UNDERSTANDING WEIGHT RESTORATION IN ADOLESCENT ANOREXIA

AS A PARENT PROJECT

by

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF

THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

in

The Faculty of Graduate and Postdoctoral Studies

(Counselling Psychology)

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

August 2015

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Abstract

Parent-led weight restoration is a key intervention of family-based treatment, an empirically-supported approach for the treatment of adolescent anorexia. Little is known about the processes by which parents implement weight restoration, and current understandings of this intervention are primarily informed by professional perspectives. The aim of this study was to increase knowledge and understanding of parent-led weight restoration by examining parents’ actions while engaged in efforts to help their adolescent recover weight. The guiding research question was, “How do parents participate in the weight restoration of their adolescent as he or she recovers from anorexia?” This multicase study (Stake, 2006) used the action project method (Young, Valach, & Domene, 2005) and conceptual framework of contextual action theory (Valach, Young & Lynam, 2002) to examine five cases of parents engaged in actions intended to help their adolescent recover weight and to alter eating disorder behaviours. Data were collected using multi-part interviews, and analyzed according to the action project method and the multicase approach. Qualitative analysis revealed parents’ treatment-related goals of adolescent weight recovery were situated in a larger system of projects and careers in the parents’ personal and family lives. Conceptualizing the parents’ actions within this system revealed personally and socially meaningful weight restoration projects, and the relational and social meaning of these projects was found to motivate and steer parents’ day-to-day weight restoration actions. Some common joint projects emerged across the cases, such as seeking support and partnership and managing burden and distress associated with tension between weight restoration and other personal and parenting projects, especially adolescent development and parent identity processes. Implications for counselling practice with parents implementing weight restoration treatments are drawn.
Preface

This dissertation is the original intellectual work of the author, K. Socholotiuk. The research activities outlined in Chapter 3 and 4 were covered by The University of British Columbia, ethics certificate number H11-03383. Ethics approval was also obtained through Children’s & Women’s Health Centre of BC, ethics certificate number CW12-0133. Lastly, as recruitment efforts took place at some Child and Youth Mental Health centres in BC, approval was sought and obtained from the Ministry of Children and Family Development, ethics certificate number 201302WRA.

Participant interviews were completed by the author in collaboration with five research assistants: P. Ackland, (Associate Professor, University of the Fraser Valley), J. F Domene (Associate Professor, University of New Brunswick), P. Nitkin (PhD, Counselling Psychology), L. Proctor (Master’s student, Counselling Psychology, Trinity Western University), and L. Wilson (PhD, Counselling Psychology). Data analysis was completed by the author and two research assistants: C. Rodericks (Master’s student, Counselling Psychology, Trinity Western University) and M. Zhu (Master’s student, Counselling Psychology, University of British Columbia).
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Acknowledgements

This dissertation would not have been possible without the abiding love and support of my Mom and Dad, as well as a wonderful group of close friends and family who witnessed my process, shared uplifting words, and offered many kindesses along the way. I feel truly blessed.

I am also indebted to my colleagues and research associates who so generously gave of their time to assist me through the data collection and analysis: Chantel, José, Laura, Leah, Patricia, Sophie, and Trish.

I want to thank my research committee for providing valuable guidance and feedback throughout the course of this study: Dr. Richard Young, Dr. Lynn Miller, and Dr. Curren Warf. I am particularly grateful for the guidance of Dr. Young, my primary supervisor. Thank you for your patience and wise counsel throughout this process, as well as the oppportunity to participate in some of your ongoing projects as a doctoral student. Those learning expeirneces were invaluable in preparing me for this project.

Also a loving acknowledgement of my faithful dog Rodger, who frequently accepted shorter walks than he would have liked and slept under my desk while much of this dissertation was written.

Finally, I am deeply appreciative of the courageous parents who participated in this project and shared their stories me. You have taught us a great deal.
Chapter 1: Introduction

Anorexia nervosa (hereafter, anorexia) is a complex eating disorder, which generally develops in adolescence and affects females at a higher rate than males (Hudson, Hiripi, Pope, & Kessler, 2007; Swanson, Crow, le Grange, Swendsen & Merikangnas, 2011). A range of physical, psychological, and behavioural features may emerge in individual cases of anorexia, but the core features are believed to essentially be the same for both males and females: (a) restricted energy intake, leading to a significantly low body weight given one’s sex, age, developmental trajectory, and physical health; (b) intense fear of becoming fat or gaining weight, or persistent behaviours that interfere with weight gain; and finally (c) evaluating one’s self-worth largely in terms of one’s body weight and shape and one’s ability to control them, disturbance in the way one’s body or weight is experienced, or persistent lack of recognition of the seriousness of the low body weight (American Psychiatric Association, 2013). These core features of anorexia propagate various actions directed at the persistent pursuit of weight loss, such as selective food restriction or other purging behaviours, such as the misuse of laxatives, excessive exercise, or self-induced vomiting. Individuals with anorexia are commonly observed to have low motivation to change their behaviours (National Institute on Health and Clinical Excellence [NICE], 2004). Success in losing weight tends to be powerfully reinforcing for those with anorexia; the more weight is lost, the more actions aimed at weight control seem to be compulsory in nature. A number of secondary difficulties are also associated with the illness, such as social withdrawal, cognitive rigidity, and depression, which seem to become more pronounced as weight is lost and diminish as weight is recovered (Accurso, Ciao, Fitzsimmons-Craft, Lock & le Grange, 2014). The mortality rate among adolescents with anorexia is relatively low. In the longer term however research has found females with
anorexia have a mortality rate 12 times greater than the annual death rate for females 15-24 in the general population, and a suicide rate 200 times higher than females of the same age in the general population (Sullivan, 1995).

Research for anorexia amongst the adolescent population is a priority in the field. Not only does anorexia take a significant toll on the adolescent’s physical, social, and emotional development and the lives of those living with and caring for the adolescent (Zabala, Macdonald, & Treasure, 2009), there is evidence to suggest adolescents with anorexia tend to respond better to treatment than adults (Wilson, Grilo & Vitousek, 2007). Furthermore, early intervention has long been recognized as one of the best predictors of interrupting a chronic course of the illness (Deter & Herzog, 1994).

Whether looking at adult or adolescent anorexia, the research tends to follow two main lines: etiological theories and treatment research. Comparatively speaking, etiological research has received far greater attention to date than treatment research, a disparity that may be related to characteristics of the illness that make clinical trials difficult, such as its low base rate in the population and high drop-out rates from treatment. In the adolescent population, family-based treatment (FBT; Lock, le Grange, Agras, & Dare, 2001), adolescent-focused individual therapy (e.g., Fitzpatrick, Moye, Hoste, Lock, & le Grange, 2010), and cognitive behaviour therapy (e.g., Fairburn, 2008) are the only manualized forms of treatment with support from experimental or quasi-experimental research. The growing collection of research on psychological treatments for adolescents over the past 2 decades is encouraging but various methodological issues have made combining the studies into meta-analyses or drawing firm conclusions about the merits of various theoretical approaches a challenge. Gowers et al. (2007) have suggested it may be for this reason that professional treatment guidelines for adolescent anorexia published by NICE and the American
Psychiatric Association continue to be based primarily on expert clinical opinions and well-conducted, but quasi-experimental studies. For example, the only NICE treatment guideline for adolescent anorexia that received a “B” grade in terms of being backed by a well-designed controlled study without randomization (the rest are “C” indicating evidence obtained from expert committee reports or opinions) was for the following: “family interventions that directly address the eating disorder should be offered to children and adolescents with anorexia nervosa” (NICE, p. 65). The guidelines do not specify what form the family intervention should take however FBT features most prominently in the research from which the guidelines were derived. It is important to note that although FBT is currently the leading and most researched treatment model to date, approximately one-third to one-half of adolescents treated do not improve (Eddy & Gray, 2014; Eisler, Dare, Hodes, Russell, Dodge & le Grange, 2000) and there is evidence to suggest the dissemination of FBT to community-based and non-specialized treatment centres has been poor (Couturier, Isserlin, & Lock, 2010; Loeb et al., 2007). In light of these challenges, research on ways to augment or enhance the model to address some of these challenges is ongoing (e.g., Couturier, Kimber, Jack, Niccols, Blyderveen, & McVey, 2014; Rhodes, Brown, & Madden, 2009).

**Family-Based Treatment**

First developed in the 1980s (Dare, 1985), FBT represents an integration of a variety of family and individual therapy models. The broad theoretical framework is informed by structural family therapy (e.g., Minuchin, Baker, Rosman, Liebman, Milman, & Todd, 1975), narrative therapy (e.g., White, 2007), behavioural theory and the medical model. A core tenet of the FBT model is “agnosticism” regarding the cause of anorexia. The agnostic position is taken in recognition of the complexity of the illness, the absence of convincing
evidence for existing etiological theories, and to deter parents from expending valuable mental energy searching for potential causes. Given the ego-syntonic nature of anorexia and the dangerous physical and psychological sequelae of starvation, FBT draws from the medical, structural and behavioural models and prioritizes the rapid reversal of weight loss by placing parents in charge of reducing eating disorder behaviours. Specifically, parents are directed to take responsibility for all food-related decisions for their adolescent until malnutrition has been reversed, weight has been regained, and other eating disorder behaviours have remitted. This aspect of FBT has been termed “parent-led weight restoration”, and constitutes the key therapeutic intervention of FBT (Lock et al., 2001). It is anticipated that parent-led weight restoration will be met with a great deal of resistance from the adolescent, and may look somewhat different for each family. To empower parents, FBT draws on some narrative techniques, and casts parents in the role of experts on their child, encouraging them to decide for themselves how to go about the “refeeding” or weight restoration. FBT encourages the externalization of the illness to help parents remain compassionate, non-blaming, but also resolute in the goal of weight restoration whilst encountering significant resistance (Lock et al.).

**Theoretical framework for parent-led weight restoration.** While the broad theoretical model of FBT represents an integration of therapeutic modalities, parent-led weight restoration is principally focused on behavioural change around eating, and the strategies and process of change are primarily conceptualized through behavioural theory (e.g., Skinner, 1953). Although it is not identified as a behavioural intervention in the treatment manual, the guiding principles of parent-led weight restoration are clearly behavioural in nature. For example, parents are encouraged to create clear expectations for meals and what will happen if expectations are not met, to locate meaningful incentives to
motivate the adolescent’s eating, and refuse to negotiate or deviate from these expectations: “Carrying out the plan and consequences is the work that must be done, and there is no getting around it” (Lock & le Grange, 2005, p. 160). Similarly, the role of the therapist in FBT is more of a consultant whose main goal is to help parents remember the tenets of FBT and apply the behavioural strategies for change. FBT assumes the anorexia and cognitive rigidity associated with malnutrition has made the adolescent an unreliable agent of his or her own change as far as food and weight gain are concerned. During parent-led weight restoration, no intervention is directed at the cognitive, emotional, or social aspects of the adolescent’s eating disorder. The responsibility for change in parent-led weight restoration rests fully with the parents.

Parent Experiences of Caring for an Adolescent with Anorexia

Given the importance of family involvement in the treatment and recovery of adolescents with anorexia by professional guidelines (e.g., NICE, American Psychiatric Association) and treatment models such as FBT, parents’ participation in the treatment of their adolescent represents a valuable focus of inquiry.

The extant literature indicates the presence of anorexia can bring powerful negative consequences for the lives of those caring for an adolescent (Keitel, Parisi, Whitney & Stack, 2010; Zabala, Macdonald & Treasure, 2009). For example, caregivers have reported high levels of anxiety and depression (Kyriacou, Treasure, & Schmidt, 2008; Orive, Padierna, Martin, Aguirre, Gonzalez, Munoz, & Quintana, 2013), subjective and objective burden (Dimitropoulous et al., 2008; Treasure, Murphy, Szmukler, Todd, Gavan, & Jones, 2001), as well as interpersonal and family relational strains (Hilledge, Beale, & McMaster, 2006). Cottee-Lang, Pistrang and Bryant-Waugh (2004) found parents perceived the experience of living with an adolescent with anorexia as a pervasive and overwhelming
“living nightmare” that made normal family life impossible (p. 173). Parenting an adolescent with anorexia also presents other challenges, as some parents have reported feeling unsupported, responsible, and blamed for their child’s eating disorder (McMaster, Beale, Hildege, & Nagy, 2004; Sharkey-Orgnero, 1999). Many of these investigations with parents have been retrospective, treatment non-specific, and have tended to describe parents’ experiences of adolescent anorexia in passive terms, for example parents being influenced or affected by the presence of anorexia in the life of their adolescent. Honey and Halse (2005, 2006) represent an important departure by investigating the actions parents took in responses to their adolescent’s anorexia and the types of coping actions and strategies they employed.

**Parent experiences of FBT.** Looking to the literature on parents’ experiences with or involvement in parent-led weight restoration, or FBT generally, the research is comparatively limited. To date, the primary representation of the role parents play during a course of FBT in clinical trials (e.g., Eisler et al., 2000; Lock, Argas, Bryson, & Kramer, 2005; Lock, le Grange, Argas, Moye, Bryson, & Jo, 2010) has been through the construct “expressed emotion” (Leff & Vaughn, 1987), operationalized as the frequency of critical comments, hostility, emotional over-involvement, positive remarks or warmth expressed by the parents toward the adolescent. To date, the role of parents’ expressed emotion on treatment outcome has been inconclusive (Le Grange et al., 2011). A small number of studies, with mixed findings, have also investigated changes in family functioning over the course of FBT treatment, measuring variables such as family cohesion, conflict and emotional expression (Ciao, Accurso, Fitzsimmons-Craft, Lock & le Grange, 2014; Lock, Couturier, Bryson, & Agras, 2006), and two studies asked parent and adolescent completers
of FBT about their satisfaction with the experience (Couturier et al., 2010; Krautter & Lock, 2004).

In sum, the research indicates parenting a child with anorexia brings many additional challenges and stresses. Some research has attended to parents’ experiences and actions of parenting an adolescent with anorexia generally; however, parents’ participation in parent-led weight restoration has not yet been the focus of inquiry.

**Contextual Action Theory and Parent-led Weight Restoration**

Generally speaking, counselling brings therapists into relationships with people as “integrated and whole beings who are able to reflect on and struggle over decisions...and who develop new and at times imaginative responses to the stresses of their environment” (Polkinghorne, p. 422, 1984). However, when parent-led weight restoration is conceptualized through the single perspective of behavioural theory, understanding of the intervention tends to be based on assumptions of human behaviour that are quite different from how people experience and explain their own behaviour, and from the assumptions about people that typically inform the work of counselling. A variety of action theorists (e.g., von Cranach & Harre, 1982; Mead, 1934; Vygotsky, 1986) have argued that human agency and the social embeddedness of human behaviour requires explanatory models that consider context and can take into account the statements people make about their reasons and intentions for doing things. Contextual action theory (von Cranach & Valach, 1983; Young, Valach, & Collin, 1996) is a conceptual and methodological framework for the study of human action that looks to the goal of action, as well as antecedent conditions and functional explanations, for understanding human behaviour. It recognizes all actions as embedded in a social and relational context, and assumes this context can reveal important meanings that would otherwise be unavailable. Contextual action theory is proposed as a
valuable framework for understanding the everyday meanings and interpretations on which parents base their actions while engaged in the weight restoration activities and processes.

The Current Study

**Research problem.** Parent involvement in the treatment of adolescent anorexia is recommended, and FBT assigns parents the crucial role of overseeing the adolescent’s weight restoration by taking direct and specific action intended to decrease eating disorder behaviours and increase weight. However, there is an absence of published literature documenting parents’ actions while engaged in parent-led weight restoration, which is problematic as this kind of knowledge can be assistive and supportive for families. Second, although behavioural theory is an established and recognized explanatory and treatment model, its underlying assumptions of human behaviour and de-emphasis of social and relational context, cognition, and emotion may be dissonant with many counsellors’ orientations, and quite removed from parents’ everyday understandings of themselves or their adolescents. It is the premise of this study that the single lens of behavioural theory offers an unnecessarily limited approach to understanding the phenomenon of parent-led weight restoration by not accounting for parental agency, the social embeddedness of parents’ actions, and parents’ unique constructions of weight restoration.

**Study purpose.** The purpose of this study was to apply the framework of contextual action theory to increase knowledge and understanding about parents’ individual and joint actions and strategies while they engaged in efforts to increase their adolescent’s weight through a process of parent-led weight restoration informed by the principles of FBT.

**Research question and strategy.** The overarching research question was “How do parents participate in the weight restoration of their adolescent as he or she recovers from anorexia nervosa?” Given the complexity of the phenomenon of parent-led weight
restoration and lack of existing research, an exploratory constructivist methodology was used. The research strategy was Stake’s (2005) multicase study approach and Young, Valach and Domené’s (2005) action-project method. Contextual action theory provided the conceptual and analytic framework.
Chapter 2: Literature Review

This chapter begins by presenting information on the prevalence and incidence rates of anorexia, the historical context of the illness, and a brief overview of contemporary etiological models. The mid-section provides a review and discussion of the leading treatment theories and the corresponding research to date, as well as current knowledge pertaining to parent experiences of adolescent anorexia. Finally, as contextual action theory provided the framework for this study of parent-led weight restoration, its philosophical assumptions and key constructs are presented in the final portion of the chapter.

Prevalence and Incidence Rates

The most current estimate for the prevalence of anorexia in the general population is 0.3% for adolescents (Swanson et al., 2011) and approximately 0.5% to 1% for adult women (Hoek, 2006; Hudson et al., 2007; Keski-Rahkonen et al., 2007), with a lower prevalence in males (Hudson et al.). When looking at just incidence, or rate of occurrence of new cases, Keel and Klump (2003) report a small effect size ($r^2 = .12$) from 1945 to 1991. However, caution is advised by the study authors, and a more conservative estimated effect ($r^2 = .06$) is recommended to account for the simultaneous and likely confounding increase during the same time period in access to medical and psychiatric care. For example, Keel and Klump’s meta-analysis found changes in diagnostic criteria accounted for more variability in incidence rates between studies than across time. It is worth noting the same caution is recommended for the interpretation of the prevalence rate as low base rates and multiple changes in diagnostic criteria over the decades have made these estimates difficult to ascertain as well (Keel & Klump).
Historical Context: Anorexia

Although anorexia was first officially recognized as a mental illness in the second edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1968), there is evidence to suggest the illness may have existed in various forms throughout history. Brumberg (1988) presents evidence for the practice of self-starvation reaching back to the Middle Ages, a behaviour possibly understood at the time as being motivated by goals of religious piety and purity. For example, some women who were eventually recognized as saints, such as Catherine of Siena, were known for engaging in practices of self-starvation. Brumberg notes the social meaning of being able to live without food during that time was a manifestation of divine power, which may have served to bring about the secondary gain of eminence. This condition was referred to as “holy anorexia” during the 13th to the 16th centuries (Vandereycken & van Deth, 1990).

Near the turn of the 19th century, British psychiatrist William Gull, French physician Ernest-Charles Leseque, and Italian physician Giovanni Grugnoli brought anorexia to the attention of the medical community in their independent descriptions of cases of extreme fasting (Habermas, 1992). Every case described by Gull (n = 4), Leseque (n = 8), and Brugloni (n = 2) involved adolescent or young adult females (Habermas; Keel & Klump, 2003). The conceptual understandings of the illness varied between Gull, Leseque and Brugloni, but each focused their intervention efforts on the medical problem of malnutrition and the primary course of treatment was feeding the patient (Striegel-Moore & Cachelin, 2001).

Early Influential Theorists

The collective works of Bruch (1974) and Minuchin (1978) have been highly influential in contemporary thinking and understandings of anorexia. Bruch’s and
Minuchin’s work followed on the heels of the psychoanalytic movement, popular during the 1940s and 1950s, where the illness was conceptualized as a response to instinctual drives and early childhood experiences. The psychoanalytic work concentrated on the disturbed eating or “oral” component of anorexia, and thinking at the time was that it represented a form of conversion hysteria symbolizing the denial of sexuality or “oral impregnation” fantasies (e.g., Waller, Kaufman, & Deutsch, 1940).

Hilde Bruch. Influenced by the work of early attachment theorists (e.g., Ainsworth & Bell, 1969), Bruch drew connections between her patients’ sense of trust and attachment with the sensitivity and appropriateness with which their mothers interacted with them during times of feeding. Bruch theorized the absence of regular, consistent, and appropriate responses to the developing child’s needs made it difficult for him or her to differentiate between experiences in biological, emotional, or interpersonal fields. By extension, the illness of anorexia was a manifestation of a deficient experience of separateness and sense of being controlled by external forces, and self-starvation functioned as an attempt to feel in control (Bruch, 1977). Bruch advised against purely behavioural responses to anorexia that employed a singular focus on feeding, advocating instead for a joint focus on nutrition and underlying psychological disturbance: “No true picture of the psychological problems can be formulated, nor can psychotherapy be effective, until the worst malnutrition is corrected” (Bruch, 1974, p. 1353).

Bruch’s theory addressed some of the more puzzling aspects of anorexia, such as why the illness seemed to target adolescents. She believed anorexia manifested during times of new experiences and expectations, and adolescence, being a highly tumultuous phase of life with many changes, made it an especially vulnerable time (Bruch, 1977). Because of the underdeveloped sense of self, she suggested adolescents felt unprepared to
grow beyond their immediate families and so continued to function with the “morality and style of thinking of early childhood, that of pre-conceptual and concrete operations…Piaget called this the period of egocentricity” (Bruch, 1982, p. 1532). Bruch’s work is widely acknowledged for the role it played in shifting thinking about anorexia from an instinctual drive to a problem linked with the development of identity and selfhood. Ego-oriented therapy, which was recently renamed adolescent-focused individual therapy (e.g., Robins et al., 1999, described below) has some of its theoretical roots in Bruch’s work.

**Salvador Minuchin.** A prominent family theorist best known for his theory of structural family therapy, Minuchin took a special interest in anorexia and published one of the first studies on its treatment for adolescents. Minuchin’s view of anorexia and its treatment was informed by his thinking on the structure and functioning of families of children with psychosomatic illnesses. The crux of the theory was that a child’s illness existed in the social context of the family and was sustained in part through the feedback processes occurring between family members. The aim was to change the family characteristics that supposedly supported the development of the illness, namely enmeshment, inflexibility, conflict avoidance, and overprotectiveness (Minuchin et al., 1978). Minuchin theorized these characteristics allowed anorexia to emerge by suppressing the child’s autonomy, promoting the expression of negative emotion within the family, and creating unhelpful alliances that undermined parental authority (Lock & Gower, 2005).

Minuchin et al. (1975) were the first to study an association between family interactions and anorexia. His team evaluated whether therapy specifically designed to alter the problematic family transactional processes (i.e., rigidity, enmeshment, overprotectiveness, and lack of resolution) would result in an alleviation of the symptoms of anorexia. The outcome indicated a success rate of 86% at follow-up, although the study was
not without methodological concerns (Lock & Gower, 2005). For example, the treatment the families received was actually quite mixed: Nearly half of the sample began the family treatment while receiving inpatient treatment, and there were a few adolescents who also saw individual therapists while engaged in the family therapy. Also, the time period for the follow-up when outcome measures were collected varied greatly (range = 18 months to 7 years), and the study used just one outcome measure: weight gain. Although weight gain is a commonly used outcome variable, it serves as a poor proxy for change in the family transactional patterns. Despite all these limitations, the impressive rate of success helped lay a strong foundation for future research on family therapy for anorexia (Lock & Gower).

Minuchin et al. (1978) noted structural theory was not meant to imply a family-based etiology for anorexia. However, the therapeutic focus of structural therapy on altering family interactions was interpreted by many to suggest a family-based theory of causation that is now firmly denounced by the Academy for Eating Disorders. In fact, the position paper from the Academy unequivocally notes there appears to be “no consistent structure or pattern of functioning in families with a member who suffers from an eating disorder; rather, eating disorders evolve a multiplicity of family contexts” (Le Grange, Lock, Loeb, & Bryson, 2010, p. 3).

**Etiological Models of Adolescent Anorexia**

Many comprehensive reviews of the research evidence pertaining to the development of anorexia exist (e.g., Adan & Kay, 2010; Polivy & Herman, 2002); however, a full review of these etiological models and research is beyond the scope of this project. What follows is a brief overview of prominent explanatory models for anorexia, including theories related to intrapersonal processes, personality, sociocultural theory, neurodevelopmental factors, and genetics.
Cognitive processes. The rise of cognitive theory in the 1970s led to understandings of anorexia that considered the role of mental processes as potential causative or maintaining factors. The cognitive model of anorexia is based on Beck’s (1964) general cognitive theory of psychopathology. When the theory is extended to anorexia, eating pathology is understood as resulting from maladaptive cognitions related to perceptions of one’s weight and shape, and the core cognitive error is overvaluation of body shape and weight when inferring personal value (Vitousek & Hollon, 1990). Overvaluation of body shape and weight, along with other related cognitive biases in attention, memory, and interpretation, are thought to be organized into knowledge structures referred to as weight-related self-schemata (Fairburn, 2008). The activation of weight-related self-schemata are thought to both cause and maintain anorexia by producing systematic errors when processing information about weight, shape, or food (Fairburn).

Personality and temperament. Personality research amongst adolescent populations is not without controversy, and there are questions about whether classification is appropriate in light of the presumed instability and ongoing development of personality traits throughout adolescence (e.g., APA, 2013). Amongst adult populations, cross-sectional and population-based research has indicated higher than average levels of certain traits for individuals with anorexia, including perfectionism and obsessive-compulsive traits (Halmi et al., 2000; Kaye et al., 1998; Keski-Rahkonen, Raevouri, Bulik, Hoek, Rissanan, & Kaprio, 2014). However, challenges inherent to the assessment of temperament and personality make investigating the role of personality in anorexia difficult (Rachelle & Lilienfeld, 2010; Vitousek & Stumpf, 2005). For example, there are problems related to who should be the informant, the individual versus a family member, the ongoing lack of consensus regarding personality disorder criteria and what assessment measures should be used, and finally the
challenge of distinguishing between personality traits that were in place prior to the onset of anorexia (trait) versus those which are a consequence of having had anorexia (scar) or currently having anorexia (state; Rachelle & Lilenfeld). Additionally, the cognitive consequences of semi-starvation (e.g., Keys et al., 1950) on personality are unique and do add an element of complexity for this area of research.

**Sociocultural factors.** Various sociocultural models have been developed for understanding the etiology of anorexia, helping to ensure the interface between the individual and the environment is not lost in the search for understanding. Theoretical models addressing cultural or social context are often informed by non-linear, systems thinking, however quantitative research designs and statistical models are largely based on assumptions of linearity and causality. The poor fit between the sociocultural theories and the methods used to investigate these theories has limited validation work in this area to date.

The idea that anorexia could be a response to the depiction of ultra-thin women in media and a preoccupation with the thin-ideal in Western culture grew to prominence in the 1980s (Garner & Garfinkel, 1980; Swartz, 1985). Stice, Nemeroff, and Shaw (1996) later proposed a dual-pathway model whereby sociocultural pressure to be thin was thought to engender body dissatisfaction, and body dissatisfaction would then motivate behaviours and emotional responses making one vulnerable to eating pathology. Other notable forerunners in the development of sociocultural theories of disordered eating include Murnen and Smolak’s (1988) theory that differences in social experiences and cultural opportunities available to men and women in Western culture represents a risk factor for eating pathology. Although their theory addresses eating issues amongst females generally, they viewed the behaviour of self-starvation as a symbolic manipulation of the body in protest to media
portrayal of the female form and what it implies about being a woman (Smolak & Murnen, 2001). Katzman (1998) offered a different perspective, proposing that female access to power in a male-dominated sociocultural context is key to understanding anorexia. In this model, it is power rather than gender that matters, and female vulnerability to the pursuit of thinness and anorexia is theorized to be related to a drive to achieve an androgynous form typical of males because it is associated with power. Finally, Fredrickson and Robert’s (1997) objectification theory is commonly referenced in explanation for the gendered risk factors associated with anorexia. By adolescence, objectification theory suggests girls have become so accustomed to their bodies as object, the notion is internalized and they start to treat themselves as though they are objects to be evaluated. The normative discontent (e.g., Rodin et al., 1985) that most women feel towards their bodies has been attributed to this process.

Finally, it is important to note that investigations of socio-demographic variables, such as a family’s socioeconomic status, parental age at the child’s birth, birth order, or parental divorce and separation, have not substantiated the presence of a typical “anorexia family” (Levine & Smolak, 2010). As Levine and Smolak point out, many theories about the predictive value of socio-demographic variables were informed by data collected retrospectively from analyses of hospital records, and many of these records were incomplete and compromised due to historic factors. For example, the assumption that anorexia did not manifest in individuals of varying ethnic backgrounds and socioeconomic statuses is now believed to reflect an underrepresentation of these individuals in hospital records, possibly due to barriers in help seeking (Levine & Smolak).

**Neurodevelopmental factors.** Southgate, Tchanturia and Treasure (2005) joined with others (e.g., Gillberg, Rastam, & Gillberg, 1994) in stressing anorexia should be
viewed as a neurodevelopmental disorder. To date, Southgate et al.’s model is the most comprehensive neurodevelopmental account of anorexia, and has generated much research attention (e.g., Rose, Frampton, & Lask, 2012; Tchanturia, Lounes, & Holttum, 2014). In collaboration with Connan et al. (2003), Southgate et al. suggest an interaction between genetic factors and various early life experiences may produce a maladaptive stress response, and a corresponding dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis. It is theorized that normative stresses associated with biological and psychosocial changes from infancy through to young adulthood may exacerbate vulnerability to eating pathology if maladaptive stress coping responses are chronically employed. More specifically, maladaptive stress coping responses are believed to be associated with prolonged elevation of a particular stress hormone, and these elevations have been linked with persistent loss of appetite regulation.

**Genetics.** It has been estimated that genetic factors may account for between 28 to 88% of the variance in the risk for developing anorexia (Bulik, Sullivan, Wade, & Kendler, 2000). Three types of research designs, including family studies, twin studies, and adoption studies, are used to investigate the heritability of anorexia. First, family studies have suggested a significantly higher lifetime prevalence of anorexia and sub-threshold eating disorders in first-degree relatives of probands (Lilenfeld et al., 1998; Strober, Lampert, Morrell, Burroughs, & Jacobs, 1990). In one study, relatives of probands were 11.3 times more likely to have anorexia than first-degree relatives of the control group (Strober, Freeman, Lampert, Diamond, & Kaye, 2000).

Unlike family studies, which cannot disentangle the relative contribution of environment and genetics, concordance rates between monozygotic and dizygotic twins permit a better estimate of environment and genetic contribution. Early research indicated
higher concordance rates for monozygotic twins (Holland, Hall, Murray & Crisp, 1984; Holland, Sicotte, & Treasure, 1988; Treasure and Holland, 1989), and later reanalysis of these data suggested the additive genetic effect to account for 88% of vulnerability (Bulik et al., 2000). Unique environmental effects were found to account for the rest of the variance, and shared environmental effects failed to account for any significant proportion of variance in risk for anorexia. Wade, Bulik, Neale, and Kendler (2000) reported a similar finding using a population-based twin study with non-clinically ascertained anorexia. In this study, heritability estimates for anorexia were found to be 58%, with unique environmental factors accounting for the remaining variance and the shared environment effect being negligible. In a separate study using a sample of female twins with anorexia syndrome, Klump, Miller, Keel, McGue, and Iacono (2001) reported estimates of heritability at 74%. Other studies (Bulik, Sullivan, Tozzi, Furberg, Lichtenstein, & Pedersen, 2006; Bulik, Thornton, Root, Pisetsky, Lichtenstein, & Pedersen, 2010; Kortegaard, Hoerder, Joergensen, Gillberg, & Kyvik, 2001) using a spectrum of broad and narrow definitions of anorexia put estimates of heritability from 28 to 58% (Thornton, Mazzeo, & Bulik, 2010).

Finally, adoption studies permit comparison of the incidence of anorexia in biological relatives and adoptive relatives, and can estimate the relative influence of genetic and shared environmental factors. Adoption studies are very rare in the field of eating disorders because of low base rates, and to date only one study has been completed. Klump, Suisman, Burt, McGue, and Iacono (2009) looked at biological and adopted female sibling pairs presenting with disordered eating symptoms (rather than clinical disorders, and not specifically anorexia). Consistent with the twin-study findings noted above, the estimates of heritability ranged from 59 to 82%.
Treatment Models for Adolescent Anorexia

Medication. Clinical trials examining the potential role for psychotropic medication in the treatment of anorexia have largely taken the form of case studies and small pilot studies (Lock & La Via, 2015). To date, no medications have been found to contribute beneficial effects in the treatment of adolescent anorexia (Hagman et al., 2011; Kafantaris, Leigh, & Hertz, 2011). A similar absence of additive benefit also characterized trials evaluating medications for adult anorexia (e.g., Norris, Spettigue, Buchholz, Henderson & Obeid, 2010). Many methodological obstacles exist for medication trials in anorexia, and it is very difficult to discern whether negligible effects of medication in these trials are due to the failure of the medication or to methodological issues. For example, in addition to the problem of low base rates limiting statistical power, medical compliance in anorexia is particularly problematic as the symptoms of the illness are not entirely disagreeable to the individual. Another important consideration that requires clarification is how being in a state of semi-starvation might interfere with the synthesis of sufficient amounts of neurotransmitters required for medication response (Crow, Mitchell, Roerig, & Steffen, 2009). In sum, although research on medication continues to be an active field of inquiry, there is currently no evidence for the use of any medication in the treatment of anorexia, regardless of whether the course is acute or chronic (Reinblatt, Redgrave, & Guarda, 2008). In light of these findings, nutritional treatment and psychotherapy remain the primary means of intervention.

Family-based treatment (FBT). The FBT approach to treatment views the adolescent’s family as a crucial treatment resource, and specific attention is given to mobilizing the parents to bring about changes to the adolescent’s disturbed eating and to reverse weight loss through parent-led weight restoration. FBT evolved from structural
family therapy (e.g., Minuchin et al., 1975), and some aspects of structural theory, such as viewing the adolescent as embedded within a family system and altering family structure by aligning the parental system, are present in its current form. FBT also borrows from narrative therapy (White, 2007) in its use of externalization to separate the adolescent from the anorexia. As weight restoration is typically met with considerable resistance, externalizing is intended to help parents be compassionate, non-blaming, and firm toward the adolescent. Being agnostic about cause, FBT views anorexia through a medical lens as a life-threatening medical condition. In keeping with its agnostic stance, no intervention strategies derived from etiological theory are used (Loeb et al., 2007). Overall, the theoretical stance of FBT on the illness of anorexia and necessary conditions for change culminate into a rationale intended to emphasize the importance of weight restoration and to help parents remain focused on weight recovery goals. Even the psycho-educational aspects of FBT tend to focus on the physical and psychological consequences of self-starvation and high mortality rates in order to galvanise parents in their role as the primary agents of change (le Grange & Lock, 2005).

In terms of practical application, FBT for anorexia has three distinct phases, and parents play an important role throughout. Approximately 20 sessions is suggested for delivering the full course of FBT (Lock et al., 2001). During phase I, parents are advised to make changing their adolescent’s disordered eating their top priority; these activities are collectively described as “re-feeding”. For example, they are encouraged to make themselves available for all meal times and snacks and to help their adolescent increase the amount he or she is eating by laying out clear expectations and establishing clear consequences (reframed in FBT as “protections”; Lock & le Grange, 2005). Parents would also be encouraged to help their adolescent begin to expand their food choices, and help
limit purging behaviours (Lock et al., 2001). Although FBT does not explicate the mechanisms or processes by which changes to the anorexic behaviours takes place during parent-led weight restoration, the way it is explained to parents and implemented in practice most closely resembles behavioural theory. The resources available to parents consist of counsellor support in applying key principles of behaviour change, such as highlighting obstacles or issues that might interfere with refeeding and providing advice on how to address them. For example, the adolescent should not be involved in health-related decision making, so a counsellor might encourage parents to have these discussions in private. Guided by the principles of FBT, parents are tasked with independently preparing a plan for how they are going to go about refeeding their adolescent. In FBT, the counsellor does not instruct parents how to go about weight restoration activities, but rather in serving as a consultant “encourages empowerment and an increased sense of self-efficacy” in the parents (Lock & Gowers, 2005, p. 604).

Once the adolescent has accepted his or her parents’ demands to eat and weight is regained and sustained at a healthy level, phase II of treatment begins. Control of eating is transferred back to the adolescent during this phase, and therapeutically the focus is typically turned to other family problems connected to, or resulting from, supporting the adolescent’s increased independence with eating. Finally, phase III focuses on establishing a healthy relationship between the parents and the adolescent where anorexia is no longer the basis for interaction. This last phase might include work on issues such as establishing appropriate family boundaries, greater personal autonomy for the adolescent, and the need for parents to adjust and reorganize their life together as their adolescent embraces his or her independence.
**Research using FBT.** Eight randomized controlled trials were located comparing various treatment approaches for adolescent anorexia. Of the eight located, seven involved FBT: four of these trials compared FBT to alternate forms of FBT, and three of these trials compared FBT to other forms of treatment altogether. A brief review of this treatment research follows, but it is important to highlight a few issues that pertain to the research on FBT, as well as the research on other approaches to anorexia treatment described below.

First, there is no consistent definition or operationalization of remission or recovery used by these trials. In almost all studies, physiological markers, such as percentage of ideal body weight or menstrual status (increasingly less common), are the primary outcome variables of interest at end of treatment and in follow-up. In response to criticism that FBT may only bring about changes in weight, and not underlying cognitive or emotional aspects of the illness, recent studies have begun interpreting the normalization of a participant’s score on various eating disorder measures or measures of general psychopathology to within 1 standard deviation of community norms in tandem with weight gain to indicate remission.

Second, most of these trials feature modest sample sizes and although recent studies have attended more carefully to issues of power, the absence of corrections for study-wise error rates is problematic, especially given the high number of comparisons typically made. While some argue this may be acceptable given the nascence of research in this area (e.g., Eisler et al., 2000; Loeb et al., 2007), it does mean the risk of Type 1 error rates are elevated, and sometimes substantially elevated. Third, because the focus of most of these trials have been on the efficacy of FBT, it is easy to overlook the significant minority of participants who drop out or fail to reach standards for remission or partial remission. When available, this review has provided information on individuals who dropped out or did not respond to treatment, along with information on treatment efficacy.
Russell, Szmukler, Dare and Eisler (1987) conducted the first systematic investigation of FBT, which was called “the Maudsley method” at that time after the hospital at which it was developed. Although the treatment was not manualized, and the sample was heterogeneous (N = 80: anorexia = 57, bulimia = 23), Russell et al. reported that after 1-year of treatment, adolescents with a short illness duration (≤ 3 years) in FBT had significantly better outcomes than those in individual supportive treatment on outcome variables of body weight, menstruation, and a measure of general adaptive health. Eisler et al.’s (1997) 5-year follow-up showed 90% of the adolescents in the family treatment condition maintained a good outcome compared to 36% in the individual therapy group. Of note, 18% of the original sample achieved an intermediate outcome, and 46% achieved a poor outcome.

The next clinical trial was conducted by Eisler et al. (2000), and was a comparison of two forms of FBT (N = 40; male = 1). The form of FBT delivered in each branch of the study were essentially identical, except one form was conjoint (involving parents and adolescent together in session) and one form was separate (parents and adolescents seen separately). After 1-year of treatment, the two forms of FBT were reported to bring about equivalent results: 37% of the sample was classified as having poor or intermediate outcomes. A 5-year follow-up to this study (Eisler et al., 2007) confirmed those who responded well to either form of treatment tended to stay well based on measures of eating disorder symptoms and body weight.

Lock, Agras, Bryson, and Kramer (2005) conducted the next published clinical trial, and compared FBT when delivered using a short-term model (10 sessions over 6 months) or long-term model (20 sessions over 1 year). A non-significant between group difference was found for the sample (N = 86), with post hoc tests suggesting the longer treatment modality
for adolescents belonging to non-intact families or demonstrating severe eating-related obsessive-compulsive features. Finally, Agras et al. (2014) compared FBT to systemic family therapy (e.g., Pote, Stratton, Cottrell, Shapiro & Boston, 2003) for a sample of adolescents and their families ($N = 158$). While FBT focused on facilitating weight gain, the systemic model addressed more general issues of family process. Agras et al. reported no significant differences between treatment groups on rates of remission, although adolescents in FBT gained weight more rapidly early in treatment. Again, while the rates of remission in this study were similar for both treatments and maintained over the year follow-up, a substantial number of adolescents from each treatment group did not meet remission criteria at end of treatment (approximately 65% for FBT and 75% for systematic) nor at follow-up (approximately 60% for both treatments).

Two open trials of FBT for adolescent anorexia have been conducted at sites external to the origin of FBT (Couturier et al., 2010; Loeb et al., 2007) in an attempt to demonstrate the “ecological utility” (Loet et al., p. 793) of FBT. Loeb et al. report their study was undertaken in recognition of controversial aspects of FBT, and a desire to demonstrate its efficacy in other clinical settings. The authors identified possible reasons why FBT has not been widely adopted by clinicians, including (a) the perception that anorexia requires intensive, long-term treatment and FBT’s recommended course of treatment, 20 sessions over the course of a year, would be inadequate; (b) the blend of theoretical models makes it “not easily identified with any particular orientation” (p. 793); (c) the atheoretical nature of its intervention strategies; and finally (d) the sharp contrast of parent-led weight restoration with traditional theories that believe anorexia to be “a maladaptive attempt at autonomy and control in the context of an enmeshed family...[where] any parental involvement, especially authoritative in nature, may exacerbate this dynamic and, in turn, worsen the disorder itself.”
Generally speaking, the two dissemination studies (e.g., Couturier et al. & Loeb et al.) were similar in design ($N = 14$, $N = 20$, respectively), where participants were recruited through community and professional referral sources. The findings of these two studies were similar to the pattern of findings in randomized clinical trials presented above. A small majority of participants responded to treatment with weight gain and improvements in some but not all areas of eating disorder pathology (weight and shape concerns were not improved). Likewise, dropout rates were comparable to the larger studies, and a significant minority were found to have intermediate or poor outcomes. Couturier et al. also assessed therapists’ fidelity to FBT, and noted the fidelity for study therapists, trained in a 2-day workshop by J. Lock and with weekly group supervision by the study’s lead author, was “considerable”, which was operationalized as a rating of 5 or higher (on a 0- to 7-point scale) 72% of the time in phase I, 47% of the time in phase II and 57% of the time in phase III.

Finally, a collection of studies re-analyzing data from the RCTs on FBT described above have sought to identify potential predictors, moderators and mediators of treatment outcome. Lock et al. (2011) found disconfirming evidence of an earlier finding (Eisler et al., 2000; Lock et al., 2005) that high levels of parental expressed emotion, especially criticism, predicted poorer outcome. In fact, le Grange, Hoste, Lock, and Bryson (2010) found quite low levels of expressed emotion in their sample of parents, and parental warmth was found to predict more favourable outcomes. Le Grange et al. (2012) found prior hospitalization, older age and duration of illness (> 3 years) continued to predict poorer outcomes after a 2-year follow-up. Doyle, le Grange, Loeb, Doyle, and Crosby (2010) found evidence to suggest adolescents who did not show early weight gain in FBT were less likely to remit at end of treatment, and Lock, Couturier, Bryson and Agras (2006) found
evidence to suggest the presence of a co-morbid psychiatric condition, problematic family
determinants (operationalized through a measure of family environment), and being an older
adolescent predicted lower rates of remission and dropout. Finally, research has also
suggested therapeutic alliance is achievable with adolescents in FBT (Forsberg, LoTempio,
Bryson, Fitzpatrick, le Grange & Lock, 2012) and that the alliance between parents and
therapist is strongest for parents early in treatment (Forsberg, LoTempio, Bryson,
Fitzpatrick, le Grange & Lock, 2013); neither study found evidence that therapeutic alliance
was connected to remission rates.

**Adolescent-focused individual therapy (AFT).** Originally named ego-oriented
individual therapy, AFT is described as a developmentally-oriented therapy derived from a
self-psychology model and psychodynamic theory (Robin et al., 1999). In AFT, the
adolescent is believed to have become preoccupied with food and weight in order to avoid
or escape negative emotions associated with developmental issues. Self-starvation and
preoccupation with food and weight is viewed as a means to escape distressing
environments and situations the adolescent does not have the skills to handle. The
overarching treatment goal of AFT is to teach the adolescent how to identify, understand,
and tolerate emotions, and to develop more constructive means of coping. Intervention
involves efforts to enhance adolescent self-efficacy, autonomy, individuation, and
assertiveness through individual counselling; meetings with parents occur as needed to
support the progress of individual treatment (Fitzpatrick, Moye, Hoste, Lock, & le Grange,
2010).

Like FBT, AFT is manualized and organized around a three-phase model of
treatment. The first phase involves developing a psychodynamic case formulation that
identifies the specific developmental challenges for the adolescent. All formulations view
anorexia to be a maladaptive attempt to cope with these challenges (Fitzpatrick et al., 2010). The therapeutic relationship is viewed as a key intervention, and techniques for change from other approaches are relevant provided they are consistent with the formulation. For example, cognitive-behavioural techniques might be used to understand the connection between thoughts and feelings, and mindfulness, relaxation or anger management could also be employed. Firm expectations for weight gain and a return to normal eating patterns are part of AFT, however, self-reflection/insight, social and interpersonal goals as they relate to the formulation are of primary importance. According to Fitzpatrick et al. (2010), strategies to encourage weight gain in AFT could include psycho-education about the risk factors of anorexia, the short and long-term consequences of malnourishment and its effect on cognition, attention, and mood. The therapist may also use his or her authority as a professional to emphasize the need for health and behaviour changes that lead to weight gain. Finally, parents and family are involved in treatment by way of collateral sessions, most of which occur at the beginning of therapy. The purpose of these sessions tends to be information gathering, educating the family about the disorder, or perhaps helping to foster a more nurturing home environment for the adolescent. Parents are not considered agents of change as in FBT, but they are encouraged to act in support of the adolescent’s self-directed change.

**Research using AFT.** Of the seven RCTs involving FBT mentioned previously, two were studies comparing FBT to AFT. First, Robin et al. (1999) compared the effectiveness of FBT to ego-oriented individual therapy (since been renamed AFT) for adolescent anorexia in a modest-sized sample ($N = 37$). Approximately 67% of individuals in FBT and 69% of individuals in AFT achieved their target weights by the end of treatment; approximately 30% of participants in each group did not respond to treatment. Although
both treatments brought about improvements for the adolescents, FBT brought about a more rapid return to physical health. Second, Lock, le Grange, Agras, Moye, Bryson, and Jo (2010) also compared FBT and AFT ($N = 121$), finding again that both treatments brought about considerable improvements for some participants, with no statistically significant differences between groups: full remission was found for 42% of FBT participants and 23% of AFT participants ($p = 0.055$). Lock et al. caution power limitations may have contributed to the non-difference, and note that statistically significant between group differences favouring FBT emerged at 6- and 12-month follow-up. Le Grange, Lock, Accurso, Agras, Darcy, Forsberg et al. (2014) conducted a follow-up study with 65% ($n = 79$) of those adolescents who had remitted at the end of treatment, finding no difference between treatment groups in terms of relapse (one from each FBT and AFT) nor marked changes in clinical presentation at 2 or 4 years.

**Cognitive-behaviour therapy.** The cognitive-behavioural approach to the treatment of eating disorders has traditionally been specific to the eating disorder diagnosis. Fairburn, Cooper, and Shafran (2003) questioned the utility of this approach, suggesting the clinical commonalities between anorexia and bulimia nervosa may be more important than those that distinguish them (Fairburn & Harrison, 2003). The original cognitive-behavioural account of bulimia nervosa has been extended to all eating disorders, resulting in a “transdiagnostic” approach called enhanced cognitive behavioural theory for eating disorders (CBT-E).

CBT-E holds that overvaluation of weight and shape and its control is fundamental to the maintenance of anorexia. Other clinical features and symptoms, such as preoccupation with food and eating, dietary restraint and restriction, body shape and weight checking, and extreme methods of weight control, are all considered to stem from this core
belief (Fairburn et al., 2003). The initial focus in CBT-E is on therapeutic engagement and motivation for change, followed by the development of a collaborative understanding or formulation of the processes responsible for maintaining anorexia. The formulation acts as a guide as to what needs to be focused on in treatment. Self-monitoring is central to CBT-E, and used early in treatment to help bring eating disorder cognitions into awareness in order to highlight the many opportunities the individual has to change unwanted or unhelpful behaviours. An emphasis on establishing a regular eating routine is also fundamental to this treatment (Fairburn, 2008). For example, an eating plan consisting of planned meals each day, along with two or three planned snacks. In CBT-E, cooperation with eating is elicited through education as to cognitive, emotional and physical consequences of starvation, and using the personal formulation of the eating disorder to help show how under-eating and being underweight maintain the disorder (Fairburn, Cooper, & Waller, 2008). Once the fundamentals of engagement, motivation, self-monitoring, and regular eating are in place, therapeutic attention turns to the maintaining processes, of which the most difficult and time-consuming is overvaluation of shape and weight and its control.

The core treatment of CBT-E offers a manualized 20-session four-phase model, with variations for extra modules for cases with clinical perfectionism, core low self-esteem, or interpersonal difficulties (Fairburn, 2008). CBT-E for adolescents is largely the same as that for adults, with modifications to involve family and to take into account the adolescent’s stage of emotional and cognitive development and social environment, such as the importance of peer relationships and the school environment (Cooper & Stewart, 2008). Parents are involved from the outset, and educated about the nature of the eating problem and the treatment; regular joint meetings with the adolescent, parent and therapist are used to help keep parents informed on the ways they can facilitate their adolescent’s efforts to
change. Therapeutic engagement is given special attention in CBT-E for adolescents in recognition they may be in treatment reluctantly or previously experienced treatment where adults were responsible for their eating. Cooper and Stewart note that CBT-E for adolescents emphasizes working on the adolescent’s behalf not on the parent’s behalf, and this distinction is maintained by having family-focused work be conducted by a separate therapist.

**Research using CBT.** One large randomised treatment trial in England, involving 35 community mental health clinics and four inpatient units, compared three forms of treatment for male and female adolescents (12 to 18 years of age) diagnosed with anorexia: non-manualized inpatient psychiatric treatment, manualized CBT specialized outpatient treatment, and non-manualized treatment as usual in a general community mental health clinic (Gowers et al., 2007). The study revealed inpatient treatment was no more effective than the outpatient programs, and the specialist treatment (CBT) was not more effective than general mental health in the short-term. Each group made progress after 1-year, with continued improvement at the 2-year mark where 33% of the sample were found to have a “good outcome” with 27% of the sample continuing to meet criteria for anorexia. More recently, Delle Grave, Calugi, Conti, Doll, and Fairburn (2013) published the findings of their community-based case-series study of CBT-E ($N = 49$), finding 63% of the sample attended the full 40-sessions of treatment with approximately 20% classified as “non-responders” (required additional treatment or showed a lack of progress) and 17% dropping out. Significant weight gains were documented amongst the completers (one-third had reached 95% of their ideal body weight), as well as improvements in general and eating disorder-specific measures of psychopathology.
Summary. At present, the three prevailing treatment approaches for adolescent anorexia are FBT, AFT and CBT-E; there is no evidence supporting psychopharmalogic interventions. By far, FBT has received the most research attention, and although the findings vary, there is some evidence it may outperform other treatments, particularly on physical outcome markers such as weight gain in the short-term. Importantly, the research also suggests a durability of positive outcomes for weight gain and eating disorder symptomatology over time for adolescents who had made significant gains during the course of treatment, FBT or otherwise. However, full remission was realized by only a portion of the samples, and a significant group of adolescents across treatment trials consistently realize poor outcomes or fail to complete the treatment. In light of these findings, the potency of the treatments needs to be interpreted in the context of these relatively low full rates of remission, and ongoing research to refine and enhance existing treatments continues to be an important focus for future inquiry (Eddy & Gray, 2014).

Parent and Caregiver Experiences of Adolescent Anorexia

There is widespread agreement that successful outpatient care for anorexia centres on family involvement and support (American Psychiatric Association, 2006; NICE, 2004). Parents can be an important resource for assisting in treatment, and invaluable source of support for the adolescent. Yet, the challenges of parenting a child with anorexia, whose life-threatening symptoms are bewildering and stressful, may bear considerably upon a parent’s ability to act in support of the adolescent’s treatment and day to day activities (Zabala et al., 2009).

The experience of caring for an adolescent with anorexia. Most investigations with parents of adolescents with anorexia have taken the form of survey research where measures are used to describe and compare, over time or to other populations, various
aspects of a parent’s experience, including levels of caregiver burden and psychological
distress (e.g., Zabala et al., 2009). Psychological distress in parents of children with eating
disorders tends to be operationalized using general measures of anxiety and depression, and
research has consistently shown caregivers of adolescents with anorexia report high levels
of anxiety and depression that tends to persist over at least a year’s time (Coomber & King,
2013; Orive et al., 2013). Caregiver burden is sometimes operationalized using general
measures of caregiving burden, covering factors like stigma, problems with services, or
effects on the family. More recently, measures of caregiver experiences particular to parents
of children with eating disorders have emerged and are receiving wider use (e.g., Haigh &
Treasure, 2003; Sepulveda, Lopez, Todd, Whitaker, & Treasure, 2007). Zabala et al.
identified eight investigations addressing caregiver burden, a few of which included
comparison groups. For example, Santoanastaso, Saccon, and Favaro (1997) found family
members of individuals with anorexia reported greater subjective and objective burden
compared to family members of those with bulimia, and Treasure, Murphy, Szmukler,
Todd, Gavin, and Jones (2001) found carers of individuals with anorexia reported higher
levels of psychological distress and greater difficulty in most areas of caregiving than carers
of individuals with psychosis. Finally, Kyriacou et al. (2008) found caregivers of those with
eating disorders had higher scores in two factors of a caregiving burden scale (difficult
behaviours, negative symptoms) than non-clinical controls.

Theoretical (Eisler, 2005) and empirical models (Kyriacou, et al., 2008) have been
developed to explain how families re-organize around an eating disorder and how parents
cope while living with someone with anorexia. Eisler’s model identifies six aspects of
family reorganization observed in a clinical setting, including (a) the central role of anorexia
symptoms in family life, (b) a constricted focus of time to the “here-and-now”, (c) a
restriction of available family interaction patterns, (d) a reduced ability to meet the needs of the family life cycle, and (e) a sense of helplessness and lost agency. Whitney and Eisler (2005) offer empirical evidence from the literature to support Eisler’s model. Kyriacou et al. used a multiple regression design to model factors associated with carer distress, defined by the study as parents’ levels of anxiety and depression. The model revealed anorexia-related problems in combination with role strain and interpersonal friction were significant predictors of carer distress. In this study, carer gender (mothers) predicted higher scores on measure of depression and anxiety, as well as measures of self-related and interpersonal strains.

A rich and growing body of qualitative research has also documented the experience of living with or caring for an adolescent with anorexia from the parent’s perspective. Hillage et al. (2006) interviewed parents (mothers = 19; fathers = 3) of adolescents diagnosed with eating disorders to understand the impact of the illness on the parents. The findings of this study revealed some parents felt as though their family had been pulled apart due to fractured social interactions, rifts amongst members, and depleted coping resources. Other parents reported experiencing a similarly stressful, difficult, and tenuous time during the illness but eventually becoming more unified as a family toward the end of the illness. Another key finding was how parents described the prolonged emotional pressure to eventually undermine their ability to cope. Anger, frustration, confusion, guilt, fear, nervousness, and physical exhaustion were terms commonly used by the parents to describe their emotional experience. Hillage et al. noted parents’ descriptions suggested a significant interpersonal and social toll, where inconsiderate comments from significant others, such as spouses, parents, other relatives, friends and work colleagues led them to give up seeking social support from outside the family. In an effort to avoid the extra burden of being made
to feel responsible for their child’s condition, parents in the study described isolating themselves or opting to withdraw from social engagements in an attempt to manage the situation.

Guided by constructivist theory, Hoskins and Lam (2001) applied critical ethnography and discursive psychology to investigate how mothers’ \((N = 3)\) understandings of themselves were influenced and changed by their daughter’s anorexia. This study used purposeful sampling, seeking mothers who could articulate their experiences, wanted to tell their story to assist others, and had indicated their view of themselves as mothers had been altered by the experience. In addition to analyzing the mothers’ individual constructions of experience, the study also examined how the mothers’ understandings of self were constituted in broader cultural views and meanings of motherhood and anorexia in families. Four main themes were found to characterize the relationship between mothering and eating disorders, including (a) feelings of care, culpability and responsibility at the onset of the disorder; (b) an assumed identity of dysfunction (“maternal dysfunction”) from the expert voice of psychology; (c) striving for perfection to “make right” in light of much that had gone wrong, and (d) attempting to change their way of being a mother, often by adopting relational constructs popular in the discourse of Western psychological thought (i.e., “boundaries”, “autonomy”) in order to negotiate a shift between being “too connected and too distant” (Hoskin & Lam, p. 169).

Keitel et al. (2010) employed grounded theory procedures and telephone interviews to investigate the salient stressors for mothers’ \((N = 10)\) whose children had received inpatient treatment for anorexia. The study revealed a variety of common stressors for these mothers. First, the burden of inadequate health insurance (the study was conducted in the United States) and finances to cover treatment was described as highly stressful by every
participant, even those parents who could afford the treatment. Stresses were also found to be connected to navigating treatment, such as choosing an appropriate course of treatment and low consensus and lack of knowledge about eating disorders amongst professionals. Negatively altered family dynamics, including a reduced ability to make family plans and the negative impact on other children in the home, were also noted. Finally, many of the mothers described considerable stress in connection to the amount of emotional energy and time devoted to caring for the child, which required changes in their personal priorities.

To examine how parents viewed the impact of anorexia on themselves and their families, as well as how parents made sense of and coped with the illness, Cottee-Lane et al. (2004) employed interpretive phenomenological analysis with mothers ($n = 7$) and fathers ($n = 4$). The authors identified eight key themes, clustered in three domains: (a) understanding the eating disorder, (b) the impact of the eating disorder, and (c) managing the eating disorder and its impact. The first domain subsumed two themes, including a slow recognition and analysis of the illness. Many parents described actions directed at finding solutions and a desire to prevent further harm, such as reading books, watching television programs, talking with lay and professional helpers, and joining organizations. The second domain subsumed three themes, the first being “the dreadful monster”, which captured how the sadness, growing distrust and relational strain felt by parents as they observed their child engage in uncharacteristically devious behaviours to avoid weight gain. The last two themes captured the impact of anorexia on parents given the risk of death and the real possibility of losing their child, which many described as overwhelming and a living nightmare with no end in sight. Finally, the last domain subsumed three themes related to parents’ feelings of frustration at not being able to get through to their child, the importance of “taking control”, and a desire for greater opportunities to share experiences with other
parents. These authors found parents’ family lives to be severely disrupted by the eating disorder, with meal times being a source of extreme stress. Many parents’ descriptions of mealtimes was like that of a battleground, lasting many hours and leaving all members of the family emotionally and physically exhausted.

Finally, Bezance and Holliday (2014) employed interpretive phenomenological analysis to analyze semi-structured interviews with mothers (N = 9) about their experience of “home treatment”, an innovative alternative approach to inpatient treatment in the United Kingdom. The authors did not identify if there were points of overlap between FBT and home treatment, but did align home treatment with intensive community based support programs based on the wrap-around model. The home treatment program involved a multidisciplinary team consisting of psychologists, nurses, and occupational therapists, and offered intensive in-home monitoring of the adolescent, supervision of meals, and some individual or family support. The authors identified three broad themes: an enmeshed mother-daughter relationship, maternal distress prior to the commencement of home treatment, and experience of help. Many of the mothers conveyed an experience of increased enmeshment with their daughters over time, related in part to the extent to which caring for the adolescent had taken over their lives. For many, “monitoring food and exercise was the first thing they thought of in the morning, and the last thing they thought of at night” (p. 390). Bezance and Holliday noted how the mothers’ sense of personal identity seemed to diminish as the illness progressed, a process the authors connected to (a) the all-consuming nature of the adolescent’s needs, and (b) the mothers’ need to make sacrifices in their own lives to accommodate these needs. Prior to treatment commencing, mothers recalled feeling despair and exhaustion, as well as a profound feeling of powerlessness and sense of helplessness in light of having tried many unsuccessful strategies to increase food
intake. In terms of these mothers’ experiences of home treatment, Bezance and Holliday describe parents needing and appreciating containment in the form of professional expertise and consistent treatment, acquiring skills to help their daughters, and rediscovering their own confidence and strength.

**How parents and caregivers respond to adolescent anorexia.** How parents respond to anorexia is believed to influence various aspects of the illness and treatment efforts. Sharkey-Orgnero (1999) used grounded theory with mothers \((n = 10)\), fathers \((n = 8)\), recovered individuals \((n = 9)\), and a sibling to develop a model of how parents and caregivers coped with and facilitated the recovery of their family member with anorexia. The study led to a four-phase model of a family’s response to anorexia. Parents were found to first “react”, a phase characterized by struggling to understand the disorder, recognizing a lack of knowledge, and fearing angry responses from their child. “Action” followed reaction, and was the phase where parents finally confronted the child about the seriousness of the eating disorder and the need to seek professional help. Maintaining and preventing relapse in progress comprised the last two stages. The first phase, reacting, was identified as the most intense for these parents. Many described a process of awakening to the reality of their daughter’s illness as they struggled to understand it and wondered what they had done wrong all while feeling helpless to make a difference.

Seeking to describe parents’ responses to anorexia in an active rather than passive way, Honey and Halse (2005) used grounded theory to examine the various actions parents described taking in response to anorexia and how parental constructions of anorexia related to parental actions. In their sample of 22 parents (14 mothers) of daughters between the ages of 14 and 18, parents were found to respond to anorexia by engaging in three kinds of activities: (a) daughter-directed activities intended to influence their daughters, such as
ongoing practical and emotional support, persuading and explaining, or using ploys to influence; (b) foundation activities intended to support the daughter-directed activities, such as researching anorexia, advice seeking, trying to stay positive and avoid self-blame, active coping; and (c) parallel activities necessitated by anorexia, but not directly intended to support their daughter, such as caring for other siblings in the context of anorexia. The study noted parents held multiple, and sometime contradictory and evolving constructions of anorexia, which influenced how parents made sense of their adolescent’s behaviours, their ideas regarding what would be supportive in her recovery, which in turn affected their own actions. Some of the constructions identified included: anorexia as a simple eating issue, anorexia as a medical illness or purely genetic disorder, anorexia as a psychological problem, and anorexia as an “unknown”.

In a subsequent study focused specifically on parental coping, Honey and Halse (2006) used grounded theory (mothers = 16; fathers = 8) to develop a model of parents’ coping strategies in response to adolescent anorexia. Parents were found to engage in coping strategies across three domains: explanatory work, thinking work, and capacity work. Explanatory work included activities such as finding out about the illness, evaluating past strategies, and comparing and assimilating information about the illness. Aspects of thinking work included strategies such as separating anorexia from the child, maintaining a helping focus, and holding realistic expectations. Finally, aspects of capacity work included parental strategies to increase capacity to carry on with the demands of caring for their daughter. Of note, Honey and Halse also compared the coping strategies they discovered with the types of coping strategies documented in popular quantitative coping inventories. In addition to finding the parents in their study frequently made use of general or common coping strategies captured in these inventories, such as maintain social support or
understanding the medical situation through communication, many items were also not relevant to parents of children with anorexia, such as caring for medical equipment at home. Importantly, the authors also noted many of the strategies documented in their findings were not represented in the inventories, suggesting there may be coping strategies specific to anorexia. For example, absent were some aspects of explanatory work, such as evaluating past strategies, and some aspects of thinking work, such as separating the illness from the individuals with anorexia, maintaining a helpful focus, and keeping expectations realistic.

**Parent experiences with FBT.** Looking at the literature on parents’ experiences with FBT, the research is comparatively limited and primarily from the quantitative or post-positivist tradition. Krautter and Lock (2004) asked mothers, fathers and adolescents for their opinions of FBT using a 10-item survey at the end of a clinical trial (Lock & Le Grange, 2001). Courturier et al. (2010) used the same survey to look at parent and adolescent satisfaction in a small, uncontrolled dissemination study of FBT. Parents and adolescents in both studies identified some needs not met by FBT, such as more individual therapy time or a desire to focus on other issues besides anorexia, but a majority rated the overall experience of FBT as acceptable and effective. In their treatment trial of FBT compared to systemic family therapy, Agras et al. (2014) also collected data on treatment satisfaction using a 0 to 10 scale. Adolescents’ rating did not differ between treatments: 5.3 (3.3) for FBT and 5.6 (2.6) for systemic, however parents’ ratings were significantly different between treatments, with both mothers and fathers rating FBT higher. Finally, it is worth noting a variety of empirically-based interventions and resources have been developed for parents involved in FBT, including meal support guidelines (Leichner, Hall, & Calderon, 2005), collaborative skills workshops for parents (Sepulveda, Lopez, Todd, Whitaker, & Treasure, 2008), and parent-to-parent consultations (Rhodes, Brown, &
Madden, 2009). Some of these interventions have been conceptualized as possible augmentations to FBT in recognition that parenting a child with anorexia presents many additional challenges.

**Summary.** Parenting an adolescent with anorexia presents many additional challenges for caregivers. Yet, caregiver involvement is important in the treatment of this illness, and parents express a desire to be involved, to understand their adolescent’s condition, and do whatever may facilitate his or her return to health (Hunt, 2010). Of the many challenges and frustrations parents describe during the course of their adolescent’s treatment, dealing with the issue of food and eating tends to be especially stressful and wearisome (Cottee-Lane et al., 2004). There is an absence of research attending to parents’ experiences and actions while engaged in FBT or components of FBT, such as parent-led weight restoration. Given the research suggesting seeking information, understanding of the illness and treatment advice is a common coping strategy of parents and caregivers (Honey & Halse, 2006; Sharkey-Orgeno, 1999), there is reason to believe parents and counsellors would find information on the processes by which parents engage in and implement parent-led weight restoration helpful.

**Contextual Action Theory and Parent-led Weight Restoration**

Contextual action theory (CAT; Valach, Young & Lynam, 2002; Young, Domene, & Valach, 2005) is an established conceptual framework for the study of human action, and represents a promising approach for the study of parents’ actions while engaged in parent-led weight restoration for their adolescent with anorexia. Application of CAT to the field of psychology has previously included studies addressing topics such as health promotion within families (Young, Lynam, Valach, Novak, Brierton, & Christopher, 2000), addiction recovery (Graham, 2009), counselling for suicidality (Michel & Valach, 1997), the school to
work transition for couples (Domene et al., 2012) and counselling for the transition to adulthood (Young et al., 2011). What follows is a brief overview of contextual action theory, its core philosophical assumptions, and how it could be extended to understanding a process like parent-led weight restoration.

A core assumption of CAT is that actions are best understood in the context in which they develop (von Cranach & Valach, 1983). The theory has its roots in historical perspectives on social action (e.g., Mead, 1934; Vygotsky, 1986), and shares some philosophical commonalities with post-modern theories that view action (or reality) as constructed through language and social representation (e.g., Gergen & Gergen, 2008). The contextual field in CAT includes the objects of a person’s physical and social world, but also assumes “people are active in engaging in their worlds and constructing it as they engage it” (Young, Domene, & Valach, 2014, p. 5,).

In recognition of the agency of human behaviour, CAT assumes action is intentional and purposeful, and a contextualized understanding is realized by looking to the goal of the action (von Cranach & Harre, 1972). The use of the term goal is intended to capture this agency and context, and it is important to note the term encompasses planned behaviour in the service of explicit goals, as well as behaviour that unfolds moment to moment in the service of tacit goals (Valach et al., 2002). CAT also assumes people tacitly make sense of their own and other peoples’ behaviours by directing their meaning-making efforts to the intentions (or goals) of the individual whose behaviour they are trying to understand. It is worth highlighting that by looking to the goal of actions for understanding, CAT can capture aspects of the every-day meanings or “lay theories” people construct about their own behaviours in addition to understandings guided by prevailing academic theory (Young et al., 2005).
To address the inherently relational processes of human action, CAT uses the construct *joint action* to capture how the meaning of most human actions is social or interpersonal in nature. In recognizing the jointness of action, the theory acknowledges that simultaneous to having private or individual goals, people participate in shared relational contexts and engage in joint actions in an ongoing way to realize common goals (Young et al., 1997). For example, even if parents appear to be working toward opposing goals related to weight restoration, as might seem to be the case during conflict, their relatedness and shared context means their actions are interconnected and always in the service of some shared goal.

**Conceptualizing action in parent-led weight restoration.** In recognition that action is a complex, multidimensional phenomenon, CAT offers the following framework to assist in formulating an understanding of individual or joint actions. The framework considers multiple perspectives on action, various levels of organization within a unit of action, and the potential for action to extend in a meaningful way across time in a system of action.

**Perspectives on action.** Action is viewed as being organized and guided by processes occurring simultaneously and interdependently at three difference levels of experience: (a) the social and contextual meaning of the action, such as a parent interpreting their adolescent’s food refusal as manipulative; (b) internal processes, which would address the cognitive or emotional processes a parent might experience during the meal with their adolescent, such as frustration and fear, and finally (c) manifest behaviours, such as the observable behaviours a parent and adolescent take while engaged in the meal, such as avoiding eye contact, sitting side by side, and speaking in neutral but firm tones. Each perspective provides distinct information about the parent’s action that guides
understanding, yet the construct of action integrates the three perspectives into a cohesive whole (Valach et al., 2002). Thus, an advantage of CAT is that various approaches or theories for understanding behaviour, such as behavioural, cognitive and affective, and social, can be accommodated.

**Organization of action.** To help guide understanding of the many goals or sub-goals that might be guiding a parent’s action in weight-restoration, CAT applies a three-tier hierarchical organization of action comprised of elements, functional steps, and intentional framework (Domene, Valach, & Young, 2014). The *elements* of action represent the lowest level of organization, and might include things such as parent’s skill level in performing meal support, including verbal phrases or physical movements, the material, relational, or professional resources available to the parent, or unconscious processes like behavioural avoidance in conflict situations. *Functional steps* are the medial level of action organization. A functional step is a sequence of related elements directed toward a common goal or sub-goal, and represents the means by which a parent might move closer to that goal. For example, a parent searching on-line for information about a high-calorie meal might be a functional step constituted by a sequence of contiguous elements like the parent’s inherent skill in researching topics, pre-existing knowledge of reputable internet-based resources, a need for anxiety-regulation, and the availability of material resources (laptop and internet service) in the absence of access to professional resources. Finally, *intentional framework* represents the highest level of action organization, and includes the overarching purposes or intentions of the parent while engaged in the action. To carry the illustration forward, the parent may engage in the functional step of researching high-calorie meals in service of the goal of increasing his adolescent’s weight before the next appointment where the intentional framework is to ensure his son is not withdrawn from school and he is not required to take
more time off work. As the above illustrates, the goals of individual and joint action are often reflected in the functional steps and elements that comprise the action.

**Systems of action.** When several discrete individual or joint actions serving a shared goal take place across a mid-length period of time, they constitute a *project*. By extension, when an organization of projects come to be highly significant in an individual’s life and exist over a long-term, they are termed a *career* (Young & Valach, 2008). Generally speaking, project and career are meant to be broad and more encompassing constructs than action thereby allowing one to make sense of individual and joint actions across time (Young & Valach). In application to the actions and process of parent-led weight restoration, parents might be viewed as engaging in several individual or joint behaviours over time directed at the goal of helping their adolescent recover weight that might constitute a “weight restoration project”. By extension, the parent’s weight restoration project may emerge in the context of a marital relationship or parenting career. Because each parent’s actions are embedded in a particular social and relational context, are steered, regulated or controlled by unique subjective cognitive and emotional processes, and are shaped by a variety of distinct behavioural sequences and resources, one parent’s weight restoration project might look considerably different from another’s despite sharing the similar goals of weight recovery.

In sum, by looking to the goal of human action, CAT adopts a very different way of looking at the world compared to traditional or contemporary theories of human behaviour in psychology (Young et al., 2005). When applied to the process of parent-led weight restoration, the CAT framework looks to the goals of a parent’s individual and joint actions, as well as antecedent conditions and functional explanations, for understanding of the action. It assumes a parent’s actions are embedded in and emerge from a social and
relational context, and this context can reveal important meanings that would otherwise be unavailable. By attending to goals of action for understanding, CAT also captures the everyday meanings and interpretations on which parents base their actions while engaged in the weight restoration activities and processes. It is a theory that addresses context extensively, a desirable attribute in light of how most theories of human behaviour try to account for context in one way or another (Young, Valach & Collin, 1996) and how the discipline of counselling psychology attends carefully to the significant contexts of people’s experiences.

**Conclusion**

This chapter has reviewed the historical context of anorexia, and provided an overview of prevailing accounts of its etiology and treatment for an adolescent population. An industrious effort has been made over the past few decades to establish and validate treatments for adolescent anorexia, and despite methodological limitations and modest rates of success, FBT appears to be a useful approach. A rich and growing body of research on parents’ experiences of adolescent anorexia was also located and reviewed in this chapter however there was a notable absence of research attending to parents’ experiences or actions while engaged in parent-led weight restoration. Given that parenting a child with anorexia brings many additional challenges and stresses, and learning about parents’ participation in the treatment of their adolescent is a valuable way to assist and provide support for families, the aim of this study was to increase knowledge of parent-led weight-restoration. More specifically, the aim was to favour the voice and experience of parents by examining parent-led weight restoration through the framework of contextual action theory.
Chapter 3: Method

The purpose of this study was to examine the phenomenon of parent-led weight restoration for adolescents with anorexia from the perspective of weight restoration as goal-directed action. The broad research question was as follows: “How do parents participate in the weight restoration of their adolescent during treatment for anorexia?” The following narrower research questions were used to address the broad research question: (a) what were the important individual and joint actions the parents engaged in with one another, their adolescent and others? and (b) what were the other important projects that seemed connected to the weight restoration processes identified in (a).

Rationale for the Methodology

This study sought to increase knowledge and understanding of parent-led weight restoration by investigating it from the parents’ perspective during the time they were engaged in these actions. Given the complexity of the phenomenon and lack of existing research, an exploratory constructivist methodology was used. Contextual action theory provided the conceptual and methodological framework, and the research strategy was Stake’s (2006) multicase study approach and Young, Valach and Domene’s (2005) action-project method. The following section outlines the rationale and fit for this research approach.

Situating the inquiry: Philosophical framework. Contextual action theory holds some philosophical assumptions that do not fit squarely with a single one of the prevailing scientific paradigms (Young et al., 2005). However, of the four main paradigms discussed in the literature (Guba & Lincoln, 1994), it most closely aligns with constructivism, and has sometimes been referred to as moderate constructionism (R. Young, personal communication, February 4, 2015).
Consistent with constructivist philosophy, contextual action theory views reality as multiplisitic, and a co-constructive process influenced by a complex of individual perceptions, sociocultural context, as well as individual and interpersonal actions. With the assumption of co-constructed realities, the conditions for knowledge creation include interaction between individuals (Lincoln & Guba, 2000), where a dynamic, authentic relationship permits a lived experience (reality) to be perceived. To allow for human agency and intentionality in understanding ontological questions of meaning, contextual action theory looks to human action. It views meaning and knowledge as constructed through action and in this way holds a more explicit ontology than most constructivisms (Young et al., 2005), hence its description as a moderate constructionism. Thus, explaining and understanding actions (reality) depends not only on social, cultural and historic co-constructions, but the behaviours, experiences and intentions of people in their everyday lives.

**Research approach: Multicase study.** Stake’s (2006) instrumental multicase study approach was used to bring organization and focus to the analysis. Case study is a common approach to inquiry, and the multicase approach is useful when the aim or purpose is to provide insight on a phenomenon. In multicase research, the term *quintain* is used to identify the phenomenon of interest: “It is an object or phenomenon or condition to be studied – a target, not a bulls’s eye....For the proverbial blind man describing the elephant, the elephant is the quintain” (Stake, p. 6). In the present study, parent-led weight restoration was the quintain. As Stake points out, the quintain is the starting point for multicase research:

To understand it [quintain] better, we study some of its single cases – its sites or manifestations. But it is the quintain we seek to understand. We study what is similar and different about the cases in order to understand the quintain better. (p. 6)
Although there may be exceptions, Stake suggests the benefits of multicase research are maximally realized with sufficient cases to show enough interactivity between situations (four or more cases), but not so many cases that the study gathers more unique examples of interactivity than a researcher can grasp (10 or fewer cases). Stake’s general recommendations for selecting cases were followed in this study: the cases were relevant to the quintain, provided both some diversity across contexts and opportunities to learn about complexity and contexts. As such, this study was open to model and atypical cases of parent-led weight restoration in recognition that each case has atypical features, and “the search for particularity competes with the search for generalizability [and] what all should be said about a single case is quite different from what should be said about all cases” (Stake, 2000, p. 439).

**Research method: Action-project method.** In multicase research, interviews and observations are common methods of generating data, and Stake (2006) notes the methods used within a study may be similar or different from case to case. In this study, data for each case was generated using Young et al.’s (2005) action-project method. A detailed account of the application of the action-project method to this study is provided below. The action-project method is based on the understanding of action as goal-directed and intentional, and was specifically developed to be used in tandem with the contextual action framework (Young et al., 2005). What this means in the context of the present study is that congruence between the beliefs or assumptions about the actions parents take together in weight-restoration and the way in which it would be investigated could be realized. Four key features of the action-project method made it well-suited for this study of parent-led weight restoration.
First, the action-project method assures understanding of parent-led weight-restoration will not be reduced to one academic theory or another that may lose meaning for the people who contributed data or for whom the knowledge is meant to help (Valach et al., 2002). By adopting a contextualized perspective, the action project method permits the complexity of parent-led weight-restoration to be recognized in the research (Valach et al.). Second, the action project method recognizes many types of explanations for behaviour, including casual and functional (Young et al., 2005), but through the lens of contextual action theory, the researcher attends primarily to the goal of the action for understanding. This teleonomical approach to explanation ensures the agency and intentionality of human action is captured in the research. Third, family-based treatment (FBT) conceptualizes parent-led weight restoration as a collaborative and cooperative undertaking between parents. As the action project method directs researcher attention to individual and joint actions and goals, it can conceptualize parent-led weight restoration as a social endeavour rather than an individual venture. Finally, the pairing of contextual action theory and the action-project method brings the advantage of being able to address processes (Young et al., 1997). This means the “how” of weight-restoration (the process) can be addressed in addition to the “what” of weight-restoration (Young, Valach, & Collin, 1996).

**Analytic framework.** Interpretive processes proceed in many ways in constructivist research (Haverkamp & Young, 2007). Contextual action theory takes a unique stance toward understanding in that the overarching explanatory model is teleonomical. Attending to action makes contextual action theory somewhat less interpretive than other forms of constructivist research. Contextual action theory is guided by hermeneutic understanding, but because action is assumed to hold pertinent contextual information (time, place, history, culture), goal-directed action is given primary consideration (Young et al., 2005).
Therefore, the meaning of data in this study was informed by a combination of the meaning made by parents engaged in weight restoration and researchers looking to the parents’ “weight restoration actions” to understand behaviour.

**Participants**

Prospective participants were parents of an adolescent diagnosed with anorexia who were engaged in efforts to increase their son’s or daughter’s weight. A broad recruitment strategy was used. With ethics approval from British Columbia’s Children’s and Women’s Hospital and the Ministry of Children and Family Development, the primary researcher made contact (email, phone, and face-to-face meetings) with the mental health professionals offering FBT or FBT-informed therapy featuring parent-led weight restoration for adolescent anorexia. Depending on protocols of the specific organization, an introductory letter (see Appendices A and B) and study posters (Appendix C) were made available to prospective participants via word of mouth by clinicians, announcements at parent group meetings, and hanging posters in the waiting areas and parent education centres affiliated with these sites. Notifications about the study were also circulated through the Twitter accounts of two Vancouver-based non-profit foundations that offer support for people with eating disorders, as well as the research opportunities page of the National Eating Disorders Association. A Facebook page was created to promote the study officially and informally, and regular postings were made to the volunteer section of Craigslist in communities throughout British Columbia and Western Washington State. It is important to note that in light of documented challenges with the dissemination of FBT (e.g., Couturier et al., 2010) and the broad recruitment strategy employed in this study, the primary researcher did not expect to find all families would receive similar forms of FBT nor have similar experiences with the treatment. Rather, the study sought parents engaged in treatment where there were
some efforts to supervise or regulate the eating activity of their adolescent diagnosed with anorexia.

In total, 11 prospective participants expressed interest in the study. Six were found to meet the inclusion criteria described below and agreed to participate. Individuals were not included in the study for reasons such as the adolescent was weight recovered and treatment was completed (n = 3), the parents had questions or concerns about their child’s eating but were not involved with professionals (n = 2), and parents met inclusion criteria but did not respond to the primary researcher’s follow-up (n = 2). Parents with questions about their child’s eating behaviours were provided with the address and intake number of the child and youth mental health centre in their community.

Six parents (four individual parents, one dyad) of five adolescents met the inclusion criteria and agreed to participate. Table 1 summarizes the demographic information for the cases. Four parents responded to posters or letters about the study shared at community-based child and youth mental health centres; one parent responded to an on-line advertisement. Parents were from Vancouver’s Lower Mainland and the Vancouver Island area of British Columbia, Canada. Two parents were the heads of single-parent homes with

<table>
<thead>
<tr>
<th>Case</th>
<th>Age (years)</th>
<th>Duration (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adolescent</td>
<td>Parent</td>
</tr>
<tr>
<td>1</td>
<td>16</td>
<td>54</td>
</tr>
<tr>
<td>2</td>
<td>13</td>
<td>44</td>
</tr>
<tr>
<td>3</td>
<td>18</td>
<td>45</td>
</tr>
<tr>
<td>4a</td>
<td>16</td>
<td>48</td>
</tr>
<tr>
<td>4b</td>
<td>16</td>
<td>42</td>
</tr>
<tr>
<td>5</td>
<td>13</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>Average</td>
<td>15.20</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>2.17</td>
</tr>
</tbody>
</table>

Note. SD = standard deviation.

With Case 3 data removed, average duration of adolescents’ illness: M = 10.3, SD = 4.9
shared custody of their adolescent, two parents lived with spouses (who did not participate in the study), and the parental dyad was married. Parents in this study were born in Canada ($n = 3$), and two Western European countries ($n = 3$). One parent identified as First Nations, while the remaining identified as Caucasian; all parents spoke English.

**Procedure**

**Screening.** A brief telephone interview screen ensured participants met basic inclusion criteria: (a) their adolescent was between 11 and 19, and (b) currently in community-based treatment for anorexia that featured parent-led weight restoration. Participants meeting inclusion criteria were emailed a copy of the introductory letter (Appendix A) and informed consent (Appendix D). Once parents responded to confirm their willingness to be involved, arrangements were made for the initial interview.

**Research team.** Due to various life circumstances external to the study, for example, schedule conflicts and travel restrictions, the research team included a number of different active members over the duration of the study. Research interviews were conducted by the primary researcher (doctoral student in counselling psychology), three graduate students in counselling psychology (Masters, $n = 1$ and doctoral, $n = 2$) and two registered psychologists (counselling psychology and developmental psychology). All research assistants involved in data collection were familiar with the method and experienced in interviewing for research purposes. The primary researcher met with each assistant for an hour prior to each research interview to review and practice the protocol and set up the interview space before the parents arrived (see Appendix E).

The research team for data analysis included the primary researcher and two Master’s–level counselling psychology students familiar with action theory and experienced in the analysis of qualitative research. The primary researcher has a background in
counselling for general psychological disorders in children and adolescent populations, including family and parent counselling and adolescent eating disorders. She also has a background in qualitative and quantitative research methodology, including 4 years of experience and training in data collection and analysis using the action-project method and contextual action theory through her involvement as a research assistant in three action project method studies. The second researcher was a female Master’s student in Counselling Psychology with research experience in adolescent self-harm and Indo-Canadian mothers’ experiences of miscarriage; her counselling training has focused primarily in family and marriage counselling and issues related to maternal health. This researcher assistant brought a strong academic knowledge of the action-project method and contextual action theory, and was trained by the primary researcher in its application to the data in this study. Finally, the third researcher involved in data analysis was also a female Master’s student in Counselling Psychology with a research and practical interest in career development and identity exploration for adolescents and young adults. She brought 3 years of experience and training in data collection and analysis using the action project method and contextual action theory through her involvement as a research assistant in two other action project method studies.

**Data Collection**

**Initial meeting.** The initial meetings took place at locations convenient for the parents, including mental health offices ($n = 3$), university research space ($n = 1$), and a community recreation centre ($n = 1$). In all cases, the informed consent was read aloud by the researcher and questions about the procedures and participation were invited and answered.
**Warm-up interview.** The warm-up interview served various purposes, including establishing rapport, learning about the adolescent’s and parent’s experience with treatment to date, and finally establishing a context for the action that would become the focus of the second phase of the initial meeting (the joint conversation). The primary researcher and a research assistant were both present for the warm-up. In each case, the context for action was established through a process by which the primary researcher invited the parents to discuss some current or ongoing issues related to their adolescent’s weight restoration. At the end of the warm-up, parents were invited to select one of these issues to discuss at greater length during the joint conversation. The warm-up conversation represented meaningful social and contextual data and so was video-recorded. The average duration of the warm-up interviews is presented in Table 2.

<table>
<thead>
<tr>
<th>Case</th>
<th>Initial Warm-up</th>
<th>Joint Conversation</th>
<th>Self-Confrontation</th>
<th>Member Check</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>00:23:35</td>
<td>00:23:00</td>
<td>02:23:43</td>
<td>01:16:40</td>
<td>04:26:58</td>
</tr>
<tr>
<td>2</td>
<td>00:22:27</td>
<td>00:16:27</td>
<td>00:51:09</td>
<td>00:33:17</td>
<td>02:03:20</td>
</tr>
<tr>
<td>3</td>
<td>00:13:37</td>
<td>00:16:50</td>
<td>00:23:01</td>
<td>00:21:45</td>
<td>01:15:13</td>
</tr>
<tr>
<td>4a</td>
<td>00:37:39</td>
<td>00:17:02</td>
<td>00:45:58</td>
<td>00:39:27a</td>
<td>03:18:27</td>
</tr>
<tr>
<td>4b</td>
<td></td>
<td></td>
<td>00:58:21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>00:20:43</td>
<td>00:18:16</td>
<td>00:57:14</td>
<td>00:38:31</td>
<td>02:14:44</td>
</tr>
<tr>
<td>Total</td>
<td>01:58:01</td>
<td>01:31:35</td>
<td>06:19:26</td>
<td>03:29:40</td>
<td>13:18:42</td>
</tr>
<tr>
<td>Average</td>
<td>00:23:36</td>
<td>00:18:19</td>
<td>01:03:14</td>
<td>00:41:56</td>
<td>02:27:06</td>
</tr>
<tr>
<td>SD</td>
<td>00:08:45</td>
<td>00:02:42</td>
<td>00:41:28</td>
<td>00:20:39</td>
<td>01:13:35</td>
</tr>
</tbody>
</table>

Note. 4a = female parent; 4b = male parent; SD = standard deviation.

*Duration of individual member check interview for female parent = 00:05:32 min, male parent = 00:07:25 min.

**Joint conversation.** In the second phase of the initial meeting, the parents engaged in a video-recorded conversation on the weight-restoration issue of their choosing. For cases with individual parent participants, a researcher participated in the joint conversation with the parent. The parental dyad had the joint conversation with each other without a
The joint conversation provided data at the level of manifest behaviour, as well as social and contextual meaning. The durations of joint conversations are listed in Table 1.

**Video self-confrontation.** Following the joint conversation, parents were invited to take a break, and then asked to complete the demographic form (Appendix F) while the researchers set up the equipment for the video assisted self-confrontation. The video-assisted self-confrontation is the final phase of the initial meeting. The self-confrontation accesses the linguistic form of the internal processes the parents had in the action while it was taking place. In this phase, each parent watched a video playback of their joint conversation, guided by the primary researcher (cases 1, 2, 4a) or a research assistant (cases 1, 3, 4b, 5), who stopped the video approximately every minute to ask the parent to recall his or her thoughts and feelings while speaking with their conversation partner. For case 4, each spouse completed the video self-confrontation privately with a different researcher; for cases with individual parent participants, the researcher not involved in the conversation conducted the video self-confrontation. In addition to providing data on internal processes, the self-confrontation also provided parents with the opportunity to contextualize their actions, reflect on the social meaning of the actions, and also provide additional information about their goals during the action, although these observations are not explicitly sought. These recollections of the parents’ internal processes were provided as close in time to the action as possible, and in this project took take place immediately after the recorded action in the joint conversation. Case 1 was an exception however as the self-confrontation procedure required more time than anticipated. Thus, this parent’s self-confrontation was split over two appointments, approximately 2 weeks apart. The average duration of the self-confrontation interviews are listed in Table 1.
**End of the initial meeting.** After finishing the self-confrontation procedure, everyone present (parents, the primary researcher and research assistant) reconvened in a common room where the honorarium was paid, the research interview was debriefed, and the next steps in the study were discussed.

**Analysis of data gathered at initial meeting.** The process for initial analysis mirrored the steps outlined in Young et al. (2005). After the initial meeting, the primary researcher transcribed the audio and video-recordings. The initial analysis was performed by the researcher along with one of the two research assistants mentioned above. The primary unit of analysis was the actions of the parents. The initial analysis involved the simultaneous analysis of all available data, including the warm-up, joint conversation, self-confrontation, with a detailed and intensive coding and annotation process on the weight restoration actions occurring in the joint conversation. The analysis involved an iterative “top down” and “bottom up” procedures through the lens of contextual action theory (Young et al., 2005).

Working minute-by-minute, the primary researcher and a research assistant read the transcriptions and re-watched the corresponding joint conversation, conducting an intensive three-level analysis of each minute. The first level was the bottom-up perspective, which involved a fine-grained coding and analysis of the specific units of manifest behaviour (elements) making up an action using pre-established codes, for example, “expressed dissatisfaction”, “asked a question”, “clarified” (see Appendix G for codes). Once coding of the elements was completed, the bottom-up analysis was augmented with the self-confrontation data, which provided information about the parent’s internal processes that occurred at the minute being coded. The self-confrontation data helped the researchers identify the action steps (functional steps) in which parents were engaged during the action
sequence (e.g., “feeling confused”, “normalizing the desire to fit into beauty ideals”, “thinking about what her daughter wants”). Finally, the last level involved a top-down analysis that allowed for an overall sense of the social meaning that contextualized the individual or dyad’s actions as well as an understanding of the overall goal (intentional framework) of the entire action sequence in the minute or minutes under consideration. In this final phase, the individual and joint goals for the entire action sequence were identified, for example, “to re-examine her position re: what she wants for her daughter with the recognition she wants to consider her daughter’s wishes, too.” Throughout this process, the researchers made notes on each minute segment by summarizing the action elements, and then jointly inferring the functional steps, individual goals, and joint goals.

Taken together, these steps created a back and forth movement between the three levels in which action was embedded. This allowed the researcher to consider the processes and behaviours that contribute to the system of action as a whole, not just features of it (Young et al., 2005). It is important to note that when knowledge is being constructed like this, constructivism assumes no two observers will construct it exactly the same way. Thus, the joint coding and analytic process described above represents a form of triangulation with the full recognition that complete confirmation would not be possible. When what was not agreed upon was considered important, the different views of both researchers were noted and recorded.

**Weight restoration projects.** In keeping with one of the purposes of action-project method (Young et al., 2005), the three-level fine-grained analysis just described provided the basis for the final step of the initial analysis: inferring and describing the unique weight-restoration projects the parents were pursuing. The initial analysis was synthesized by the primary researcher into a single two-page narrative written from a goal-directed perspective
using as much of the parents’ original language as possible. At this point, the primary researcher reviewed the case narratives and the identified unique weight restoration project with her supervisor. For Case 4, three narratives were written: one for each parent participant so as to reflect their individual actions during the conversation, as well as a joint narrative to reflect the joint action of the dyad. Separate individual narratives were used as each spouse’s narrative might have referred to private material revealed in the self-confrontation.

**Final meeting: Second interview and member check.** At the second and final meeting, held approximately 8 weeks after the initial meeting, the primary researcher presented parents with the written narrative and the possible primary and associated weight restoration projects. The purpose of reviewing these narratives was to elicit the parent’s thoughts as to whether the identified project fit their subjective experience of weight-restoration. The primary researcher carefully reviewed the narrative with each parent, and discussed whether the identified project seemed to represent their experience, and if not, how it could be changed to better represent it. This second interview was audio-recorded and transcribed by the primary researcher as an additional source of data.

**Honoraria**

Following the initial and second interview each parent was given an honorarium in the amount of $25.00 as an expression of gratitude for their involvement and to off-set any costs incurred as a result of their participation for example, fuel, and parking.

**Data Analysis**

The overall analytic strategy for this study was informed by Stake’s (2006) multicase approach and contextual action theory. Analysis of data for each case proceeded in stages and involved the intensive within-case analysis followed by a cross-case analysis where the
purpose was to understand how each case, and then the collection of cases, answered the research questions. Contextual action theory provided the interpretive framework throughout. In total, the data set included the transcribed warm-up interviews, the joint conversations, and self-confrontations from the first interview, the follow-up member-check interviews, demographic information, and researcher reflections. It is worth noting that data from the member-check interview was interpreted in a similar way to data from the warm-up interview: both were considered to represent meaningful social and contextual data. The primary researcher consulted data from the transcribed member check interview to supplement and extend her understanding of the identified weight restoration project, as well as draw out any additional processes, projects and careers that seemed additive or pertinent to understanding the weight restoration project.

**Within-case analysis.** Following the initial analysis, where the weight restoration project and action-theoretical summary for each case was created, the researcher sought to understand how each individual case answered the research questions. The within-case analysis was guided by the verified projects from the initial analysis, and sought to describe the important individual and joint actions the parents took while engaged in those projects. Consistent with the multicase approach, the aim of the within-case analysis was to describe the complexity of the weight restoration project as it was located in its own situation. Regular consultation with the primary researcher’s research supervisor and co-researchers helped ensure faithfulness to the analytic process, and the weight-restoration stories and actions of the parents. Each within-case analysis was concluded by several assertions concerning what was found to be important or salient about the parent’s actions in each specific case. It is worth noting at this point that assertions are a form of generalizing, the purpose of which is to better understand the quintain. As Stake (1995) points out, it is not
uncommon for case study researchers to “make assertions on a relatively small data base, invoking privilege and responsibility of interpretation” (p. 12). In this study, the search for understanding what seemed to be important about each case “within its own world” (Stake, 2006, p. 56) was guided in part by the research questions, contextual action theory, and a desire to understand how the parents being studied viewed and experienced weight restoration. In drawing assertions for the cases in this study, the researcher based her conclusions on the available evidence with full recognition that other valid interpretations exist.

**Cross-case analysis.** Neither the multicase approach nor contextual action theory emphasizes the comparison of cases as a primary research strategy. For example, from the multicase perspective, the studied cases are a selected group of instances chosen for better understanding of the quintain (Stake, 2006), and in contextual action theory, uniqueness of the action unit and project is assumed (Young et al., 2005). Yet both approaches would acknowledge the individual cases in this study share the common phenomenon of parent-led weight restoration, and are hence categorically bound together. Therefore, while comparison can obscure situationality and complexity, it is a grand research strategy offering a useful approach to conceptualization that can facilitate learning about the quintain (Stake).

To some extent, aspects of the cross-case analysis took place concurrent to the individual case analysis; however, full attention was not given to the cross-case analysis until the within-case analysis was completed. Stake describes this process as the case-quintain dilemma: “during work on the single case, the collection of cases remains mostly at the back of the mind....but there is tension: the single case and collection of cases vie for more attention” (2006, p. 1). To manage the tension and remain focused on the activity of
the individual case, a working document was created to hold potential and emerging commonalities for when the cross-case analysis began in earnest. The cross-case analysis took the following form. First, a comparison was made of how each case answered the research questions. Second, significant similarities and distinctions between the weight restoration projects were identified, supported by quotations from warm-up interviews, joint conversations, self-confrontation interviews, and the member-check interviews. Finally, using an interpretive process similar to that described for the within-case assertions, key assertions were made based on the primary researcher’s understanding of important findings between cases.

**Trustworthiness and Rigour**

Criteria for credibility and rigour in qualitative research are tied to the philosophical underpinnings of the scientific paradigm guiding the inquiry (Morrow, 2005), as well as the approach and purpose of the study (Mertens, 2010). Validity is enhanced when there is congruence between the epistemological and ontological assumptions of the researcher and the chosen methodology. Careful attention was given in the design of this study to ensure consistency between the overarching paradigm, the conceptual framework, the selected method of data creation, and the research questions.

Significant efforts were also made to encourage open dialogue and feedback from the research participants. For example, all members of the research team had training in counselling and research interviewing, and had previously been involved in research projects prior to their work on this project. This study was also designed with a warm-up interview to provide time establish rapport and for parents to share about their adolescent and their general experience with treatment thus far. Finally, the member check interview was conducted with an openness and curiosity regarding the parents’ responses to the
identified projects. The primary researcher was intentional in noting and expressing appreciation for corrections or clarifications offered, and the narratives and projects were modified until parents expressed satisfaction with the final form.

A precondition for adequate interpretation of data in qualitative research is having collected sufficient evidence from which to make interpretations. In this study, the criterion of sufficiency was attended to by gathering in-depth data over a period of time, for example, the video and audio recordings of the warm-up, joint conversation, video self-confrontation and member check interview. The use of multiple data sources in this project also allowed for variety of evidence, sometimes called triangulation (Morrow, 2005), enhancing the interpretive status of the data. The use of multiple data sources coupled with the close contact between the primary researcher and the data sources (immersion) also speak to the criteria of prolonged and deep engagement (Lincoln & Guba, 2000).

The video self-confrontation procedure served as an important validity check on data gathered in the joint conversation, and also enabled access to very specific data from the parents on their internal cognitive and emotional processes occurring moment-to-moment in the joint conversation. In this way, it also served as a form of triangulation whereby a parent’s personal constructions of meaning, in addition to social representations of meaning contributed by the researcher’s own analytic process, were captured and represented in the data. Further, the narrative and statement of parents’ weight-restoration projects also served the important purpose of verification in terms of ensuring the identified projects constructed from the data aligned with parents’ understandings of the project or could be discussed and modified until it did.

In recognition that constructivist research is values-mediated, this study used consensus processes to guard against bias related to selective interpretation or disregard of
counter-evidence. Consensus processes were embedded in data collection (self-confrontation and member check interview), as well as data coding and analysis. Discrepancies in coding or categorizing of data were discussed between two researchers, until consensus regarding the appropriate interpretation was reached. Regular consultation with the primary researcher’s supervisor also took place throughout data collection and analysis.

Finally, the goals of a constructivist / contextual action theory approach to scientific inquiry are idiographic and emic, and so it is assumed that these understandings will not generalize to all populations, but might transfer to subpopulations or smaller communities bearing characteristics similar to participants involved in this study. Detailed or “thick” descriptions of the parents’ experiences are provided in Chapter 4 so readers may make “naturalistic generalizations” (Stake, 2000, p. 442) or judgements about the applicability of these research findings to their own situations.

**Ethical Considerations**

The study received ethics approval from the University of British Columbia, as well as the British Columbia Children’s and Women’s Hospital and the Ministry of Children and Family Development ethics review boards. The physical safety of the adolescent, as well as ensuring parents had access to support following the research interviews, were important considerations in the design of this study. For this reason, inclusion criteria stipulated the parents and adolescent had to be connected to and involved with a treatment team to participate. Further, in recognition that parents would be describing personal experiences that might be stressful and associated with difficult feelings, informed consent was treated as an ongoing process, rather than a single event. For example, if a parent was expressing strong negative affect, or seemed to be hesitating in response to some aspect of the study
procedures (e.g., video self-confrontation), parents were encouraged to share only in ways that felt comfortable, and would have been reminded of the voluntary nature of the project and the option to reconsider their involvement with full honorarium.

Because the primary researcher is a trained counsellor with experience treating adolescent eating disorders, it was made clear in the telephone interview screen and informed consent that involvement in the study was not a form of counselling or therapeutic intervention. During the implementation of the study, interview protocol was regularly and carefully reviewed prior to each interview, and debriefed with co-researchers to ensure the nature of the parent conversations was in keeping with research not counselling.

Finally, in an effort to protect the confidentiality of the parent participants, various personal details not bearing significantly to the meaning of the case have been altered (e.g., Haverkamp, 2005). All parents’ names, and the names of other individuals mentioned in their cases, have been changed. To further safeguard the anonymity of parents recruited through agencies, parents were advised that the researcher would not disclose their participation in the study to the agency, although they were welcome to do so if they wished. Finally, as all parents were provided with narratives containing examples of how they would be presented, quoted and interpreted, the primary researcher asked and listened carefully for signs of concern and responded accordingly.

**Delimitations**

In response to challenges encountered with recruitment, the study as implemented differed somewhat from its original design. Many of the changes were based on feedback from staff at locations assisting with recruitment who indicated (a) families may be too overwhelmed by the requirements of weight restoration to entertain research involvement, and (b) some of their programs offered parent-led weight restoration informed by FBT.
principles, but not in its manualized form. As such, changes were made to the design of the study and inclusion criteria with the hope of decreasing barriers for participation.

First, a change was made to the proposed length of the study. The original design followed the traditional action-project format, including three face-to-face interviews, with email or telephone monitoring between the second and third interview. This was described to prospective participants as an 8 to 10 hour commitment over 4 to 5 months. The study was shortened to include 2 face-to-face meetings over 2 months, with a 2-3 hour time commitment. The implication of the truncated design was the study could no longer track the progress of parents’ weight restoration projects over time; however, the parents’ weight projects could still be identified and verified by the parents.

Second, the original study sought parents who were in the early stages of parent-led weight restoration for adolescent anorexia as part of an FBT approach. This inclusion criterion was relaxed to include (a) parents at early, mid or late stages of weight restoration, and (b) parents involved in treatment that featured parent-led weight restoration, either informed by the principles of FBT or the manualized form of FBT. This modification was found to be in keeping with Stake’s definition of the quintain as a target, not a bull’s eye. And, although this change meant the study would not be investigating a “pure” form of parent-led weight restoration as outlined by FBT, it might well reflect the experience of parents attempting parent-led weight restoration in community based treatment centres.

Finally, the original study intended to interview two parents or caregivers about their weight restoration actions. This was in keeping with action-project method of interviewing participant dyads and the underlying philosophy of FBT that parents work together as a cohesive unit in response to anorexia. This inclusion criterion was relaxed so that single parent participants could be involved in the study. By changing this criterion, the study
gained a number of participants (four of the five cases were single participants) however understanding of the parents’ individual and joint actions was based more heavily on parents’ descriptions of and reflections upon described action, and less on direct observation of these actions as enacted in conversation with a co-parent or caregiving partner.
Chapter 4: Findings

The aim of this study was to explore parents’ actions while helping their adolescent recover weight through parent-led weight restoration. The overarching research question was: “How do parents participate in the weight restoration of their adolescent as he or she recovers from anorexia?” The following narrower research questions brought focus to the analytic process: (a) what were the important individual and joint actions in which the parents were engaged with one another, their adolescent and others? and (b) what were the other important projects that were connected to the weight restoration processes identified in (a).

All parents in the study were involved in parent-led weight restoration with their adolescent informed by principles common to family-based therapy. Thus, the parents shared the common “superordinate” treatment-related goal of helping their adolescent recover weight, a goal they were working toward through a myriad of similar and distinct actions. The primary interest of this study was to identify and describe the unique weight restorations projects and processes that emerged for each parent as they went about implementing parent-led weight restoration for their adolescent.

Presentation of Findings

The findings of this study are presented in a way to allow the reader sufficient access to the data to consider the conclusions drawn by the researcher and also engage in a process of drawing his or her own conclusions. This format is in keeping with Stake’s (2005) description of the case researcher as “teacher” using a combination of two pedagogical methods whereby the researcher describes what she has learned (didactic) and also provides material for readers to learn on their own (discovery learning).
The chapter has three main sections: the within-case findings, the cross-case findings, and the key assertions. The first section, the within-case findings, is presented in rich detail in order to remain true to the case study approach as the “intrinsic study of a valued particular” (Stake, 2005, p. 238), and allows the reader access to the uniqueness, complexity, and diversity of the cases. However, prior to the within-case findings, as an advanced organizer for readers, Table 3 outlines the basic structure of the individual case presentations. Each case begins with an overview of the pertinent background information, covering general contextual details such as the family context and the duration of the adolescent’s illness. Subsumed under background information are two sub-sections: (a) interview context, intended to acknowledge and differentiate the actions and intentions parents described taking in relation to weight restoration from the goals parents brought to the research interview, and (b) weight restoration context, which attempts to locate the parent’s general state of progress with parent-led weight restoration.

Table 3

*Basic Structure of Within-Case Findings*

<table>
<thead>
<tr>
<th>Case X</th>
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<tbody>
<tr>
<td>Background Information</td>
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<tr>
<td>Interview context</td>
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<tr>
<td>Weight restoration context</td>
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<tr>
<td>Weight Restoration Project</td>
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<tr>
<td>Projects Summary</td>
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<tr>
<td>Project Exposition</td>
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<tr>
<td>Assertions</td>
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</tbody>
</table>

Following the background information, the parent’s unique weight restoration project is presented. The weight restoration project is a summary statement representing a parent’s individual and joint goal-directed weight restoration actions identified in the final stage of the initial analysis of data and validated by the parent (see Chapter 3). Following the weight restoration project, an overall projects summary of the case written from a
contextual action theory perspective is presented. The projects summary represents what
the researcher has learned about the case based on the analysis using the action-project
method and having been guided by the research questions and the framework of contextual
action theory. After the projects summary, a full exposition of the parent’s experience with
weight restoration is provided. Essentially, the project exposition of each case describes in
full detail the relevant projects and important individual and joint actions which the parents
described or engaged in with one another, their adolescent and others. Each case concludes
with a set of assertions, which represent the researcher’s main learnings from the particular
case with recognition that other valid interpretations exist.

The second section of this chapter contains the cross-case analysis. Although an
attempt has been made to present each case in sufficient detail so the reader may also make
good comparisons, the cross-case section of this chapter represents the researcher’s
understanding of the aggregate of cases, paying particular attention to the common and
distinct processes that seemed to emerge. Finally, the chapter concludes with a summary of
the key assertions or main learnings from the researcher’s perspective for this collection of
cases.

Please note, the following abbreviations will be used throughout the chapter to
indicate the interview conversation from which a parent’s quote was drawn: WU = Warm
Up Interview; JC = Joint Conversation; SC = Self-Confrontation Interview; MC = Member
Check Interview. Each quote is accompanied by a number, which represents the line in the
document from which the quote was drawn.
Within-Case Analysis

Case 1: Pamela.

Background information. Pamela is a married woman with a 16-year old daughter, Heather; Pamela’s husband (Geoff) chose not to join her in the study. At the time of the interview, Pamela reported Heather had been suffering from anorexia for approximately 16 months and she had been engaged in parent-led weight restoration for approximately 9 months. Heather had not been hospitalized due to the eating disorder. Her illness and treatment required substantial changes to Pamela’s work and life schedule, and contributed to a significant loss of family income over the year. To Pamela’s knowledge, there is no history of other individuals in their family experiencing an eating disorder.

Interview context. Following the telephone screening, Pamela attended the initial data-gathering interview which involved a warm-up interview with two researchers, a conversation about her weight restoration activities with the primary researcher, and a video playback (self-confrontation) with the research assistant. As time expired before the video playback could be fully completed, Pamela returned 2 weeks later to finish this portion of the interview with the primary researcher. Approximately 2 months later, Pamela took part in the second interview (member check) with the primary researcher in order to negotiate the description of her weight restoration project for Heather.

In the research interview, it was important for Pamela to convey how time consuming and overwhelming her life had become since undertaking parent-led weight restoration. She highlighted the various issues and circumstances that created obstacles for her, and described things others could have done to make the job a little easier. She frequently described situations, past and present, involving herself, her daughter, her husband, and her daughter’s counsellor. She outlined the many challenges she encountered
in feeding Heather a high calorie diet, and described how she had addressed the challenges or was attempting to overcome them. Pamela expressed a variety of emotions during the interview, including frustration, anger, worry, dissatisfaction, as well as gratitude at having identified Heather’s eating disorder quickly and the opportunity for treatment to teach her daughter more adaptive ways of coping in the future. Pamela sometimes expressed her frustration through laughter and her sadness through tears. She often invited or elicited acknowledgement or agreement from the researcher (“You know?”, “Right?”), but did not seem to really expect a response.

*Weight restoration context.* Pamela’s general experience of parent-led weight restoration was that it was mentally, emotionally and physically exhausting. Despite being overwhelmed, Pamela reported making progress over the past 9 months. Pamela continued to provide meal support for three meals and snacks each day in order to interrupt various eating disorder behaviours, such as eating very slowly or hiding food. Heather was not making any food-related decisions yet herself, and had just begun eating at restaurants and going with Pamela to the grocery store, although usually choosing to stay in the magazine section.

*Weight-restoration project.* The following description of this project was presented to Pamela for validation at the member check interview:

*Taking on all the responsibility for weight restoration and wanting others to be involved, in a context of feeling overwhelmed.*

Pamela did not request any changes to the weight restoration project (“No, no. I did enough talking that you pretty much got me [laughs].” MC183).

*Projects summary.* From a contextual action theory perspective, Pamela’s weight restoration project emerged within a pre-existing relational career with her husband, Geoff
characterized by separateness and abandonment), as well as a longer-term parenting career and adolescent development project. The weight restoration project also emerged within Pamela’s physical health career as a middle-aged woman and cancer survivor in a body and shape-conscious culture. Pamela saw her weight restoration project as related to her personal sense of herself (someone who overcomes hardships), her ongoing relational career with Geoff, her daughter’s agreeable nature, and an unsuccessful attempt to engage professionals in a joint support project. Pamela had assumed primary responsibility for weight restoration in a context of family financial hardship and the absence of social or practical assistance, which she viewed as contributing to a perpetual sense of being overwhelmed. Seeing little response from Geoff or professionals to her bids for partnership, Pamela joined closely with Heather in challenging eating disorder behaviours, and described providing one another with mutual emotional support and understanding. Most of the time, Pamela’s project seemed to be the dominant focus of her relationship with Heather, so much that Pamela expressed grief for the year she and Heather had lost to the eating disorder.

In addition to the identified weight restoration project, Pamela was engaged in a number of different projects and processes that seemed to be connected to the processes of weight restoration, including: (a) support and partnership, (b) mother-daughter relationship, (c) normal adolescent development, and (d) a personal health project. Table 4 offers a summary of the key projects and related projects and processes identified for Pamela.
Table 4

*Key Projects and Processes: Pamela*

<table>
<thead>
<tr>
<th>Key Projects</th>
<th>Related Projects and Processes</th>
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<tbody>
<tr>
<td>Weight Restoration</td>
<td>• Taking on all the responsibility for weight restoration and wanting others to be involved, in a context of feeling overwhelmed</td>
</tr>
</tbody>
</table>
| Support and Partnership      | • Requesting partnership with Geoff, and reluctantly accepting his disengagement and feeling abandoned  
• Partnering with Heather on her weight restoration and providing mutual support  
• Seeking partnership with professionals and feeling disappointed |
| Mother-daughter Relationship | • Mourning loss of the year to the eating disorder  
• Feeling closeness and hoping for a better future relationship |
| Adolescent Development       | • Encouraging normal adolescent development                                                      |
| Personal Health              | • Setting aside her personal health project                                                        |

*Project Exposition: Actions and relational processes.* The following section describes in fuller detail the important individual and joint actions Pamela engaged in with Geoff, Heather, and various professionals. It also outlines the additional projects and processes that emerged in the process of analyzing Pamela’s joint and individual weight restoration actions.

*Support and Partnership.* Pamela described taking many actions in relation to others that indicated processes connected to support and partnership. First described are the two key support and partnership processes Pamela took in relation to Geoff: requesting partnership and feeling abandoned. The support and partnership projects Pamela described engaging in with Heather (working together) and Heather’s counsellor (seeking partnership with professionals and feeling disappointed) are presented second.

Pamela described taking many actions in relation to Geoff that were about eliciting his assistance in the weight restoration activities. For Pamela, the broader social meaning of
partnering with Geoff in weight restoration was that it might reduce her stress, improve conditions for Heather, and possibly better his relationship with his daughter:

And I’m saying to him, “She’s 16. She’s only going to be home for another little bit. You're not-, you know, making the time to go through something that is this difficult for her. And then she’s going to be gone. You’ve got to make a point of spending some time with her, that you want to do this stuff with her. Why don’t you try to make it easy for her?” (WU286)

Pamela’s joint actions with Geoff were not typically consensual or mutually cooperative, which contributed a difficult emotional dimension to the project. Pamela described an ongoing struggle between her and Geoff that pre-dated their daughter’s diagnosis and treatment that hindered her weight restoration efforts (“And, you're just like, ‘Really? [After this many] years of marriage, and we’re still having the same conversation?’ So that’s been tough because I think [weight restoration] would have been easier had it been the two of us.” WU230).

Despite these challenges, Pamela worked toward the goal of productive joint actions through actions strategies like soliciting his help (“[I] reach out with my husband and say, ‘I really need your help with this.’ And, had calm conversations, crying conversations, screaming conversations-, when Heather wasn't there. Like, I've had every conversation I can think of.” SC185), and eventually forcing the issue with him to receive the help she needed (“If I hadn’t, again, forced the issue, he wouldn’t have done anything.” WU208).

Many of Pamela’s actions were steered by feelings of frustration at her husband’s seeming disengagement and unhelpfulness:

So much of that frustration with him not-, I keep saying, “him not buying in”, but him not-, just-, wanting to find out “What can I do to help?” I've never heard him say that. I've never heard him say “What do you need me to do to help?” (SC665)

Offering to inform Geoff about Heather’s treatment, inviting him to attend family counselling sessions, purchasing material to educate him about eating disorders, and directly
communicating disappointment and frustration to him were other actions Pamela noted taking to engage Geoff. These actions seemed to be energized by feelings of desperation, sadness, surprise, and disappointment:

And, like what surprises me is that, he never-, he doesn’t ask about coming. He-, if I make a thing about it, like "You never ask about how it went or how things are going" or whatever, that’ll last for like, I don’t know, a week or two or something, like "How did it go?" or "What did you talk about or whatever"...And then he stops. (WU234)

Pamela noted her actions in relation to Geoff changed once she accepted Geoff was not going to participate voluntarily. Motivated by the exhaustion at managing the responsibilities on her own and weariness at trying to motivate him to be involved, Pamela appointed Geoff the task of doing meal support once a day. She provided him with detailed instructions and corrective feedback in order to ensure the meals happened in a supportive and helpful way for Heather. Pamela’s cognitive and emotional processes in assigning Geoff to a meal included considering Heather’s current state of progress (“Like, if it had been really, really hard, like in the beginning [when] she wasn't eating... I would have said ‘Fine then! Never mind. I’ll do it.’ SC528), the need to reduce her own day-to-day stress, and feeling concern about what accepting Geoff’s disengagement might teach Heather about getting her own needs met:

You kind of think about what you're teaching her as well, as far as accepting what is not necessarily everything that you want. And I know there's a balance between, you know, you have to accept a certain amount but at the same time, you go [gestures insisting on what she wants]. (SC536)

Pamela noted how her goal of sharing weight restoration responsibilities with Geoff sometimes created other problems she then had to address (“She comes home and goes ‘Mom, Dad did this at breakfast’, or ‘Dad did...’, you know, “I only had 5 minutes for breakfast, and we almost missed the bus.”’ SC505). Pamela responded by reminding Geoff what meal support required, and also encouraging Heather to speak to her dad about her
concerns (‘And that’s the debate. I’ve talked to him. I’ve talked to her about, you know, ‘You need to say that to your dad...you need to talk to your dad and tell him.’” SC507).

Pamela’s action step of suggesting Heather speak with her dad was motivated by ongoing uneasy feelings that weight restoration was making her a “helicopter parent” and was working in opposition to a more general parenting goal that Heather would learn how to express herself and ask for what she needs.

Pamela expressed a desire to accept within herself that Geoff had disengaged and she was doing parent-led weight restoration on her own. This acceptance goal was motivated by feelings of resignation, wanting to be free of the ongoing stress and frustration she felt at hoping for assistance but not receiving it, and also memories of feeling alone and unsupported by Geoff during two major personal health crises of her own (“I think a part of me knew that I’d probably have to do this by myself. Because if I did [cancer] by myself, I think I’m doing this by myself.” WU244). However, strong feelings of not wanting to accept his disengagement given the stress it created in her own life, as well as concern for how it may affect Heather’s recovery, created tension between Pamela’s acceptance and participation goals (“He can’t even see that what he’s doing affects her. And that changing what he does or says would be helpful to her. And he can’t even see that.” SC472).

Other cognitive and emotional processes Pamela noted experiencing in relation to the tension was remembering how during various times of stress and crisis in Geoff’s own life she had supported him, and feeling frustrated and resentful that he was neither responding to her distress and need for support nor acknowledging her actions and efforts. Pamela noted an internal sense of feeling emotionally and physically abandoned to do weight restoration on her own:

[Researcher: I don't know if abandonment is the right word, but like, left alone....?] Yes! Yes, because you do go through marriage thinking that the person's going to
help you.... And then feeling like, you know, it is your daughter, too. And why are we-, why am I doing all this....? (SC167)

These internal processes steered action steps like occasionally breaking down and crying, withholding expressions of affection and appreciation for Geoff, and strategizing ways to cut corners (on occupational projects or her own sleep and self-care, usually) in order to accomplish all she needed to do.

Pamela’s support and partnership project also involved many joint processes with her daughter. Of the many joint actions she described taking with Heather, a good proportion were guided by the goals of weight recovery and the practical implementation of meals. Pamela shared in detail about these important actions, some of which are described in Appendix H. Generally speaking, many of Pamela’s joint actions with Heather extended over time and seemed to make for a joint project between the two of them:

At some point when we [counsellor, Heather and Pamela] had that one meeting when there was some stuff going on, and [the counsellor] made the comment that, “You know, this is about Heather”. And, I'm going, "Yeah, I get that. I know that. I really know that. But, please understand, Heather and I have worked out that-, we know we're doing it together.” (JC57)

To help realize the goal of being successful in parent-led weight restoration, Pamela sought Heather’s cooperation to challenge and change eating disorder behaviours (“And just trying to say [to Heather], ‘Okay, so then, you know, how can we-, help you? ....Like, what are the things that are challenging for you? Okay, so...then how about if we pick one of those things?’” JC52). Pamela’s internal processes about working collaboratively with Heather included gratitude for her daughter’s agreeable nature (“She's definitely not the kid that's yelling and screaming, she’s not throwing up. She's not-, she'll just be like, ‘Ok.’” JC105), while at the same time feeling frustrated because Heather’s agreeability sometimes masked underlying issues (“It's not telling me that's more frustrating than just telling me. Just saying, ‘You know what? Just couldn't eat my snack this morning’. You go, ‘Okay
fine’, or you know, ‘We'll work it out.’” SC389). Pamela also described some internal dissonance between her hope of receiving cooperation and help from Heather and goals related to her adolescent development project (described below):

For her personality, she needs-, one of the things she has to learn about is standing up for herself more. And, you know, there's a part of me that goes, “I want her to yell at me and go “No! I don't want to do that” kind of thing, right? But, at the same time, you're going, I also need help trying to get through this. (SC288)

In wanting to act collaboratively with Heather but then encountering obstacles, such as Heather verbally complying but behaviourally avoiding, Pamela was reminded of Geoff (“She's like her dad....where it's like she might say yes, but then she might not do it.” JC105), which motivated feelings of concern (“Thinking about like, the frustration, that that gives me in my life with him. And thinking, I don't want her to be doing that, right? I don't want her to be going through life avoiding confrontation at all cost.” SC379), and worry about a possible unwanted future as a parent (“A little bit of ‘Aaghh! Is this going to be my life time sentence?’ [laughs] You know, with my husband and my child and the way that she does that same thing that he does?” SC363). These internal processes seemed to strengthen Pamela’s motivation to engage in explicit actions related to building a strong foundation for Heather’s future mental health and emotional well-being (see supporting adolescent development project, below). Finally, Pamela also described various joint actions with Heather that seemed to be steered by the goal of providing mutual support and understanding. These actions seemed to suggest the presence of a support project between Heather and Pamela:

Like if we're having a really bad day for different reasons, we'll like go, "I need a hug". And we'll give each other a hug and go, "Okay, we're just gonna get through this. I know it's hard” You know? She'll say, "I know it's hard". You know, and stuff like that. (JC6)
In addition to the support and partnering projects with Geoff and Heather, Pamela described engaging in many joint actions with Heather’s counsellor (primarily), and also the community dietician. In the absence of her husband’s involvement, Pamela hoped to partner closely with professionals for practical guidance and support (“Yeah, that’s still ongoing with that, trying to figure out how to do this without the person that I feel like-, or who is supposed to be-, helping you.” SC12). Pamela wanted to receive explicit direction and support from the counsellor on how to respond to day-to-day issues she encountered:

And it would have been nice to have it more structured around pushing the boundaries. Around, “okay, let's push this boundary, let's push this, and see how you do with that. And then report back.” You know? Like “how did you deal with that particular stress thing?” (SC329)

Pamela attempted to realize the goal of professional partnership by stating her need for direction and requesting time alone with the counsellor:

And asking, and saying, “I need this, can you do this?” And him asking the powers that be and the answer coming back being “Nope. This time is just for your daughter. Or you together, but not you by yourself.” (SC18)

Pamela felt dissatisfied, frustrated and hampered by the denial of her request. She believed time alone with the counsellor would benefit Heather’s treatment (“I think the therapist would have had a lot easier time doing the job and understanding the child if I had been able to share with him.” SC14):

We have a ton of stuff that’s going on...that I’m not sharing with my 16-year old. But we’ve got a lot of stress going on in the house that I'm sure is going to be affecting her with this, and I need to be able to fill in the counsellor with that. And, I can’t do that. (WU156)

Additionally, Pamela believed time alone with the counsellor would have been a productive step toward realizing her goal of better managing her own stress in a context of limited social supports and resources. For Pamela, managing her own stress level was a crucial step in service of overall treatment:
Cause, a part of it is also, like-, I’m under all this stress, and you realize that when I’m stressed I’m putting her under more stress, she feels more guilty about having an eating disorder, and [then] she’s causing me more stress! So why don’t you help me with my stress so that she's not feeling stressed about causing my stress? (SC310)

Pamela tried communicating with the counsellor via email, but found it difficult and unproductive (“We’ve done a few, and they’re not that successful. Because I can’t get it across...and every question gets another question… so having that over email is just crappy, right?” SC27). Motivated by feelings of frustration at the fruitlessness of her attempts to engage the counsellor, Pamela reduced her help-seeking actions, did not share additional family information, and began taking more assertive weight-restoration actions on her own initiative:

I'm going to take the initiative. I’m just going to push, push, push. And you guys have to scream and tell me. Heather, you have to tell me, or you have to tell [counsellor], or [counsellor] has to- someone has to tell me, otherwise I’m just going to keep pushing.... And um, but for me, it’s like-, you just, you need to keep at it, you need to keep pushing and pushing and pushing because otherwise you’re never going to get anywhere. You’re never going to change it if all you do is talk about how bad a week you had, or whatever. And it’s like okay, how about we talk about how we’re going to change this. (WU172)

Finally, it is worth noting that Pamela was referred to a parent support group in a neighbouring community by Heather’s counsellor, however she chose not to attend due to practical barriers of scheduling and also a concern (based on a past experience with her cancer treatment) that her struggles might somehow be invalidated by the stories of parents dealing with more extreme eating disorders.

*Monitoring Heather’s progress.* Pamela’s approach to weight restoration was planned, strategic and intentional, and comments during the interviews suggested a project related to monitoring Heather’s progress in overcoming the eating disorder behaviours.

Some of the monitoring actions Pamela described taking included keeping track over time how long Heather took to complete her meals (“It's that 45 minutes [to eat a meal]). But it
was, you know, an hour to an hour and a quarter.” WU46) and some diminished rule-boundedness around eating (“[It’s] more comfortable for her if we’re all eating the same meal...it’s getting less important. It was more important in the beginning.” WU100).

Sometimes Pamela felt encouraged at seeing progress, which contributed to feeling more confident about her weight restoration actions. Other times, when beholding slow or no progress, such as finding a second stash of hidden lunch snacks in Heather’s room, she felt frustrated, discouraged, and confused (“And to find the second bag. And find so much in it was just-, “Aghhhh!” [exhaling, frustrated]...We're not getting anywhere...!” (SC429).

Monitoring Heather’s progress was also a strategy Pamela employed in the service of goals related to other projects, such as the adolescent development project and her personal health project (see below).

*Mother-daughter relationship.* Heather’s eating disorder and the weight restoration project consumed significant amounts of Pamela’s time, attention, energy and resources, supplanting many normative activities she and her daughter might have done together (“I feel like I'm missing a part of what the life should have been this last year. Like, you know, you’re almost mourning it....because...you're not doing the things you would normally be doing.” SC234). Pamela reported feeling deep sadness at the year lost to the eating disorder, fear of losing more time, and concern that she would always worry for Heather:

So just sort of feeling that sense of loss, like losing a year. And not knowing how long you're going to lose it. And, also thinking about, uhm, you know, am I ever going to feel comfortable? Am I always going to watch her? And I think, till the day I die, I'm going to be....as soon as she's under stress... I don't think I'll ever get over that. I was going to say, we even do that with cancer....but to be honest, you know what, I don't think about that with cancer. (SC258)

Despite the fear and feelings of loss, Pamela also noted feeling thankful Heather’s illness was identified early, that she is confronting these challenges early in life, and feeling appreciation for what the process has taught her about Heather (“You know, an appreciation
of the things I've learned about her...and hope that she is going to work out how to do those
things.” SC333). Pamela also expressed hope her relationship with Heather might be closer
and stronger for having gone through this together:

> I think that over the years....Heather and I will probably look back at this and go
"yeah, you know, we've kind of, we did it together." And, you know...Not that we
weren't close already, but it certainly formed a bond even more so, right? (SC754)

Adolescent development. Not only did the weight restoration actions alter and
displace many normative and preferred actions with her daughter, Pamela noted that some
of the action steps she took to realize weight restoration goals were counterproductive to the
steps she wanted to take to develop normal adolescent life skills, like autonomy and
independent problem solving:

> And I’m going, I feel like-, and I don’t-, I still don't know how much, and in what
way, to support her? And how much to have her just do it on her own and, and, go
through whatever the consequences are... if I help her with it, am I teaching her?
Or, am I just doing it for her and then she doesn’t have to do it. And, that’s-, I’m
still having trouble with that, you know, as a parent. And you know, you hear about
helicopter parents, and stuff like that like, you know, and it’s like, how much do
I...do? (SC355)

To move toward the goal of teaching Heather to ask for what she needs, Pamela used
naturally occurring opportunities in the day-to-day context of weight restoration not to
rescue her daughter from situations she believed she could handle. Pamela noted feeling
frustrated and concerned when Heather did not take initiative in asking for what she needed,
wondering what kind of assertiveness and confidence is typical for a 16 year-old, and
reflecting back on how she handled herself at 16.

Finally, Pamela reported internal processes of problem solving when and how to step
back from some of her meal support activities, wanting to trust, and not wanting to rescue in
the context of feeling of anxious for Heather’s well-being:

> And now, sort of going, “okay, where do I let go of stuff?” I don't know. So, we've
developed that new pattern, and that's fine, [but] there's still a part of me that still
really worries about it. But at the same time, you kind of go, “Okay, I need to, you know, trust that she is getting better and that she'll start doing some of the stuff on her own”. So, trying to...less helicopter parent! (laughs) 'Caus-, 'cause you're still somehow the helicopter parent. (SC869)

*Personal health.* Pamela reported Heather’s weight restoration and well-being motivated her to put off her own personal weight-loss goals and take actions counter-productive to these goals. Pamela’s weight-loss goal was meaningful in regards to both her physical health (“And I know, for cancer, being heavier is a risk factor. And I know it's a risk factor for other stuff.” SC989) as well as her own body image and personal sense of identity:

And the thing is that the person I am inside my head isn't in this body. Is not in this body, and hasn't been for a long time. And yet, I look in the mirror and I go....that's not who I am inside my head. (SC993)

Pamela reported feeling stuck between wanting to resume her own weight-loss activities that would contribute to these life-facilitative projects (health and identity), but hesitating given the potential for these actions to be detrimental to Heather (“So, and then, I’m just logically trying to figure out how do I change for me, and still make it so that she keeps her weight the same?” SC973). Pamela’s dilemma about when and how to act on her weight-loss goals was complicated, in part, by feelings of guilt at having engaged in a joint weight loss project with Heather prior to eating disorder diagnosis (“It's like, a combination of guilt...still feel guilty. Don't know what to have done differently...but still feel guilty, because of the focus on losing weight [Researcher: That had been something you had been doing together...?] Yeah.” SC993).

Pamela described engaging in various strategies to see if there might be a way forward with losing weight despite the conflicting goals. One of these strategies, mentioned above, was closely monitoring Heather’s progress for indicators of improvement that would signal it might be alright to resume her own weight-loss activities. Pamela sought advice
from the dietician, which she experienced to be unhelpful, and also wanted input and
guidance from Heather’s counsellor (“Do I encourage her to go with me to go to the gym?
Do I....(pause)...I don't know what to do with that.” SC961) but the privacy issue associated
with having no access to one-on-one counselling time proved a barrier (“And how do I ask
that question? Because I don’t want to ask the question in front of my 16 year-old anorexic
daughter.” SC27). Observing Heather make progress motivated Pamela to begin taking
small actions in the service of her weight-loss goal (“So I’ve been saying ‘You need to stop
looking at what I’m eating’ and saying ‘Okay, mom needs to eat exactly the same thing.’”
SC35). Pamela also shared plans to re-commence additional weight-loss actions once
Heather resumed full-days at school.

Finally, Pamela noted wanting to help Heather by modeling healthy body attitudes,
and this awareness motivated Pamela to consider her weight-loss actions and intentions very
carefully. Pamela reported concern that her own body (being at a heavier weight and having
been through body-altering surgeries) might somehow have contributed to Heather’s eating
disorder and be hampering her recovery:

I still feel guilty. I still feel like-, like she looks at me and goes “Yeah, I don't want
to look like you...” I’d never ask her that....Um. But-, I mean, I just think she must
look at me and go, well, “I don't want to look like you when I'm older. So, I'm going
to keep going [with the eating disorder].” (SC969)

Despite these concerns and feelings of discomfort with her own body, Pamela
reported taking intentional and very challenging action steps in service of modelling body
confidence and acceptance to her daughter:

But at the same time, you know, we just went camping and we went and did showers
together....And I'm not feeling comfortable doing it. But at the same time, going, I
can't be showing her I’m not comfortable (tearful). Because it's about being
comfortable in your skin, whatever size that you are. And there's a whole awful part
around it as well (tearful), trying to teach her about....being comfortable around-,
being comfortable in your own skin, but at the same time not being comfortable in
mine right now (crying). (SC1148)
**Assertions.** First, Pamela connected many of her actions with her husband, for which she felt abandoned, sad, and frustrated, to her weight restoration project. However, some of the feelings motivating these actions appeared to be based on emotional memories that let her fight against past and present injustices in relationship with her husband. Second, many of Pamela’s ongoing relationship projects were a source of problems; the relationship project with Heather (although also a source of problems) was the one valuable relational resource she identified. Finally, Pamela’s weight restoration project was integrated with her own identity processes, which both helped and complicated her weight restoration processes.

**Case 2: Quinn**

**Background information.** This case describes the experience of Quinn, a single mother of two daughters. Quinn’s youngest daughter, Sarah (aged 13) was diagnosed with anorexia approximately 11 months prior to the interview; Quinn had been doing parent-led weight restoration for 10 months. Sarah resides part-time with Quinn and part-time with her father, James. Sarah had not been hospitalized for the eating disorder, and there was no reported history of other individuals in the family experiencing an eating disorder.

**Interview context.** Following the telephone screening, Quinn attended the initial data gathering interview which consisted of a warm-up interview with two researchers, a conversation about her weight restoration activities with a research assistant, and a video playback with the primary researcher. Approximately 2 months following the initial interview, Quinn participated in a second interview in order to negotiate the description of her weight restoration with her daughter with the primary researcher.

The day before Quinn attended the initial research interview, Sarah had a weigh-in with a dietician and lost 2 pounds. This was Sarah’s first significant weight drop since
beginning treatment, and Quinn explained at the outset of the warm-up interview that she was feeling emotional and very concerned:

So I just want to let you know. Like, last week, if we would have had this discussion, it might have been more positive. However, yesterday we went and got Sarah weighed, and she’s lost 2 pounds (crying). So...(crying), it’s just...a bit of a hard time again. (WU6)

It seemed Quinn’s intention during the research interview was to discuss and process her feelings about Sarah’s recent weight loss, and to understand how she lost it in order to know what to do about it. Quinn engaged in a variety of processes related to identifying and evaluating possible causes for the weight drop, many of which concerned James, Sarah, as well as Quinn herself. During the interview, Quinn described herself and others, including Sarah, James and various health care professionals in past and current situations. She expressed a variety of emotions, including fear, uncertainty, dissatisfaction, frustration, sadness, anger as well as gratitude for the sense of being supported by James and his family. Quinn provided examples to illustrate her experiences, and at various times, stated plans, described possible situations, and asked the researcher to speculate on matters with her. At various moments throughout the interview, Quinn seemed to express her uncertainty and self-doubt in the form of mild sarcasm and nervous laughter, and her fear and distress through tears.

Weight restoration context. Quinn discovered parent-led weight restoration shortly before formally connecting with the mental health team in her community. She shared how the parent-led approach gave her courage and confidence to attempt meals with Sarah:

Like, it makes so much common sense. But when you’re in the middle of trying to figure out how to get your child to even eat a grape at night-, even one grape she wouldn’t eat! Then, you-, you can’t think straight. I guess? You’re just so stressed out. It’s, it’s so simple, but it really, really did help...It changed things. Because I had-, it gave me the power to say that that was okay to do. So, when I first did that, the very first day, I got her up in the morning, she didn’t have a shower, didn’t get her phone or anything. She came right to the table, and I sat her there and made her
breakfast. She wouldn’t eat it. Fine. “You’re sitting at the table. Life doesn’t start until Sarah eats”, I started telling her. (WU36)

Sarah’s diagnosis and treatment took place around the same time Quinn was scheduled to undergo surgery. Recovery from the surgery necessitated Quinn take some months off work, and Sarah lived with her full-time during this time. Sarah steadily gained small amounts of weight during this time, and when Quinn returned to work Sarah resumed dividing her time between homes and attending school again. From the outset, her father and members of his family attended mental health appointments, were informed about family-based treatment, and kept apprised of her progress. The time off work had exhausted Quinn’s savings, and the possibility that Sarah’s recent weight drop could be the start of a relapse was stressful on many levels, especially Quinn’s ability to support the two of them should she be required to take more time off work:

Well, I had a lot of savings, and I used it all. And I think that’s really, the um... [Researcher: Your safety net...] Yeah. It’s all gone (crying). It’s hard. Because I always had that there for that. And that’s why it was there. And thank God I had it but, now what? Now what if it happens again, I have-, I can’t take any time off work, I don’t have any money, I don’t know how I’m going to help her! (SC2)

**Weight-restoration project.** The following weight restoration project was shared with Quinn at the member check interview for validation:

*To be successful with weight restoration while maintaining a sense of balance and harmony in your home and in relationship with others.*

Quinn found the project to be a valid representation of her experience, offering a correction in the narrative on the month in which Sarah was diagnosed (“It seems pretty accurate. Uhmm, she actually started in March, not April...Yeah, it looks like a pretty good summary.” MC6).

**Projects summary.** From a contextual action theory perspective, Quinn’s identified weight restoration project emerged within a pre-existing relationship and co-parenting
career with James, and both of these careers significantly influenced Quinn’s goals and strategies in the weight restoration project. Quinn also saw her weight restoration project as related to her own personality, her daughter’s attributes, as well as various financial and occupational constraints. In light of depleted financial and time resources, Sarah’s weight restoration was a “high-stakes” venture that Quinn needed to succeed. Quinn attempted to implement the weight restoration project without altering pre-existing projects with James. This proved to be a considerable strain but one Quinn felt powerless to change. Overall, Quinn seemed to experience Sarah’s weight restoration as an emotionally, financially, and logistically straining ordeal.

In addition to the identified weight restoration project, Quinn described engaging in many action sequences that suggested additional and related projects and processes, including: (a) following the treatment guidelines and staying empowered (to fight the eating disorder), (b) maintaining peaceful relationships, (c) adolescent development, (d) professional engagement, and (e) life balance. Table 5 offers a summary of the key projects and related processes identified for Quinn:
Table 5

**Key Projects and Processes: Quinn**

<table>
<thead>
<tr>
<th>Key Projects</th>
<th>Related Projects and Processes</th>
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<tbody>
<tr>
<td>Weight Restoration</td>
<td>• To be successful with weight restoration while maintaining a sense of balance and harmony in your home and in relationship with others</td>
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<tr>
<td></td>
<td>• Trying to elicit Sarah’s cooperation</td>
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<td></td>
<td>• Trying to adhere to treatment guidelines and staying empowered</td>
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<tr>
<td>Maintaining Peaceful Relationships</td>
<td>• Maintaining James’ involvement and viewing James’ weight restoration project as separate from hers</td>
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<tr>
<td></td>
<td>• Deviating from meal plan to reduce conflict with Sarah</td>
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<tr>
<td>Adolescent Development</td>
<td>• Accommodating some of Sarah’s requests to support her friendship/social/activity goals</td>
</tr>
<tr>
<td>Professional Engagement</td>
<td>• Feeling supported to take action against the eating disorder</td>
</tr>
<tr>
<td>Life Balance</td>
<td>• Managing conflict between weight restoration and other life projects and careers</td>
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**Project exposition: Actions and relational processes.** The following section expands upon the above-mentioned projects and processes that emerged in the process of analyzing Quinn’s joint and individual weight restoration actions.

**Maintaining peaceful relationships.** The following describes some of Quinn’s individual and joint actions that seemed to suggest a project of maintaining peaceful relationships in relation to James and Sarah. First described are Quinn’s actions in relation to James, which seemed to centre on ensuring his ongoing involvement in weight restoration. The peace-maintaining actions Quinn took in relation to Sarah are described second, and seemed to centre around minimizing conflict during meals.

Quinn described many joint actions in relation to James, and many of her action strategies seemed to be steered by the broader goal of ensuring his ongoing participation in Sarah’s weight restoration. It seemed Quinn’s main strategy for maintaining James’
involvement was to continue relating to him in the manner they established while co-
parenting Sarah prior to her diagnosis:

We don’t talk much face to face. I text him once in a while, just to say, you know, “She ate well today”, or um “Her weight is this”, or “I’m dropping her off tomorrow”. You know, there’s no-, we don’t hate each other. (WU154)

As split parents, that’s the reality. It’s going to be a different world at their place than it is at your place. And I totally get that. It’s just in this case, it’s a little, it’s just more stressful. (SC146)

Quinn’s goal of maintaining peace to ensure James’ involvement was found to be intertwined with and shape other actions she took in relation to him and weight restoration. For example, Quinn hoped Sarah’s meals would happen similarly at both homes, but was reluctant to take direct action steps toward the goal for concern it might interfere with James’ involvement, and by extension, hamper Sarah’s weight restoration. Quinn viewed James’ involvement as contingent on preserving feelings of goodwill between the homes, and past experiences made Quinn wary of how offering suggestions, asking for information, or requesting things be done a particular way might be misperceived and disrupt amiable relationships:

I should be asking them more, but I don’t, I don’t want...to be a bitch either, you know? [Researcher:...do you feel like you would be being a bitch if you did that? Or that they would interpret it that way?] Yeah. Yes, they would definitely interpret it that way. Yes. (JC114)

I don’t know how to explain it. And, it’s probably just my interpretation of it all, and who knows if I’m right. But, it’s uncomfortable if you make anything uncomfortable for them. [laughs]. They make it double or triple uncomfortable for you [laughs]. So basically, I just don’t go there. (JC120)

In light of Sarah’s recent weight loss, not knowing the details of Sarah’s meals at her dad’s home proved especially stressful. Quinn shared that in choosing to avoid direct action that might interfere with James’ cooperation, she would indirectly gauge the likely quality of Sarah’s meals there by monitoring changes in Sarah’s weight (i.e., if weight goes down, perhaps meals are not happening), whether James was reporting conflict with Sarah (“He
fought with her every single meal... But I’m glad because to me that means he must be pushing her a little bit more.” MC163), and making inferences based on her knowledge of James (“But, he’s not one that is going to get up and cook her breakfast at 8:30 in the morning, I’m pretty sure. But, I don’t know. I’m not there.” WU163).

In addition to having similarity in meals between homes, Quinn also hoped Sarah would receive congruent and healthy messages about food and activity from both her parents. Again, Quinn did not take action to realize this goal, but described an internal process of feeling gratitude for the effort James was making as well as concern at how Sarah might interpret some of his health habits:

He likes to maintain his weight, and he runs on the treadmill, and he eats salads, and he’s very active and healthy. Which is good, but, I’m not sure if she sees that in the right way. And, his idea of a calorie meal is not my idea of a calorie meal (laughing), right? But, he tries. He does try. (WU56)

In addition to not wanting to upset James and risk his involvement, Quinn also shared a self-perceived lack of skill in asking others to do things (“I’m not really good at-, I mean, how do you make other people do things? I-, I don’t know.” [JC83]; “I’m always the person that is like, ‘I’ll do that for you.’” [laughing to herself, SC182]). Also, because Quinn could sympathize with the constraints of James’ work schedule, she was motivated to be sensitive to the ways his schedule would make doing meals and meal support a challenge (“I feel the same way when I’m at work for a 12 hour shift. How-, you know? He’s powerless as I am. How do you make them eat when you’re not home?” JC79). In light of the misgivings about her own skills, wanting to be understanding of James’ situation, Quinn wondered whether her goals in relation to James were even realistic:

Cause one person’s idea of portion, even, is different than another’s. Or calorie, you know? Everything is different. How they cook it. You know, do they use as much oil and butter and...and like, I buy the 3% milk and put it in the 1% container, and all kinds of stuff, right? (SC7)
To tolerate the stress associated with not knowing about Sarah’s experience while at her dad’s house, Quinn employed various strategies, such as reminding herself of instances where James or his family had taken time to supervise meals (e.g., picking Sarah up at lunch time on school days), and expressing gratitude for shared parenting for breaks it afforded her and the support it provided for Sarah (“But it is a good family support...She knows at grandma’s house, you eat. We’re very lucky for that.” MC145).

Quinn’s project of maintaining peaceful relationships also encompassed actions with Sarah. Although Quinn expressed a desire to respond with greater firmness when Sarah would try to talk her into making “healthy” (lower calorie) dishes or talk her out of scheduled snacks or meals, it was very difficult for Quinn to implement. Quinn noted that her willingness to discuss and negotiate meals with Sarah generated internal conflict because she knew parent-led weight restoration advises against this:

I also probably give her too much, um, it’s not a power, but we discuss what we’re going to have for dinner...which I know-...you’re suppose to just make it and bring it to her and she’s suppose to eat it. But I’ve found that I-, it’s-, such a struggle to do that. (WU125)

Quinn explained the reason she accepted Sarah’s input was to avoid constant fights and struggles. For Quinn, minimizing conflict via accepting Sarah’s input was originally done in service of maintaining some balance at home:

Like if I was to make her a bacon sandwich....I know she’s not going to eat it and it’s just going to be a huge, huge fight. But, that’s what she needs! But how do you balance living at home with that...? (WU126)

At Quinn’s member check interview, she shared how this strategy for minimizing conflict had become an even greater source of tension over time, and this realization motivated a redoubling of her efforts to adhere to the treatment strategy (“I’m letting her have a little less control over the dinner part because it was getting to be too much of a conflict. And-, and I was making things that were not as good [i.e., high calorie].” MC90).
Challenges for Quinn in adhering to the weight restoration included figuring out how to enact the meal plan in day-to-day life, and also recognizing when Sarah was taking her off the meal plan (“It’s funny. You know what you should do, but you can’t get yourself to do it, exactly the right way.” WU129):

I did it for 2 days last week, and it was great. Of course, “I hate you! I’m going to my dads! Blah, blah, blah” and I’m like “Okay, fine, whatever. Just go sit over there, and dinner will be ready”. By the time dinner was ready, she came to the table, and she ate every bite. And she never said a thing. And it was amazing. And I know this! And I don’t know why I keep getting off track. She’s just so good...she’s going to be a lawyer or something. She’s just, so good at getting my head spun around and cooking something that she likes. (MC96)

The process of considering Sarah’s food preferences to avoid conflict created stress for Quinn in other ways, including (a) the expense of the food Sarah preferred and (b) hindering the goal of feeding Sarah sufficient calories to recover weight:

It’s hard because she wants to tell me what she’s going to eat. And I have to balance that against, one, what I can afford, and two, what is going to give her enough calories to sustain herself. And it’s a hard-, it’s a hard balance to make. It is. (JC12)

In an effort to realize both the goals of weight recovery and minimizing conflict, Quinn took steps like purchasing Sarah’s preferred meat in the States (where it was cheaper) and sneaking extra calories into meals when she could (“I always put a bit of mayonnaise on there, or try to if she’s not watching me, but she’ll usually park herself right at the island, and watch everything I’m cooking.” WU131). To balance weight recovery with minimal conflict, Quinn also noted sometimes outwardly expressing approval and acceptance of Sarah’s food choices (i.e., junk food) while internally experiencing concern and frustration:

Yesterday she ate a chocolate bar, which I was...grateful because she hasn’t eaten a chocolate in, probably, 6 months? But it wasn’t enough, for a snack. But I didn’t want to make that a big issue because I was happy that she was able to eat a chocolate bar... meanwhile thinking, oh, that’s 200 calories less than what I wanted you to eat! (JC20)
Adolescent development. At the level of social meaning, Sarah’s interest in re-engaging friendships and typical teenager routines was a positive indicator of progress for Quinn (“She was going back to her dad’s more often, her friends were around again. She was alive again” SC65). Sarah had recently been expressing more requests for autonomy in how to spend her time and when she ate meals (“’Oh, mom, my friends are around. I don’t want to-, my life can’t be run by snacks and eating times.’” WU18), which Quinn wished to support (“You don’t want to say, “Okay, you can’t have friends over!”” WU24). Wanting to trust Sarah’s progress, and also meet some of her own needs (“And she was doing so well, so I was kind of thinking, well, you know, maybe she has a point there. I don’t want to get up that early either! [laughing] On my only days off!” WU116), Quinn had begun allowing Sarah to deviate from the scheduled meal plan. However, the news of Sarah’s recent weight drop highlighted conflict for Quinn between the goal of supporting Sarah’s socializing and weight recovery goals, leading Quinn to see Sarah’s requests in a new light:

Because we have specific times, 8:30 in the morning we eat, then we have lunch at 12, we have snack at 2:30, eat at 5:30 and then you have an evening snack at 8. 8:30 [Researcher: That’s very structured] It has to be! Has to be. And, she’s been going fine with that. But then she starts hanging out with her friends, and they don’t want to eat, and then “Why should I eat if my friends aren’t eating?” (WU18)

Sarah’s eating disorder and the parent-led weight restoration project also seemed to frustrate some of the goals Quinn held for her daughter to take part in an extra-curricular sport at her high school. The following quote, taken from Quinn’s member check interview, illustrates the dilemma Quinn faced in light of Sarah’s failure to gain weight over the past few months:

Like, what I was thinking was-, maybe because she hasn’t been gaining [weight], we could tell her, you know “we love you, we support you in your [activity]. You can still go 2x a week, but we don’t want you on the travel team this year.”

....[Researcher: How do you think she will respond? She’ll be disappointed, probably?] I-, yeah. It all depends on her friend, of course. If her best friend is
going to be able to go on the travel team, then she will be very disappointed. ‘Cause then she’d get to go and do all those fun things without her, and they want to do it together, right? Yeah. My poor dear. But you can’t have everything all at once. And I guess she might as well start learning that now [laughs] (MC30)

Professional engagement. Quinn reported participating with professionals as part of her weight restoration activities. Early in Sarah’s illness, Quinn’s goal was to have Sarah in hospital with the superordinate goal of finding help (“When it first started, of course, I was all for that. ‘Let’s get her in hospital!’ Like, ‘She needs help! People are going to help you there’. And we got blood tests, and her tests were all normal, her potassium level was good. Like, she was good still [Researcher: healthy enough to stay at home...] Yeah.” SC84). This help-seeking goal was motivated by Quinn’s exasperation, worry, and a perceived need for professional assistance:

Which, seemed...hum... weird... because I needed help so bad and nobody would help us! ...And, she was eating nothing. And we’d take her to the doctor, and we’d get her lab work, and she’d be fine. And then they’d send her home with us, and we’re like, “What are we suppose to do with her?” (SC86)

Feeling distraught and worried (“[That] was the hardest point. I mean, besides crying all the time, I really thought she was going to be going into a hospital...it was just the most stressful period of my life. Bar none.” MC147), as well as let down and uncared for (“And nobody cares, like... Sure, send us to another psychiatrist, great! And it wasn’t very helpful.” SC88), Quinn sought help from the internet, and researching information on-line was empowering (“It changed things. Because I had-, it gave me the power to say that [feeding her] was okay to do.” WU42) and produced a shift in Quinn’s thinking which supported her taking meal support actions.

Approximately 6 weeks after fruitless help-seeking, Quinn began parent-led weight restoration with the support of a counsellor and a physician knowledgeable about eating
disorders. Quinn noted that working with professionals was a productive action step in helping her realize the goals of weight restoration:

> It seemed to be when we started with [the physician] that [Sarah] started to pay attention a little more to what we were trying to do. For sure. And with him just backing me up and telling me, “Yeah, you do need to be a little more powerful and a little more assertive, and it’s okay”. You’re just in such a guilty mode that you can’t think of doing that somehow. (MC177)

_**Life Balance: Managing strain between weight restoration and other life projects.**_

Quinn’s distress in response to Sarah’s recent weight drop was not only about her failing to maintain or gain weight. The broader social meaning of the weight drop was that should it be the signal of a relapse, Quinn believed she lacked the resources to help her daughter. Quinn believed her full-time presence at home was key to Sarah’s improvement (“Cause, to me, the only thing that worked was that I was available to be home with her” SC355). Having depleted her financial resources taking care of herself and Sarah in the months previous, Quinn had no way to provide what she believed Sarah would need (“I don’t have any money left to do that. Like, I’m done. I’ve done everything I can. And, all my cards are out, and gone.” SC351). Quinn expressed renewed feelings of stress and frustration at the eating disorder (“It’s so stressful. It’s so hard. What is so hard about eating? You know, it’s- It’s something everybody does all day!” WU16), guilt (“You should be home with your children [crying], if you can” JC65), and despair (“I can’t do anything. I lost all my sick days at work.” JC63). For Quinn, the weight drop also shattered her hope that Sarah’s treatment would be an “exceptional case” where relapse could be avoided:

> At the time, she was good. I was-, I thought, oh, this is working out perfectly...I guess, you-, like to think that maybe you’d be the one (laughing)... And I was really thinking that until yesterday. And I guess that why I’m so, out of it now-, Is, it was like somebody just took my legs out from under me when I was running. (SC73)

From Quinn’s perspective, the prospect of Sarah relapsing was upsetting on another level: it would create a situation that was at odds with the sense of herself as financially self-
sufficient (“Being financially supportive of myself is very important [tearful] to me. And it’s hard to admit that, maybe...It’s tough.” SC2). Weight restoration was also complicated for Quinn by her occupation, which she personally enjoyed despite the fact it required shift-work and long hours. Quinn shared trying to turn aside feelings of guilt at how her job and schedule took her away from Sarah, but found it difficult in light of the fact that her being home seemed to help Sarah fight the eating disorder while working seemed to have allowed it to take hold again (“And, of course, I feel so guilty because I think, of all these other things, that I caused all this. But I know in reality that’s not true. But, you always think that” SC80). Struggling to recall details about Sarah’s weight over the previous weeks also stirred strong negative emotions about Quinn’s sense of herself as a mother:

How could I not know these days? I should know these things! Like, but it’s, you don’t. It is-, they’re important, beyond important, but I don’t remember them. And, and feeling inadequate and-, and-, and “Oh my gawd, how could you forget something so important?” I’m a terrible mother. (SC194)

Finally, shortly after Sarah resumed her regular routines and began dividing her time between both homes again, Quinn reported purchasing a horse as part of a self-care project to ease lonesome feelings she experienced at Sarah’s absence:

But she was getting better, and I was letting her go. You know, like you’re supposed to do. And so I finally-, I actually felt a little lonesome, and I went and bought a horse! (laughs). Because I had had horses previously, before we broke up, but I couldn’t afford it when we broke up. I sold my horse, and I had been missing it so much. So, I went and got a rescue horse. And I was spending some time with her, and just adding to my financial burden now! [laughing to herself]. (JC39)

Quinn criticized herself for having purchased the horse, but did not regret it (“Just wasn’t a wise decision! [laughing quietly]. But I knew what I was getting into...I needed it. I love it. And, I don’t regret it. But it is an extra silly thing.” SC43).

Additional weight restoration processes. Quinn seemed to hold the goal that Sarah would come to recognize her illness, with the broader goal of gaining some cooperation
from her in the weight restoration process. Quinn took actions such as discussing Sarah’s weight loss after her last appointment, motivated by internal processes of worry and fear (“It’s very, emotional for me. It’s hard for me not to cry. And then she gets all upset and says I’m making a big deal, and that I make her feel like she’s sick! Which she is sick!” WU92). Quinn also communicated her fear and desperation with Sarah, suggesting a solution she knew would be disagreeable (a babysitter), and asking Sarah to suggest ways she could help her eat (“But I did actually tell her. I don’t know what to do. Should I get a baby sitter for you? ... Like what can I do? But she didn’t really reply to that. She’s only 13.” WU96).

In the early days of Sarah’s treatment, Quinn recalled feeling angry at the eating disorder in addition to feeling self-doubt, fear, and powerlessness. One action that helped Quinn stay empowered and take steps toward her weight recovery goal was putting signs with positive messages about food (e.g. “food is fuel”) about the house:

They were up for a couple of months. It just helped me. Because I was so angry at the eating disorder and I thought, I’m going to tell it. So I just got the crayons out, and I did really colourful little sayings and put them up everywhere in the house (laughing). ....I think it helped me ‘cause I just...didn’t know who to scream at! Because when I was trying to make her eat, and I would look at those signs, and think, you know, this is why I’m doing this. Yeah...definitely trying to have more power, and just laying it [meals] out does work. But it’s harder than you think it would be. And some days it works like a charm, but you have to-, some days it doesn’t. And you can’t just give up because of that one day or one meal. You’ve got to just try again. (MC121)

Trying to understand the things that might have caused Sarah’s eating disorder was also a strategy Quinn used to fight against the eating disorder. However, having an intuitive sense of what contributed to Sarah’s illness, but not knowing the actual cause, also contributed to feelings of fear and uncertainty:

[Researcher: What was going on there?] Well, scared. ...I don’t know how school’s going to go for her. It’s high school and-, is that what got her into this? Is-, is how
she reacts socially with others? Like, how is she going to deal with-, some of those older girls very mean! (SC238)

**Assertions.** First, Quinn was hampered in her weight restoration actions and projects by emotional memories of past conflict with Sarah’s dad and members of his family. Second, many of Quinn’s actions and projects detrimental to weight restoration (negotiating with Sarah, trying to implement weight restoration without altering pre-existing projects with James) were related to her beliefs, enacted in her relationship with her ex-partner and daughter, that she lacked the skill to ‘get other people to do things’ and that trying to do so might negatively affect the emotional dimension of the project and impede its progress.

**Case 3: Rose**

**Background information.** Rose is a married woman with teenaged children; her 18-year old son (Cody) was diagnosed with anorexia 3 years ago. Rose’s husband, Dan, chose to not take part in the research interview. At the time of the interview, Rose had been attempting parent-led weight restoration with minimal success for approximately 12 months; her son’s treatment has not required changes to her work schedule nor affected family income. Cody had been hospitalized one time for the eating disorder, but it was short-term for medical stabilization with no treatment. There is no known history of other individuals in Rose’s family experiencing an eating disorder.

**Interview context.** Following the telephone screening, Rose attended the initial data gathering interview which consisted of a warm-up interview with the primary researcher and a research assistant, a conversation about her weight restoration activities with the primary researcher, and a video-playback with the research assistant. Rose shared feeling uneasy with the video-taping, and the video-playback in particular. The primary researcher validated these concerns, and suggested various ways to ease the discomfort, including the option to discontinue with full honorarium. Rose desired to be involved in the study, and
believed she would forget about the camera during the warm-up and joint conversation. The video-play back was handled by having her sit far back from the screen, and relying primarily on the audio. Approximately 2 months following the initial interview Rose participated in a second interview with the primary researcher in order to negotiate the description of her weight restoration project.

In the research interview, it seemed that Rose’s intention was to explain the challenges she faced in implementing parent-led weight restoration and why it did not seem like an especially effective treatment for her son. Rose’s manifest behaviours while sharing about her project-related actions during the interview included things like describing herself, Cody, and Dan, as well as sharing her perceptions of past and present situations related to Cody’s eating disorder and her attempts to do parent-led weight restoration. Rose expressed a variety of emotions, such as frustration, dissatisfaction, disapproval, fear, disappointment, anger, and hope. She often provided examples and expressed her beliefs and opinions, making occasional humourous statements and laughing with the researcher. In response to the researcher’s paraphrases and requests for clarification, feeling states, and more information, Rose sometimes agreed, disagreed, clarified and elaborated on things she had previously shared.

Weight restoration context. Rose reported finding parent-led weight restoration to have not worked well with Cody. She talked about things she had tried and was currently doing to help Cody recover weight, and in some ways weight maintenance seemed to have replaced the goal of weight recovery (“[His weight] hasn’t changed. So, I feel that’s- that’s progress itself, really.” WU149). Rose saw many obstacles to implementing parent-led weight restoration, with Cody’s age and developmental phase being the biggest (“So he’s his own person....He’s 18. If he’s not going to eat, he’s not going to eat.” WU133). Rose
reported that Cody’s refusal to acknowledge his illness and talk about it was a problem and significant barrier to weight restoration:

I think that’s his problem. He’s not ready...I don’t think he’s ready to get better. I don’t think he thinks there’s an issue. That’s why we don’t talk about it because he doesn’t think there’s anything wrong. He thinks he’s okay. Even when I’ve caught him with the scales, and the diuretics, and the- uh, laxatives, and everything else. You know, doesn’t think he has a problem...even though he knew why he was hospitalized, he doesn’t see it as a problem. (MC20)

In addition, Rose wondered to what degree stigma around being male and having an eating disorder was a factor. She expressed sadness and fear for Cody as he seemed marooned in a place somewhere between being very ill and well (“[He’s] not sick enough to be in a hospital, thank goodness. And he’s not well enough to be left to his own devices, either. So he’s-, he’s in no-man’s land, really.” WU155).

Weight restoration project. Rose had stopped attempting to implement the meal support strategies for parent-led weight restoration; however, the superordinate goals of normalized eating and weight recovery were very much present in her mind. She engaged in many actions related to these superordinate goals, which coalesced into the following weight restoration project:

Recognizing Cody’s adulthood and wanting to let him go, yet feeling afraid to let him go and wanting to be involved in his treatment.

When Rose was provided with a narrative description of this project, she reported it seemed accurate as described and did not request any changes.

Projects summary. From a contextual action theory perspective, Rose’s weight restoration project was undertaken within the context of her husband’s disengagement, Cody’s stage of life and “stage of change” vis-a-vis the eating disorder (denial), and the treatment and support available. The weight restoration project emerged within a pre-existing parenting project, and Rose anticipated both would draw to a close once Cody
turned 19. Rose and Dan were estranged in their perceptions of Cody’s illness and needs, which contributed tension and conflict to that relationship, undermining its potential for mutual support. Inadequate professional assistance contributed further role strain as Rose felt solely responsible for ensuring Cody’s physical safety. Rose experienced Cody’s eating disorder and unsuccessful treatment as a frightening, solitary, and prohibitive ordeal.

Subsumed under Rose’s broader weight restoration project were projects related to (a) support and partnership, (b) Cody’s physical safety, (c) adolescent development, and (d) coping. Table 6 offers a summary of the key projects and related processes identified for Rose.

Table 6

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<thead>
<tr>
<th>Key Projects and Processes: Rose</th>
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<tr>
<td><strong>Key Projects</strong></td>
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<td>Weight Restoration</td>
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**Project exposition: Actions and relational processes.** The following section describes in fuller detail the important individual and joint actions Rose engaged in with Dan, Cody, and the professionals involved in his treatment. It also contains a description of the additional projects and processes that emerged in the process of analyzing Rose’s joint and individual weight restoration actions.
Support and partnership. Rose described taking actions that indicated projects and processes related to support and partnership. First described are the main support and partnership processes Rose took in relation to her husband, including tolerance and disappointment, followed by the support processes she described taking in relation to treatment professionals, including seeking help and feeling shut out.

Rose explained that she and Dan held different opinions about the kind of treatment Cody needed, and these differences had undermined cooperative undertakings between them in relation to Cody’s eating disorder. Rose shared that Dan believed Cody ought to be in hospital and had withdrawn his support of and participation in Cody’s care with the community-based mental health program. Rose seemed to be engaged in a tolerance project with Dan where her goal was wanting him to keep watch over Cody with her, while accepting his beliefs and actions in response to the eating disorder. Rose noted the difference of opinion created friction and conflict, and discussions about Cody’s eating disorder and how to respond to it were infrequent and not helpful to her (“But he doesn’t express his worry to me. Just his frustration.” MC60). Rose seemed to respond to Dan’s disengagement by taking primary responsibility for overseeing Cody’s appointments and monitoring his eating and weight ([Researcher: Do you talk about how to respond- ....you and your husband]? No”. No. ‘Cause that’s my department.” WU53). Rose was able to identify with the distress and upset Dan felt toward Cody’s anorexia, however, adopting the same position herself seemed too great a risk:

‘Cause you know, I feel sometimes like-, I’ve said “Okay, let’s just see what Cody does on his own. Just-, let him do what he wants to do.” But, then he might get really sick, so-, so why would I want to do that? (WU163)
Despite understanding her husband’s perspective, Rose expressed disapproval and felt disappointed (“I don’t know whether most dads kind of stand back and say ‘Just let him get on with it. Let him get on with it.’” WU57).

Rose’s support and partnership project with professionals was complicated, in part, by Cody’s preference that she have minimal participation in his counselling and medical appointments. In the hope of fostering a connection between Cody and the professionals, Rose yielded to his preference and attended only a small portion of Cody’s appointments with a physician. Rose reported feeling angry at not knowing details about how Cody was doing (“It makes me mad that I’m not involved, he’s my child, and I don’t know anything.” SC14), but also relieved that he was talking to people while wishing he would talk more with her:

I’m just hoping, if he doesn’t talk to me-, that’s why if he’s talking to [counsellor], and [counsellor’s] not telling me anything, that’s fine. As long as he’s talking...I don’t care who he talks to, as long as he talks to somebody. (JC99)

In the time between the first research interview and the member check interview, Rose’s goal of wanting involvement with professionals to support Cody had not changed, but she had reluctantly agreed with his counsellor’s request she stop making appointments on Cody’s behalf. When Rose considered the request to “step back” from the professional’s perspective, she noted finding it both sensible and logical, but also upsetting:

Yeah. I understand it-, because he’s got to want to get better and recover. And if he doesn’t, what’s the point? What’s the point in coming for appointments to not take part, you know. It’s just-, I feel like he’s been forgotten about. (MC30)

Rose also experienced internal conflict at the request because that action step undermined her goals of monitoring his health indirectly via in-office weighings, contact with professionals and for counselling to be an emotional outlet for Cody:

So he’s not coming for any appointments. He hasn’t been seen since I came with him in...August, I think. ...So he hasn’t been weighed since way before that. So I’ve
got no idea where he’s with his weight because he’s been told-, you know, he needs to make this appointment. ...I’d rather drag him, kicking and screaming to his appointments. But then if he’s coming, he’s not taking part, he’s not working, is he? What’s the point? (MC16)

Rose reported feeling nervous about what will happen when Cody turns 19, predicting he will fall through the crack between the youth and adult system on purpose. The idea of this unwanted possible future for Cody was upsetting and not in keeping with her hopes for her son (“Yeah, I just don’t want to see him living his life-, the rest of his life just on-, on the verge between sickness and health.” MC120).

*Cody’s physical safety.* Despite having stepped back from attempting parent-led weight restoration using the principles of family-based therapy, Rose continued to want to feed Cody as much food as possible, and this goal seemed to be related to a project of keeping Cody physically safe (i.e., sufficient mental and physical functioning to keep him out of hospital). The goals of supporting Cody’s autonomy and coping through accommodation (see below) featured prominently in the types of actions Rose took to ensure his physical safety. Rose had figured out ways to both accommodate Cody’s food preferences and realize her goal of keeping him out of the hospital, noting a trade-off for accommodating Cody’s food preferences was the assurance he would at least eat something (“And as a rule, he’s quite good about ‘Prepare it, he’ll eat it.’” WU123). Rose engaged in actions like preparing dishes she knew he liked, and gently encouraging him to eat while always being mindful of not pushing too hard (“And so, I mean, we try and persuade him to. But I’m also aware of not-, of not-, getting into an argument. And then making the eating a big issue. Because then he won’t eat anything.” WU117). More subtle action strategies included purchasing full-fat versions of the foods he liked, sneaking in additional calories to dishes whenever possible, and arranging for a stress-free environment at meal times:
Because, I’m not there at meal time. Normally I’m working later. So my husband’s there, and that’s when there'd probably be some-, some issues and tension, probably. So we decided that it would be best that [Cody] sit with the girls and he eats. And then if he doesn’t eat, you know, then it gets reported back. (JC168)

Rose’s project of keeping Cody physically safe was at odds with the adolescent autonomy project (described below), and motivated steps to mitigate the tension created by the conflict. In the service of the safety project, Rose described trying to exercise her dwindling parental influence while she could (“At the moment, I’m encouraging him to do what he needs to do. And at age 19, I’ve got no say about any of it.” JC235), and discouraging him from taking major steps toward independence, such as moving out. In support of the autonomy project, Rose tried to accept that Cody’s right to independence outranked her wish to know and oversee his eating (“I just have to hope that he is eating at work. Because I can’t be with him 24-7, and I also can’t force him to eat.” JC158), despite wishing it were not the case (“I mean, if it was up to me, I’d sit on his chest and force food down his throat. But, I can’t do that, can I?” MC50).

Adolescent development. Rose’s adolescent development project was characterized by multiple and sometimes conflicting processes. First described are the key processes related to acknowledging and accepting Cody’s autonomy, followed by a reluctance to trust Cody’s self-governance and ongoing indirect monitoring.

Respecting and supporting Cody’s desire for self-direction and autonomy was an aspect of Rose’s adolescent development project that featured prominently in Rose’s weight restoration project. Much to Rose’s dislike, the overarching goals of the adolescent autonomy seemed to out-rank the goals of weight restoration. In Rose’s mind, once Cody turned 19, her influence as a parent or right to have a say about Cody’s activities and decisions would end:
I really do feel there is a difference with him being older. Because, not only do I think he is an adult, he’s 18. But he also feels that. He’s 18, he’s working, he’s-, you know? And if- “I’m not going to eat this, I’m not going to eat that. And what are you going to do about it?” And then, I’m stuck. What do I do about it? (MC92)

In addition to explicitly reminding herself of the reality of Cody’s life stage and need for autonomy, Rose also acknowledged his independence by supporting his desire to get a job. She described feeling pleased to see him take the initiative, and also hopeful the job might help him focus on something other than food and his weight. She shared uneasy feelings given his work schedule meant being away from home during most meals:

Well, yeah, I want him to be able to- you know, to be motivated to get a job so he can eventually move on and do what he wants to do. But then, I can’t keep an eye on him and what he’s eating, like I’d like to. (WU141)

Given the project of adolescent development and fostering Cody’s autonomy outranked weight restoration, Rose saw her only option was to trust Cody to eat enough food to not lose weight. In light of scarce evidence to suggest Cody would eat well or communicate honestly about his eating, this was an unwanted trusting position for Rose that came with much uncertainty and motivated action steps intended to indirectly monitor Cody’s eating behaviours and mental state. Rose reported closely watching and evaluating Cody’s physical presentation day to day, although finding it an unsatisfying substitute for actually knowing his weight or how he was feeling (“But it’s hard to say, you see him day-in-day-out, so it’s hard to judge.” JC40). Rose also noted reading Cody’s posts on a social media site, an action step motivated by fear for his safety and that proved to be a source of self-critical feelings for Rose (“Oh, no, I’m one of those moms! Nightmare parents that spy on their children” ...yeah, oh, I found out so much crap.” JC110). Rose noted checking the site was also an unsatisfying substitute because she could do nothing with the information without alerting Cody to the fact that she read his posts. Finally, Rose described how her other children were a helpful source of information on how Cody was doing, and would let
her know when they had found things, such as unprescribed medications, diet pills, and on
one occasion, a suicide note. Rose reported feeling grateful her other children brought these
things to her attention, and taking the action steps like throwing the items away and,
typically, not confronting Cody ([Researcher: So what’s it been like when you have spoken
to him about stuff?] “Denial, denial, denial, denial.” JC6). Knowing that Cody was seeing
a counsellor had helped Rose abide the fear that accompanied discovering these items:

Yeah, at this point, you’re not going to get anything out of him. I’m just hoping, if
he doesn’t talk to me, that’s why if is he talking to [counsellor], and [counsellor’s]
not telling me anything, that’s fine. As long as he’s talking. (JC99)

Coping. Some of the actions Rose described taking in relation to Cody and others in
her life were about dealing calmly and adequately with the problems and associated
difficulties that came with her son’s eating disorder. First described are coping actions Rose
took in relation to Cody, such as accommodating his requests. Actions she described taking
to support herself, including avoiding unnecessary stress, and finally a relationship between
prolonged coping and identity processes, are then outlined.

Rose noted many joint actions with Cody that indicated a coping process of
accommodation where the intent was to contend with the “demands” of the eating disorder,
and to avoid causing further upset or problems. The primary strategies Rose described
using were to adapt to Cody’s requests and avoid saying things he might misinterpret as
critical or evaluative. In two different interviews (JC and MC), Rose shared a poignant
memory of having once made a comment to Cody that was misinterpreted and enormously
upsetting for him. Since then, Rose reported taking intentional steps to avoid words or
comments in conversation that might be upsetting, which seemed to be anything related to
his own or others’ weight or appearance (“Do you know how hard it is to not comment on
anything like that? It’s so difficult...Even watching people on t.v., or people at the
store...just “Don’t even look at them, don’t mention them, don’t even think about weight at all.” JC205). Rose acknowledged her strategies seemed a bit unreasonable, but fear and worry about potential negative consequences made her unwilling to risk otherwise (“Tippy-toe, tippy-toe, tippy-toe....It’s just crazy, really. But it’s just easier that way. Avoid it. ‘Cause otherwise he’ll go away thinking ‘Oh, they said I was really fat. Nobody loves me. What am I going to do?’” JC219).

Rose did not talk about needing or seeking support for herself, but in response to inquiry by the researcher noted speaking weekly with extended family on the phone and finding their sympathy and reassurance to be a comfort. Rose was not aware a parenting support group existed in a neighbouring community, but did not believe it would offer her much help. In the early days of Cody’s illness, Rose noted spending time researching anorexia and looking for parenting advice, although she noted that she no longer does this (“Well, no matter what I’m looking at, they don’t tell me what-, they tell me what I found out, you know, a year ago, nothing new.” JC144).

Finally, Rose reported that concern for Cody’s illness had taken over much of her personal and family life and was affecting her other children, especially her youngest. She described feeling guilty and self-critical of her parenting while trying hard to be attentive to all her children’s needs:

[My daughter] says I do everything for Cody. And everything’s focused around Cody. And...to a degree, she’s right. It-, but not so they’re left out. Because, obviously, I’m always thinking about “Is he eating?”, “What is he doing?”, “Is he doing this, and doing this.” (JC62)

Rose also shared lingering negative self-judgements about having missed early warning signs of Cody’s eating disorder, feeling guilty her other children were the ones to discover it and finally alert her and Dan (“‘Oh, I’m a horrible mother!’ That’s what I’m thinking about. Horrible, horrible mother... How do you not know that your son’s been ill?"
It took the two younger children to say “I think there’s something wrong with Cody.”

**Assertions.** First, Rose connected her action of walking on “tippy-toes” around Cody, from which she reports feeling fear and stress, to her projects of supporting Cody and ensuring his physical safety; she did not connect these actions as supporting Cody’s “eating disorder career”. Second, Rose was engaged in various mutual projects (with Cody, Dan, professionals), but they were minimally cooperative, with disagreement and conflict in the goals and nature of engagement. Actions that accommodated or facilitated others’ goals often contributed a powerless and fearful emotional dimension to these projects. The unwanted project-goals and steps impacted Rose’s identity processes and generated unwanted and personally incongruent sub-projects.

**Case 4: David and Marie.**

**Background information.** David and Marie are a married couple with teenage children. Their daughter, Amanda (aged 16), received a diagnosis of anorexia approximately 10 months prior to the research interview and was hospitalized for approximately 1 month shortly after her initial diagnosis. Amanda’s treatment did not require changes to their work schedules nor did it impact their financial situation. At the time of the interview, they had been implementing parent-led weight restoration for approximately 11 months. There was no reported history of other individuals in the family experiencing an eating disorder.

**Interview context.** Following the telephone screening, the couple attended the initial data gathering interview which consisted of a warm-up interview with the primary researcher and a research assistant, a weight restoration conversation with one another on a topic of their choosing, and finally a separate video playback with one of the researchers.
Approximately 2 months following the initial interview the couple participated in a second interview in order to negotiate the description of their unique weight restoration project with the primary researcher.

In the joint conversation, David and Marie discussed many topics related to figuring out how to trust their daughter in light of upcoming challenges associated with giving her more freedom. It seemed that David’s intention was to find and maintain a discussion with Marie on topics that were current and might seem relevant to the researcher’s project. It seemed Marie’s intention was to discuss their mutual concerns about Amanda while thinking carefully about the way she described her experiences for the research project. During the interview, Marie and David described themselves, and expressed perceptions of one another and Amanda. Both expressed a similar set of emotions, including uncertainty, worry, fear, doubt, as well as surprise and joy at witnessing recent indicators of progress with Amanda’s treatment. Both were observed to acknowledge one another’s statements verbally and non-verbally (head nods), agreeing, disagreeing, clarifying, and occasionally expressing humour and laughing.

Weight restoration context. The focus of the couple’s joint conversation was trusting Amanda, especially in light of her upcoming return to full-time school and recent requests for greater autonomy. A summary of the couple’s help-seeking experience and their approach to implementing parent-led weight restoration in the early months of Amanda’s treatment is provided in Appendix I. It is worth highlighting a few things about the couple’s experience during that time to situate what follows. First, a key strategy the couple described using was being in agreement about how to approach Amanda’s meals and activities. They noted learning the value of agreement early on, and shared that sometimes agreement came easily and other times it was only realized after many arguments and
discussions. Second, the couple both believed family-based treatment was the right treatment for them, but its day-to-day implementation was more challenging for Marie than David. Marie shared having encountered practical and emotional struggles with carrying out weight restoration, and noted that to implement it properly she eventually had to change who she was:

We’ve had this role, unfortunately. You know, me-, I’m the kind one, the understanding one and David sets the rules. And he’s, you know, the disciplinarian. And, it took several weeks, or months I would say, for me to understand that with-, by me being kind, I was prolonging her illness. Uhm, so I had to really-, I had to kind of-, in a way-, really change who I was. And, that was tough for me. But it was absolutely necessary. (WUM140)\(^1\)

A few weeks prior to the research interview, Amanda achieved her target recovery weight. With the start of the school year approaching, Marie and David wanted to find out if Amanda was prepared to handle returning and as kind of a test had decided to fully transfer decisions about food back to her:

So she hasn’t had a full school day since [11 months ago]. And, um, so of course that makes me very nervous because her problems are mostly social with her peers. And, so what we did was, to kind of test her, we stepped back totally. David and I agreed, we said “Okay, is she ready for school?” “Is she ready to manage her eating?” She has to make herself-, she has to make the right choices. (SCM18)

**Weight-restoration project.** The following weight restoration project was validated by David and Marie at their Member Check interview:

*Trusting Amanda, yourself, and one another (trust-restoration) while gradually transitioning away from the structured and predictable meal support routine.*

\(^1\) The parent’s initial (M or D) is added in this case to indicate the speaker.
Both David and Marie believed the project should mention trusting Amanda in the context of having done re-feeding and meal support for many months. At the time of the interview, Marie and David were transitioning from trusting in the treatment approach (re-feeding and meal support) to trusting Amanda:

[In the beginning], we were helpless. And then, through the help we got and the information we got from the doctors at the hospital and counsellors, we then knew [when she was released from hospital] what to focus on initially. And you’re absolutely right. It has changed and now it is a lot about trust. Yes. (MCD85)

Yes, the trust issue is-, I think it’s easier and harder in some ways. Because the meal plan was-, there was so much structure. Right? It was very-, in a way, quite easy to say “Okay, this is correct. So we do the meal plan, and it has to be-, you have to follow it 100%”. Which was stressful for me because I was worried about messing up, forgetting an essential ingredient or something, right? ....[But now] there’s situations where she calls in...“Is it okay, I’d like to stay here for dinner?” And then, you think “Uh, is it okay?” (MCM96)

Projects summary. From a contextual action theory perspective, the couple’s joint project emerged within a pre-existing parenting project, as well as identity and relationship careers for David and Marie. The weight restoration project took form in the context of Amanda achieving and maintaining her ideal weight, and a joint adolescent development project between Amanda and her parents. The couple viewed Amanda’s weight restoration as a fight to save her life, although in some ways experienced their trust-related weight restoration project to be more challenging to implement than re-feeding. Both David and Marie assumed roles in relation to weight restoration that played to their personal strengths, making their partner a trustworthy and valuable resource in terms of validation, information and support. In Marie’s case, changing aspects of herself was required to carry out weight restoration. David’s and Marie’s individual understandings about Amanda’s eating disorder, her progression with treatment, as well as their unique relationships with Amanda, contributed to distinct perceptions of her status in relation to them as parents and her progress toward recovery.
A number of individual and joint projects and processes were subsumed under the couple’s broader weight restoration project. In relation to Marie, David seemed to have a project of vetting weight restoration actions for agreement and consistency. In relation to David, Marie seemed to have projects of (a) receiving assurance and (b) taking primary responsibility for meals and school-related issues. Other joint projects for the couple seemed to be related to (a) gauging Amanda’s emotional well-being, (b) support and partnership, and (c) adolescent development. Table 7 offers a summary of the key projects and related processes identified for David and Marie:

Table 7

**Key Projects and Processes: David and Marie**

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<thead>
<tr>
<th>Key Projects</th>
<th>Related Projects and Processes</th>
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<td>Weight Restoration</td>
<td>• Trusting Amanda, themselves, and one another (trust-restoration) while gradually transitioning away from the structured and predictable meal support routine</td>
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*Project exposition: Actions and relational processes.* The following section describes in fuller detail the important individual and joint actions David and Marie were observed to engage in with one another during the joint conversation and also described taking with one another and Amanda. It also contains a description of the additional
projects and processes that emerged in the process of analyzing the couple’s joint and individual weight restoration actions.

David: Fidelity and Adherence. Many of David’s actions in relation to Marie seemed to be about vetting their individual and joint actions for consistency with plans and intentions the two of them had previously agreed upon concerning Amanda. A key goal for David was to have understanding and agreement about their concerns, and to make plans together on how to address them. One strategy he used to realize this goal was noticing whether Marie’s concerns or perceptions seemed to match his own experiences with or perceptions of Amanda. If David recognized a discrepancy between their concerns (“She watches [Amanda] carefully and thinks about what will she do maybe for snack...I worried about that half a year ago. I realized, I’m in a different place when it comes to Amanda.” SCD11), he would highlight the incongruity by telling Marie:

Yeah. When she leaves the house for half a day, that makes me uneasy, and I’m thinking about trust. With eating, it’s not on my mind. So, I sort of wanted to express to her that, I’m okay. I trust her eating. (SCD23)

David also worked toward the goal of agreement, openness and joint planning by confirming with Marie when he found their concerns aligned and describing in greater detail what his particular concerns were:

I was expressing to Marie that I’m also worried when school starts, and there are certain things that I’m worried about. So I-, I was sort of putting it out there, and said, “Yeah, Marie, overall...I want to find out...how can we-, how can we measure her emotional stability? How do we find out when she’s in trouble? And-, and sort of, was saying “Yep, a couple of things we’ll be noticing”. But...overall, I feel currently very good because Amanda’s very open at that time. She didn’t used to be. Never-, never in her life. And she was very, very secretive when she was in a lot of trouble. And so over the past weeks, she opened up more than ever before, and um, I-, I sort of at that point try to tell Marie, “Okay, this is where my worries are”. (SCD72)

David shared that, in the past, Marie sometimes did not express her concerns to him and would move ahead with decisions or actions without discussing it with him. These past
experiences motivated David to pay more close attention to how Marie described situations in case there was an unspoken need for assistance (“So, Amanda’s worried about Phys-Ed. But, um, Marie already talked to her. So I’m trying to understand-, why is Marie focusing on that topic and does she need any help?” SCD77). David shared feeling upset and disappointed at learning Marie had indeed been worrying about some school-related concerns and had not been included in Marie’s efforts to address them:

Um, so, if she’s so worried about Amanda, what Amanda would have for breakfast and lunch, why didn’t she tell me that? She sort of already had a plan. [Researcher: You want to be included.] I want to be included. That was, for us, that was very clear. Because we sometimes were on different pages, and sometimes we didn’t agree. We needed to agree, and the best way to do it is to sort of put out a plan. Whether it’s written or not. Let’s say, “Okay, this is what I think, this is what you think, do we agree? Yes.” (SCD57)

David expressed the upset feelings to Marie indirectly by including himself in the planning (“And the way I express it is-, was sort of, ‘Let’s make a plan’. I know she already has one, but it’s sort of, ‘Let’s put it out there together’.” SCD67). Finally, David also seemed to use the more subtle strategy of inferring whether issues needed further attention and discussion based on how worried or confident Marie appeared when discussing her perceptions of Amanda or upcoming situations:

So, I think it comes back to, “Okay, when she’s going to school, do we trust her?” I trust her. Marie just told me, she trusts her. Okay. She’s not babying her. Because, if she was babying her, she would say “Okay, I make sure I drive her to school, and then maybe I meet her for lunch, and then I’ll check on her-, will I have messages” or whatever. She’s not doing it. We did that last school year, when she was sort of going there for 1-hour a day. But what I’m hearing from Marie-, now she trusts her. [Researcher: ...how was that for you to hear her saying that?] Very good. Very comforting. Because we are on the same page. We sort of-, okay. Monday morning, let her go. (SCD161)

**Marie: Receiving assurance & dealing with meals and school issues.** Some of Marie’s actions in relation to David seemed to suggest a project related to receiving assurances that their plans and actions in connection with Amanda were working. For
example, although Marie agreed with the plan to trust Amanda with her eating to test her, it was difficult for Marie to feel confidence in the action plan in light of her knowledge that eating disorders are characterized by deception and her daughter’s nature is to be a bit disorganized (“She’s sometimes, she’s a bit chaotic.” JCM59). As such, Marie sought assurances from David to help regulate the worries that would arise as she went about implementing their joint plans for trusting Amanda:

I kind of-, I need his reassurance. And it’s been-, it’s been really helpful. If we-, in the past, David and I talk about what we want, and then we talk with Amanda about it. And that’s...that’s been very helpful. And Amanda has usually-, when she knows in advance what to expect, that-, that works well, and not that surprise later. (SCM91)

At the time of the interview, Marie had not yet discussed with David the worry she had about the appropriate amount of meal-related assistance and support to give Amanda as she returned to school (“I think-, there’s still a lot of anxiety in me...of not doing it right. Like, how much support does she need for school? Should I...plan out the lunches or is she ready?” SCM89). In light of the division of tasks in their household, Marie felt more responsibility for and awareness of the practical issues related to food. Although she shared David’s worry about the school-related social stresses Amanda might encounter, she was also concerned about how to best support Amanda meal-wise. For example, Marie was trying to anticipate the kind of meals Amanda liked that could be packed in a lunch bag, and was worried about whether Amanda would be able to get up early enough to eat her breakfast. Marie’s actions in relation to this project included planning lunch meals Amanda would like, asking Amanda if she had worries about doing meals at school, carefully monitoring her daughter’s emotions as the first day of school drew closer, and reassuring herself:

When she was at home, it’s easy to make something for lunch, right? But it’s more difficult for school. ... I’ve tried to come up with ideas, and uh...yeah. Amanda
does not seem to be worried. But I know if it’s too much of the same food, she-, I worry about her not liking and not eating it. I’m also worried about her getting up, and having to get up early now. And getting used to the early breakfast, not being able to sleep-in in the morning. That kind of thing. But she-, actually, she knows. [laughs]. (SCM112)

Marie’s relationship with her daughter seemed to afford her more confidence and trust in Amanda’s readiness to deal with the social stresses of school. For example, in the interview, Marie told David about a worry Amanda expressed to her about using the change room during physical education class because of scars from having cut herself in the past. Not aware the change room was an issue for his daughter, and wanting to help his wife, David suggested a plan whereby Marie would talk further with Amanda and encourage her to take the class. David’s suggestion created a little conflict for Marie (“Do I want to do what I think is right? Or do I want to do what my husband tells me to do-, to talk to her.” SCM143) because she had already talked with Amanda about it and felt confident she should (and could) handle it on her own. Marie further explained her inner struggle was related to her goal of not wanting to undermine Amanda’s confidence or rescue her from facing challenging situations:

I’m not afraid to talk to her, it’s just-, but I would have liked to have avoided that conversation because then she knows I worry about it. And, then I want to leave it up to her. I want her to be able to say, “I want help here”. I want her to be able to come to me, and not say-, not problem-solving for her. And it might not even be a problem. (SC159M)

_Gauging Amanda’s emotional well-being._ A mutual trust concern for David and Marie in connection to Amanda was that she might become over-involved in her peers’ problems again and find herself emotionally distraught. David noted how Amanda’s weight (as measured by a scale) was a tangible marker of progress and recovery during re-feeding, and the absence of such an indicator for her emotional well-being presented a new
challenge. As such, it seemed as though finding a way to monitor and receive feedback on Amanda’s emotional well-being had become an important joint project for the couple.

David engaged in various individual actions in relation to this project, such as itemizing potential signs that might suggest Amanda was doing poorly, drawing on his own sense of Amanda’s progress based on her recent interactions with him and Marie, and trusting the professionals involved with Amanda, like the school counsellor, would serve as extra “eyes and ears”. Various joint actions with Marie were also prominent in David’s engagement with this project, and included voicing his particular concerns to Marie, and making requests to plan together about how to spot trouble and what to do about it. David noted his worry was eased by knowing he and Marie held similar concerns, and learning Marie trusted Amanda in areas he felt unsure. Indeed, some of David’s trust in Amanda seemed to derive from the close relationship he knew to exist between Marie and his daughter.

I was sort of putting it out there, and said, yeah, “Marie, overall...um, I want to find out...how can we-, how can we measure her emotional stability. How do we find out when she’s in trouble?” and- and sort of, was saying yep, a couple of things we’ll be noticing it, but...overall, I feel currently very good because Amanda’s very open, at that time. She didn’t used to be. Never-, never in her life. And she was very, very secretive when she was in a lot of trouble. And so over the past weeks, she opened up more than ever before, and um, I- I sort of at that point try to tell Marie, “Okay, this is where my worries are.” (SCD72)

For Marie, Amanda’s emotional well-being and eating habits were closely connected, and for this reason she continued to weigh her daughter and watch her eating behaviours more carefully than David: (“Although I know she’s doing really well, I still weigh her. And now she’s off her meal plan, she’s gained more weight than when I told her when to eat and what to eat.” JCM3). Marie recognized she brings her own anxiety to project of gauging her emotional well-being, and her anxiety may unduly undermine her confidence in Amanda:
Also, the ‘Is it me or is it her?’ So, is she-, ...how much, I cannot look inside of her, so is she still struggling? ....or is it me, am I overly anxious? (SCM10)

It also comes from-, because we missed things. Right? I mean it’s-, suddenly you realize your daughter is suicidal. And, uh, that’s...once you’re afraid, when you wake up your daughter-, or you might find them-, that’s really horrible. So, you are-, that’s what you learn. You have to watch out. (SCM253)

Joint actions Marie took in relation to David about Amanda’s emotional well-being included sharing her concerns about Amanda’s eating, checking whether his perceptions of her progress matched her own, and feeling encouraged by his confidence and that his impressions of Amanda’s progress matched her own:

I liked his positive reinforcement that, you know, he said, weight wise, he trusts her. So, you know, he gave me the message “You can relax a bit”. And also, you know, he sits next to her when she eats. So, he...kind of uh...is very close to her. So, it was good for me to hear that he said-, you know, he thinks she’s enjoying-, she’s able to enjoy [food] more. And, [take a] second helping. (SCM32)

Marie’s close relationship with Amanda also allowed her to know the things that were concerning Amanda about school better, and provided her with an opportunity to influence her daughter’s choices in a positive way. She speculated that David might worry more about how Amanda was doing emotionally because his relationship with Amanda did not include this kind of a connection:

She comes more to me than to him. So, you know, she comes to me for advice. That’s-, that’s the one thing that has pulled us though that-, with all the emergency room visits, and her being suicidal. Everybody has said, “When she’s in crisis, she comes to you.” (SCM209)

Support and Partnership. Seeking explicit agreement and offering and instilling hope were two key processes that emerged in David’s and Marie’s support and partnership project.

A prominent joint goal David and Marie held in relation to their weight restoration project was to make well-reasoned, mutually agreed upon and fair decisions on trust-related matters. The couple’s actions in the service of this goal included telling the other about the
issues that concerned them and how it made them feel, suggesting ideas for addressing problems, and asking for the other’s wants, opinions, and feelings on various matters.

Consider the following example of the couple discussing Amanda’s recent request to get her driver’s licence:

JCM67: And the driving, we can-, we can take it a bit slowly. I mean, if there’s issues coming up that she’s reckless or-, then it’s up to us to say, you know “Wait 3 months, we try again”. What do you think?

JCD68: I think that doesn’t work.

JCM69: It doesn’t work.

JCD70: So I thought, what if she came right at her birthday in the summer, “Now I want to start driving”. I thought-, and I think we talked about it-. I thought, ‘I have to say ‘yes’” because I have no grounds for saying ‘no’. Um. So, I would-, I would say ‘yes’. And I would only say, “Okay, let’s check with your doctor on your medication” because some of that stuff makes you sleepy.....

JCM73: So-, so why do you think there is no-, once she starts driving, we can’t say “wait 3 months”?

JCD74: [pause] She will not respect the trust-, the judgement. She would say “who are you to-, to tell me that I should wait?”

JCM75: You think?

JCD76: ....I think we would-, we would lose her trust or her support if we said “You are not ready”. She feels ready, she wants to go. And I think we cannot stop her, we can’t-, we can work with her and try to guide her.

In this exchange, both David and Marie wished to support Amanda’s desire to drive, but disagreed on how to go about it. In her self-confrontation, Marie noted feeling both pleased and nervous about Amanda’s interest in driving and also proud of her daughter for challenging herself to do something that was a little frightening for her (“She’s just-, the last few days, she-, she kind of suddenly - driver’s licence...she wants to work. So [laughing], so it’s a bit much...but it’s also-, I know it’s great.” SCM170). However, unlike David, Marie felt confident Amanda would still respect them if they agreed to the request with certain conditions, such as handling it responsibly. Marie made sense of her and David’s different perspectives based on their individual relationships with Amanda (“We’re-, we
kind of-, [sigh]. David and Amanda had a lot of conflict. So, I think he’s-, he’s a bit worried about rocking the boat. Whereas I think she could handle it.” SCM199):

And also-, you know, he’s also talking about the respect that Amanda has for us. So he-, we see it differently. He thinks she has less respect, and I see more. Maybe that’s again-, she comes more to me than to him...So, in that way, I think-, I assess it that-, that our relationship is good enough for-, if I say “You know what, I don’t think you’re ready. Let’s wait”. She would respect that. And he sees it differently. (SCM209)

David saw it quite differently, believing he and Marie should make trust-decisions based on Amanda’s present condition not her condition over the past year (“Yes, let’s trust her” and let’s not make it overly conditional...back to normal. Not a helicopter mom or dad saying, “we really need to watch you every step.” MCD40). However, David’s suggestion of giving unconditional trust was not without some internal doubt or reservation: he drew confidence in knowing that graduated licensing would mean Amanda would not soon be driving alone (“And to me, it’s not even sort of an immediate risk because the real risk I think starts when they are out by themselves which now is more than 1 year away.” SCD104).

Being supportive, encouraging and helpful to one another was a salient support and partnership goal evident throughout David and Marie’s interactions. Instilling hope in the other based on their own hope and distinct relationship with Amanda seemed to be a familiar action step for both David and Marie. In addition to the supportive communication strategies the couple used to discuss their concerns, such as sharing opinions and perceptions of Amanda’s progress and validating one another’s areas of concern, the couple also looked back over their individual and collective memories of various times and ways they had witnessed Amanda handle challenges well:

JCM85: Yeah, I’m just-, I have to say, I’m a bit nervous about her school starting.
JCD86: Mhmm. [pause]. When-, remember this morning, surely you remember that, all of a sudden, she announced at the breakfast table, “It’s now 5 months...that I have not been thinking about self-, self-harming”.

JCM87: No, “I haven’t done any self-harming”

JCD88: “I haven’t done any self-harming”.

JCM89: Five months.

JCD90: That was a huge deal. For her, that was a huge deal for her to tell us. I was not aware that she’s keeping record about these things

JCM91: I didn’t know either...

JCD92: I-, I had no idea.

JCM93: Mmmm

JCD94: But, uh, telling us...I think is a huge step.

SCM235: I think he’s trying to...turn me around, right? To give me, uh, tell me something really positive...

SCD167: And then, I thought, I’d bring it up. That Amanda mentioned this morning, all of a sudden, “I’ll tell you something”. That’s pretty intimate, that’s pretty close to her....she never talked to us about-, some of her problems. She never-, we talked about a couple of things because all of a sudden we put the knives away and stuff like that. And we-, um, like when she was at her worst, we searched her room. Things like that, so. And now, all-, all of a sudden, she makes an announcement. And I think that’s a huge trust in-, in Amanda telling us: “Okay, I want to share something”. So, to me, this is a huge sign that, we can-, we can rely on sort of, Amanda’s ability to communicate right now. And if that stopped, that would be a sign. Or maybe she would even tell us if there was some trouble.

For David and Marie, it sometimes seemed as though one had confidence or insight in the areas where the other had the greatest worry, and both were observed to offer their unique perspective to the other with the purpose of encouraging their spouse:

JCD6: Now that she’s reached that minimum weight, uh, I trust her with eating, and then I look at her attitude and I see she’s-, she can almost enjoy eating. Um, she helps herself, and to me, that’s sort of, is a more important indicator than the weight. That she reaches-, now all of a sudden she starts reaching out for a second helping, right. I haven’t seen that for like a year or so.

SCM35: So, it was good for me to hear. That he said-, you know, he said-, he thinks she’s enjoying, she’s able to enjoy it more. And, and with the second helping.

JCD80: I think, um, we have the tools to work with her. I’m not sure...if we would sort of, get her support, in saying, “You know what, Amanda, we think we
need to work on this or that again.” Sometimes I think she’s so strong she might decide she does whatever she wants, and worst case, she runs away.

JCM83: I’m really not worried about her running away. I think, what she-, what you just said, what she’s seen with friends, I know-, I think she knows she has a good home. [pause]. And I-, if there’s a setback, we know what to do. And she knows what to do...

SCM223: It surprised me to hear that he’s-, I mean-, I don’t know how serious he was about that-, about her running away. I mean, it was a fear when she was very, very sick. But, uhm, no. I mean, I think she really feels-, she appreciates us. She appreciates her home. And she’s said so often-, she has met many people with-, who really struggle at home. Yeah. So I-, I try to tell that. He-, I don’t know, sometimes he’s a bit...pessimistic. You know, so I try to reassure him with that that I don’t worry about it, and why.

Adolescent development. Finally, it was important to both David and Marie that their weight restoration project actions were also consistent with goals they had of supporting the maturation of healthy adolescent behaviours in their daughter, like better managing her emotional connections and behaviours with peers, taking responsibility, and making decisions and solving problems without over-relying on her parents. Both were mindful of not “rescuing” Amanda from challenging situations and waiting for her to initiate action toward realizing her own goals. Consider the following quotes from David’s (presented first) and Marie’s self-confrontation:

And it was the same that we did with my son. When they say “Can I do it [learn to drive]?” we say “Yes”. But then we don’t take any other action. We leave the action for the kid because we think it is part of it that they figure out, where’s an ICBC office? And they have to schedule it. And they have to ask us, “can we go now, or can we go tomorrow”? [laughing to himself] (SCD104)

I said to her that-, uh...she said she was nervous about [driving], but she wants to do it. And I said that’s-, I like that. That she wants to challenge herself, even though she’s a bit scared for it. And, we-, we told her how she could get there. (SCM174)

Communicating messages of confidence in Amanda’s ability by not doing things for her was one of Marie’s strategies in support of maturation goals and the adolescent development project (“And, then I want to leave it up to her. I want her to be able to say, ‘I want help here’. I want her to be able to come to me, and not say-, not problem-solving for
Marie also noted refraining from saying or doing things that might reveal the true nature of her worry for Amanda, like how she felt when she requested to drive or begin working part-time (“It’s just kind of ‘Whoa!’ I said that to [David], not to her.” SCM170).

David’s action strategies in service of the adolescent development project included things such as arguing in favour of responding without conditions to Amanda’s request to drive (“That to me means a full yes, and not, sort of the option to, and then pause for 3 months. For me, that would go against what we’re trying to do with her.” SCD115), and also monitoring to ensure his and Marie’s joint actions in relation to Amanda were in keeping with their goal of supporting autonomy and responsibility:

So for me, with phys-ed, I was wondering what Marie actually wants. I didn’t know until that point, so I was asking her quite directly, “Where do you stand? Do you want to sort of protect her, and get maybe a fake excuse not to go to PE?” She could-, but then I heard, “No, no. She has to do it”. Which to me means Marie supports it. I felt Marie was right on, and she feels good about it. It’s not a touchy subject. I think it used to be-, like half a year ago or so. They were much more worried. And I think if Marie and Amanda wanted it, they would go to the doctor and say ‘write me something’, whatever it is, if it’s asthma or so-, but no. Amanda wants it, Marie wants it, so I’m okay. (SCD86)

**Assertions.** First, Marie and David’s weight restoration project was a mutually supportive, adequately resourced and cooperative joint venture. Second, the couple’s roles and actions in implementing the project were integrated with and motivated by various personal identity processes. David’s role was more congruent with his identity processes than Marie’s, and this sometimes created an element of disagreement and conflict in their engagement and implementation of the weight restoration project. Finally, the couple’s distinct identity processes and relationship projects (with Amanda) seemed to contribute to variations in the social meaning of the weight restoration project and were reflected in the actions of each parent.
Case 5: Terri

**Background information.** Terri’s 13-year-old daughter (Emma) received a diagnosis of anorexia approximately 4 months prior to the research interview. Terri and Emma’s father, Jack, separated approximately a year previously but were working together to support Emma in her treatment. Jack did not participate in the interview. Terri estimated Emma had been suffering from the disorder for approximately 12 months, and she had been doing parent-led weight-restoration for approximately 3.5 months. Her daughter was never hospitalized for the eating disorder and there is no known history of other individuals in her family experiencing an eating disorder. Terri was taking time off work for Emma’s weekly counselling sessions (appointments occur during business hours), but otherwise involvement in Emma’s treatment had not created financial strain.

**Interview context.** Following the telephone screen, Terri took part in the initial data-gathering interview which consisted of a warm-up interview with two researchers, a conversation about her weight restoration experiences with the primary researcher, and then a video playback with the research assistant. Approximately 2 months following the initial interview, Terri participated in a second interview to negotiate a description of her weight restoration project with her daughter with the primary researcher.

In the research interview, it seemed that Terri’s intention was to clarify her own thoughts and beliefs about how to best support her daughter (who now has an eating disorder) in a world where “the thinner you are the easier it is to be liked”. Terri noted her thoughts on this topic were relatively unformed, and she was hoping to gain some clarity in verbalizing them. Terri also shared being mindful of how she represented herself in the joint conversation with the researcher, intentionally sharing experiences she thought might be important for the researcher to hear while also being mindful of how much detail she
wanted to provide. Terri’s manifest behaviours in the interview included describing herself and how she relates to Jack and Emma, and also describing some of Jack and Emma’s personal characteristics. Terri expressed a variety of emotions related to the weight restoration process, including uncertainty, sadness, surprise, dissatisfaction, gratitude, doubt, frustration, levity, and hope. Terri’s desire to find levity amidst the trying circumstance of Emma’s eating disorder was expressed through light-hearted and humorous reflections on her own actions and those of others she described in the interviews.

*Weight restoration context.* The year prior to Emma’s difficulties with anorexia, Terri and Jack had home schooled Emma while travelling (“We wanted to-, or so it was the thought, avoid middle school chaos [laughs]. Give her perspective of the world...hoping to avoid social problems.” WU6). The following year, although Emma maintained her typically high grades, Terri began to notice she was not eating breakfast, not taking lunches, and always counting calories. Over the course of the year, Terri grew increasingly concerned at the amount of weight Emma had lost. Initially, Emma refused to discuss the issue and resisted Terri’s attempts to help:

Uhm, and eventually, by the end of grade 8, she was able to reach out for help. And say, “Actually...yeah. Let’s go to the doctor”. You know, so we went to the doctor, and they finally connected her with the eating disorder clinic. And through the summer we’ve been doing the weight restoration. (WU14)

Terri expressed gratitude for having the eating disorder identified quickly and that it was caught in a relatively timely fashion. Reflecting on the early days of weight restoration, she shared how stressful that time was for her and Emma:

The summer was like, and you know, sticking to menu plans and sticking close to home. And, uh...just thinking of how freaking trapped I felt. I was the go-to parent, 24-7, practically. You know, [Jack] would come and-, and do stuff. But you know, it was-, it was all me. And as I was talking about that, and I was just like, “oh my god, that was just horrible.” (SC230)
Terri shared feeling disappointment about the summer she and Emma lost to the eating disorder (“It wasn’t the summer that I wanted for me, and it wasn’t the summer I wanted for her. Uhm, you know. And it just, it really freaking...sucked.” SC234).

At the time of the interview, Emma’s weight had plateaued and was not quite at the target weight set out by her treatment team (“I think she has a couple of pounds to go. ...And then, the counsellor’s like, you know, ‘A little bit more, you need to...little bit more.’” JC117). Feeling pleased with Emma’s current weight and progress, Terri was beginning to gradually step back from overseeing her eating as closely as she had over the summer (“So that’s where we’re at. I think she’s eating enough. I think she thinks she’s eating enough, and then-, I want to believe that she’s eating enough, and not withholding.” JC121).

**Weight-restoration project.** The following description of Terri’s unique weight restoration project was validated by her at the member check interview:

*Implementing weight restoration while dealing with the conflict you experience in seeing and accepting your daughter as she is (e.g., inactive and socially withdrawn) while hoping for the best for her, inside and out (e.g., fit, strong, and self-assured).*

Terri requested the project reflect that she both sees her daughter for who she is and accepts her, and that hoping for the best for Emma encompasses physical beauty as well as inner beauty, with her inner qualities and characteristics being most important.

**Projects summary.** From an action theory perspective, Terri’s joint project emerged in the context of a pre-existing parenting project and relationship career with Jack, a separation from Jack, as well the broader social context of the “thin-ideal” culture and a physically-active family lifestyle. Terri experienced weight restoration as an unwanted interruption to her and Emma’s lives from which she was eager to move on. The experience
introduced uncertainty to her personal beliefs as a woman and a parent, summoning a confusing re-evaluation of the way these belief systems intersected in relation to Emma, and whether her beliefs left room for Emma to find her own way and be herself. Terri participated in Emma’s weight restoration by suppressing and deferring her own emotions and needs, and taking on unwanted roles in relation to Jack and Emma.

In addition to the identified weight restoration project, Terri also appeared to be engaged in projects related to (a) “pulling together” with Jack for Emma’s well-being, (b) strengthening Emma’s self-esteem, (c) a relationship with Emma, (d) professional support, (e) trusting her daughter, and (f) feeling responsible and making peace with the eating disorder. Table 8 offers a summary of the key projects and related processes identified for Terri.

Table 8

*Key Projects and Processes: Terri*

<table>
<thead>
<tr>
<th>Key Projects</th>
<th>Related Projects and Processes</th>
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<tr>
<td>Weight Restoration</td>
<td>• Implementing weight restoration while dealing with the conflict experienced in seeing and accepting [Emma] as she is while hoping for the best for her, inside and out</td>
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<tr>
<td>‘Pulling-Together’ with Jack</td>
<td>• Family meals; Setting aside preferred ways of relating in her separation; Negotiating conflicts arising from disparate parenting philosophies</td>
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<tr>
<td>Strengthening Emma’s self-esteem</td>
<td>• Encouraging physical activity; Affirming Emma’s positive traits; Re-evaluating personal beliefs about social acceptance</td>
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<td>• Sadness at relational distance and guilt/grief at not realizing it sooner; Seeking to repair and rebuild the relationship</td>
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<td>Professional Support</td>
<td>• Uneasy feelings about Emma’s target weight</td>
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<td>Choosing Trust</td>
<td>• Choosing to be optimistic, but not naïve</td>
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<tr>
<td>Making Peace with the Eating Disorder</td>
<td>• Feeling responsible, but refusing to be stuck in blame and guilt; Trusting a solid foundation was laid for Emma</td>
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Project exposition: Actions and relational processes. The following section describes in fuller detail the important individual and joint actions Terri engaged in with Jack, Emma, and the professionals involved in her treatment. It also contains a description of the additional projects and processes that emerged in the process of analyzing Terri’s joint and individual weight restoration actions.

“Pulling together” with Jack. Pulling together in support of Emma’s treatment was Terri’s primary goal in relation to Jack. An important joint action Terri described taking in order to realize this goal was having Jack resume eating meals at her home so they could do meal support together with Emma. However, in the light of their recent separation, re-engaging with Jack in joint goals related to Emma’s treatment was in direct conflict with the goals of her separation project:

So for us, pulling together, for her, was a bit of a-, a no brainer. Uhm, but there obviously were those awkward moments where, you know, like I really didn’t want to see his face a lot of the times, too, right? “I want to be separate from you.”

(WU70)

Terri noted initially feeling indignant and angry that weight restoration meant resuming some of her former roles in relation to Jack. To realize the superordinate goals of helping Emma and being successful with weight restoration, Terri set aside her feelings and preferred ways of relating to Jack in their separation:

At first it was like, “Oh, you still want me to cook for you?” Like, literally. “Oh, you don’t want to come over on the weekends, but you’re okay during the week, after you come home from work and you’re tired I feed you?” Like, “Hello? Uh, that’s not happening”. And then, you know, it’s like, “Actually, we need to do this for Emma. Darn. Okay” So, suck it up. Bury those emotions [laughs]. (WU74)

Terri’s joint actions with Jack were not only complicated by the separation project, but she and Jack also held disparate philosophies on how to parent Emma, which had implications for their preferred actions in response to Emma’s eating disorder and weight restoration:
I have a little voice in the back of my head that says, well, you know, his voice, “Well, life is hard, and it’s not always easy…” And then I’m like, well, “Why can’t it be?” [laughs]. Really? Just because you had a tough upbringing doesn’t mean that, you know, our kid has to have one. Like...really? We don’t all have to experience pain, do we? (SC41)

Although not captured in the quote above, Terri did partially agree with Jack’s view (“Keeping your kid safe from pain is pretty key. Uhm, also knowing to grow with life, you have to have challenges and pain.” MC84). However, when it came to the emotional pain of not fitting in socially, Terri strongly believed that being slim would be a helpful protective factor for Emma (“The thinner you are, the more beautiful you are, the easier the world is for you. Like, I-, I truly...believe that. You know, they’ve done studies on it.” WU90).

Terri’s underlying beliefs about culture, body image, and acceptance, coupled with her parenting goal of wanting the best for her child motivated various actions directed toward the hope that Emma would maintain but not exceed her ideal weight (see self-esteem project, below):

You know, part of wanting the best for your child is to look...really awesome, as well. And she does, she looks awesome now. She doesn’t look skinny, she just looks-, you know, she’s slender, and she’s beautiful. And, uh, you know, I kind of wish that upon her. I would never tell her that. You know, but I-, you know, but it’s kind of that whole package, right? You want your kid to be.....to fit in, to have awesome friends, and obviously that's easier if you look a certain way as well. (WU102)

Terri’s parenting philosophy and views on culture and beauty shaped her approach to weight restoration, sometimes creating conflict between her and Jack. For example, Terri’s underlying beliefs made it easy to sympathize with Emma’s misgivings about the treatment team’s target weight and contributed to Terri’s reluctance to continue adding calories to her meal plan:

MC112: [Researcher]: But there’s some aspects of the re-feeding that created some uneasiness?
MC113: Oh, totally. Yeah. A lot of uneasiness. For her, and I’d say for myself as well. What if they’re wrong? What if they make her gain too much weight, and then-, and then she feels like she’s...too heavy.

MC114: [Researcher]: And that might keep her from going out and being social?

MC115: Yeah. Yeah, you’ve hit it-, I think you’ve hit it really well. It’s sad, it’s scary.

MC116: [Researcher:] And how-, I mean, so what you do is take steps forward [toward weight restoration]. You trust the physician, counsellor, people who specialize in the disorders...and that’s the conflict, as a parent?

MC117: Well, conflict as a parent, and conflict as a woman. It’s a conflict that I’m sure she’s having as well.

In light of this internal conflict as a parent and a woman in implementing weight restoration, Terri adopted some actions strategies for helping Emma recover weight that were in conflict with Jack’s. Terri hoped to go about re-feeding Emma using more healthy foods in order both to role model healthy eating habits and avoid unnecessary weight gain.

Because Jack did not share her philosophy about avoiding hardship and being slender as a means of protecting Emma from painful experiences, Terri noted Jack’s approach to re-feeding was quite different (“Her dad’s like, ‘Oh, I’ll just bring some more Timbits over, that’ll get the weight up [laughs].’ ‘I really want the weight up, but do you really want her eating white flour and sugar? And fat, together?’” JC136).

Terri dealt with the conflict by acknowledging Jack’s freedom to make his own choices (“The health food....it’s kind of my philosophy against his philosophy. Right? And that’s the way that he chooses to be, and run his life. And, you know. What am I going to say, right?” WU76), minimizing its importance and seeing it from a more positive perspective (“Like, she eats healthy most of the time. Maybe that’s just their thing.... And not that I’m totally against junk food. I mean, I have ice cream in my freezer.” WU84), and giving Emma the option to adopt whatever eating habits she prefers (“I’ll just role model what I role model, and she can choose what she wants.” WU108).
Choosing to tolerate Jack’s approach to weight restoration and its potential to work against her own goals in relation to Emma helped Terri come to a resolution about her conflict with Jack about healthy foods. However, Terri continued to experience conflict in relation to Jack, and within herself, about whether her desires for Emma were healthy and reasonable or harmful:

The blame is coming at me from her dad. Uhm, we had a conversation the other day-, you know-, this is quite typical where he’ll say, ...“You’re having these ideas that you want for our kid, but maybe that’s not her ideals, that’s not what she wants”. Yeah. So I’m feeling kind of blamed for having these desires for my daughter, which in my mind are healthy things. I want her to be healthy. I want her to be able to go out and call friends, like those are things I want for her. (SC41)

Feeling the blame from Jack seemed to motivate Terri to consider whether Jack’s perspective might be true. Terri engaged in various processes related to re-examining what she wants for her daughter and questioning her understanding of her daughter’s wishes for herself. Overall, Terri’s main conflict seemed to be between her goals of wanting to accept Emma for who she is, to protect her from pain / give her the best, and for Emma to be free to follow her own path:

I see her pain and her anguish at the anxiety of not being able to do things. And it’s like, well, I know she wants to do what she used to do. But the little voice is like, well, maybe that’s not her path. And maybe I should just not have those dreams for her, because my dreams for her are going to-, I won’t be able to appreciate her as she is now because I’ll want something different for her. (SC53)

Finally, Terri also shared various internal processes in response to Jack’s belief that their separating somehow caused Emma’s eating disorder. Terri noted feeling self-doubt and guilt at times, but also undeserving of Jack’s blame, aware the eating disorder may have developed regardless of their separation. The negative judgement and criticism from Jack created complex feelings of self-doubt and misgivings that carried forward into her actions in relation to Jack, Emma and weight restoration:
And so just sort of thinking about that, like “oh, did I make the right choice [to let her stay home on her own, do her own meal?]” Like, I got these critical texts [from Jack], but are they really, really being critical? Or were they not? Sifting through that, I just-, my go-to is: I’m always feeling judged and I’m always feeling criticized by him, so I just read that into most situations as a natural go-to. (SC190)

*Strengthening Emma’s self-esteem.* Terri described taking various actions with Emma where the intention was to helping her daughter feel good about herself, to love herself and to go about it in a healthy manner. Taken together, these actions and intentions seemed to suggest a project related to strengthening Emma’s self-esteem:

You know, ‘cause in the end, there’s that healthy factor. Right? I feel good about myself, and I have a healthy relationship with food. I mean that would be the big picture, if I wanted anything for her. Like, that’s it. I feel good about myself, I love myself. (JC15)

In addition to the action steps mentioned above (wanting to go about weight restoration with healthy foods and role modelling healthy food choices), Terri also encouraged Emma to join with her in physical activities (“You know, cause I’m a fairly fit person too, right? So it’s like, ‘Let’s go out and get some exercise. Let’s get fit, and feel good about ourselves.’” WU92). In response to Emma’s preference to spend most of her time at home, Terri created a house rule to encourage physical activity:

Yeah, because you know there are bottom lines in the house. Like she has to have one activity that she does a week. Yeah, she chose horse-riding. Yeah, so I’m like, great. I don’t care what it is. Do something that’s outside, and yeah, somewhat active. (MC98)

Terri also noted having conversations with Emma about the weight-gain focus of treatment, and expressed understanding of Emma’s concern about her weight, and sharing her own feelings of uncertainty:

I know she’s afraid of being overweight, as well. ....She’s talked to me, like “What if I’m at that weight?” And I’m like...[expressing understanding]... Her question is: “What if this is my weight?” You know, “Why do they want me to get...more weight?” (JC27)
Terri was going along with the recommendations of Emma’s treatment team and continuing to increasing Emma’s calorie intake, although internally having some misgivings and feeling uneasy. Other actions Terri noted taking in support the self-esteem project included sending more messages of love to her daughter, sharing affirmations, as well as paying her daughter compliments on her appearance. Terri questioned whether saying “you’re beautiful” would be helpful or harmful in light of Emma’s eating disorder, and shared thinking Emma may appreciate it or not even pay attention to it:

I tell her she’s beautiful a lot now, and I’m not so sure...if that’s the message I should really be sending as well? But it just sort of comes off the tongue, “You’re beautiful”. [Researcher: But you’re not sure if it’s...] Because it’s such an external thing, too. Right? I mean, she’s obsessed with her external body, and her face..., and the amount of time she spends with make-up and hair and things like that. She’s-, so when I say that she’s beautiful, and like, it just slips off the tongue, it’s nice, you know, it’s probably something she likes to hear. Then, like, I don’t really mean it like, exterior. I do, but I also mean it on the interior. But I don’t know if she’s hearing that as much, as just the exterior. And I’m just mom, anyway. Right? (JC39)

Recognizing Emma’s potential sensitivity to comments about food and weight, Terri also noted withholding remarks to Emma about her food choices:

I don’t say anything about food, you know? Like, it’s yeah, I’d love her to eat more vegetables, or salad, or “Do you need to eat this late at night?” Those kind of comments that-, that healthy eating mindset-, which I’m not saying anything about. I don’t want to trigger anything, right? But it’s like, “ohh, that’s-, that’s still that same conflict”. I want her to eat well, I want her to look good, I want her to feel good about herself and her accomplishments, and not stress about stuff. So I almost can’t say anything. (MC87)

Terri’s goal of supporting Emma in maintaining her weight in a range where she would be healthy and physically slim was not only a weight recovery goal (described above), but also a goal in relation to the self-esteem project. Because the goal of weight maintenance also seemed to be Emma’s goal, the broader social context for Terri was the sense that she was supporting Emma to realize her own goals of being happy, confident and able to connect easily with friends. As mentioned above, discussions with Jack had
prompted Terri to re-evaluate her underlying beliefs and reasoning around the strategies she was using to support Emma’s self-esteem project, asking herself whether these goals were truly shared with Emma:

SC1: [Researcher]: So, as you were talking there, and talking a little about your daughter’s ideas about what looks good and stuff, do you remember what you were thinking or feeling?

SC2: Uhm, yeah. Just trying to put pieces together. Being kind of confused myself. How do I express what I think she might be going through? Yeah, and then looking at it, I’m thinking, “Are those my thoughts, or her thoughts?” As I’m watching it back, I’m thinking, those are-, those are my thoughts, and those are my confusions. And maybe my issue more than her issue. My issue for her?

Terri’s evaluation of her own beliefs in relation to cultural ideals related to body shape, self-esteem, and social acceptance was an ongoing process, and at the member check interview, her internal processing on the issue included consideration of how body dissatisfaction is often a key aspect of an eating disorder (“But knowing the disease part of it-, you could be a freaking pencil and still be unsatisfied with what you see.” MC119).

*Mother-daughter relationship.* In the weeks preceding Terri’s research interview, she came to learn she and Emma held different perceptions of their relationship. Terri had always known Emma to be conservative in discussing her thoughts and feelings, but believed their relationship to have been positive:

Over the last few weeks, actually, she’s been talking a little bit more about her feelings and stuff. Basically, she’s been like, “Why would I talk to you? I learnt in this family to keep my emotions to myself” and so, you know, “I don’t talk to you”. Well, okay, “Good thing you have someone [counsellor] to talk to now.” (JC51)

Terri noted these exchanges with Emma contributed to feeling of sadness and led her to reflect back on her parenting with some self-doubt and grief:

There’s a little bit of grief around that. That she doesn’t feel safe talking about stuff to me ...If our kids are our mirrors of us, and she doesn’t want to share-, you know again, it’s like, “Oh, is that something that-, something that I’ve done wrong? Or could have done better? But definitely in that moment, just like, “That sucks.” (SC124)
The internal processes Terri shared in response to Emma’s revelation included normalizing Emma’s perception of their relationship (“No matter what you do, your kid’s gonna hate you for it. And I think that’s normative, too. Obviously with the teenage years, right? Like we’re fighting-, they’re fighting against us to get their own individuality, right, so.” JC55), feeling critical of herself (“Having-, having the little mother guilt around that too. Like, “Uhhh, you’ve only got one opportunity to raise a kid.” SC91), while also being mindful to not get too pulled down by the guilt:

Yeah, I mean, guilt is there-, but on a scale of 1-10, it’s-, it’s not super heavy... cause part of the last-, my life, is just you know, kind of-, you can’t redo stuff, or you know, so I don’t live in the-, I don’t sit in that guilt. (SC97)

Terri noted taking actions intended to re-build connections between her and Emma, such as attempting to have more conversations about her feelings and experiences (“Yeah, when she lets me. It’s small windows, very, very small windows of time where, she’ll kind of open a door, and then she’ll shut it really loudly. “You don’t understand me!” Slam. [laughs] But we’re getting there.” JC63), and directly expressing to Emma regret for the stress and hardship her and Jack’s separation created in her life.

*Participation with professionals.* The actions Terri shared in relation to the professionals involved in Emma’s treatment did not seem to suggest a particular project, but the actions she described taking in relation to the counsellor were generally cooperative. Terri noted feeling empowered and grateful to have the counsellor’s treatment recommendations as an authority to settle food-related battles in the early days of re-feeding Emma:

‘Well, I’m not going to eat this. What are you going to do about it?” kind of stuff. “Well, you need to eat it”. You know, “your therapist said you need to eat it”. It’s so nice to have someone else to be like-, “She said!” “She said to do it, so do it”. (laughs). What a life saver! And even now, right? It’s just that-, I love that, because the parent always gets dumped on, like “What do you know?” (WU62)
Choosing trust. Trusting Emma with more freedom around her eating and activities was an ongoing project for Terri. Terri approached the trust issue by choosing to be optimistic and hopeful, but not naïve (“Being 98% sure that things are going great and on track and having that 2%- little bit of doubt- ...it’s an eating disorder. Like, that makes you do crazy things.” SC219). Terri was motivated to trust Emma by reflecting on how well Emma had been doing with the treatment and recognizing some troubling behaviours may be related to anxiety or teenage-angst, rather than the eating disorder:

I don’t think she’s hiding. Like-, like when she goes to eat at school she goes to eat in the counsellor’s office. She doesn’t want people to see her eating. She’s got a thing about people seeing her eat... I think that’s the anxiety part of it. But I truly believe she’s actually eating, she’s not dumping it in the garbage. Which is great to have that trust. (JC77)

Additional strategies included connecting with her sense of her daughter as someone who is trustworthy and capable of making good choices (“You know, she’s a smart, responsible kid. She makes great choices.” JC129), as well as her own personal desire for her and Emma’s lives to return to normal (“You know, you’re parenting a perfectly normal kid, and then all of a sudden, you know, mental health interrupts, it’s like-., Oh.” JC123).

Terri also noted that trusting Emma with responsibility had been an integral part of her parenting approach since she was young (“Because we’ve always given her tons of responsibility. Even when she was little, you know, ‘Like what do you want to wear?’ ‘Just a dress.’” JC109), and taking it back during re-feeding felt quite unnatural (“Re-feeding was really, really hard for me because I’d given her so much-, so much freedom, and...she was ready for those responsibilities. So it was weird taking the reins...back.” JC111).

Overall, Terri seemed to find trusting came more easily to her than being cautious (“It’s hard to not trust it. And it’s hard to remember sometimes there’s mental health stuff.”)
When she reflected on the reality that Emma’s eating disorder was a mental illness, however, the cautionary aspect of her goals in relation to Emma came more to the forefront:

Well, I’m teasing apart, what’s what? Right? So, you know, again, back to the weight restoration and what is her body type, and what part of that is the disorder, what part of that is anxiety, what part of that is just actually...true. Right? When a kid says, “I’m not hungry” Do you know-, at this stage in the game, 3 months in...you know, “I’m not hungry”. Well, “Are you not hungry? Are you going to eat....” You know, “Are you saying that because you’re scared you may get fat? Or are you...just not hungry?” That’s the weird part right now. (JC103)

Making peace with the eating disorder. In keeping with the superordinate goals of her parenting philosophy (protecting from pain) Terri expressed at times feelings of guilt and sadness at the possibility that she could have done something different as a parent to have prevented the eating disorder. In Terri’s case, she shared regret for being “complicit” with the eating disorder in the early stages of the illness by allowing Emma to go so long without eating by trying to be compassionate about her daughter’s desire to fit in at school. Terri noted that the guilt took the form of general and non-specific regrets about her parenting of Emma in general:

You know, I look back, and I’m not sure if I was as present as I should have been through a lot of her growing up. It’s easy to be in the day-to-day, blah-blah-blah, yeah-yay-yay, uhm. So I’m definitely thinking-, thinking about those...and yeah, having-, having the little mother guilt around that too. Like, “Uhhh, you’ve only got one opportunity to raise a kid”. If I wasn’t so caught up in my own stuff, then. (SC91)

She also wondered how separating from Jack affected Emma and whether she made the right decision:

So when I see it through his lens, I get it. You know. And I go, “Oh yeah, right. I’m the bad person”. And then I see it through my lens, and I’m like “No. This is okay”. Because you’re like, “Is it selfish? Or is it taking care of yourself?” If I live with [him], I’m not a very nice person. (MC30)

Despite feelings of responsibility, Terri noted many actions and processes related to making peace within herself and in relation to the presence of Emma’s eating disorder.
Terri’s main strategy for realizing peace was to counter feeling stuck and the difficulty of situations by taking a more light-hearted approach (“Yeah, and just finding levity in it. Just the opposite of the angst is the levity. What are you going to do? Cry? Like, I guess I could. I just don’t want to get stuck in that shitty spot.” SC198), and remaining grounded in the belief that Emma’s upbringing was strong and she will come through the eating disorder a stronger person:

I know that she’ll come out of it-, and she’ll come out of it stronger. So there’s-, there’s hope for her. You know, because the foundation that we laid was pretty strong, really. ...We screwed up a bit, with some parenting, obviously, but I don’t think...that-, hope that’s not a life-long predicament. Uhm, you know. So I can laugh about it, because it’s a little silly. (SC148)

Finally, it also seemed as though a part of Terri’s peace-making project was reconciling in her mind how her daughter became vulnerable to an eating disorder in light of her and Jack’s love for activity and the outdoors (“You know, we raised our kid outside sailing and mountain climbing and all that stuff, right? And she sits on the couch and...[mom gestures slapping hand to head]) JC55; “Just the absurdity of it all. Yeah, raising a kid that way-, that seems pretty awesome. It’s a little crazy, but at the same time, it is...what it is.” SC136).

**Assertions.** First, Terri’s weight restoration project was integrated with and impacted by her identity processes as a parent and woman. Second, inadequate resources (informational or psycho-educational) may have contributed to Terri viewing her intentions of helping Emma maintain a slim figure as favourable to her weight restoration and self-esteem projects. While Terri recognized preoccupation with body weight and shape and its control were inherent to anorexia, she did not recognize the “eating disorder thinking” embedded in some of her processes of weight restoration and strategies for strengthening Emma’s self-esteem.
Cross-Case Analysis

The second step in the analysis involved a comparison of the cases with each other, considering both the commonalities and distinct processes between them. Despite many differences between the cases in terms of family life and parenting arrangements, the means and stage of treatment, the duration of the adolescent’s illness and developmental stage, as well as various financial and social contexts, analysis revealed the following areas of overlap between the cases: the competing goals of weight restoration and adolescent development, altered relationships with the adolescent, the desire for partnership and need for professional assistance, parental identity processes, and feedback processes. Three distinct or unique processes that emerged in the analysis conclude this section of the chapter.

Commonalities.

**Competing goals: Weight restoration and adolescent development.** The weight restoration projects of all parents were enacted in the context of their adolescent’s developmental stage. Despite the fact that the developmental stages for the parents’ adolescents spanned from early to late adolescence, all parents commented on the ways in which their adolescent’s stage of life interacted with his or her weight restoration goals and projects. For some, there was uncertainty about whether issues or concerns they had with their adolescent were attributable to “normal teenager” behaviour, the anorexia, other mental health concerns, or their adolescent’s developing personality (Cases 1, 2, 4 and 5).

Also, some parents commented on how the level of supervision and monitoring required to succeed in weight restoration seemed counter-intuitive to the level of supervision and monitoring they were accustomed to giving (or wanted to give) their adolescent. Parents all commented on feeling uncertain about how to negotiate the goals of weight
restoration with goals of supporting their adolescent’s agency and healthy development. Some parents noted trying to work on both simultaneously (Cases 1, 2, 4 and 5), and one parent found the goals to be incompatible (Case 3). The following quote from Pamela illustrates the conflict between the goals of weight restoration and adolescent development:

(Pamela): I still don't know how much, and in what way, to support her [in asking for what she needs or wants]. And how much to have her just do it on her own and, go through whatever the consequences are. And I still don't know how much of that to do because I don't know how much of it-, if I help her with it, am I teaching her? Or, am I just doing it for her and then she doesn't have to do it. And, that’s-, I’m still having trouble with that, you know, as a parent. And you know, you hear about helicopter parents, and stuff like that like, you know, and it’s like, how much do I...do? (SC357)

It seemed all parents were engaged in the difficult and ongoing process of trying to balance an appropriate level of protectiveness or watchfulness over their adolescent in light of the illness with a desire to support developmentally appropriate amounts of autonomy and self-directedness.

**Relationship with the adolescent.** Parents all commented on how the eating disorder and the process of implementing weight restoration altered their relationship to their adolescent in unwanted ways. Some parents noted how being successful with weight restoration required them to let go of their preferred relationship with their adolescent (Cases 1, 2, 4 and 5), and relate to their adolescent as if she were at a much younger developmental stage (Cases 1, 2, 4 [female parent], and 5). One parent noted grieving the loss of the relationship she thought existed between her and her daughter (Case 5), and another noted mourning the loss of shared experiences with her daughter during the year she was ill (Case 1). Despite these unwanted relational changes, some parents noted feeling closeness to their adolescent while implementing re-feeding (Cases 1 and 2), and a few parents expressed hope the experience would not interfere with a preferred close relationship with their adolescent in the future (Cases 1, 4 and 5). The desire to repair and
rebuild the relationship seemed to move to the forefront of some parents’ minds as treatment progressed (Cases 1, 4 [male parent], and 5).

**Partnership and support.** All parents perceived the adolescent’s other parent as an important and potentially valuable resource in the weight restoration project. The actions parents described taking in relation to their adolescent’s other parent seemed to have the common intention of making weight restoration a cooperative undertaking or partnership. Conflicts in, and impediments to, parents’ joint actions with the adolescent’s other parent seemed to be related to the parents’ perceptions (or formulations) of the meaning of the other’s attitudes and actions toward them, the eating disorder, and the adolescent. Some of the parents heading single parent homes, or undertaking weight restoration without assistance of a partner, also described seeking cooperation from their adolescent in the form of practical support (Cases 1, 2, 5).

All parents noted seeking assistance from professionals for the various doubts, dilemmas, and internal struggles they experienced in the implementation of weight restoration. With the exception of Case 5 (whose community had a specialized eating disorder program), all parents found the outcomes of their early help-seeking efforts to be disappointing and frustrating. Once parents were connected with eating disorder professionals, some commented on how helpful the professional “voice of authority” was to their success with weight restoration (Cases 2, 4, 5). These parents noted feeling empowered and relieved to reference the professional when dealing with their adolescent’s protests and arguments. In fact, one parent expressed gratitude for how the professional voice of authority helped shield her, and her relationship to her daughter, from her daughter’s anger and contempt (Case 5). For some parents, disappointment or disagreement with the help and suggestions offered by professionals reduced their help-seeking
behaviours (Cases 1, 3, and 5) and it was not uncommon for parents to seek out resources on their own to supplement information that was provided by their professional contacts (Cases 1, 2, 3, 4 [male parent]).

A lack of understanding about eating disorders was observed to be a barrier for parents, and all shared informal theories about how their son or daughter came to develop the eating disorder (Cases 1, 2, 3, 4 and 5). Parents drew on their beliefs about the cause of the eating disorder (and what was helping adolescent recover) to guide their weight restoration actions, sometimes aiding and sometimes hindering progress.

**Parent identity processes.** Sometimes, the informal theories parents held about the cause of their adolescent’s eating disorders included ideas about past actions they took that may have contributed to their son or daughter’s diagnosis (Cases 1, 2, 3, and 5). It was not uncommon to hear parents describe general regrets, like wondering about one’s parenting approach or having missed warning signs, and specific regrets, such as joint dieting or potentially disruptive changes to the adolescent’s family life. Despite having read or been informed by professionals that the causes of eating disorders are multifactorial and not well understood, parents expressed varying degrees of internalized blame and guilt, represented in negative identity statements (i.e., “horrible mother”, “terrible parent”). In some cases, weight restoration also seemed to intertwine with parent identity processes by straining and displacing the parents’ other important personal and occupational projects and careers (Cases 1, 2, 3, and 5). Finally, almost all parents noted the ways in which their personal and interpersonal strengths and / or weaknesses aided (Cases 1, 4 [male parent], and 5) or frustrated (Cases 2, 4 [female parent]) their weight restoration actions.

**Feedback processes.** All parents in the study talked about the processes by which they sought and received feedback on their weight restoration actions. Parents were
simultaneously attentive to objective indicators of progress, such as fluctuations in the adolescent’s weight or the adolescent’s eating behaviours (eating slowly, taking a second helping, hiding food), as well as subjective or indirect indicators, such as the adolescent’s mood or anxiety, self-harm behaviours, or social engagement. For many parents, the secrecy and strength of their child’s eating disorder behaviours was connected to an enormous rupture in trust and, to varying degrees, all parents seemed to be engaged in a process of rebuilding or restoring trust. For many of the parents, an open, honest relationship was associated with progress and facilitated their trust, and break-downs in communication were perceived as relational strains that created worry (Cases 1, 2, 3, 4 and 5). This was especially true for cases where the adolescent had reached or was nearing target weight (Cases 4 and 5).

**Unique Processes.** First, a variety of unique processes emerged in Case 3, and offered a contrast to the weight restoration processes of the other cases in the study. It is worth noting that Case 3 may offer an example of some of the obstacles to implementing this treatment approach with adolescents on the cusp of young adulthood, such as the adolescent’s sense of himself as an adult as supported by the completion of school and entry into the work force, and the role of family-specific understandings on how the transition-to-adulthood takes place. For example, in this family, the transition period seemed to be of short duration and the transfer of self-governance to be complete upon the adolescent’s 19th birthday. Case 3 also differed from the other cases in terms of the adolescent’s gender and duration of illness. Finally, although the level of treatment support available to parents in this study was variable, there seemed to be a striking inadequacy of structural supports and resources in this case. Thus, unlike the other cases, where the parents’ weight restoration actions seemed to be organized about long-term goals of recovery, most of Rose’s weight
restoration goals and processes seemed to be aimed at ensuring her son’s safety day-to-day, in the short-term.

A second unique weight restoration process that emerged was Pamela’s perception of an explicit and mutual joint weight restoration project between herself and her daughter. Like other parents, Pamela described engaging in many non-consensual joint actions with her daughter in the service of the weight restoration goals. However, unlike the other parents, Pamela described processes of explicit partnership that encompassed practical as well as emotional support that were enacted concurrent to the less consensual weight restoration goals. It is worth noting the mutual project between Pamela and her daughter also seemed to emerge within aspects of her personal and family life that were distinct from other cases, including: the complex historical and relational processes characterizing Pamela’s relationship with her husband, the congenial aspects of her daughter’s temperament and Pamela’s acute expressed need for support. Overall, the joint project with her daughter seemed to meet some of Pamela’s needs for support, but also seemed to have associated unique challenges, such as an experience of being misunderstood by the counsellor and feelings as though their joint project was being undermined, and an internal experience of uncertainty and mild guilt at asking her daughter to also consider her needs in some aspects of the weight restoration process.

Finally, a third unique process amongst the cases was the emergence of a challenging process of trust restoration subsequent to an arduous albeit successful process of weight restoration in Case 4. All parents in this study described the various ways the secrecy and tenacity of anorexia had compromised the trust they had in their adolescent, especially pertaining to meals and eating. Similarly, all parents described some collection of covert and overt strategies for testing their adolescent’s progress with treatment that were
considered relevant to the matter of the parent’s trust. However, the adolescent in Case 4 was the only one in this study who had achieved her target weight, and compared to other parents, David and Marie seemed to have entered more fully and explicitly into a project of trust restoration. Although there was some disagreement between the couple as to whether processes of weight restoration were still ongoing, there was clear agreement that many of their joint goals and processes were now guided by the goal of re-establishing a trusting relationship with their daughter.

Key Assertions

The within-case and between-case analyses represent a detailed analysis of the weight restoration projects for all five cases. The following key assertions represent the primary researcher’s best attempt to summarize both sets of results. The key assertions were constructed after an intensive review of the within-case and between-case analysis, and represent the key findings of this study from the perspective of contextual action theory.

Key Assertion #1. Treatment-related weight recovery goals were situated in a larger system of projects and careers in the parents’ lives. Conceptualizing parents’ weight restoration goals as existing within a distinct social system revealed personally and socially meaningful weight restoration projects that reflected the multiple sources of influence in the parents’ personal and family lives.

Key Assertion #2. The social meaning of the parents’ weight restoration projects had a considerable motivating influence on their weight restoration actions and processes. The complexity of the connection between weight restoration and the parents’ other projects and careers (identity, occupational, adolescent development, marriage and family relationships) was also reflected in the actions of parents while implementing weight restoration.
**Key Assertion #3**: Weight restoration was a burdensome project for reasons beyond the gravity of the adolescent’s illness. Sources of burden were identified at all levels of social meaning, internal processes and manifest behaviours, including: (a) the non-consensual aspect of the parents’ joint actions with the adolescent, which encompassed fighting, pleas for cooperation, and high levels of parental supervision and watchfulness; (b) conflictual aspects of the parents’ joint actions with the adolescent’s other parent; (c) competing goals (and steps) between weight restoration and other important projects and careers, especially the adolescent development project; (d) ambiguous feedback processes for cognitive and emotional aspects of adolescent’s weight restoration; (e) challenges presented to parental identity processes; and (f) the practical and logistical strain (time-processes) of preparing and supervising meals.

**Key Assertion #4.** Parents planned, engaged in, and experienced weight restoration as a relational process with their adolescent, the adolescent’s other parent, and their professionals helpers. In communicating and interacting with these others, parents formulated (or constructed) understandings of these encounters in relational terms. The parents’ weight restoration actions and projects were “relational constructions”.

**Key Assertion #5.** Some dimensions of the projects were determined and supported by social structures that facilitated or inhibited weight restoration (depending on the resources available to the parent). In these cases, structural factors were represented at the level of material, personal, and professional resources (including psycho-education). Structural resources were found to influence parents’ goals, as well as their functional and emotional processes while implementing the weight restoration projects.
Chapter 5: Discussion

This study sought to understand the actions of parents in helping their adolescent with anorexia recover weight while engaged in treatment featuring parent-led weight restoration. The parents’ experience of parent-led weight restoration was observed to be a complex, relational and socially constructed series of joint goal-directed actions that could meaningfully be described as a weight restoration project. This discussion relates the findings reported in the previous chapter to the relevant literature on parental experiences of adolescent anorexia. It begins with a review of the rationale for the study and is followed by contributions the study offers the research literature. Theoretical, methodological and counselling contributions of the study are considered next, and the chapter concludes with a discussion of the limitations of the study and potential directions for future research.

Summary of the Research Problem

This study emerged at the intersection of two main problems. First, clinical guidelines for the treatment of adolescent anorexia recommend parental engagement, and family-based treatment (FBT) involves parents by instructing them to take specific action aimed at decreasing eating disorder behaviours and increasing the adolescent’s weight. Despite the major role parents play in this treatment, especially during parent-led weight restoration, parental experiences and actions while engaged in the process had not yet been the focus of inquiry. Second, the theoretical model for parents’ actions and strategies while engaged in weight restoration is guided primarily by behavioural theory and professional perspectives, which does not account for parental agency, the social and relational aspect of parents’ actions, or parents’ unique constructions of weight restoration. The current study sought to address these problems by examining parents’ weight restoration actions through
the framework of contextual action theory, thereby offering a holistic perspective that would bring the voice of the parent forward while recognizing the agency of their behaviours.

Summary of Findings

This contextual action theory analysis of parents’ weight restoration actions revealed weight restoration to be a goal-oriented, relational and situationally-embedded phenomenon. First, parents’ treatment-related goals of adolescent weight recovery were situated in a larger system of projects and careers in the personal and family lives of the parents, and conceptualizing the parents’ weight restoration actions within this system revealed personally and socially meaningful weight restoration projects. Second, the relational and social meaning of the parents’ weight restoration projects had a motivating influence on their weight restoration actions and processes. For example, the parents’ weight restoration projects were decidedly intertwined with other important projects and careers (identity, occupation, parenting, marriage and family relationships) and the complexity of this interconnection was reflected in the parents’ actions. Third, weight restoration was burdensome for parents, and the sources of burden were identified at all action perspectives. For example, sources of burden for parents in this study included the non-consensual aspect of their joint actions with the adolescent, conflictual joint actions with the adolescent’s other parent, and competing goals (and steps) between weight restoration and other important projects and careers, especially the adolescent development project. Uncertain and ambiguous feedback processes in connection to the cognitive and emotional aspects of adolescent’s weight restoration, challenges presented to parental identity processes and the practical and logistical strain of preparing and supervising meals were also identified. Fourth, this study found parents’ weight restoration actions and projects to be “relational constructions”. Parents planned, engaged in, and experienced weight restoration as a
relational process with their adolescent, the adolescent’s other parent, and their professional helpers. Finally, a wide range of structural resources were found to be involved in parents’ actions, as well as their functional and emotional processes while implementing the weight restoration projects. Depending on the resources available to the parent, structural factors related to a parent’s material, personal, and professional resources (such as time with the professional helpers, helpfulness of advice, and perceived knowledge) were found to facilitate or hinder the parents’ weight restoration actions.

**Contributions to the Literature**

**Emotional component of parents’ weight restoration actions.** First, the emotional aspect of the parents’ actions while engaged in weight restoration was in keeping with the range and quality of emotions documented by other qualitative studies on the experience of caring for an adolescent with anorexia (Beale et al., 2005; Bezance & Holliday, 2014; Cottee-Lane et al., 2004; Hilledge et al., 2005; Keitel et al., 2010; Sharkey-Orgnero, 1999). Parents in this study also described experiencing many adaptive and productive feelings, such as hope, resourcefulness, determination, loyalty and love, as well as powerful feelings of fear, anger, abandonment, confusion, grief, and frustration. Second, much of the literature addressing parents’ emotions has been conducted using linear, cause-and-effect models with a limited number of constructs, such as expressed emotion (e.g., Lock et al., 2010), and anxiety or depression (e.g., Coomber & King, 2013; Orive et al., 2013). The findings of this study extended current knowledge of parents’ emotional experiences of adolescent anorexia by documenting the functional role of parents’ emotions in motivating and steering weight restoration actions. In addition to emotion being a response connected to the illness, this study found parents’ emotions to be interconnected with and motivate a
myriad of actions and processes. At times the parents’ emotions also were the focus of
goal-directed action, as in cases of self-regulation.

**Burden and displaced projects.** Previous research has documented the tremendous
strain parents encounter when caring for a child with anorexia (e.g., Cottee-Lang et al.,
2004; Keitel et al., 2010; Kyriacou et al., 2008; Zabala et al., 2009). The parents in the
current study were also found to experience considerable amounts of distress and burden in
caring for their adolescent, but unlike previous research, the findings of this study offer an
account of or explanation for some aspects of that burden. For example, from a contextual
action theory perspective, it seemed to be the case that the strain and burden parents
encountered arose, in part, from the ongoing competition and conflict between the goals of
the parents’ weight restoration projects and other personal, occupational, or family projects.
In some instances, the parents’ weight restoration projects were found to displace and
overtake other important projects integral to the parents’ own lives, as was the case with
parent identity processes. Some parents in this study, particularly the mothers, noted how
the actions and steps of weight restoration impeded and negatively impacted processes
related to their own personal and material identities. Hoskins and Lam (2001) previously
documented how the experience of mothering a child with anorexia set in motion a
protracted process of identity redefinition situated in larger cultural scripts, and Bezance and
Holliday (2014) noted a diminished sense of identity as parents were consumed with their
daughter’s needs to the neglect of their own. Keitel et al. (2010) also described an altered
sense of self as mothers’ time and energy resources invested in caring for the adolescent
required changes in other priorities. The current study found some mothers’ weight
restoration actions to have a straining and displacing effect on other personal, parenting, and
professional projects that were intertwined with identity processes. It is hoped this finding
adds to the small but growing body of research that has allowed mothers to emerge as more than “shadowy one-dimensional figure[s]” (Hoskins & Lam) in eating disorders research.

**Adolescent development.** In this study, parents’ weight restoration projects were enacted in the context of the adolescent’s developmental stage. All parents noted the level of supervision and monitoring required in weight restoration seemed counterintuitive to the level of supervision and responsibility they wanted to have for their adolescent’s activities. Cottee-Lane et al. (2004) have also described the difficulty parents encounter at the increased involvement in their adolescent’s life during treatment for adolescent anorexia, noting the response to be incongruous with adolescence as a time for greater freedom and parents relinquishing some of their responsibilities. To help parents understand and come to terms with the great deal of parental involvement required for parent-led weight restoration, Lock and le Grange (2005) describe anorexia to have “effectively [stopped] adolescent development” by throwing off physical maturation, isolating the adolescent from normal peer relationships, and because of the illness, leading them to become much more involved with parents than normal teenagers would be (p. 46). It is worth noting that although the majority of the parents in this study had accepted the importance of taking control of meals in the service of helping their adolescents regain control over their eating, their actions clearly indicated weight restoration and adolescent development projects could be and were enacted simultaneously with reciprocal influence. Indeed, the parents in this study were observed to attempt a meaningful integration of the adolescent development goals into weight restoration projects, and vice versa.

**Relationship with the adolescent.** The relational nature of parent-led weight restoration was apparent in the study finding that the enactment of the parents’ weight restoration projects was intertwined with many relationships and projects, especially the
parent-adolescent relationship. Gilbert et al. (2001) previously reported on the perceived change in the relationship between parents and their daughters, having identified strains related to the loss of trust due to the eating disorder, fear of saying the wrong thing and various feelings of resentment. Cottee-Lane et al. (2004) also described the negative impact of the eating disorder on the relationship between parents and their adolescents; particularly salient was the challenge of maintaining a positive relationship while trying to manage the difficult behaviour. The parents in this study similarly described how anorexia and the weight restoration process altered their relationship to the adolescent in unwanted ways. However, the study findings extend current understanding of the parent-adolescent relationship as it is presently documented by revealing the parent-adolescent relationship to be an active, live relational system within and from which parents set goals and enacted weight restoration. For example, goals related to the parent-adolescent relationship, such as wanting to preserve, mend, or rebuild relational bonds, steered some parents to engage in actions counterproductive to weight restoration, sometimes resulting in feelings of closeness and other times tension or conflict.

**A desire to act in partnership.** A wide range of partnerships between parents and the adolescent’s other parent were described in this study. Even when partnerships were challenging, the parents perceived the adolescent’s other parent as an important and potentially valuable resource and source of support in weight restoration. Other studies (Gilbert, Shaw & Notar, 2001; Honey & Halse, 2006) have also documented the value parents find in working together to improve or maintain their capacity to respond adaptively to the demands of caring for an adolescent with anorexia. Consistent with the findings of the present study, Honey and Halse also noted some parents were required to invest
considerable time and energy to include uninvolved partners or to influence a partner’s actions or attitudes around their adolescent’s eating disorder.

For some parents in this study, especially the parents undertaking weight restoration unaided by a partner, the relational aspect of weight restoration was extended to professionals. No studies were located that documented the potential for professionals to represent meaningful partners for parents undertaking weight restoration largely unaided by others. This may be connected to the fact that viewing the professional as a partner may not be in keeping with the FBT conceptualization of the counsellor as a coach or consultant (Lock & le Grange, 2005).

Finally, a robust finding in the literature is the mixed experience parents have noted in regards to professional support and assistance (e.g., Keitel et al., 2010; McMaster et al., 2004). Although it was certainly the case that parents’ expressed satisfaction with professional support in this study fell on a continuum, it is worth noting that no parents reported negative experiences related to being made to feel guilty or responsible for their adolescent’s eating disorder and many found the professional voice of authority to benefit their weight restoration efforts. The main challenges relevant to the parents in this study were feeling shut-out by professionals and desiring more opportunity for individual consultation.

**Resources.** Hilledge et al. (2006) and Keitel et al. (2010) have previously noted how a scarcity of resources, especially financial and social, were perceived by parents as contributing significantly to the challenges of caring for a child with anorexia. The findings of this study extend these observations by documenting some of the ways in which the availability and use of resources may be manifested in parents’ weight restoration actions. For example, weight restoration required many resources, including social capital and
resources derived through cooperative partnerships with significant others and professionals, time, finances, illness-specific knowledge, as well as intrapersonal skills and strengths. In this study, the weight restoration projects that were more abundant in resources appeared to unfold in a different manner from those lacking in resources. Lack of resources appeared to be a major barrier for some parents’ weight restoration projects, often creating practical and emotional challenges that diverted parental attention and energy away from the goals of weight restoration.

**Weight restoration as a parent project.** In this study, parents were found to act jointly with their adolescent, their adolescent’s other parent, and treatment professionals relative to the goals of parent-led weight restoration. As such, parents’ weight restoration activities were found to be goal-directed and existing within social and relational systems that revealed distinct and meaningful weight restoration projects. The current study revealed that in addition to applying behavioural strategies to bring about changes in their adolescent’s eating behaviours, parents engaged in a myriad of explicit and tacit goal-directed actions and strategies for weight restoration that were embedded in and emerged from a larger system of intertwined projects and careers. Honey and Halse (2005) previously examined parents’ explicit actions in response to their daughter’s anorexia in general, and found parental constructions of anorexia informed these actions. The current study was the first to examine parents’ individual and joint actions in response to the implementation of parent-led weight restoration, and represents an important shift in focus from the predominantly quantitative representations or determinants of parents’ experiences of parent-led weight restoration, such as expressed emotion (e.g., Lock et al., 2012), or descriptions of parents’ passive responses to the experiences of caring for an adolescent with anorexia that have been emphasized in this area.
Theoretical Contributions

Parent-led weight restoration for adolescent anorexia is a component of a larger treatment program (FBT). While FBT has a well-developed theoretical model and rationale, the process of parent-led weight restoration has received comparatively little conceptual attention. By positioning parent-led weight restoration within contextual action theory, the findings of the current study offer an approach to conceptualizing parent-led weight restoration that encompasses the behavioural framework while also attending to the parent’s actions in context. In doing so, the current study extends previous understandings of parent-led weight restoration by documenting it as a relationally embedded and personally meaningful goal-directed phenomenon. Indeed, the parents in this study described their experience of parent-led weight restoration as a goal-oriented, intentional process that was informed by and emerged from shared goals and joint actions with others. The findings also exemplify the considerable role of social meaning, parents’ cognitive-emotional processes, and the structural resources of the identified weight restoration projects on the actions parents took and the relational processes that emerged.

As mentioned above, the dominant approach of the existing research regarding parents’ emotions has been to conceptualize and describe these experiences as a response to or result of parenting an adolescent with anorexia. A potentially useful contribution of the present study was its conceptualization of parents’ emotions as they occurred in action as part of a relational framework. For example, parents’ emotions were not only described but documented as having a role in the formulation of weight restoration plans and behaviours, such as the way certain goals and actions were facilitated by some emotions and inhibited by others, to sometimes be the goal of parent’s actions, or to have a role in the interactive or joint processes of weight restoration. Describing parents’ emotions as they occurred in
action offers a new perspective to extend traditional approaches of constituting parent’s emotions as primarily outcomes or predictors of treatment efficacy (e.g., Lock et al., 2012).

In sum, conceptualizing parental emotion and weight restoration actions from the perspective of individual and joint action may contribute to efforts to achieve a more adequate understanding of the complex process of parents’ actions and behaviours in response to weight restoration activities, particularly in looking for ways to enhance parental adherence to parent-led weight restoration (e.g., Ellison et al., 2013; Godfrey et al., 2105), or facilitate transfer of the FBT treatment to clinical practice (Couturier et al., 2014).

**Methodological Contributions**

This study breaks ground in the published literature connected to FBT in two main ways, both of which relate to the importance of employing alternate systems of inquiry and methodological diversity to permit expanded understanding of a subject matter. First, understanding and knowledge development of a process like parent-led weight restoration is enhanced when that inquiry is informed by a variety of systems of knowledge creation, especially when selected for their suitability in understanding particular aspects of reality (Polkinghorne, 1984). Parents’ actions in response to anorexia and food refusal represent an important means of creating change in anorectic behaviours, and the study of these actions requires a system of inquiry that can account for the special characteristics of human action. The current study’s use of the action-project method and case study approach were able to attend to statements parents made about their intentions and reasons for their behaviours and actions in weight restoration, and in doing so shed light on an aspect of parents’ experience with parent-led weight restoration that had previously been undocumented. Second, the video self-confrontation (Young et al., 2005) used in this study is an innovative research technique. The current study documents its utility in capturing parents’ tacit theories,
intentions and interpretations of their observed and described actions, thereby making these experiences available as empirical realities. Understanding of parents’ weight restoration actions was valuably enhanced by referencing the internal processes and social meaning of the actions as described in the video self-confrontation.

**Counselling Contributions**

The current study explored the actions and strategies of parents while helping their adolescent recover weight. Although generalization is not emphasized in multicase study, a collection of cases such as this may be considered a very small step toward “grand generalization” (Campbell, 1975). The understanding and knowledge of the weight restoration process outlined in this study may be assistive for counsellors working with parents and their adolescents from an approach that features parent-led weight restoration.

First, the findings of this study show parents’ actions in weight restoration are embedded amongst other projects and careers in the parents’ personal and family lives. Although the gravity of their adolescent’s illness was powerfully motivating, the complexity of the connection between weight restoration and the parents’ other projects and careers was evident in parental actions. Counsellors working with parents or families on weight restoration would do well to consider the multidimensional and relational context of parents’ actions, and assist them in explicitly identifying their various goals and projects related to both weight restoration and ongoing daily life. For example, it may be helpful for counsellors to discuss with parents whether their weight restoration projects are devised in such a way that it is possible and practical to engage in successful project steps. The following aspects seem particularly relevant: (a) the complimentary and competing goals between weight restoration and other important projects and careers, especially as related to parent identity processes and adolescent development projects, (b) the spousal relationship
and the ways in which parents feel supported and/or disconnected, and (3) an exploration of
the parents’ beliefs or constructions about anorexia and the connection between those beliefs
and their weight restoration actions when negotiating and managing treatment strategies.

Second, there is an inherently relational nature to parents’ weight restoration
projects. Parents gained knowledge and understanding about their role, the illness of
anorexia, and weight restoration through relational processes within themselves, with their
adolescent, the adolescent’s other parent and family members, as well various professionals.
Because viewing weight restoration in relational terms is reflective of how parents see their
actions, it will be helpful for counsellors to consider ways in which to incorporate and carry
out concepts of relational construction when working with these families. The physical
presence of all family members for session is protocol for FBT, however, this second
recommendation reaches beyond the physical encounter of family members in the session.
Counsellors are encouraged to attend to the relational constructing processes the parents
engage in while in sessions, as well as in their lives outside of counselling. For example,
instead of “finding a way to increase the adolescent’s calorie intake”, a counsellor might
pose meal-related questions like “What is this parent doing? Who else is involved? What
are they doing together?” to reveal more about the parent’s goal-directed weight restoration
actions from a relational framework.

Third, the conceptual emphasis on behavioural theory in FBT is understandable
given its functionality and practicality for manualizing and researching. However, the
dissemination of FBT into community-based and non-specialized treatment centres has been
poor, and fidelity to the FBT in practice is weak (Couturier et al., 2014; Lock et al., 2010).
Even when therapists were provided with training and weekly supervision on FBT as part of
a research trial, adherence to the approach was problematic (Couturier et al., 2010). In light
of substantial literature in counselling psychology suggesting it is the helping relationship, not techniques, that bring about change (e.g., Wampold, 2007), and most counsellors are trained to think holistically about client issues and attend to the social context and culture in conceptualizing issues and addressing counselling process, counsellors may find a behavioural and symptom-focused approach challenging to embrace (Wilson, 2000). This begs the question of how might counsellors be helped to work comfortably and productively with the FBT approach when its conceptual frame, assumptions about change, and view of the person may be at odds with their general counselling theory. Although FBT does not call weight restoration “a project”, the goals of treatment are clearly and explicitly about parents taking action in partnership with others over a period of time. As a holistic and comprehensive meta-theory, contextual action theory may offer a way for counsellors to work congruently with FBT while maintaining the explicitly goal-directed focus on weight restoration.

Finally, the results of this study suggest the value and importance of the professional relationship, especially for parents who live in alternative family structures, such as single parent or co-parenting situations, or when weight restoration is undertaken without spousal support. All parents in this study sought assistance from professionals for the various doubts, dilemmas, and internal struggles they experienced in the implementation of weight restoration. Given the relational nature of weight restoration, it seemed as though the efforts of parents undertaking projects on their own could have been substantially improved if there was a sense of partnership with the professional. Counsellors working with these parents would do well to consider innovative or adjunct sessions to support these families (e.g., Rhodes et al., 2011).
Limitations

This study could have been strengthened in a variety of ways. To begin, there was a lack of diversity in the study sample of parents, which were mostly mothers who identified as Caucasian. It is reasonable to expect the actions and projects of fathers and mothers from diverse ethnic and cultural backgrounds may be distinct and diverge in important ways from those described by parents in this present study. In addition, the underrepresentation of fathers is an important limitation not uncommon to research on caregivers’ experiences of anorexia. Considering how prominently husbands and ex-partners featured in the described actions and projects of mothers in this study, it would have been informative had their voices been captured and represented more explicitly in these findings.

Second, the issue of demand characteristics should also to be considered in interpreting the findings of the study. This common artifact of conducting research is perhaps more problematic in research where participants are meant to be blind to the purpose of the study, but it is worth noting that most parents expressed their awareness of the study context, wanting to pay close attention to how they described their experiences, and to share at a level that felt comfortable and would be helpful to the researcher.

Third, this study cannot speak to what extent parents’ weight restoration actions changed or evolved over time. The longitudinal design typical of action-project research was eliminated from this study in the hopes of decreasing time-barriers for parent involvement. The lack of tracking and monitoring of parents’ weight restoration actions and projects over time imposed a time-limited perspective that could speak to neither the change and evolution of projects over time nor the extent to which the actions were beneficial in realizing treatment goals. However, given weight restoration processes may unfold over
longer periods of time, the 3 to 6 month time frame of traditional action project method may not have been long enough to speak to questions of the outcome of parents’ actions.

Fourth, in real life, a parent’s weight-restoration actions would take place constantly in many contexts, but issues such as privacy and practicality make access to these actions very difficult. Action-project method was developed with this challenge in mind, and in its traditional form, the method looks at interactions and dialogue between a participant dyad thereby allowing for data on joint action. For the single-parent cases in this study, researchers acted as conversation partners to create a dyad, and this represents a departure from traditional action project method studies. With the exception of Case 4, the findings of this study are based on one parent’s descriptions of the weight restoration actions they engaged in with others, rather than observations of actions taken in relation to the adolescent’s other parent. In these cases, the other parent’s perspective on and meanings for the described action is missing. Given the relational nature of weight restoration projects, it is reasonable to expect the absence of this data diminished the richness and fullness of the findings. Additionally, it is worth noting these parents’ weight restoration projects emerged in the broader social context of a publicly funded healthcare system in the province of British Columbia, and so all services accessed by the parents in this study were free. Also, although the healthcare system is based on the provision of commensurable levels of healthcare for all residents, three of the five cases in this study lived in smaller communities away from urban centres where the specialized provincial eating disorder programs are located.

Finally, although few counsellors working with an eating disorder population tend to adhere to treatment manuals (Tobin et al., 2007), and a case study approach would not presume uniformity in parent’s treatment experiences, the treatment support experienced by
parents varied widely, and perhaps complicates the “petite” generalizations made by the reader. Close fidelity between the adolescent’s treatment and the manualized form of FBT was part of the original design of the study, but this criterion was also relaxed in an effort to decrease barriers to parental engagement.

**Future Research**

This study continues the line of research documenting parents’ experiences of caring for an adolescent with anorexia. Given treatment for anorexia typically spans many months and even years, it would be useful for future research to track parents’ weight restoration projects over time using longitudinal methods, such as the traditional form of action-project method. Not only would it be important to understand the evolution of parents’ projects during the active phase of weight restoration, but over the full duration of treatment as well. As some parents in this study noted, leaving the structure and predictability of the meal plan and schedule while transitioning responsibility for eating back to the adolescent brought a host of new challenges with even less guidance than was available during weight restoration. Given the high risk for relapse amongst eating disorders, and the desire parents have to help their adolescent re-engage in life as a normal teenager, it would be valuable for future research to understand the challenges encountered and actions and strategies taken by parents during the transitioning period.

Finally, another potentially useful direction for future research would be to incorporate the voice of the adolescent or siblings alongside that of the parents in the effort to better understand the processes of parent-led weight restoration within the family context. Not only would this enrich understanding of the weight restoration projects as they are enacted in the family, but would offer considerable insight for families and counsellors to the relational processes occurring between parents and the adolescent, as well as possible
changes taking place over time in the adolescent’s eating disorder. Given ambivalence and denial of the eating disorder is common amongst adolescents with anorexia, a mixed-methods approach that could incorporate numerical data alongside parents’ experiences might be considered.

**Conclusion**

This study sought to increase understanding of parents’ actions while helping their adolescent with anorexia recover weight through parent-led weight restoration. It examined parents’ actions through the perspective of contextual action theory in order to attend to parents’ actions in context and bring the voice of the parent to the forefront. The application of this conceptual framework, coupled with multicae approach and action project method, showed how the phenomenon of parent-led weight restoration existed in five different contexts (cases). Findings from this study revealed parent-led weight restoration to be an embedded and relational endeavour constructed over time through a series of joint goal-directed actions. The parents’ joint actions could be meaningfully described as a weight restoration project.

The findings of this study contribute to the existing research on parents’ experiences of treatment and caregiving, and new insights were offered by way of the study’s focus on parents’ joint goal-oriented activities while engaged in parent-led weight restoration. The findings of this study supplement and extend current thinking about how parents go about implementing weight recovery goals, suggesting that in addition to applying behavioural strategies to bring about change, parents undertake a myriad of explicit and tacit goal-directed actions and strategies that are embedded in and emerged from a larger system of intertwined projects and careers in their lives.
Finally, as parental involvement is an elemental component for the treatment of adolescent anorexia, and parent-led weight restoration in particular, it is hoped the results of this study may assist counsellors and health professionals discover better ways to assist and provide support for parents engaged in the treatment of their child. In full consideration of the limitations of the current study, directions for future research and various suggestions were offered for counsellors working with parents engaged in parent-led weight restoration.
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Appendix A: Introductory Letter for Caregivers

Dear Prospective Participant:

This letter describes a research project I am conducting as part of my PhD in Counselling Psychology at the University of British Columbia. The goal of my research is to better understand how parents/caregivers work together to increase their adolescent son or daughter’s weight when he or she is in family-based treatment for an eating disorder.

I work as a part-time counsellor, and have provided therapy to families whose adolescents are in treatment for eating disorders. This research study is being conducted as part of my student role at UBC, however, and is not related to my counselling work. As such, my role will not involve working with you or your child in a treatment capacity.

Who Can Participate?
I am looking for parent/caregiver volunteers who are willing to talk about their experiences while trying to increase the weight of their adolescent diagnosed with an eating disorder.

What’s Involved?
Participation in this study involves two face-to-face meetings.

At the first meeting, parents/caregivers will take part in a brief, video-recorded interview with myself and another researcher. If two parents/caregivers are present, this interview will be followed by video-recorded conversation between the parents/caregivers on a topic of their choosing that is related to their adolescent’s weight-restoration. If one parent/caregiver is present, a research assistant will participate in the video-recorded conversation with the parent/caregiver. Following the conversation, each parent/caregiver will independently watch a video playback of that conversation, guided by a researcher who will ask the parent/caregiver to recall his or her thoughts and feelings while speaking with their partner. Total time for this first meeting is approximately 2 hours.

At the second meeting, approximately 1 month after the first, parents/caregivers will review a short, written summary of the conversation from the first meeting. This summary will outline a possible ‘weight restoration project’ unique to the parents/caregivers. Each parent/caregiver will be asked whether the identified project represents their experience, and if not, how it could be changed to better represent it.

What if I decide to change my mind about participating?
A parent/caregiver’s decision about getting involved in this study is entirely voluntary. If two parent/caregivers are involved, both need to be in agreement about this. Even if both parents/caregivers have agreed to participate, however, either one may later choose to refuse to participate in any section of the study and/or withdraw from the research entirely.
Refusal to continue with the study, or to participate in parts of the study, will bear no negative consequence to the medical care, education, or other services to which parents/caregivers or the adolescent is entitled to or is presently receiving.

**Will my taking part in this study be kept confidential?**
Yes. Parent/caregiver identity will be kept strictly confidential. All documents, audio and video recordings will be identified only by code number, and will be password protected, encrypted and stored in a locked filing cabinet. Only members of the research team and I will have access to the documents, audio recordings and video recordings.

A professional colleague of mine may have forwarded this letter to you in confidence, and he or she has not shared with me the names or contact information of people receiving this letter. Only those parents/caregivers who contact me for more information or to indicate interest in participating in the study will become known to me. I will not inform the individual who provided you with this letter with the names of parents/caregivers who decide to be involved or declined to participate in the study. However, you may inform the treatment provider of your involvement, if you wish.

Once this research is completed, it will result in a doctoral dissertation that will be housed in the UBC library and available to the public upon request. Participants will not be identified by name in any reports of the completed study.

**Interested?**
If you wish to participate in this study, or would like more information about the study before deciding, please contact me (information below). You are welcome to leave me a confidential voice-mail message if I am not available, and I will return your call as soon as possible.

The principal investigator for this project is my research supervisor, Dr. Richard Young. He can be reached at the University of British Columbia at (604) xxx-xxxx or at xxxxxxx.xxxxxx@xxx.ca

Thank you so much for your interest in the study.

Sincerely,

Krista Socholotiuk, MA
Ph.D (Cand.)
University of British Columbia, Dept. of Education and Counselling Psych.
Confidential Contact Information: (604) xxx-xxxx | xxxxx.xxxxxxxxxx@xxxxx.com
Appendix B: Introductory Letter for Treatment Teams

To Whom it may Concern:

My name is Krista Socholotiuk, and this letter outlines a research project I am conducting as part of my PhD in Counselling Psychology at the University of British Columbia (UBC). The name of the research project is *Understanding Weight Restoration in Adolescent Eating Disorders as a Parent Project*. The principal investigator for this project is my research supervisor at UBC, Dr. Richard Young.

I’d like to provide you with some details about the study for your information, as well as the contact details for myself and my research supervisor should you wish to discuss this project or have any questions and/or concerns.

**What’s the Research Objective?**

I am conducting this research with parent/caregivers willing to talk about their experiences while trying to increase the weight of their adolescent diagnosed with an eating disorder. The goal of my research is to better understand how parents/caregivers work together to increase their adolescent son or daughter’s weight when he or she is in family-based treatment for an eating disorder.

This research is not about the parent/caregivers’ experiences of the counselling or treatment for their adolescent’s disorder, but the everyday actions and joint processes by which they work to increase their adolescent’s weight. My role will not involve working with the parents/caregivers in a treatment capacity (or with the adolescent, whatsoever).

**What’s Involved?**

Parents/caregivers will be informed their involvement in this project is completely unrelated to their adolescent’s treatment and/or their own treatment. They will also be informed that a decision to withdraw from the study, or from parts of the study, will have no bearing on the medical care, education, or other services to which they or their adolescent is entitled to or is presently receiving.

**The Research Process**

Parents/caregivers involved in this study will participate in two face-to-face meetings. In sum, the total time involved in this whole project will be about 2 to 3 hours over one month’s time.

At the first meeting, parents/caregivers will first take part in a brief, video-recorded interview with me and another researcher. This part is designed as a warm-up conversation to help them settle on a topic or issues to discuss. If two parents/caregivers are involved, this brief interview will be followed by video-recorded conversation between the parents/caregivers on a topic of their choosing that is related to their adolescent’s weight-
restoration. If one parent/caregiver is present, a research assistant will participate in the video-recorded conversation with the parent-caregiver. Following the conversation, each parent/caregiver will independently watch a video playback of that conversation, guided by a researcher who will ask the parent/caregiver to recall his or her thoughts and feelings while speaking with their partner. Total time for this first meeting is approximately 2 hours.

At the second meeting, approximately 1 month after the first, parents/caregivers will review a short, written summary of the conversation from the first meeting. This summary will outline a possible ‘weight restoration project’ unique to the parents/caregivers. Each parent/caregiver will be asked whether the identified project represents their experience, and if not, how it could be changed to better represent it. Total time for this meeting is approximately 45 minutes.

**Further Information**?
If you have any questions related to this research project, or wish to discuss it further, please do not hesitate to contact myself or my research supervisor, Dr. Young. Dr. Young can be reached at the University of British Columbia at (604) xxx- xxxx or at xxxxxx.xxxxx@xxx.ca

Sincerely,

Krista Socholotiuk, M.A
Ph.D (Candidate)
University of British Columbia
Counselling Psychology Program
Department of Educational & Counselling Psychology, and Special Education

Confidential Telephone: (604) xxx-xxxx
Confidential Email: xxxxxx.xxxxx@xxxxx.com
Appendix C: Recruitment Poster

Parents...

Does your son / daughter have an eating disorder?

Are you doing parent-led weight restoration?

Your experiences are important to us!

We need your help to learn about parent’s experiences of helping their adolescent recover weight.

We want to learn about how parents or caregivers of an adolescent with an eating disorder act together during the weight-restoration phase of family-based treatment.

We’re seeking parents and/or caregivers who are in parenting or parent-like with the adolescent:

- Participants will take part in 2 separate interviews with researchers
- Total time commitment will be 2-3 hours over approximately a 1-month period
- The interviews will take place at a location that is private and convenient for you
- Participants will receive an honorarium of 25$ per person per interview

Any information you share will remain confidential. Participation in this study may help you during the process of weight restoration, and will provide valuable information that will help other families and professionals understand this intervention.

For more information about this study, please contact Krista Socholotiuk at 604.XXX.XXXX or | XXXX.XXXXXXXX@XXXXXX.ca. (Information about the study can also be found at: www.xxxxxxxx.xxx/xxxxxxxxxxxxxxxxxxxxx)

Conducted by:

Dr. Richard Young (primary investigator) Krista Socholotiuk, MA
xxxxxxx.xxxx@xxx.ca | 604.xxx.xxx Dept. of Educational & Counselling Department of Educational & Counselling
Psychology, and Special Education Psychology, and Special Education
The University of British Columbia The University of British Columbia
Appendix D: Informed Consent

CONSENT FORM

Understanding Weight Restoration in Adolescent Anorexia as a Parent Project

Principal Investigator: Dr. Richard A. Young, R. Psych., Professor
University of British Columbia, Dept. of Education and Counselling Psych. (604) xxx-xxxx | xxxxxxxxxx.xxxxxx@xxx.ca

Co-Investigator: Krista Socholotiuk, Ph.D (Candidate)
University of British Columbia, Dept. of Education and Counselling Psych. (604) xxx-xxxx | xxxxxxxxxx.xxxxxx@xxxx.ca

This research is being conducted as part of the requirements for Krista Socholotiuk for the Doctor of Philosophy (PhD) degree in Counselling Psychology at the University of British Columbia.

Purpose
We are interested in finding out how parents/caregivers jointly participate in and experience the weight restoration of their adolescent son or daughter who is involved in a family-based form of treatment for an eating disorder.

Procedures
If you consent to participate in this study, your involvement will consist of two face-to-face meeting. The total time involved for participation in this project will be 2 to 3 hours over approximately a 1 month period.

At the first meeting, your involvement will consist of participating in a video-recorded interview with a researcher (approximately 10 minutes). This will be followed by a video-recorded conversation between yourself and the researcher on a topic of your choosing related to your adolescent’s weight restoration. Finally, you and a different researcher will view a video playback of the conversation during which you will be asked to recall your thoughts and feelings as you spoke with the researcher.

At the second meeting (approximately 1 month later), you will be asked to review a written summary of the conversation from the first meeting. This summary will outline a possible ‘weight restoration project’. You will be asked for feedback about whether the identified project represents your experience, and how you would like it changed, if at all.

Potential Risks
There are no known risks associated with being involved in this study, but people sometimes feel a little uncomfortable being video-recorded and / or watching themselves on the video recordings.
Potential Benefits
You may find that talking about your adolescent’s weight-restoration with the researchers to be helpful to you.

Confidentiality
Your identity will be kept strictly confidential. All documents, audio recordings, and video recordings will be identified only by code number, and will be encrypted, password protected, and kept in a locked filing cabinet. Only the research team will have access to the documents, audio recordings and video recordings. You will not be identified by name in any reports of the completed study.

How the Results be Used
The results of this research will be included in a dissertation that will become a public document in the University of British Columbia library once completed. The findings may also be published in appropriate academic and/or professional journals.

Expenses & Honorarium
To help defray the cost of participating, any parking or public transit fees will be reimbursed. To express my gratitude for your participation, each participant will be remunerated 25.00 for each interview. Remuneration is not dependent on your completion of the study, and will be proportional to your involvement.

Contact for Information about the Study
If you have any questions or desire further information with respect to this study, you may contact the principal investigator, Dr. Richard Young, at the phone number or email address listed above.

Contact for Concerns about the Rights of Research Participants
If you have any concerns about your treatment or rights as a research participant, you may contact the Research Subject Information Line in the UBC Office of Research Services at (604) 822-8598.

Consent
Your participation in this study voluntary. You have the right to refuse to participate in this study. If you decide to participate now, you may still choose to withdraw from the study at any time without any negative consequences to the medical care, education, or other services to which you or your child are entitled to or are presently receiving.

Your signature indicates that you have received a copy of this consent form for your own records. Your signature indicates that you consent to participate in the study.

__________________________________________  __________________________________________
Participant Signature                      Date

__________________________________________
Printed Name of the Participant Signing Above

Thank you for your willingness to participate in this study!
Appendix E: Interview Protocol Sheet

Set-up & Preparation
- Get there early to set up and test equipment
- Greet participant(s) warmly and engage in small talk
- Privately note and assess the participant(s) sense of safety and comfort

Preliminary
- Ease into the process with questions / comments related to whether, how they came to find out about the study, finding the interview space, etc.
- Lead investigator reads and explains informed consent form with each participant separate from their partner (if 2 people)
- Any questions about the procedures or their involvement will be addressed.
- Remind participants their decision to be involved is voluntary, and they are free to withdraw their participation at any point, without explanation, if they so desire.
- Press Record on Audio & Video equipment

As we mentioned in the consent forms, we will be video- and audio-recording everything, to make sure we have accurate records of what is going on. I’ll just turn the equipment on now.

Warm-up Interview Considerations
- Give brief overview of the interview schedule (warm-up, joint conversation, and self-confrontation interviews).

Priming for Topic (informal conversation)
As you know, our study is about the experience of parent-led weight restoration / meal-support. Particularly, we’re interested in coming to understand the everyday activities and issues you encounter while working to restore your child’s weight and eating habits. So we’re asking parents to think about what things they have done / are doing that relate to help your child regain weight. After we discuss a few of these current and real issues you’re facing, you’ll have a video-recorded conversation on one of the identified issues of your choosing with X. Once the conversation is completed, you and Y will view the video-recording of the conversation you just had.

- Explain the time:
  There is no set time limit to the conversation we have together about the issue you choose; however, in previous studies using this method conversations typically go on for approximately 15 minutes.

Start Warm-up:
Before we go onto these things, we would like to take a few minutes to get to know you and your child. Can you tell us a bit about him / her? How did you come to find out about the diagnosis? How was that for you? What have you done / and what do you continue to do to help you and your child regain weight?
Joint Conversation (with single parent): Weight Restoration Action

- Employ **non-directive reflections** that allow the participant’s experiences, actions, and actives related to the topic unfold.
- If necessary, and if appropriate, use summarizing and paraphrasing to help the participant keep on their chosen topic.

**Transition from Interview to Self-Confrontation**

- Have Demographics Form ready and give to participant(s) to complete

**Video-Assisted Self-Confrontation**

- Have ‘thought bubble’ image in sight
  
  *You and I are going to review the video-recording of the conversation you just had. I’m going stop the recording at pre-established intervals (e.g., 1 minute), and invite you to recall your thoughts and feelings occurring at the time of the action. This procedure will be repeated until the entire videotape of the conversation is completed.*

- Stop after each minute – ask the participant: “*what do you recall thinking or feeling in that minute?*” or “*How did it feel to say that in that moment*”?
- Allow the video to play to completion of the thought / idea, rather than rigidly adhering to the minute-by-minute framework.
- Before resuming the video-play back, ask: “is there anything else you’d like to add?”
- Note the start time when you resume the video-play back.

**Post-Interview Checklist**

- Debrief with the participants – “How was that for you?” “Do you have any questions?”
- Quickly scan the demographics and consent form to ensure no important omissions
- Obtain verbal permission to contact the participant should further clarification be needed upon transcription and analysis. Circle participant’s answer
  
  Yes
  No

Phone # & Conditions for Call Back (e.g., no message, do not identify yourself, only call work):

**Reflections on the Interview**

- What did we do well?
- What might you have done differently?
- Now you’ve done another interview, what else have you learned or what other wisdom have you gained?
Appendix F: Demographic & Biographical Information

Your Age: _____
Child’s Age: _____

Your Sex:
□ Male
□ Female
□ ____________________

Your Educational Background:
□ Some high school
□ High school
□ Some post-secondary
□ Post-secondary degree
□ Some graduate study
□ Graduate degree
□ Other: ____________________________

Employment Status: Are you currently...? [check all that apply]
□ Employed for wages
□ Self-employed
□ Out of work & looking for work
□ Out of work but not currently looking for work
□ Homemaker
□ Student
□ Retired
□ Unable to work
□ ____________________________

What is your ethnic / cultural background?

Can you estimate in which of the following groups your household income falls?
□ Less than 10, 000
□ 10, 000 to less than 20, 000
□ 20, 000 to less than 30, 000
□ 30, 000 to less than 40, 000
□ 40, 000 to less than 50, 000
□ 50, 000 to less than 60, 000
□ 60, 000 to less than 80, 000
□ 80, 000 to less than 100, 000
□ 100, 000 or more
□ Prefer not say

What is the relationship between you and the adolescent in weight restoration? (e.g., daughter, son, stepson, niece, etc.)

If employed: Has involvement in your adolescent’s treatment required changes in your work schedule?
□ No
□ Yes (please explain, use back if more room needed):

To your knowledge, how long has your adolescent had an eating disorder?
Since: ________ (approximate date month/year:)

Has your adolescent ever received in-patient care for his/her eating disorder?
□ Yes
□ No

How many months have you been engaged in parent-led weight restoration?
____ months

Have you or a family member ever been diagnosed with an eating disorder?
□ Yes (myself)
□ Yes (family member). Relation: ____________________________
□ No
□ Unsure: ____________________________

Marital Status:
□ Married
□ Widow
□ Separated
□ Divorced
□ Single
□ _______________

How many people total live in your home?

How many children under 19 live in your home?

How are these children related to the adolescent undergoing weight restoration? [check all that apply]:
□ Biological
□ Half-sibling
□ Adopted
□ Step
□ _______________

What was your country of birth?

What was the date (month/year) your family began treatment for the eating disorder?

To your knowledge, what eating disorder does your adolescent have?
□ Anorexia Nervosa
□ Bulimia Nervosa
□ Eating Disorder, Not Otherwise Specified
□ Unsure
□ _______________
### Appendix G: Codes for Analysis

**Acknowledges**  
Minimal statement, such as um-hummm, that acknowledges the statement by the other.  
“Yes”, “sure”, “OK”,

**Advise**  
I think the best idea for you is to get a job in the short term and then think about your educational concerns in the long-term

**Agrees**  
“Yes, I agree”; “that’s true”; “you’re right”; “I concur”; “We see eye to eye”

**Ambiguous Response**  
Response is unclear, not readily interpretable, has more than one possible meaning, hazy or fuzzy meaning

**Answers Question**

**Apologizes**  
“Sorry, I apologize”, “Opps”, “my bad”

**Approves**  
Positive evaluative or judging statement (affirms)  
“It’s a great idea that you’re _______”

**Validates**  
“That’s fantastic”, “it’s good”, “it’s fine”

**Asks for clarification** (further explanation or expansion)  
“How do you feel about that?”  
“What does it feel like when you _______?”  
“Tell me more about that sadness”

**Asks for justification or reasons**  
“When was it that you moved out of your parent’s home?”

**Asks for opinion or belief**  
“What was your rationale for making that choice?”

**Asks for speculation or hypothetical scenario** (challenges)  
“What if...?”  
“Let’s say _____ happened? ”  
“How do you think you would handle that?”

**Clarifies**  
Usually in response to ‘asks for clarification’. Involves giving more information to clear up an ambiguity or misinterpretation

**Complains**  
“My employer gives me every crappy shift. It ruined my weekend plans.”

**Confirms**  
“So you are coming for dinner tonight?”  
Response to a request for future information

**Continues other’s statement**  
After an interruption  
Continues own statement after a pause

**Demands**  
Tells the other what to do
**Describes the future**
“My mother will be visiting next week.”

**Describes other** [in the annotation, mention who the ‘other’ is]
“It seems to me that you ________ “(is usually used with express perception)
“It sounds to me that your sister is really trying to work things out with the family”

**Describes the past**
“I told my mother that I was grateful for everything she’s done for me.”
“I went to college 5 years ago”
“When I was a kid, I was bit by a dog and now I can’t seem to get over it”
“I used to hate my brother”

**Describes possibility or hypothetical situation**
“If I can’t get into UBC, I know I will be disappointed”

**Describes self**
“I suck at tennis”
“I’m a generous person”
“It really wasn’t like me to behave that way”

**Describes situation or event**

**Disagrees** (denies)

**Disapprove**
Negative evaluation or judging statement
“I don’t like them”
“She really should have known better than to behave like that”

**Dismissive or diminishing statement**
“Oh, c’mon”, “Don’t be silly”, “That’s nonsense” “Whatever”

**Elaborate**
Extends a previous statement
Provides more information, adds depth to a previous statement, gives a deeper explanation

**Evaluative or judging statement**
Focused on a phenomenon, or event, or person with approving or disapproving

**Expresses anger**
Irritation, exasperation, rage, disgust, envy, torment
“I was so pissed off with him”, “I was furious”

**Expresses belief or disbelief** (concrete as opposed to tentative)
“I just know things are going to work out”; “I don’t believe in God”; “I can’t believe this is happening to me”

**Expresses desire**
I need, I want, I wish...

**Expresses disgust**
Usually more of a facial expression, distaste, expression of not liking or loathing
“It totally grossed me out. It was disgusting to be in that cell with all those crack addicts”

**Expresses dissatisfaction**
“School isn’t what I thought it would be”
Expressions of dissatisfaction; sometimes coded with expression of sadness or some other emotion

**Expresses doubt**
“I’m not sure I can handle that; I doubt I have the ability to get into university”
Questioning – has emotional content; not about indecisiveness
“I don’t know about that, I don’t know if that fits for me”
Possible others – disagrees, dismissive statement

**Expresses fear**
Horror, nervousness
Overwhelmed, expressing a lot of concern

**Expresses frustration**
“It totally sucks that I didn’t get the job I wanted”
Expresses gratitude
“Thank you”; “I really appreciate what you’re doing here”; “I’m thankful for this opportunity”

Expresses humour
Tells a joke, says something funny (either intentional or not)
Contextual use of humour, use of wit, lightheartedness, kidding around

Expresses joy
Happiness, cheerfulness, zest, contentment, pride, optimism, enthrallment, relief

Expresses like
Liking of idea, object, person; not love

Expresses love
Affection, lust, longing

Expresses perception or opinion or hunch
It’s usually a tentative statement or interpretation
“It seems to me that you may be quite similar to your dad in that way”; “Correct me if I’m wrong, but I think....”

Expresses realization
expresses an ‘ah-ha’ moment in the present tense
“I realize that these people are very important to me”; “Wow, I never thought about that before” (add surprise to the code);
“Oh no, really. I hadn’t thought about that consequence before” (add disappointment to the code)

Expresses sadness
Suffering, disappointment, embarrassment, shame, neglect, regret, sympathy
“I was so depressed about it”; “I was really hurt when my stepmother attacked me like that”

Expresses surprise
More of a facial expression
“Oh wow!”; “I was really surprised that she reacted that way”

Expresses Uncertainty
Is about decision-making, not being able to sort something out, not able to accurately predict
“I’m not sure”; “I can’t decide what option to take”

Expresses understanding
I get that; I see where you’re coming from; That makes sense; I see what you mean

Expresses worry
“I’m worried about my exam”

Incomplete statement
Can be questions, statements, or sentences

Interrupts
Invites or elicits a response
Use of a hand gesture to elicit a response from a client
“you know what I mean?” “right?”

Laughs

Paraphrases
Repeats a pervious statement; repeats a previous statement in your own words

Partial agreement
“Sort of”; half-hearted agreement

Pause
Silence; a pregnant pause; a break in the sentence or dialogue

Praises
Compliments, admiring remark, accolade, congratulates
“good for you”, “look at you”, “congratulations”, “it’s terrific that you have such great insight”
Provide explanation

Provides example

Provides information
“You can get an application on line if you go to the website”

Reflects affect
Capturing an image that is beyond what was previously stated
Beyond paraphrasing
Advanced empathy, empathy
“You felt disappointed when you didn’t get into UBC this year”

Reflects cognition
Advanced empathy, empathy
“That was a tough situation for you”; “You didn’t think that was the right way to go”; “So you’ve been thinking about a number of career options over the last year”

Requests
Asks the person to do something; Asks for
“Could you sign this form?”

States a plan
“I’m going to go to school next term”; “I will be here next week for my appointment.”

Suggests
“I’d like to suggest that your father didn’t mean to hurt your father”

Summarizes

Unintelligible response
Cannot be understood on tape or though interpretation
Appendix H: Case 1 Supplemental Data

Implementing Meals

Pamela reported many goal-directed actions related to the practical implementation of meals. In keeping with family-based treatment goals, Pamela reported goals related to preparing and supporting Heather’s completion of meals containing sufficient calories. Pamela reported internal processes of “not knowing” how to do re-feeding that motivated action steps related to informing herself through consultations with a dietician, researching information online, and purchasing books:

And trying to deal with, like-, the meals thing. I did go to a dietician. And we did have a couple of things. But her suggestion was like, was around 3300 calories a day. I’m going...”3300 calories a day! And 3600 on the day she rides!? Start trying to put that into something and try to pack that into a day!” And with a kid who is eating really, really slow...you barely finish one meal and she's onto the next one and you're trying to pack all this stuff in. AND, she's like, going, “I don't want to eat it.” (JC4)

Facilitating the ideal conditions for Heather to complete meals was also an important goal for Pamela, and she discovered knowing the menu in advance helped Heather’s eating. Pamela reported engaging in action steps of creating a store of weekly menus in Excel, consulting a dietician for advice on foods to include, locating resources online to make high-calorie menu planning easier, and dealing with Heather’s anxiety when menus are not prepared in time. These action steps were motivated by internal processes of feeling let down by the professional advice (SC4: “But she, the dietician, would send me like-, some recipes and I’m going like, ‘Oh, well, three of those things work...’”), and feeling stressed and pressured to fit menu planning into daily schedule that was already bursting:

There is a big focus on food. Like...”When is the next meal? What am I having? [Are you] going to be posting a menu...?” The menu has been the bane of my existence. I've always said, it's like a four-letter word, m-e-n-u. (WU5)

Elements of time constraints and limited financial and energy resources, as well as Pamela’s need to manage stress and achieve pressing occupation-related goals, motivated a sequence of goal-directed actions related to making meal preparation and implementation more efficient:

I’ve learned a few tricks...cooking a big batch of quinoa and putting it in the freezer.... then just taking it out what we need, throwing it into the microwave. So it’s one less
thing as part of the meal for me to do. So, trying to-, sort of, streamlining it a little bit (WU60) Despite the streaming-lining strategies, Pamela continued to be pressed for time to complete her occupation goals:

Go take her to riding or pick her up off the bus, and then back to work, and then do snack...and then do dinner and then do snack [again] and then (laughing) ...somewhere in there fit in, you know, get my office at 11 O'clock and go, "Okay, I need to get some work done". Yeah, and trying to get some sleep...yeah.” (JC211)

Pamela’s goal of supporting Heather’s calorie consumption and weight gain was realized by action-steps of trying to achieve the ideal conditions for meal completion. Pamela reported cognitive process of figuring out how to help Heather eat via trial-and-error (“Figuring out what worked for her. That, okay, “This is how I can get her to eat. If I do this, she'll eat.” SC861), which included actions like sitting beside or across from Heather during meals, not discussing food, watching the television for distraction, and simple verbal prompts:

Okay, you need to eat. Maybe you want to leave that fork in your hand, even if you’re not using it”....cause she would just like put the fork down, and once she got the fork and knife put down, getting it picked back up again was really huge. (JC220)

Pamela also reported action steps of travelling to Heather’s school on week-days to each lunch with her. Restaurant meals were infrequent for Heather at the time Pamela was interviewed, but when they did happen, Pamela reported using more eye-contact and facial expressions to subtly direct Heather’s attention to her eating. She also reported taking various actions steps intended to help public meals go smoothly:

We went out for dinner in March for my birthday. And we got the menu ahead of time, figured out what we were going to order, talked about it ahead of time, got them to bring us a spare plate, and we-, I took off...because it was a fairly big meal...and so I took off some. And then, "Now, okay, you need to eat that". And then made sure we had lots of time to eat while we were there. And since then, I think we’ve done a couple of meals at Subway, which...what I find with her, because it’s anxiety, once she actually does something....and gets though it, and it’s a 10/10, then next time it’s a 9, if it’s exactly the same thing. (WU81)

For meals involving other people, such as Heather’s father or extended family, Pamela reported internal emotional processes of feeling stressed (”[Those meals are] stressful for me too because I'm like, trying to like manage....what's going on because I can feel Heather getting worse and worse, right? And, and just trying to deal with it, right? “ JC17) which again motivated various actions steps related to the goal of creating ideal eating conditions (“Keep
trying to redirect it to something else that’s not food. Something else that we all kind of want to talk about. Try to-, try to do that.” JC18).

Monitoring Heather's Progress

Pamela also reported internal processes and taking action steps related the making and monitoring progress on Heather’s weight restoration. Pamela’s approach to weight restoration was planful, strategic and intentional, and her comments suggested an internal process of monitoring Heather’s progress in over-coming various eating disorder behaviours, such as how long she takes to complete a meal (“It’s that 45 minutes [to eat a meal]. But it was, you know, an hour to an hour and a ¼” WU46) or the importance of everyone eating the same food (“[It’s] more comfortable for her if we’re all eating the same meal...it’s getting less important. It was more important in the beginning” WU100). Sometimes Pamela noted feeling encouraged at seeing progress, which contributed to feeling more confident in herself. Other times, when beholding slow or no progress (e.g., like finding a second bag of lunch snacks hidden in Heather’s room), Pamela felt frustrated, discouraged, and confused:

And we went through all that stuff [with the counsellor]. And to find the second bag. And find so much in it was just, “agghhhh” [exhaling, frustrated], you know? We're not getting anywhere...! I mean, I do feel since I did find that, that it is slowly-, I mean we are slowly getting better. (SC425)

I find that bag of stuff, and I'm going, like... I don't know what to do with this! I don't know whether to talk to her about it? I don't know whether to talk to [counsellor] about it? I-, because I did that already. That did- nothing changed...she’s doing it again (SC442)

Pamela reported shoring up resolve to keep working toward weight restoration by reminding herself of how far they had come, recognizing genetic factors are at play (“And thinking to myself, too, about you know, wow, genetics really do kinda...you know what I mean? Like it really does” SC377), and connecting with the personal sense of herself as someone who overcomes hardships (“Proof positive one person can do it! You can do it! [Interviewer: You are}) Yep. (laughs). Which I kind of knew...[Interviewer: You knew you'd make it...). Oh yeah, that we could. Well yeah. Yeah. Sure.” SC616).

The monitoring of Heather’s progress with meal completion and eating disorder behaviours was itself an action step in service of other goals Pamela held for herself (e.g., a personal heath project, see below), and also served as feedback that she used to realize her goal of supporting Heather to assert herself and act with more autonomy. Pamela reported internal processes of problem-solving when and how to step back from some of her meal support
activities, wanting to trust, and not wanting to rescue in the context of feeling of anxious for Heather’s well-being:

And now, sort of going, “okay, where do I let go of stuff?” I don't know. So, we've developed that new pattern, and that's fine, [but] there's still a part of me that still really worries about it. But at the same time, you kind of go, “Okay, I need to, you know, trust that she is getting better and that she'll start doing some of the stuff on her own”. So, trying to...less helicopter parent! (laughs) ‘Caus-, ‘cause you're still somehow the helicopter parent... (SC863)
Appendix I: Case 4 Suppplemental Material

David and Marie’s Help Seeking Experience

In time before Amanda received the diagnosis, Marie and David consulted professionals with concerns about potential food allergies or psychosomatic stresses being the source of their daughter’s appetite loss, stomach pains, and steady weight drop. Neither of them expected an eating disorder was underlying their daughter’s symptoms, which also included self-harm, very low mood, and suicidal ideation:

...Finally one doctor said, “I didn’t find anything. That’s psychological”. And, uhm, we looked out for help, for a counsellor. And we thought, well, there must have been some stress related to her social life, in school, or this or that. Uh, but we never thought it would be an eating disorder. (WUD17)

I, naively, I thought an eating disorder in our family would be...what would be the right things to say...I mean, I didn’t consider it possible. Because, I always tried to be raising-, I have 2 girls, and I was, you know, positive body image and never-, you know, I never put the focus on dieting or, you know, to look great or something. I mean, that’s how we raised them. (WUM6)

The role of the eating disorder in Amanda’s problems was finally understood after presenting at their local emergency room (“She sort of reached out herself. She said, “I need to go to emergency. I can’t stand it anymore”. She wouldn’t tell us. But then she would tell the emergency nurse. And the emergency nurse told us” WUD39). Amanda began seeing a child and youth therapist and a psychiatrist in her community, however neither suggested the re-feeding approach of family-based therapy (The psychiatrist, he even went the opposite. He said to Amanda, “Eat. You decide. You eat whatever you feel like” And then it got so bad that she lived on, I would say, I could gestimate that it was 500 calories a day that she ate.” WUM87). Motivated by feelings of desperation and fear for her daughter’s life (“I mean for me, it’s so hard. I watch my daughter die in front of my eyes real slowly. And I’m absolutely helpless” WUM60), Marie began researching and found information on family-based therapy. She and David both agreed the approach made sense to them, and they attempted to implement it at home on their own with Amanda, but with minimal success:

And we watched the videos very carefully. And, sort of agreed on the main points. That the parents have to be...very strong. They have to be in agreement. They have to make a deal with your kid. We started that, uhm, but we didn’t really know...how to handle it well. Looking-, looking back. (WUD74)
The problem was, of course, Amanda wouldn’t support it, because it was something that “you guys made up and you forced me to”, and it-, “and my doctor said something else.” (WUM89)

A month or so after their visit to the hospital emergency, Amanda agreed to inpatient treatment at an adolescent psychiatric unit where the re-feeding approach of family-based therapy was used. With the backing of the treatment team at the hospital, and a specialized eating disorder clinician at discharge, David and Marie began the difficult process of refeeding Amanda at home in earnest:

And then we looked at the videos, and they made sense. So we sort of agreed on that. But then we didn’t really have support from any of our therapists or our psychiatrist, as such. When we sort of got the big agreement, what will work, and where we can sort of work together, was when she was in the hospital. So at that point, I felt sort of, “okay, we have a plan”. Before that, we often felt, we don’t have a plan. We’re getting desperate. (WUD111)

The decision that led to the meal plan, that was fairly easy. And David and I agreed, you know, this makes sense, this is what we’re going to do. But then, uhm, how it would work, that was very difficult. (WUM117)

**Implementation of Meals and Re-feeding**

In the beginning, Marie shared how the actions of re-feeding and weight restoration created both practical and emotional struggles for her. Practically, the responsibility of ensuring the meals she prepared for Amanda were of sufficient calories was daunting (“I cook from scratch. I try-, you know healthy, organic foods and stuff. And-, I’m just-, so suddenly, okay, “what is that that I’m cooking? How much calories is that? How many-, you know, how do I portion it out?” And, so that as one struggle in “how do I do it?” WUM122). Marie’s emotional struggle was linked to how the re-feeding actions were felt to be in sharp conflict with her role in relation to her daughter and her goals of being caring toward her (“David is very, you know, “this is logical, this makes sense, let’s put it [food] down there”. And, this is where-, for me, a personal challenge arose. It was-, you know, I want to be caring, understanding to my daughter.” WUM120). In the beginning, the conflict was so great that Marie could not bring herself to do meal support with Amanda (“Oh my god. I’m going to put so much food in front of her, and demand for her to eat it”. And-, and I know she can’t. You know, so I felt very sorry for her.” WU128M). Marie explained a personal transformation was needed for her to appreciate how some of her re-feeding actions motivated by caring and understanding (e.g., allowing Amanda to eat half her food, to avoid eating certain foods, or skip
snacks if she was not feeling well) were hindering and not helping the goal of weight restoration:

That I realized, you know, it triggered something in myself. And, I needed to work through that. So, now I can talk about it because I understand what happened to me. But, uhm, it was-, a real struggle. Because it took me a quite some time to understand that by my-, by me-...We’ve had this role, unfortunately. You know, me-, I’m the kind one, the understanding one and David sets the rules. And he’s, you know, the disciplinarian, kind of. And, uhm, it took several weeks, or months I would say, for me to understand that with-, by me being kind, I was prolonging her illness. Uhm, so I had to really-, that was-, you know, I-, I had to kind of, in a way, really change who I was. And-, and-, and that was tough for me. But it was absolutely necessary. (WU140M)

David recalled his goal during this time was quite clear and straightforward: to follow the hospital instructions and know for certain Amanda was receiving sufficient calories.

So we knew it’s 2500 calories. And, uhm, I said “So, Marie, let’s do the plan, like we learned. Let’s put it visible, written somewhere-, where she can see it, and she knows this is the deal we agreed on, and sort of knows the times when she needs to sit there”. And Marie sort of put a high level plan together. And, I said “I want the details. Did you count the calories?” And she said, “No I can’t”. And I realized she cannot. And I thought, “Okay, we have to”. I will, uh, I will start a little argument. And, we had quite some arguments and I said, “Marie, if we are off a little bit, if it’s 2400 or something, I’m fine. But, I cannot guess. I want to know. Let’s count the calories”. And that was very, very hard because I realized she couldn’t do it at that time. And, uh, I said, “Marie, let’s do it. Otherwise, I disagree. And it’s-, it’s not working”. (WU134D)

Some of the helpful things for David and Marie during the early re-feeding phase included having the backing of the hospital doctors (“Yeah, sort of saying, “It’s not us. We’re backed up by BC Children’s, and our doctors who said. It’s not that we invented [this], or we force you. You sort of, this a disease, it is so strong, this is the treatment. You need to follow that. If not, you need to rest.” WUD201), making meal plans, deals, and gaining agreement on the menu with Amanda ahead of time (“When she sort of says, “You know I don’t eat this”. I said, “Amanda, we agreed on it, and uh, we know you have a limited choice, but we agreed to...sort of, talk about it the day before.” WUD201), and externalizing the eating disorder:

The disease is so strong, yeah. And-, and you need to be stronger than the disease. That’s the saying. That’s it. She had-, how do you call it? Relapse? Where she would all of a sudden crash again, and just...not eat anything. “Okay. That’s the disease.” (WUD207)

David noted how early on in the process he tried to understand eating disorders better through books and information recommended by professionals, and both he and Marie noted that letting go of trying to understand the root cause of their daughter’s eating disorder helped
them focus on re-feeding (“Like, and I talked to the doctor, and she said, ‘Doesn’t matter. Even if we found out, it wouldn’t help us right now. Better forget it. We don’t know.’” WUD230). Marie noted that watching Amanda get worse and worse, despite the help they were receiving, helped her let go of trying to identify the underlying cause:

Maybe then [when emergency staff told them to clear Amanda’s room], for me, it clicked that I thought, “It doesn’t matter why, it doesn’t matter-, kind of-, it just-, what matters right now is saving my daughter’s life”. Whatever it takes, I have to save her life. And that made it easier. (WUM236).