the security of childhood.
4. I eat when I am upset.
5. I stuff myself with food.
6. I wish that I could be younger.
7. I think about dieting.
8. I get frightened when my feelings are too strong.
9. I think that my thighs are too large.
10. I feel ineffective as a person.
11. I feel extremely guilty after overeating.
12. I think that my stomach is just the right size.
13. Only outstanding performance is good enough in my family.
14. The happiest time in life is when you are a child.
15. I am open about my feelings.
16. I am terrified of gaining weight.
17. I trust others.
18. I feel alone in the world.
19. I feel satisfied with the shape of my body.
20. I feel generally in control of things in my life.
21. I get confused about what emotion I am feeling.
22. I would rather be an adult than a child.
23. I can communicate with others easily.
24. I wish I were someone else.
25. I exaggerate or magnify the importance of weight.
26. I can clearly identify what emotion I am feeling.
27. I feel inadequate.
28. I have gone on eating binges where I felt that I could not stop.
29. As a child, I tried very hard to avoid disappointing my parents and teachers.
30. I have close relationships.
31. I like the shape of my buttocks.
32. I am preoccupied with the desire to be thinner.
33. I don’t know what’s going on inside me.
34. I have trouble expressing my emotions to others.
35. The demands of adulthood are too great.
36. I hate being less than best at things.
37. I feel secure about myself.
I think about bingeing (overeating).

I feel happy that I am not a child anymore.

I get confused as to whether or not I am hungry.

I have a low opinion of myself.

I feel that I can achieve my standards.

My parents have expected excellence of me.

I worry that my feelings will get out of control.

I think my hips are too big.

I eat moderately in front of others and stuff myself when they're gone.

I feel bloated after eating a normal meal.

I feel that people are happiest when they are children.

If I gain a pound, I worry that I will keep gaining.

I feel that I am a worthwhile person.

When I am upset, I don't know if I am sad, frightened, or angry.

I feel that I must do things perfectly or not do them at all.

I have the thought of trying to vomit in order to lose weight.

I need to keep people at a certain distance (feel uncomfortable if someone tries to get too close).

I think that my thighs are just the right size.

I feel empty inside (emotionally).

I can talk about personal thoughts or feelings.

The best years of your life are when you become an adult.

I think my buttocks are too large.

I have feelings I can't quite identify.

I eat or drink in secrecy.

I think that my hips are just the right size.

I have extremely high goals.

When I am upset, I worry that I will start eating.

People I really like end up disappointing me.

I am ashamed of my human weaknesses.

Other people would say that I am emotionally unstable.

I would like to be in total control of my bodily urges.

I feel relaxed in most group situations.

I say things impulsively that I regret having said.

I go out of my way to experience pleasure.

I have to be careful of my tendency to abuse drugs.

I am outgoing with most people.

I feel trapped in relationships.

Self-denial makes me feel stronger spiritually.

People understand my real problems.

I can't get strange thoughts out of my head.

Eating for pleasure is a sign of moral weakness.

I am prone to outbursts of anger or rage.

I feel that people give me the credit I deserve.

I have to be careful of my tendency to abuse alcohol.

I believe that relaxing is simply a waste of time.

Others would say that I get irritated easily.

I feel like I am losing out everywhere.
85. I experience marked mood shifts.
86. I am embarrassed by my bodily urges.
87. I would rather spend time by myself than with others.
88. Suffering makes you a better person.
89. I know that people love me.
90. I feel like I must hurt myself or others.
91. I feel that I really know who I am.
# YOUTH SELF-REPORT FOR AGES 11-18

**Please Print**

<table>
<thead>
<tr>
<th>YOUR FIRST NAME</th>
<th>MIDDLE NAME</th>
<th>LAST NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**YOUR SEX**
- [ ] Boy
- [ ] Girl

**YOUR AGE**

**ETHNIC GROUP OR RACE**

**TODAY'S DATE**

<table>
<thead>
<tr>
<th>Mo.</th>
<th>Date</th>
<th>Yr.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**YOUR BIRTHDATE**

<table>
<thead>
<tr>
<th>Mo.</th>
<th>Date</th>
<th>Yr.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PARENTS' USUAL TYPE OF WORK**, even if not working now (Please be specific—for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)

**FATHER'S TYPE OF WORK:**

**MOTHER'S TYPE OF WORK:**

Please fill out this form to reflect your views, even if other people might not agree. Feel free to print additional comments beside each item and in the spaces provided on pages 2 and 4.

---

## I. Please list the sports you most like to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

<table>
<thead>
<tr>
<th>Sports</th>
<th>Compared to others of your age, about how much time do you spend in each?</th>
<th>Compared to others of your age, how well do you do each one?</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Less Than Average</td>
<td>Average</td>
</tr>
</tbody>
</table>

- [ ] None
  - a. 
  - b. 
  - c. 

## II. Please list your favorite hobbies, activities, and games, other than sports. For example: cards, books, piano, cars, crafts, etc. (Do not include listening to radio or TV.)

<table>
<thead>
<tr>
<th>Hobbies</th>
<th>Compared to others of your age, about how much time do you spend in each?</th>
<th>Compared to others of your age, how well do you do each one?</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Less Than Average</td>
<td>Average</td>
</tr>
</tbody>
</table>

- [ ] None
  - a. 
  - b. 
  - c. 

## III. Please list any organizations, clubs, teams or groups you belong to.

<table>
<thead>
<tr>
<th>Organizations</th>
<th>Compared to others of your age, how active are you in each?</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Less Active</td>
</tr>
</tbody>
</table>

- a. 
- b. 
- c. 

## IV. Please list any jobs or chores you have. For example: paper route, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.)

<table>
<thead>
<tr>
<th>Jobs or Chores</th>
<th>Compared to others of your age, how well do you carry them out?</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Below Average</td>
</tr>
</tbody>
</table>

- a. 
- b. 
- c. 

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U. of Vermont, 1 So. Prospect St., Burlington, VT 05401.
V. 1. About how many close friends do you have? □ None □ 1 □ 2 or 3 □ 4 or more
(Do not include brothers & sisters)

2. About how many times a week do you do things with any friends outside of regular school hours?
(Do not include brothers & sisters) □ less than 1 □ 1 or 2 □ 3 or more

VI. Compared to others of your age, how well do you:

- a. Get along with your brothers & sisters? □ Worse □ About Average □ Better □ I have no brothers or sisters
- b. Get along with other kids? □ □ □ □
- c. Get along with your parents? □ □ □ □
- d. Do things by yourself? □ □ □ □

VII. Performance in academic subjects. □ I do not attend school because __________________________

Check a box for each subject that you take

- a. English or Language Arts □ Falling □ Below Average □ Average □ Above Average
- b. History or Social Studies □ □ □ □
- c. Arithmetic or Math □ □ □ □
- d. Science □ □ □ □
- e. __________________________ □ □ □ □
- f. __________________________ □ □ □ □
- g. __________________________ □ □ □ □

Other academic subjects – for example: computer courses, foreign language, business. Do not include gym, shop, driver’s ed., etc.

Do you have any illness, disability, or handicap? □ No □ Yes—please describe:

Please describe any concerns or problems you have about school:

Please describe any other concerns you have:

Please describe the best things about yourself:
Below is a list of items that describe kids. For each item that describes you now or within the past 6 months, please circle the 2 if the item is very true or often true of you. Circle the 1 if the item is somewhat or sometimes true of you. If the item is not true of you, circle the 0.

<table>
<thead>
<tr>
<th>Please Print</th>
<th>0 = Not True</th>
<th>1 = Somewhat or Sometimes True</th>
<th>2 = Very True or Often True</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2</td>
<td>1. I act too young for my age</td>
<td>0 1 2</td>
<td>40. I hear sounds or voices that other people think aren't there (describe):</td>
</tr>
<tr>
<td>0 1 2</td>
<td>2. I have an allergy (describe):</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>0 1 2</td>
<td>3. I argue a lot</td>
<td>0 1 2</td>
<td>41. I act without stopping to think</td>
</tr>
<tr>
<td>0 1 2</td>
<td>4. I have asthma</td>
<td>0 1 2</td>
<td>42. I would rather be alone than with others</td>
</tr>
<tr>
<td>0 1 2</td>
<td>5. I act like the opposite sex</td>
<td>0 1 2</td>
<td>43. I lie or cheat</td>
</tr>
<tr>
<td>0 1 2</td>
<td>6. I like animals</td>
<td>0 1 2</td>
<td>44. I bite my fingernails</td>
</tr>
<tr>
<td>0 1 2</td>
<td>7. I brag</td>
<td>0 1 2</td>
<td>45. I am nervous or tense</td>
</tr>
<tr>
<td>0 1 2</td>
<td>8. I have trouble concentrating or paying attention</td>
<td>0 1 2</td>
<td>46. Parts of my body twitch or make nervous movements (describe):</td>
</tr>
<tr>
<td>0 1 2</td>
<td>9. I can't get my mind off certain thoughts (describe):</td>
<td>0 1 2</td>
<td></td>
</tr>
<tr>
<td>0 1 2</td>
<td>10. I have trouble sitting still</td>
<td>0 1 2</td>
<td>47. I have nightmares</td>
</tr>
<tr>
<td>0 1 2</td>
<td>11. I'm too dependent on adults</td>
<td>0 1 2</td>
<td>48. I am not liked by other kids</td>
</tr>
<tr>
<td>0 1 2</td>
<td>12. I feel lonely</td>
<td>0 1 2</td>
<td>49. I can do certain things better than most kids</td>
</tr>
<tr>
<td>0 1 2</td>
<td>13. I feel confused or in a fog</td>
<td>0 1 2</td>
<td>50. I am too fearful or anxious</td>
</tr>
<tr>
<td>0 1 2</td>
<td>14. I cry a lot</td>
<td>0 1 2</td>
<td>51. I feel dizzy</td>
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<td>0 1 2</td>
<td>15. I am pretty honest</td>
<td>0 1 2</td>
<td>52. I feel too guilty</td>
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<td>0 1 2</td>
<td>16. I am mean to others</td>
<td>0 1 2</td>
<td>53. I eat too much</td>
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<td>0 1 2</td>
<td>17. I daydream a lot</td>
<td>0 1 2</td>
<td>54. I feel overtired</td>
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<td>0 1 2</td>
<td>18. I deliberately try to hurt or kill myself</td>
<td>0 1 2</td>
<td>55. I am overweight</td>
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<td>0 1 2</td>
<td>19. I try to get a lot of attention</td>
<td>0 1 2</td>
<td>56. Physical problems without known medical cause:</td>
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<tr>
<td>0 1 2</td>
<td>20. I destroy my own things</td>
<td>0 1 2</td>
<td>a. Aches or pains (not stomach or headaches)</td>
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<tr>
<td>0 1 2</td>
<td>21. I destroy things belonging to others</td>
<td>0 1 2</td>
<td>b. Headaches</td>
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<tr>
<td>0 1 2</td>
<td>22. I disobey my parents</td>
<td>0 1 2</td>
<td>c. Nausea, feel sick</td>
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<tr>
<td>0 1 2</td>
<td>23. I disobey at school</td>
<td>0 1 2</td>
<td>d. Problems with eyes (not if corrected by glasses) (describe):</td>
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<tr>
<td>0 1 2</td>
<td>24. I don't eat as well as I should</td>
<td>0 1 2</td>
<td>e. Rashes or other skin problems</td>
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<td>0 1 2</td>
<td>25. I don't get along with other kids</td>
<td>0 1 2</td>
<td>f. Stomachaches or cramps</td>
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<td>0 1 2</td>
<td>26. I don't feel guilty after doing something I shouldn't</td>
<td>0 1 2</td>
<td>g. Vomiting, throwing up</td>
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<td>0 1 2</td>
<td>27. I am jealous of others</td>
<td>0 1 2</td>
<td>h. Other (describe):</td>
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<td>0 1 2</td>
<td>28. I am willing to help others when they need help</td>
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<tr>
<td>0 1 2</td>
<td>29. I am afraid of certain animals, situations, or places, other than school (describe):</td>
<td>0 1 2</td>
<td>57. I physically attack people</td>
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<tr>
<td>0 1 2</td>
<td>30. I am afraid of going to school</td>
<td>0 1 2</td>
<td>58. I pick my skin or other parts of my body (describe):</td>
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<td>0 1 2</td>
<td>31. I am afraid I might think or do something bad</td>
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<td>0 1 2</td>
<td>32. I feel that I have to be perfect</td>
<td>0 1 2</td>
<td>59. I can be pretty friendly</td>
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<td>0 1 2</td>
<td>33. I feel that no one loves me</td>
<td>0 1 2</td>
<td>60. I like to try new things</td>
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<td>0 1 2</td>
<td>34. I feel that others are cut to get me</td>
<td>0 1 2</td>
<td>61. My school work is poor</td>
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<td>0 1 2</td>
<td>35. I feel worthless or inferior</td>
<td>0 1 2</td>
<td>62. I am poorly coordinated or clumsy</td>
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<td>0 1 2</td>
<td>36. I accidentally get hurt a lot</td>
<td>0 1 2</td>
<td>63. I would rather be with older kids than with kids my own age</td>
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<tr>
<td>64. I would rather be with younger kids than with kids my own age</td>
<td>85. I have thoughts that other people would think are strange (describe):</td>
<td></td>
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<tr>
<td>65. I refuse to talk</td>
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<tr>
<td>66. I repeat certain acts over and over (describe):</td>
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<tr>
<td>67. I run away from home</td>
<td>86. I am stubborn</td>
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<tr>
<td>68. I scream a lot</td>
<td>87. My moods or feelings change suddenly</td>
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<td>69. I am secretive or keep things to myself</td>
<td>88. I enjoy being with other people</td>
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<tr>
<td>70. I see things that other people think aren't there (describe):</td>
<td>89. I am suspicious</td>
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<tr>
<td>71. I am self-conscious or easily embarrassed</td>
<td>90. I swear or use dirty language</td>
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<td>72. I set fires</td>
<td>91. I think about killing myself</td>
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<tr>
<td>73. I can work well with my hands</td>
<td>92. I like to make others laugh</td>
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<td>74. I show off or clown</td>
<td>93. I talk too much</td>
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<tr>
<td>75. I am shy</td>
<td>94. I tease others a lot</td>
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<tr>
<td>76. I sleep less than most kids</td>
<td>95. I have a hot temper</td>
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<tr>
<td>77. I sleep more than most kids during day and/or night (describe):</td>
<td>96. I think about sex too much</td>
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<td>78. I have a good imagination</td>
<td>97. I threaten to hurt people</td>
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<td>79. I have a speech problem (describe):</td>
<td>98. I like to help others</td>
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<td>80. I stand up for my rights</td>
<td>99. I am too concerned about being neat or clean</td>
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<tr>
<td>81. I steal at home</td>
<td>100. I have trouble sleeping (describe):</td>
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<tr>
<td>82. I steal from places other than home</td>
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<td>83. I store up things I don't need (describe):</td>
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<td>84. I do things other people think are strange (describe):</td>
<td>101. I cut classes or skip school</td>
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<td>102. I don't have much energy</td>
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<td>103. I am unhappy, sad, or depressed</td>
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<td></td>
<td>104. I am louder than other kids</td>
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<td>105. I use alcohol or drugs for nonmedical purposes (describe):</td>
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<td>106. I try to be fair to others</td>
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<td>107. I enjoy a good joke</td>
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<td>108. I like to take life easy</td>
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<td>109. I try to help other people when I can</td>
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<td>110. I wish I were of the opposite sex</td>
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<td></td>
<td>111. I keep from getting involved with others</td>
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<td></td>
<td>112. I worry a lot</td>
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</table>

Please write down anything else that describes your feelings, behavior, or interests
Instructions:
Please read each statement and mark a cross in the column which most closely expresses your agreement or disagreement with the statement. There are no right or wrong answers, and your responses will remain totally confidential, so please answer as honestly as you can.

<table>
<thead>
<tr>
<th>Statement</th>
<th>agree strongly</th>
<th>agree moderately</th>
<th>neither agree nor disagree</th>
<th>disagree moderately</th>
<th>disagree strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel fitter as a result of my anorexia</td>
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<td>2. Anorexia expresses my inner anguish</td>
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<td>3. Anorexia has left me unable to feel</td>
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<td>4. Anorexia helps me get through life</td>
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<td>5. Anorexia has made me depressed</td>
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<td>6. I feel that I am more attractive to others as a result of my anorexia</td>
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<td>7. I feel bad that my anorexia is a concern to others</td>
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<td>8. I see my anorexia as being dependable and consistent</td>
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<td>9. I have hurt those close to me because of my anorexia</td>
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<td>10. Anorexia gives structure to my life</td>
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<td>11. Anorexia lifts me above others</td>
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<td>12. I wish my anorexia would go away and leave me alone</td>
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<td>13. I feel protected by my anorexia</td>
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<td>14. Anorexia has numbed my emotions</td>
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<td>15. Having anorexia means I can wear the clothes I want</td>
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<td>16. Anorexia allows me to avoid the disruption of having periods</td>
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<td>17. Anorexia is something I am good at</td>
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<td>18. I feel unable to escape from my anorexia</td>
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<td>19. Anorexia shows I can do at least one thing better than other people</td>
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<td></td>
<td>agree strongly</td>
<td>agree moderately</td>
<td>neither agree nor disagree</td>
<td>disagree moderately</td>
<td>disagree strongly</td>
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<tr>
<td>20. Anorexia is a skill</td>
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<td>21. I hate the fact that my parents worry about me because of my anorexia</td>
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<tr>
<td>22. I use anorexia to communicate my distress/unhappiness to others</td>
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<td>23. My anorexia makes me feel secure</td>
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<td>24. In being anorexic, I am an expert</td>
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<td>25. Because of anorexia I don't have to worry about becoming pregnant</td>
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<td>26. Anorexia is my cry for help when things go wrong</td>
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<td>27. I hate the way that anorexia controls my life</td>
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<td>28. My anorexia helps me to keep control</td>
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<tr>
<td>29. Anorexia helps me to control my emotions</td>
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<td>30. Anorexia takes up all my time</td>
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<td>31. Anorexia limits my emotional expression</td>
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<td>32. Anorexia has taken over my personality</td>
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<tr>
<td>33. I am fighting against my anorexia</td>
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<td>34. Having anorexia stops my monthly period pains</td>
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<td>35. Because of anorexia I can push my body further than I used to</td>
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<td>36. I feel better about my appearance because of my anorexia</td>
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<td>37. Anorexia means I no longer have PMT/PMS</td>
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<td>38. I am fed up with thinking constantly about food</td>
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<td>39. Anorexia gives purpose to my life</td>
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<td>40. I HATE being anorexic</td>
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<td>41. I value my anorexia because it makes me feel safe</td>
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<td></td>
<td>agree strongly</td>
<td>agree moderately</td>
<td>neither agree nor disagree</td>
<td>disagree moderately</td>
<td>disagree strongly</td>
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<td>42. I can show my emotions through my anorexia</td>
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<tr>
<td>43. I'm sick and tired of being anorexic</td>
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<td>44. I like the way anorexia makes me look</td>
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<td>45. Having anorexia makes my body work better</td>
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<tr>
<td>46. My anorexia helps me to organise my world</td>
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<td>47. I feel that anorexia has suffocated my natural emotions</td>
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<td>48. I am in better physical shape as a result of my anorexia</td>
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<td>49. I feel guilty for the worry my anorexia has caused to my friends</td>
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<td>50. I feel sorry for the effect anorexia has had on my family</td>
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</tbody>
</table>

Please check you have answered all the questions.

Many thanks for filling in this questionnaire
<table>
<thead>
<tr>
<th>Please answer the following statements according to your personal beliefs. Mark each statement true or false by checking the appropriate box.</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. It is sometimes hard for me to go on with my work if I am not encouraged.</td>
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<tr>
<td>2. I sometimes feel resentful when I don't get my own way.</td>
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<tr>
<td>3. On a few occasions, I have given up doing something because I thought too little of my ability.</td>
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<td>4. There have been times when I felt like rebelling against people in authority even though I knew they were right.</td>
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<td>5. No matter who I'm talking to, I'm always a good listener.</td>
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<td>6. There have been occasions when I took advantage of someone.</td>
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<td>7. I'm always willing to admit it when I make a mistake.</td>
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<tr>
<td>8. I sometimes try to get even rather than forgive and forget.</td>
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<tr>
<td>9. I am always courteous, even to people who are disagreeable.</td>
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<tr>
<td>10. I have never been irked when people expressed ideas very different from my own.</td>
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<td>11. There have been times when I was quite jealous of the good fortune of others.</td>
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<td>12. I am sometimes irritated by people who ask favours of me.</td>
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<tr>
<td>13. I have never deliberately said something that hurt someone's feelings.</td>
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Appendix C – Vignettes and Pilot Questions
Scenario 1:

Directive Vignette:

Jenny has an eating disorder. She is meeting with her therapist for the first time. After saying hello to the therapist Jenny sat quietly looking out the window.

_The therapist said he was really glad Jenny came to the appointment because it shows that she is ready to make some changes to her eating disorder. He asked Jenny to describe her biggest problem with her eating._

Motivational Vignette:

Jenny has an eating disorder. She is meeting with her therapist for the first time. After saying hello to the therapist Jenny sat quietly looking out the window.

_The therapist said, although everyone is different, some people have mixed feelings about coming to therapy. He expressed interest in how Jenny was feeling about being at the appointment._

Scenario 2:

Directive Vignette:

Elizabeth told her therapist that her vomiting had increased in the past week and that she had lost weight.

_The therapist said she knew Elizabeth must be feeling really awful about the week and asked Elizabeth to think of ways to decrease her vomiting next week._

Motivational Vignette:

Elizabeth told her therapist that her vomiting had increased in the past week and that she had lost weight.

_The therapist asked Elizabeth how she was feeling about the increase in her vomiting and expressed curiosity about how the rest of the week went._
Scenario 3:

Directive Vignette:

Jenny has had anorexia nervosa for 2 years. Jenny has been repeatedly forced into hospital to gain weight. For the first time, she is expressing openness to coming into hospital for weight gain.

*Jenny’s doctor expressed her relief that she had finally decided to give up her eating disorder.*

Motivational Vignette:

Jenny has had anorexia nervosa for 2 years. Jenny has been repeatedly forced into hospital to gain weight. For the first time, she is expressing openness to coming into hospital for weight gain.

*Jenny’s doctor said she was curious about her change of heart regarding hospitalization and asked her how this came about.*

Scenario 4:

Directive Vignette:

Jessica has anorexia nervosa and typically exercises quite a bit during the week. At her therapy appointment Jessica tells her therapist that she did not exercise at all during the past week.

*Her therapist said: “Wow, no exercise last week, you must feel really good about that.”*

Motivational Vignette:

Jessica has anorexia nervosa and typically exercises quite a bit during the week. At her therapy appointment Jessica tells her therapist that she did not exercise at all during the past week.

*Her therapist said: “That’s a change from your regular exercise pattern, I am wondering if you have any ideas about why that happened?”*
Scenario 5:

Directive Vignette:

Caroline said that the only reason she came to today’s assessment was because her parents forced her to. She told the therapist that she wished her parents would just leave her alone.

_The therapist said she knew that Caroline didn’t think she was ready to make any changes to her eating disorder but that she expected Caroline would feel differently soon._

Motivational Vignette:

Caroline said that the only reason she came to today’s assessment was because her parents forced her to. She told the therapist that she wished her parents would just leave her alone.

_The therapist acknowledged that Caroline was in a difficult situation and expressed interest as to why Caroline didn’t want to be at the assessment that day._

Scenario 6:

Directive Vignette:

Karen tells her therapist that she is thinking about trying to decrease the amount of time she spends running.

_Karen’s therapist said that she thought that it was a great idea for Karen to decrease her exercise and that she thought it would be best if Karen only exercised twice a week for thirty minutes._

Motivational Vignette:

Karen tells her therapist that she is thinking about trying to decrease the amount of time she spends running.

_Karen’s therapist suggested that it might be helpful for Karen to think about both the costs and benefits of Karen decreasing her exercise and asked if there was anything she/he could do to support Karen in her making a decision._
Scenario 7:

Directive Vignette:

<table>
<thead>
<tr>
<th>Wendy has anorexia nervosa. For the past two months she has been attending weekly therapy appointments. This week Wendy’s weight increased by 1 kilogram.</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Wendy’s therapist said to Wendy that she must be really proud that she was able to increase her weight this week.</em></td>
</tr>
</tbody>
</table>

Motivational Vignette:

<table>
<thead>
<tr>
<th>Wendy has anorexia nervosa. For the past two months she has been attending weekly therapy appointments. This week Wendy’s weight increased by 1 kilogram.</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Wendy’s therapist expressed interest in how Wendy was feeling about her change in weight this week.</em></td>
</tr>
</tbody>
</table>

Scenario 8:

Directive Vignette:

<table>
<thead>
<tr>
<th>Jennifer has anorexia nervosa and had been losing weight for several weeks. However, this past week she maintained her weight.</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Jennifer’s therapist said that Jennifer must have worked really hard to eat more this past week. She encouraged her to keep up the good work.</em></td>
</tr>
</tbody>
</table>

Motivational Vignette:

<table>
<thead>
<tr>
<th>Jennifer has anorexia nervosa and had been losing weight for several weeks. However, this past week she maintained her weight.</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Jennifer’s therapist asked how she was feeling about the past week. The therapist asked if there was anything that she did that Jennifer found to be unhelpful or helpful.</em></td>
</tr>
</tbody>
</table>

Pilot Questions

1. How possible do you think it is that the situation described in the story could happen in real life?

<table>
<thead>
<tr>
<th>Would definitely not happen in real life.</th>
<th>It might happen in real life.</th>
<th>Would definitely happen in real life.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

2. Do you feel the therapist in this story makes assumptions about the client’s thoughts or feelings?

<table>
<thead>
<tr>
<th>The therapist does not make any assumptions.</th>
<th>The therapist makes some assumptions.</th>
<th>The therapist makes a lot of assumptions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Appendix D – Quantitative and Open-ended Questions to be Used with the Vignettes

During Data Collection
1. How caring do you find the therapist in this story?

<table>
<thead>
<tr>
<th>Not at all caring</th>
<th>Somewhat caring</th>
<th>Extremely caring</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

2. How warm do you find the therapist in this story?

<table>
<thead>
<tr>
<th>Not at all warm</th>
<th>Somewhat warm</th>
<th>Extremely warm</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

3. If you were Jenny, how much would you trust this therapist?

<table>
<thead>
<tr>
<th>I would not trust this therapist at all</th>
<th>I would somewhat trust this therapist</th>
<th>I would really trust this therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

4. If you were Jenny, how much do you think you and this therapist would agree on goals for therapy?

<table>
<thead>
<tr>
<th>We would not at all agree on goals for therapy</th>
<th>We would agree somewhat on goals for therapy</th>
<th>We would completely agree on goals for therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

5. If you were Jenny, how much would what the therapist has said in this story influence your confidence in you being able to change?

<table>
<thead>
<tr>
<th>Would make me feel a lot less confident</th>
<th>Would not influence how confident I feel</th>
<th>Would make me feel a lot more confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

6. If you were Jenny, how much do you think this therapist would include you in decisions made about your treatment?

<table>
<thead>
<tr>
<th>I would never be included</th>
<th>I would sometimes be included</th>
<th>I would always be included</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

7. How helpful do you think this therapist would be for adolescents with eating disorders?

<table>
<thead>
<tr>
<th>Not at all helpful</th>
<th>Somewhat helpful</th>
<th>Extremely helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Open-ended Questions:

1. THINKING BACK OVER THE SCENARIOS, WHAT KINDS OF THINGS DID THE THERAPISTS SAY THAT WERE RELATED TO THE EXTENT TO WHICH YOU WOULD TRUST OR NOT TRUST THEM?

   TRUST:

   NOT TRUST:

2. THINKING BACK OVER THE SCENARIOS, WHAT KINDS OF THINGS INFLUENCED THE EXTENT TO WHICH YOU THOUGHT YOU WOULD BE ABLE TO AGREE ON GOALS FOR THERAPY WITH THE DIFFERENT THERAPISTS?

   AGREE ON GOALS:

   NOT AGREE ON GOALS:

3. THINKING BACK OVER THE SCENARIOS, WHAT KINDS OF THINGS DID THE THERAPIST SAY OR DO THAT WOULD HAVE INFLUENCED YOUR CONFIDENCE IN YOU BEING ABLE TO CHANGE?

   MORE CONFIDENT:

   LESS CONFIDENT:

4. THINKING BACK OVER THE SCENARIOS, WHAT KINDS OF THINGS DID THE THERAPISTS SAY OR DO THAT WOULD HAVE INFLUENCED THE EXTENT TO WHICH YOU THOUGHT YOU WOULD BE INCLUDED IN DECISIONS MADE ABOUT YOUR TREATMENT

   WOULD BE INCLUDED:

   WOULD NOT BE INCLUDED:

5. OVERALL, WHAT KINDS OF THINGS COULD A THERAPIST SAY OR DO THAT WOULD BE HELPFUL FOR ADOLESCENTS WITH EATING DISORDERS?

6. OVERALL, WHAT KINDS OF THINGS COULD A THERAPIST SAY OR DO THAT WOULD BE UNHELPFUL FOR ADOLESCENTS WITH EATING DISORDERS?
Appendix E – Readiness and Motivation Interview
# EDE/RMI Coding Sheet

**Date:** ______________________  
**ID:** ______________________  

**Initial Interview**  

**Notes on General Eating Habits**  
Have your eating habits varied much from day to day?  
Have weekdays differed from weekends? Have there been any days when you haven’t eaten anything?

**Fear of Weight Gain**  
* Over the past 4 weeks have you been **scared** that you might gain weight or become fat?

<table>
<thead>
<tr>
<th>Last 4 Weeks</th>
<th>[ ]</th>
<th>Problem: yes no</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 2</td>
<td>[ ]</td>
<td>Notes:</td>
</tr>
<tr>
<td>Month 3</td>
<td>[ ]</td>
<td></td>
</tr>
</tbody>
</table>

- Precontemplation: ____%  
- Contemplation: ____%  
- Action/Maintenance: ____%  
- Internality: ____%  

Notes (what are you doing to work on your fear of weight gain?):

**Feelings of Fatness**  
* Over the past 4 weeks have you felt fat?

<table>
<thead>
<tr>
<th>Last 4 Weeks</th>
<th>[ ]</th>
<th>Problem: yes no</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 2</td>
<td>[ ]</td>
<td>Notes:</td>
</tr>
<tr>
<td>Month 3</td>
<td>[ ]</td>
<td></td>
</tr>
</tbody>
</table>

- Precontemplation: ____%  
- Contemplation: ____%  
- Action/Maintenance: ____%  
- Internality: ____%  

Notes: (what are you doing to work on reducing feelings of fatness?)
Restraint Over Eating
Over the past 4 weeks have you deliberately been trying to cut down on what you eat, even if you haven’t managed to do this? How often? What is the purpose of cutting down? Have you done this to try and change your shape or weight?

Last 4 Weeks [ ]
Month 2 [ ] Problem: yes no
Month 3 [ ] Notes:
Precontemplation ___%
Contemplation ___%
Action/Maintenance ___%
Internality ___%

Notes (what have you done to restrict? AND what are you doing to not restrict?):

Weight Loss/Weight Maintenance
* Over the past 3 months have you been trying to lose weight?
If no: Have you been trying to make sure that you do not gain weight?
Current weight ______

Over Past 3 Months [ ] Problem: yes no
Precontemplation ___%
Contemplation ___%
Action/Maintenance ___%
Internality ___%

Notes (what are you doing to work on your weight?):

Menstruation
* Have your periods started yet? What has happened to your periods? Do you get one every month? * How many periods have you had?

On Pill: yes no
Problem: yes no
Notes:

Number of Periods over the past 3 Months [ ]
Precontemplation ___%
Contemplation ___%
Action/Maintenance ___%
Internality ___%

Notes (what are you doing to try to get your periods back?):
Importance of Shape
*Is having a thin shape important to you?*

Last 4 Weeks [ ]
Month 2 [ ]
Month 3 [ ]

Importance of Weight
*Is being very light/weighing very little important to you?*

Last 4 Weeks [ ]
Month 2 [ ]
Month 3 [ ]
Precontemplation _____%
Contemplation _____%
Action/Maintenance _____%
Internality _____%

Problem: yes no
Notes:

Notes (what are you doing to work on reducing the amount of influence that shape and weight have on your self-evaluation?):

Objective Bulimic Episodes
*In the past 4 weeks have there been any times when you felt that you have eaten too much in one go, and others would agree it's a really large amount of food?*
*Did you feel out of control, or that you just couldn't stop when it happened?*

Number of Days [ ][ ]
Number of Episodes/Month [ ][ ][ ]
Month 2 - Days [ ][ ]
Month 3 - Days [ ][ ]
Precontemplation _____%
Contemplation _____%
Action/Maintenance _____%
Internality _____%

Problem: yes no
Notes:

Notes (what are you doing to reduce bingeing?):
Longest Continuous Period Free from Objective Episodes Over Past 3 Months
* Were there ever 2 or more weeks that passed in the last 3 months when you didn’t binge?
Must be more than 2 weeks [ ] [ ]

Dietary Restriction Outside of Bulimic Episodes
* Outside the times when you have lost control over eating, have you been restricting the amount you eat? Immediately before or after?

This should be the average degree of dietary restriction:
0 - No extreme restriction outside of binge
1 - Extreme restriction outside of binge (less than 1200 calories)
2 - No eating outside of binge

Month 1 [ ]
Month 2 [ ]
Month 3 [ ]
Precontemplation ___%
Contemplation ___%
Action/Maintenance ___%
Internality ___%

Problem: yes no Notes:

Notes (what are you doing to reduce restricting in between binges?):

Self Induced Vomiting
When was the last time you were ill and vomited? What made you vomit/ why did you vomit?

If yes to self-induced vomiting, did you do this to keep your weight down, to stop from getting fat, putting weight on?

Number of Days [ ] [ ]
Number of Episodes/Month [ ] [ ] [ ] [ ]
Month 2 - Days [ ] [ ]
Month 3 - Days [ ] [ ]
Precontemplation ___%
Contemplation ___%
Action/Maintenance ___%
Internality ___%

Problem: yes no Notes:

Notes (what are you doing to reduce vomiting?):
**Laxative Misuse**

Have there been times when you have eaten more than you have been happy with and felt that you have had to do something about it?

- Number of Days
- Number of Episodes/Month
- Average Number
- Month 2 - Days
- Month 3 - Days

Type of Laxative

Precontemplation __%__
Contemplation __%__
Action/Maintenance __%__
Internality __%__

Notes (what are you doing to reduce your use of laxatives?):

**Diuretic Misuse**

Do you ever take any sorts of pills to help you deal with the feeling of having eaten too much?

*If yes, what do you take ____________________*

- Number of Days
- Number of Episodes/Month
- Average Number
- Month 2 - Days
- Month 3 - Days

Precontemplation __%__
Contemplation __%__
Action/Maintenance __%__
Internality __%__

Notes (what are you doing to reduce your use of diuretics?):
**Other Extreme Methods for Controlling Shape or Weight**
Over the past four weeks, have you done anything else to try to change your shape of weight?

*If yes, what do you do _____________*

| Number of Days | [ ] | [ ] |
| Number of Episodes/Month | [ ] | [ ] | [ ] |
| Average Number | [ ] | [ ] | [ ] |
| Month 2 - Days | [ ] | [ ] |
| Problems: yes no |
| Month 3 - Days | [ ] | [ ] |
| Notes: |

Precontemplation ___%
Contemplation ___%
Action/Maintenance ___%
Internality ___%

Notes (what are you doing to reduce your use of diuretics?):

**Intense Exercising**
What sort of exercise do you usually do? Which sports? How often?
Over the past 4 weeks have you exercised, done sports or worked out in order to keep your weight down?

| Number of Days | [ ] | [ ] |
| Time/Day | [ ] | [ ] | [ ] |
| Month 2 - Days | [ ] | [ ] |
| Problem: yes no |
| Month 3 - Days | [ ] | [ ] |
| Notes: |

Precontemplation ___%
Contemplation ___%
Action/Maintenance ___%
Internality ___%

Notes:

**Denial of Seriousness**
(If BMI is less than 17.5)

In the past 3 months have you felt that being at your current weight presents any serious health risks?

Yes No
Vita Auctoris

Name: Shannon Lorraine Zaitsoff

Place of birth: Surrey, British Columbia

Year of birth: 1976

Education:
- Mountain Secondary School
  Langley, British Columbia
  1990-1994

- Simon Fraser University, Burnaby, British Columbia
  1994-2000, B.A. Honors

- University of Windsor, Windsor, Ontario
  2001-2003, M.A.
  (currently enrolled in the Ph.D. program)